



State of Illinois
Illinois Department of Public Health

Illinois Comprehensive Cancer Control Plan, 2012-2015

August 2012

PREFACE

The U.S. Centers for Disease Control and Prevention (CDC) defines comprehensive cancer control as “an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention (primary prevention), early detection (secondary prevention), treatment, rehabilitation, and palliation.” The concept is built on the recognition that effective cancer prevention and control planning and programming should address a continuum of services that range from primary prevention and early detection through effective treatment, quality care, and end-of-life issues.¹

From a cancer control perspective, cancer is best described as “a process that starts in health and progresses through events that cause normal cells to acquire the properties of malignancy...”² The process continues from there until remission or death. Cancer control involves fighting this process at every stage from health to death. It means primary prevention, early detection, treatment, palliation and helping patients and their families cope with the ravages of disease processes.

The CDC’s goal for Comprehensive Cancer Control (CCC) is to address cancer through integrating and coordinating a complete range of activities to achieve maximal impact on a population’s cancer burden using the limited, available resources to accomplish desired cancer prevention and control outcomes.¹ CCC requires a broad partnership of public and private sector stakeholders whose common mission is to reduce the overall cancer burden within the jurisdiction.

Comprehensive Cancer Control is based on the following principles:¹

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

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

The Illinois Comprehensive Cancer Control Plan (plan) provides a framework for action to reduce the burden of cancer in Illinois using the principles described. Its purpose is to provide an organized approach to cancer prevention and control efforts for the entire state of Illinois. This plan is intended for use by individuals and organizations, in all areas of cancer prevention and control, statewide. The goals are broad and directed at all populations in Illinois. Based on the priorities identified here, this plan presents recommendations and examples of strategies intended to support a statewide, community-based and community driven approach to comprehensive cancer control.

In order for the vision of the plan to be achieved, the strategies must be implemented. This plan will serve to mobilize individuals, organizations, institutions and communities committed to fighting cancer. These groups can use this plan to select and implement strategies that are consistent with their own priorities and missions. Effective implementation of these diverse strategies will require an ongoing, coordinated and collaborative effort. All partners must use the plan to have the greatest impact on cancer prevention and control in Illinois.

The Illinois Comprehensive Cancer Control Plan is a product of extensive collaboration by contributing partners. In part, it is adapted from the preceding plan: *Illinois Comprehensive Cancer Control 2005-2010 State Plan*. Some of the structure and language of that prior plan has been retained in this updated document.

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EXECUTIVE SUMMARY

The Illinois Comprehensive Cancer Control Plan provides a framework for action to reduce the burden of cancer in Illinois. Its purpose is to provide an organized approach to cancer prevention and control efforts for use by individuals and organizations, in all areas of cancer prevention and control throughout the state.

In 2012, 65,980 Illinoisans will learn that they have cancer. Cancer is the leading cause of death for Illinoisans between the ages of 45 and 64, and is second only to diseases of the heart as being the most common cause of death in our state. For Illinois men, lung, prostate and colorectal cancers were the top three cancers, accounting for 51 percent of all cancer deaths during the period of 2002-2006. During this same period, lung, breast and colorectal cancers were the top three cancers, accounting for 50.8 percent of cancer deaths, in Illinois women.

During the period of 2009 to 2012, cancers in Illinois men are projected to increase by 1,520 additional new cases while cancers in Illinois women are projected to increase by 1,130 additional new cases. The top three cancers projected to increase are prostate, lung and colorectal in men and breast, lung and colorectal in women.

Disparities in access to cancer prevention and treatment, related to ethnicity, race, economic status and distance from high quality health care services, increased the overall cancer burden among residents of Illinois. For example, compared with white Illinoisans, ethnic minorities are a disproportionately more likely to lack health insurance. Approximately 10 percent of the white population in Illinois was uninsured in 2009, while African Americans had 19.5 percent uninsured and Hispanics had 25.6 percent, more than twice that of the white population.

This comprehensive cancer control plan has been developed through the collaboration of volunteers from across the state who dedicated themselves and their time to moving comprehensive cancer control forward. Those volunteers, with assistance and direction from the Illinois Department of Public Health, addressed six priority focus areas: Primary Prevention, Early Detection, Access to Care, Survivorship, Data and Surveillance, and Research and Clinical Trials. Assessments of these priority focus areas, along with related goals, objectives and intervention strategies, are presented in the contents of this plan. The

Illinois Cancer Partnership (ICP) and other stakeholders will be involved in the plan implementation process and will be responsible for collecting data and reporting outcome measures to measure progress toward the outcomes of the intervention strategies.

INTRODUCTION

In 2011, an estimated 65,610 Illinois residents learned that they have cancer. Cancer is the second most common cause of death in Illinois, but for persons between the ages of 45 and 64 in Illinois, cancer is the leading cause of death. Cancer incidence and mortality are not just health problems. Cancer is also an education problem, an economic problem, and a quality-of-life problem. “Cancer is a complex set of diseases that must be understood from multiple perspectives,” according to the National Cancer Institute.³

Researchers are learning more about the causes of cancer and how it grows and progresses. They also are looking for new and better ways to prevent, detect, diagnose and treat it and ways to improve the quality of life for people with cancer during and after treatment. Research has led to many advances in cancer prevention and treatment, and scientists continue to search for more effective approaches. Because of this progress, many cancer victims are living longer and are enjoying a better quality of life.⁴

Cancer Definition^{4,5}

Cancer is a disease in which abnormal cells divide uncontrollably, invade other tissues, and spread to other parts of the body through the blood and lymph systems. Although there are many kinds of cancer, they all start when abnormal cells grow out of control.

Cancer begins in cells which are building blocks that form tissues that make up organs of the body. Normal body cells grow, divide, and die in an orderly process as the body needs them. When cells grow old, they die, and new cells take their place. However, sometimes this orderly process fails and cancer begins to form. For example, new cells form when the body does not need them, and old cells do not die when they should. These extra cells can form a mass of tissue called a growth or tumor resulting from abnormal cells growing out of control.

Through a process known as metastasis, some cancer cells may travel through the bloodstream or lymphatic system to other parts of the body, where they grow and form new tumors that replace normal tissue. In addition, cancer cells may originate in the blood and blood-forming organs, and then multiply throughout the body, causing harm because they displace normally functioning blood cells.

If the spread of cancer cells is not controlled by treatment, the result is likely to be serious illness and death.

Not all tumors are cancerous. Tumors that are not cancerous are called benign. Benign tumors can cause problems by growing very large and pressing on healthy organs and tissues without invading the tissues. Since they do not invade, they do not spread to other parts of the body (metastasize) and are rarely life threatening.

Cancer Risks⁴

Health care professionals often cannot explain why one person develops cancer and another does not. But research shows that certain risk factors increase the chance that a person will develop cancer. The following are the most common risk factors for cancer:

- Growing older
- Tobacco use
- Poor diet, lack of physical activity, or being overweight
- Alcohol use
- Exposure to Sunlight
- Ionizing radiation
- Certain chemicals and other substances
- Some viruses and bacteria
- Certain hormones
- Family history of cancer

Many of these risk factors can be avoided. However, others, such as family history, cannot be avoided. People can help protect themselves by avoiding known risks whenever possible. Over time, several factors may act together to cause normal cells to become cancerous.

The most preventable cause of cancer death is the use of tobacco products. Each year, more than 180,000 Americans die from cancer that is related to tobacco use. Using tobacco products or regularly being exposed to secondhand smoke increases the risk of cancer. The second leading cancer risk is poor nutrition and lack of physical activity related to obesity.

When thinking about the risk factors associated with developing cancer, the following should be kept in mind:

- Not everything causes cancer.
- Cancer is not caused by an injury, such as a bump or bruise.
- Cancer is not contagious. Although certain viruses or bacteria may increase the risk of some types of cancer, no one can "catch" cancer from another person.
- Having one or more risk factors does not mean that you will get cancer. Most people who have risk factors never develop cancer.
- Some people are more sensitive than others to the known risk factors.

Some risk factors can be avoided, such as prolonged ultraviolet light exposure or smoking. Other risk factors, such as age, race and family history, are unalterable and may increase the risk of a cancer diagnosis. Populations at high risk for certain types of cancer depend on the various risk factors such as identifiable disparities, obesity, lifestyle, environment, race or genetic makeup. Black men, for example, are more likely than white men to be diagnosed with prostate cancer. Individuals who smoke tobacco products are at high risk for developing lung cancer. There are certain populations (Eastern European Jewish, Dutch and Icelandic) that can have mutations in predisposition genes (BRCA 1 and BRCA 2) that give them a higher chance of getting cancer than people from other ancestral backgrounds. Colon cancer occurs mostly in older age groups. Therefore, screening becomes especially important as individuals increase in age.

People who believe they are at risk for cancer should discuss concerns with their health care provider. They should also ask their health care provider about scheduling regular checkups and screening tests to enable early detection and reduce the risk of death due to cancer.

Illinois Demographics

Illinois, with approximately 56,000 square miles, is the 24th largest state in land area.⁶ It has approximately 42,000 square miles in farmland which represents 75 percent of the total size. In 2010, Illinois had a population of 12 million and was ranked the fifth largest state by population.⁷ Of this population, 13 percent lived in rural areas. Illinois has 102 counties with Cook County having the largest population of nearly 5.2 million in 2010.⁸

According to the 2010 U.S. Census, Illinois' population consisted of 71.5 percent whites, 14.5 percent blacks, and 14 percent Asian and other races. Of these races, 15.8 percent were reported as Hispanic. Females make up 50.7 percent of the population.⁶ In 2009, the median age was 36.2 years with 75.4 percent of Illinoisans being age 18 and older.⁷ People older than the age of 65 represent 12.4 percent of the population.⁶

In 2009, Illinois' per-capita personal yearly income was \$28,469 and the median household income was \$53,974 with 13.3 percent of the population living below the poverty level.⁶

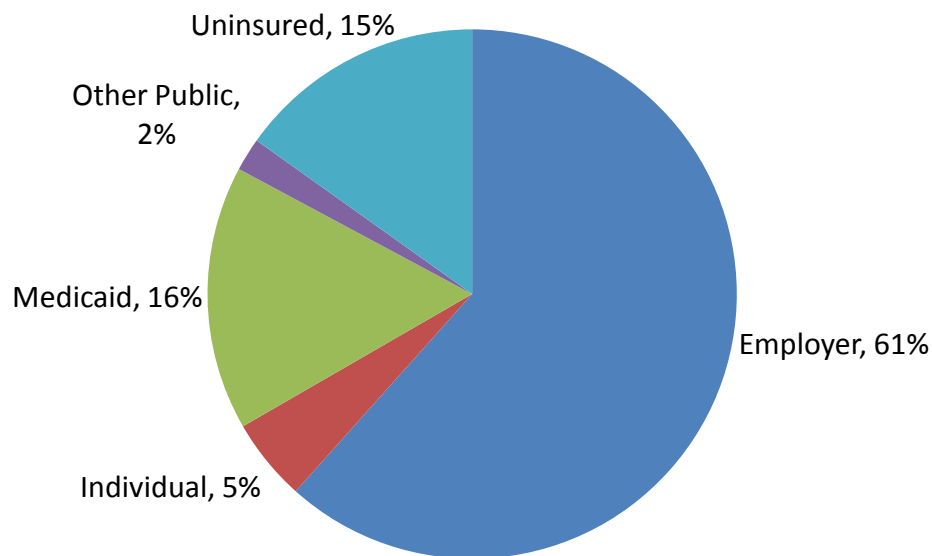
Health Care Coverage

Uninsured

Nearly 1.8 million, or 14 percent of Illinois residents, were uninsured in 2009. Being uninsured is a common disparity that is not limited to poor Illinois residents. Many people have health insurance through their jobs or are covered by a family member's employer-sponsored insurance, but not all employers offer health insurance. With the cost of health insurance premiums continuing to rise, employers are anticipated to increase cost-sharing requirements in employer-sponsored insurance plans. What is not known at this time is what the impact will be of the Patient Protection and Affordable Care Act (ACA). The ACA contains substantial new requirements aimed at increasing rates of health insurance coverage. These include a mandatory expansion of Medicaid programs to cover individuals in households with incomes below 133 percent of the federal poverty level; a requirement that states develop and run health insurance exchanges through which individuals and small businesses can purchase health care coverage; a requirement that large and mid-sized

employers – including state governments – provide qualifying coverage to employees or face the possibility of penalties; and a requirement that most individuals purchase or otherwise obtain coverage. At the time of publication of this plan it is unknown what the impact of the Patient Protection and Affordable Care Act will be for cancer patients and survivors. As depicted in Graphic 1, 15 percent of Illinois residents younger than 65 years of age were uninsured in 2009, and 18 percent received coverage through the Medicaid program. The majority of Illinoisans (61 percent) were enrolled in employer-sponsored insurance plans.⁹

Graphic 1: Illinois Health Insurance Coverage, Ages 0 - 64, 2008-2009



Source: The Henry J. Kaiser Family Foundation, statehealthfacts.org⁹

Racial and ethnic minorities disproportionately lack health insurance. Approximately 10 percent of the total white population was uninsured in 2009. The black population had 19.5 percent uninsured and the Hispanic population had 25.6 percent uninsured, more than twice that of the white population. Other racial/ethnic populations represented 14.3 percent of the uninsured in 2009.⁹

Lack of insurance frequently affects younger adults. The population between the ages of 0 and 18 represent 15.4 percent of the uninsured while those in the same age group, who are living in poverty, represent 7.7 percent of the uninsured. In

2009, 8 percent of the children under the age of 18 were uninsured compared to the national average of 10 percent.⁹

Medicaid and Medicare

The Illinois Department of Healthcare and Family Services (HFS) is responsible for providing health care coverage for adults and children who qualify for Medicaid including low-income families lacking health insurance, children who are wards of the state, low-income senior citizens, individuals with disabilities, elderly in nursing facilities, and people struggling with catastrophic medical bills. In 2009, 18 percent of the state's total population (all ages included) was enrolled in Medicaid compared to the United States average of 19 percent. Illinois residents enrolled in Medicare in 2009 represented 14 percent compared to the national average of 15 percent.⁹

CANCER INCIDENCE AND DEATH RATES IN ILLINOIS

In February 2010 the Illinois State Cancer Registry (ISCR) released a report entitled *Top 10 Cancers in the State of Illinois*. This report is a valuable resource for comprehensive cancer control in Illinois, bringing focus to the most prevalent cancers comprising the state's cancer burden, and identifying trends and disparities that will inform the Illinois Cancer Partnership (ICP) as it implements the Illinois Comprehensive Cancer Control Plan. The following paragraphs in italics are directly quoted from the ISCR report.¹⁰ However, the graphics in this section were produced by the ICP using the ISCR data. Further information on the ISCR report on top 10 cancers can be obtained by accessing the report directly on the Internet at the following address:

http://www.idph.state.il.us/cancer/pdf/ERS_10_06_Top_10_Cancers.pdf.

It was estimated that 1.5 million Americans would be diagnosed with cancer and 562,300 would die from the disease in 2009.¹¹ In Illinois, nearly 64,400 new cancer cases were projected in 2009 (32,600 males and 31,800 females, respectively), and at the same time 25,200 Illinoisans were expected to die from cancer-related causes (12,800 males and 12,400 females, respectively). Cancer is the second leading cause of death in Illinois, after only diseases of the heart. Each year, billions of dollars are spent on cancer-related health care. Cancer has emotional and physical costs as well. It affects everyone involved from the patient to family members, friends, and coworkers.¹¹

In recent years, the overall cancer incidence rate and mortality rate have declined, mostly because the rates for the three most common cancers in men (lung, prostate, and colorectal cancers) and for two of the three leading cancers in women (breast and colorectal cancers) have dropped. The rate reductions likely reflect the impact of increased screening, reduction of risk factors, and improved treatments.¹²

The majority of all new cancer cases come just from a few common cancers, and the majority of cancer causes of death also are just due to a small number of selected cancer sites. Using cancer incidence and mortality data from 1992 through 2006, this report identified the top 10 cancers diagnosed and the top 10 cancer causes of death in Illinois, by sex and race/ethnicity. (Incidence refers to the number of newly diagnosed cases during a specific time period. The extent or occurrence or incidence rate of cancer varies by age, sex, ethnicity and location. Ed.) The information presented in this report could be useful in public education of major cancer burdens and in the assessment of needs for cancer control and prevention programs.

Incidence Rates

Prostate, lung and colorectal cancers were the top three cancers in men, together accounting for more than half of all cancers, but their share has slightly dropped, from 58.6 percent of all cancers in 1992-1996 to 54.4 percent in 2002-2006. The rank of top 10 cancers did not change much. The only noticeable rank change was that melanoma of the skin has jumped from the ninth place to the seventh place; there were 2,295 more cases of skin melanoma reported in 2002-2006 than in 1992-1996.

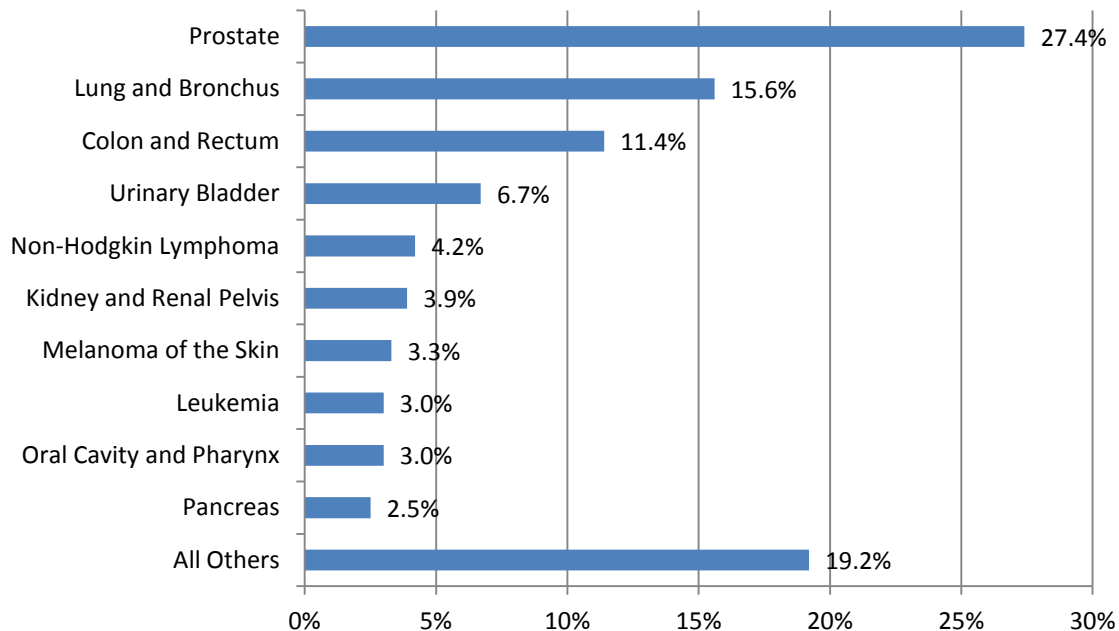
It is important to note that over the past 10 years, ISCR has increased its efforts to collect skin melanoma cases from dermatologists and labs. Prior to the effort, ascertainment of melanoma cases, especially the early stage, could have been incomplete because these cases were diagnosed and treated at physician offices which, unlike hospitals, did not routinely report cancer cases to ISCR. Therefore, the increase in skin melanoma could in large part due to ISCR's improved case ascertainment. But it also could be related to increases in new melanoma cases, greater screening efforts, or changes in diagnostic criteria.

The top three cancers in women were breast, lung, and colorectal cancers, with a combined share of 53.6 percent and 55.9 percent of all cancers diagnosed in 2002-2006 and 1992-1996, respectively. Two female only cancers (uterine and ovary) also showed up on the top 10 list.

An examination of the top 10 lists in men and women revealed that bladder cancer was common in men but not in women, while thyroid cancer was common in women but not in men.

Among men, prostate cancer was the No. 1 cancer in all racial groups and in Hispanics as well; lung cancer and colorectal cancer ranked the second and third in all racial groups, however, in Hispanics, the rank order was reversed in 2002-2006. Pancreas cancer ranked sixth in blacks but 10th in whites and Hispanics and ninth in Asians. Skin melanoma was on the top 10 list only in whites (seventh). Stomach cancer was the eighth most common cancer in blacks and seventh most common cancer in Asians and Hispanics, but it was not on the top 10 list in whites. Liver cancer was relatively common in Asians and Hispanics and was ranked fourth and seventh, respectively.

Graphic 2: Top 10 Most Commonly Diagnosed Cancers in Illinois Men, all Races, 2002-2006



Source: Illinois Department of Public Health, Division of Epidemiologic Studies, Illinois State Cancer Registry¹⁰

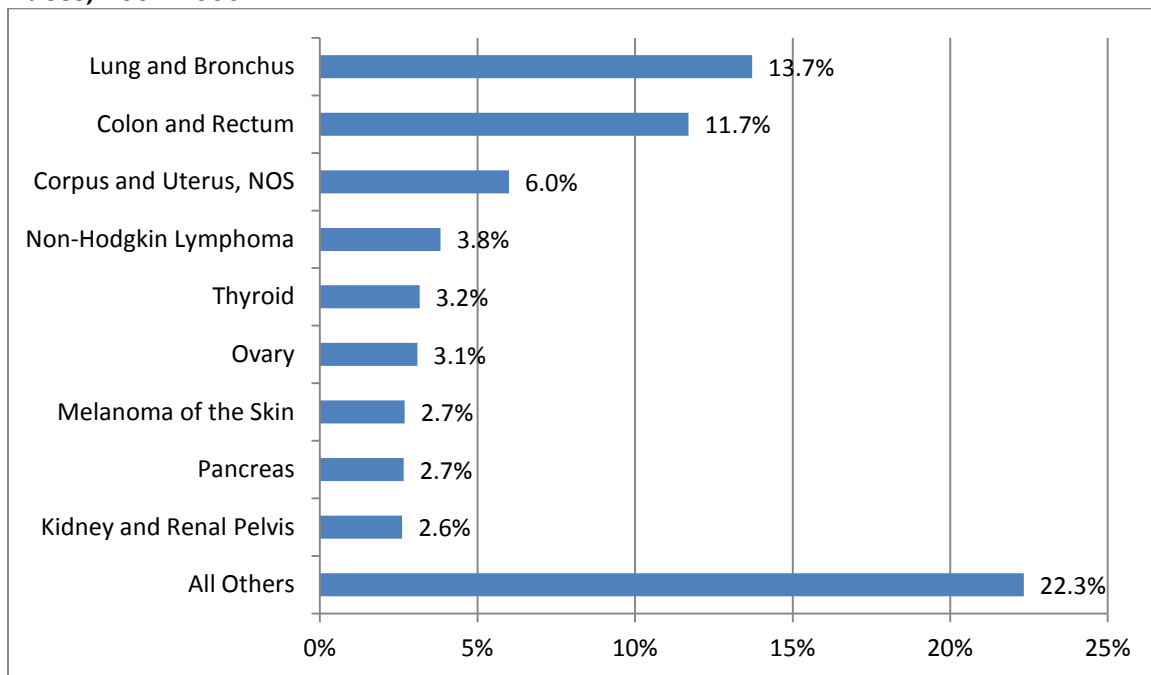
(As depicted in Graphic 2, prostate, lung and colorectal cancers are the top three cancers that account for 54.4 percent of all cancers most commonly diagnosed in Illinois men during the period of 2002-2006. For additional data and breakdowns by race and ethnicity as well as gender, please see the original report published by the Illinois State Cancer Registry.¹⁰

Among women, breast cancer, lung cancer and colorectal cancer were the top three cancers. Colorectal cancer was more common than lung cancer in Asians and Hispanics. Uterine cancer was the fourth most common cancer among all racial/ethnic groups except among Asians. For Asians, thyroid cancer was more common than uterine cancer.

Other noticeable observations of the women's cancer incidence ranking include 1) skin melanoma was the eighth most common cancer in whites but was not a top 10 cancer in other racial/ethnic groups; 2) pancreatic cancer was the fifth most common cancer in blacks and ninth in Asians, but it was rather rare in whites and Hispanics; 3) colorectal cancer incidence noticeably declined among all racial/ethnic groups except blacks; 4) cervical cancer was the sixth most common cancer in blacks and Hispanics and the 10th in Asians, but it was not on the top 10 list in whites; 5) a steady decline in cervical cancer incidence was seen among blacks, Asians, and Hispanics; 6) although cervical cancer incidence declined among blacks, Illinois black women still had the highest rate of

cervical cancer in 2002-2006 among blacks in the United States (<http://www.cancer-rates.info/naaccr/>); and 7) an increase in lung cancer incidence was observed among whites and blacks, but the increasing trend was not seen for Asians and Hispanics.

Graphic 3: Top 10 Most Commonly Diagnosed Cancers in Illinois Women, all Races, 2002-2006



Source: Illinois Department of Public Health, Division of Epidemiologic Studies, Illinois State Cancer Registry¹⁰

(As depicted in Graphic 3, breast, lung and colorectal cancers are the top three cancers that account for 53.6 percent of all cancers most commonly diagnosed in Illinois women during the period of 2002-2006. For additional data and breakdowns by race and ethnicity as well as gender, please see the original report published by the Illinois State Cancer Registry.¹⁰

Death Rates

Lung cancer was the leading cause of cancer death, accounting for more than 30 percent of all cancer deaths in men and more than 20 percent in women. The proportion of cancer deaths due to lung cancer in men has dropped slightly, from 32.5 percent in 1992-1996 to 30.6 percent in 2002-2006. In women, however, the proportion has increased from 21.9 percent to 24.8 percent during the same periods.

In men, colorectal and prostate cancers are the second and third leading cause of cancer death, accounting for about 10 percent each of all cancer deaths. In women, breast cancer was the second leading cancer cause of death, contributing to more than 15 percent of all cancer deaths. Colorectal cancer was the third leading cancer cause of death, contributing to more than 10 percent of all cancer deaths in women.

Changes to the top 10 list over time were minor. In men, the percent of death due to stomach cancer declined, and it was replaced on the top 10 list by liver cancer in 2002-2006. In women, the only change was that myeloma and stomach cancer alternated the ninth and 10th places over time.

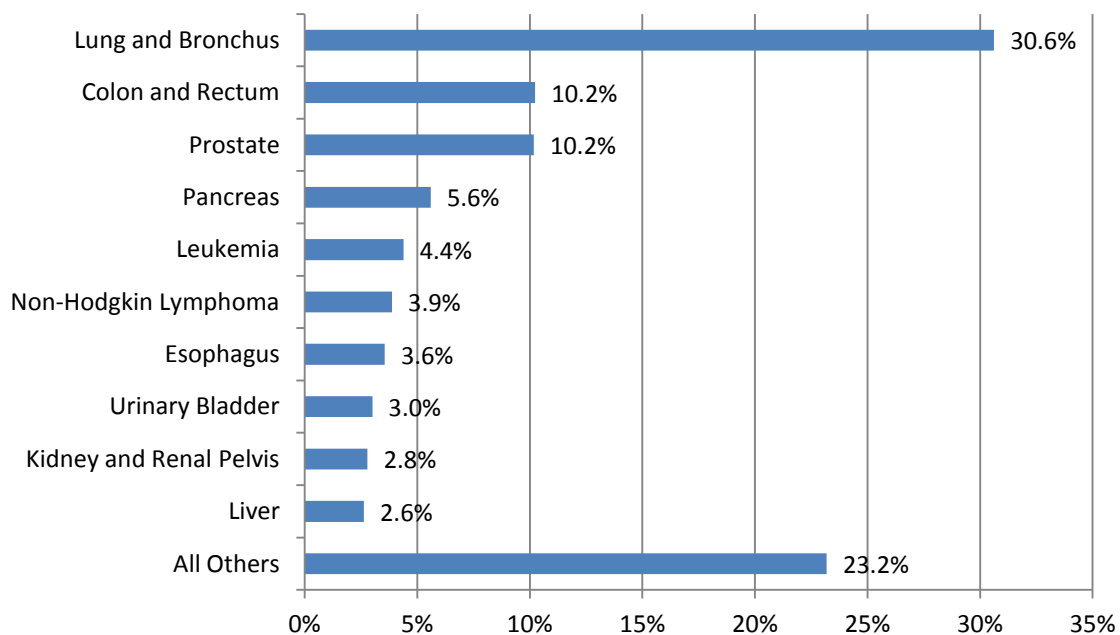
Generally, death rates of lung, prostate and colorectal cancers declined steadily in men. The death rate of lung cancer declined 16 percent from 1992-1996 to 2002-2006 in whites, 28 percent in blacks, 8 percent in Hispanics but increased 16 percent in Asians; the death rate of colorectal cancer declined 28 percent in whites, 10 percent in blacks, 35 percent in Hispanics, 8 percent in Asians; and the death rate of prostate cancer declined 11 percent in whites and 25 percent in blacks, 10 percent in Asians, and 23 percent in Hispanics.

In men, pancreatic cancer was the fourth leading cause of cancer death among all racial/ethnic groups except Asians (fifth). There was a substantial increase (53 percent) in the death rate of pancreatic cancer in Hispanics from 1992-1996 to 2002-2006.

In men, liver cancer was the third leading cancer cause of death in Asians, fifth in Hispanics, and seventh in blacks, but it was not one of the top 10 cancer causes of death in whites.

Black men had greater death rates for all the cancers on the top 10 cancer causes of death list except bladder cancer. White men had a higher death rate of bladder cancer.

Graphic 4: Top 10 Leading Cancer Causes of Death in Illinois Men, all Races, 2002-2006



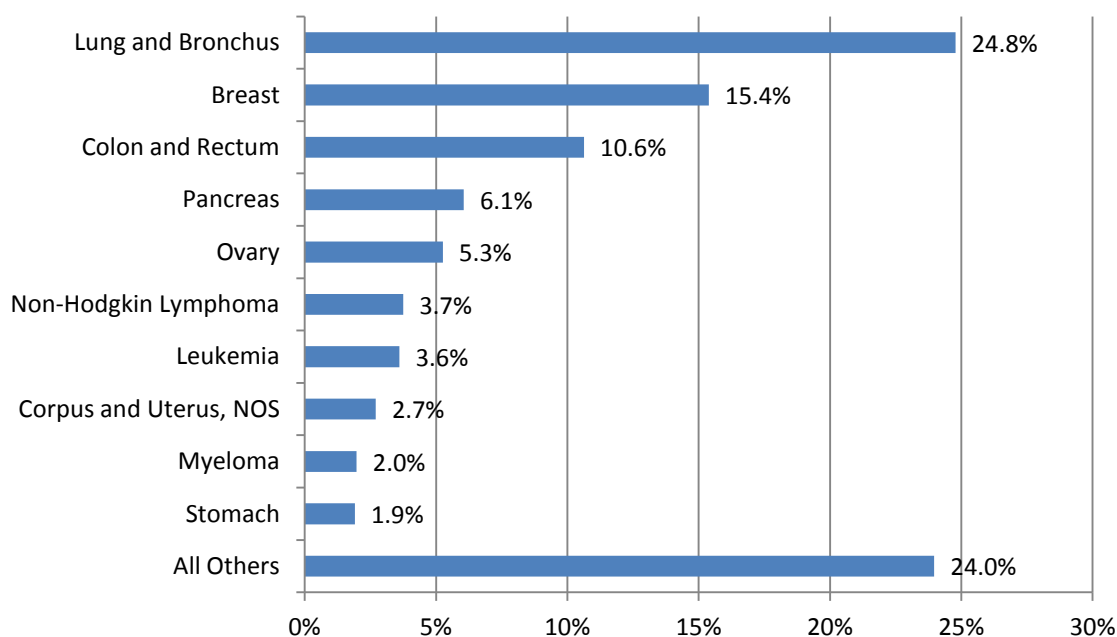
Source: Illinois Department of Public Health, Division of Epidemiologic Studies, Illinois State Cancer Registry¹⁰

(As depicted in Graphic 4, lung, prostate and colorectal cancers are the top three cancers that account for 51 percent of the leading causes of all cancer deaths in Illinois men during the period of 2002-2006. For additional data and breakdowns by race and ethnicity as well as gender, please see the original report published by the Illinois State Cancer Registry.¹⁰

In females, the substantial decline in death rates was seen for breast cancer in all racial/ethnic groups except Asians. The death rate of breast cancer in Asians increased 13 percent from 1992-1996 to 2002-2006. In white women, the death rate of lung cancer increased 5 percent during the same period.

Compared to the other races, black women also had the highest death rates for the majority of the top 10 cancer causes of death, including lung, breast, colorectal, pancreatic, uterine, and stomach cancers. White women had greater death rates of ovary and brain cancers, leukemia, and non-Hodgkin's lymphoma than blacks. Asian and Hispanic women had lower death rates in all top 10 cancer causes of death than their black and white counterparts.

Graphic 5: Top 10 Leading Cancer Causes of Death in Illinois Women, all Races, 2002-2006



Source: Illinois Department of Public Health, Division of Epidemiologic Studies, Illinois State Cancer Registry¹⁰

(As depicted in Graphic 5, lung, breast and colorectal cancers are the top three cancers that account for 50.8 percent of the leading causes of all cancer deaths in Illinois women during the period of 2002-2006. For additional data and breakdowns by race and ethnicity as well as gender, please see the original report published by the Illinois State Cancer Registry.¹⁰

Projections of Future Cancer Incidence (New Cases) in Illinois

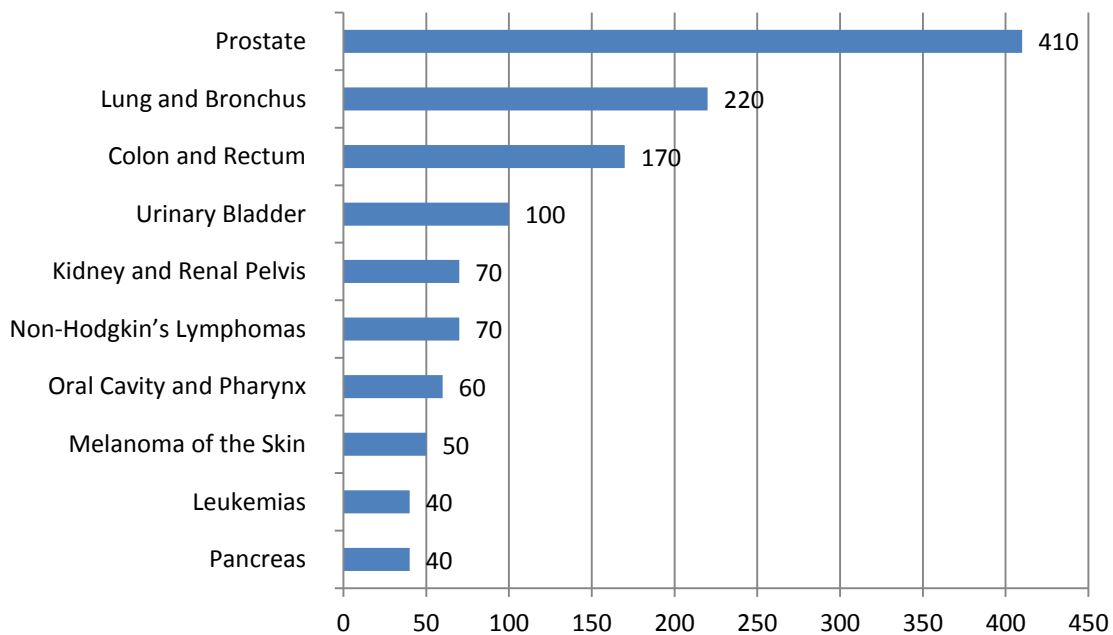
It is often reported that incidence rates for some cancers are on the decline. That is, the number of new cases per 100,000 people has been declining for some cancers. This rate change may give the false impression that the cancer burden is lessening. That is not true. The burden of cancer in Illinois is growing each year. The number of cases diagnosed each year in Illinois is actually increasing for many cancers. Graphics 6 and 7 illustrate the increasing diagnoses for the fastest growing cancers in Illinois.

The cancers listed in Graphics 6 and 7 represent the 10 cancers with the highest number of projected, additional diagnoses for men and women respectively. The values in these charts represent expected increases in new cases based on cancer incidence data from the Illinois Department of Public Health, Illinois State

Cancer Registry as of November 2010. These projections are offered as a rough guide and should not be regarded as definitive.

It is projected that cancer diagnoses in Illinois men will increase by 1,520 additional, new cases over baseline during the period 2009 to 2012.¹³ As depicted in Graphic 6, prostate and lung cancers are not only the top two cancers in Illinois men, but the number of cases of these cancers is increasing at the highest rates. These two cancers combined will increase by 630 new cancer diagnoses from the baseline of 2009 through 2012, representing 51.2 percent of the 1,230 total additional cancer diagnoses projected for men for these 10 fastest growing cancers listed in Graphic 6.

Graphic 6: Projected Increase in New Cancer Cases in Illinois Men, all Races, 2009-2012

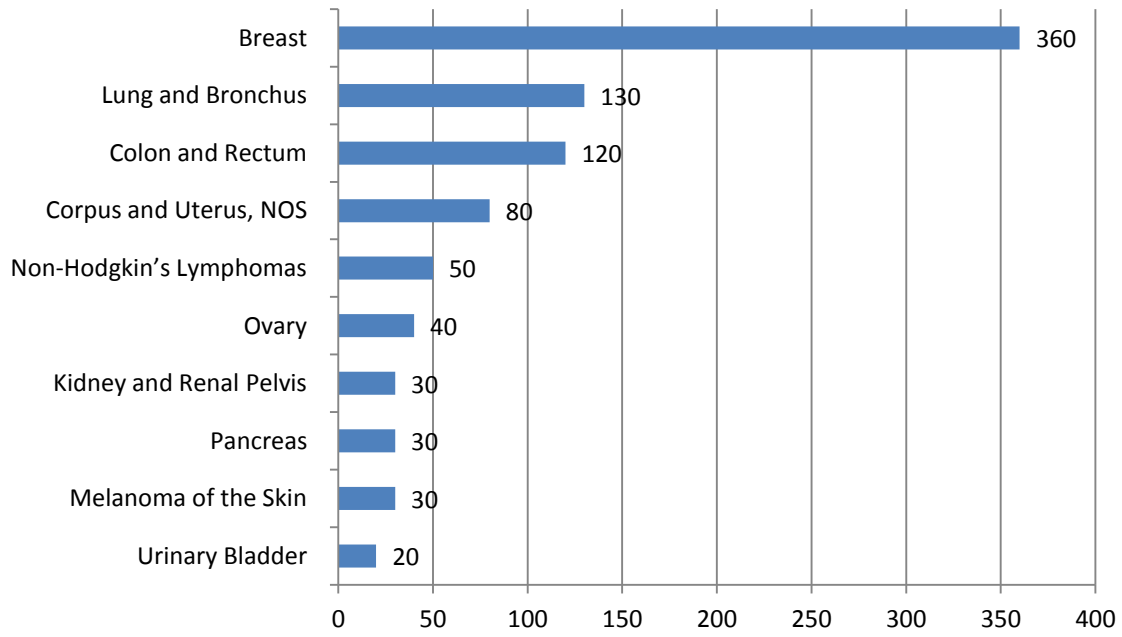


Source: Illinois Department of Public Health, Division of Epidemiologic Studies, Illinois State Cancer Registry¹³

It is projected that cancers in Illinois women will increase by an additional 1,130 new cases during the period of 2009 to 2012.¹³ As depicted in Graphic 7, breast and lung cancers are the top two cancers in Illinois women. They are also the two cancers for which the number of diagnoses is growing fastest. These two cancers combined will account for 490 new cancer cases in Illinois women in 2012

as compared to 2009, representing 55 percent of the 1,130 total projected new cancer diagnoses among these 10 fastest growing cancers listed in Graphic 7.

Graphic 7: Projected Increase in New Cancer Cases in Illinois Women, all Races, 2009-2012.



Source: Illinois Department of Public Health, Division of Epidemiologic Studies, Illinois State Cancer Registry¹³

CANCER BURDEN AND CHALLENGES FOR COMPREHENSIVE CANCER CONTROL IN ILLINOIS

Below are summaries of the findings and conclusions of the six substantive work groups who produced this comprehensive cancer control plan. The goals, objectives and strategies recommended by the work groups can provide guidance to anybody or any group interested in advancing the cause of cancer control in Illinois and are recommended to all volunteers who want to participate in this comprehensive, statewide effort.

Primary Prevention

Primary prevention is the complete prevention of disease through approaches that inhibit exposure to certain risk factors. Creating an integrated, comprehensive primary prevention program in collaboration with all the relevant cancer prevention partners will not only reach individuals at risk more effectively but utilize resources and manpower in a cost-effective manner. According to the National Cancer Institute, prevention is the first line of defense against cancer.⁴

Tobacco Use: Preventing the onset or continuance of tobacco use, people can reduce their chances of many forms of chronic disease, including many identified forms of cancer. Smoking adversely affects every organ in the human body. In the latest Surgeon General's report on the health effects of smoking, there is evidence sufficient to infer a causal relationship between smoking and bladder, cervical, esophageal, kidney, laryngeal, leukemia, lung, oral, pancreatic, and stomach cancers.¹⁴ According to the American Cancer Society, 30 percent of cancer deaths in the United States can be attributed to tobacco use.¹⁵ In Illinois, the smoking-attributable mortality rate per 100,000 population for 2000-2004 was 263.

Nutrition, Physical Activity and Obesity: An estimated 300,000 deaths per year may be attributed to obesity with the risk rising as weight increases. Overweight and obesity are associated with an increased risk for some types of cancer including endometrial (cancer of the lining of the uterus), colon, gall bladder, prostate, kidney, and postmenopausal breast cancer.¹⁶

UV and Radon Exposure: An estimated 58,000 cancers were diagnosed and 11,000 deaths were reported nationally in 2007, which could possibly have been prevented by protection from the sun or tanning beds.¹⁷ Radon is the second leading cause of lung cancer following smoking and is the leading cause of lung cancer among nonsmokers. Radon-induced lung cancer claims an estimated 22,000 lives annually in the United States and 1,160 lives annually in Illinois.

Primary Prevention Goals, Objectives and Strategies

Goal 1: Decrease the proportion of Illinois residents who use tobacco products.

Objective 1: Decrease current smoking rates for adults.

Strategy 1: Increase policy efforts that will impact smoking rates.

Strategy 2: Encourage the development and implementation of model curricula for medical schools, nursing programs, and other health professions schools.

Strategy 3: Use social marketing techniques when designing primary prevention programs directed at hard-to-reach populations.

Strategy 4: Support implementation of evidence-based tobacco prevention and cessation programs targeted at adults.

Strategy 5: Conduct targeted, planned outreach activities to educate health care professionals, the media, the public and policymakers about genomics, including ethical, legal and social issues.

Objective 2: Increase utilization of the Illinois Tobacco Quitline.

Strategy 1: Increase the number of health care providers who refer to the quitline through the Fax Referral Program.

Strategy 2: Partner with other chronic disease programs and partners to promote the quitline.

Strategy 3: Develop and strengthen partnerships with organizations working with disparate populations to increase referral to the quitline.

Objective 3: Decrease the current smoking rates for youth.

Strategy 1: Implement evidence-based tobacco prevention programs for students, especially when used in combination with youth engagement in community tobacco use prevention activities, to have a positive impact on prevention of youth initiation.

Strategy 2: Engage youth to participate in policy and media advocacy to build community linkages and community wide support for tobacco prevention policies.

Strategy 3: Encourage the development and implementation of model curricula for medical schools, nursing programs, and other health professions schools.

Strategy 4: Advocate for enforcement of youth tobacco access laws.

Goal 2: Decrease the proportion of Illinois residents who are overweight.

Objective 1: Increase the proportion of adults who consume five or more servings of fruits and vegetables a day.

Strategy 1: Increase the number of health care delivery systems engaged in comprehensive, evidence-based approaches for the treatment and management of persons who are overweight or obese.

Strategy 2: Increase public education efforts on healthy eating practices.

Strategy 3: Advocate for policies that promote and increase healthy food choices.

Strategy 4: Increase the number of worksite wellness initiatives addressing physical activity.

Objective 2: Increase the proportion of youth who consume five or more servings of fruits and vegetables a day.

Strategy 1: Increase policies that promote and increase healthy food choices in schools.

Strategy 2: Encourage the development and implementation of model curricula for medical schools, nursing programs, and other health professions schools.

Strategy 3: Conduct targeted, planned outreach activities to educate health care professionals, the media, the public and policymakers about genomics, including ethical, legal and social issues.

Objective 3: Increase the proportion of adults who regularly participate in moderate physical activity.

Strategy 1: Enhance community environments to support physical activity.

Strategy 2: Increase public education efforts on the importance of physical activity.

Strategy 3: Advocate for policies that promote and increase physical activity.

Strategy 4: Increase the number of worksite wellness initiatives addressing physical activity.

Strategy 5: Encourage the development and implementation of model curricula for medical schools, nursing programs and other health professions schools.

Objective 4: Increase the proportion of high school students who regularly participate in moderate physical activity.

Strategy 1: Increase the number of schools implementing evidence-based programming focusing on physical activity.

Strategy 2: Decrease the number of schools that receive physical education waivers.

Strategy 3: Increase policies that promote and increase physical activity in the school environment.

Goal 3: Decrease the proportion of Illinois residents who are exposed to unsafe levels of environmental carcinogens.

Objective 1: Reduce exposures to UV radiation.

Strategy 1: Increase public education efforts on the importance of sun safety.

Strategy 2: Collaborate with child care facilities to implement policies on sun safety.

Objective 2: Reduce exposures to radon in all indoor areas.

Strategy 1: Increase the number of homes tested for radon levels and mitigated if elevated levels are found.

Strategy 2: Increase the number of rental units, schools, work places, and day care centers tested and mitigated if elevated levels are found.

Strategy 3: Develop programs to assist economically challenged homeowners to test and mitigate if elevated radon levels are found.

Strategy 4: Establish statewide standards to include radon control features in new construction.

Early Detection

Late-stage cancer detection, diagnosis and treatment has resulted in higher cancer mortality and poor survival rates. Early detection involves medical exams, tests and self-exams to find signs and symptoms of cancer. For many types of cancer, it is easier to treat and cure the cancer if it is found early. This provides an opportunity for prompt treatment while the cancer is small and localized. Breast cancer can be detected early through regular breast self-examinations, clinical breast exams (CBE) and mammography. Cervical cancer can be detected early through Pap tests and pelvic exams. Colorectal cancer can be detected early through regular fecal occult blood testing (FOBT) and/or colonoscopy. Prostate cancer can be detected early, in the absence of symptoms, through a digital rectal exam (DRE) and a prostate-specific antigen (PSA) blood test. Skin cancer, testicular cancer and oral cancer also can be detected early through regular self-examination. However, the signs and symptoms of cancer may be overlooked by health care providers as well as patients. Cancer screening tests can help detect cancer at an earlier stage: The earlier the stage, the better the prognosis. Promotion of early detection education and screening tests is needed to decrease cancer death rates.

Early Detection Goals, Objectives and Strategies

Goal 1: Increase the knowledge of the general public to include all diverse groups and health care providers regarding early detection guidelines and the importance of screenings for breast, cervical, colorectal, oral, prostate, skin and testicular cancers.

Objective 1: Increase early stage cancer detection, diagnosis and treatment while in the organ of origin before metastasis.

Strategy 1: Educate the general public on early cancer detection and cancer screening guidelines.

Strategy 1: Educate non-oncology health care workforce about cancer issues and strategies to encourage people to acquire a yearly comprehensive physical exam.

Strategy 3: Educate physicians on how to adopt a systematic approach for recommending early detection screenings for their patients.

Strategy 4: Focus and concentrate improvement of early detection activities initially on the following 34 southern Illinois counties due to the high cancer prevalence and death rates.¹⁸

- Alexander
- Bond
- Clay
- Clinton
- Crawford
- Edwards
- Effingham
- Fayette
- Franklin
- Gallatin
- Hamilton
- Hardin
- Jackson
- Jasper
- Jefferson
- Johnson
- Lawrence
- Madison
- Marion
- Massac
- Monroe
- Perry
- Pope
- Pulaski
- Randolph
- Richland
- Saline
- St. Clair
- Union
- Wabash
- Washington
- Wayne
- White
- Williamson

Access to Care

Convenient access to quality health care services is necessary for effective cancer prevention, early detection, timely and accurate diagnosis of cancer, appropriate treatment, supportive care, and follow-up for patients and family members. Disparities in access to cancer control and treatment can have many causes, starting with patients and providers lacking the necessary information to access good care, and extending to insurance status, limited transportation options, limited availability of local health care providers, cultural and language barriers, uncertain quality of existing available services, and administrative rules about seeking care across county or state lines. Illinois faces all of these disparities.

According to the U.S. Census Bureau, 1.6 million people in Illinois had no health insurance throughout 2008, and many more had only intermittent or inadequate coverage during that year. Insurance coverage also is distributed unevenly among the population, with Hispanics and African Americans having lower rates of coverage.^{19,20} Furthermore, 16 percent of Illinois residents report having no primary personal health care provider, with higher percentages in urban counties.²¹ The distribution of American College of Surgeons (ACoS) Commission on Cancer certified facilities in Illinois is uneven in both rural and urban areas, thus limiting access to appropriate, high quality cancer care for many Illinois residents.²² The availability of reliable

transportation to and from diagnostic and treatment services is a key requirement for quality care,²³ and is unevenly available across the state. Health care providers commonly lack current knowledge about, and easy access to, needed services for patients. These services include social, financial, and psychological support for patients and families; the best medical care; and access to the latest treatment through the availability of clinical trials. This information is needed to better serve all persons affected by cancer regardless of age, gender, race/ethnicity, health coverage, or income.

Access to Care Goals, Objectives and Strategies

Goal 1: Increase access to cancer resources and services, especially among diverse, underserved, and underinsured populations.

Objective 1: Increase access to cancer treatment and supportive care.

Strategy 1: Increase access to local, state, and national cancer care services via resource programs, libraries, websites, and navigation programs.

Strategy 2: Educate health care providers about the cancer care needs of diverse, underserved and uninsured.

Strategy 3: Enhance transportation services for diverse, underserved and underinsured populations.

Strategy 4: Develop resources, such as GIS techniques, electronic health records, and other available databases and information sources, to identify and measure disparate burden of cancer and related adverse conditions across the state.

Strategy 5: Identify effective methods to serve high-risk populations, and share those with the partnership.

Objective 2: Increase access to cancer treatment and supportive care services provided by, or at the standard of, ACoS approved cancer centers.

Strategy 1: Increase access to, and publicity about, free and low cost cancer screening, treatments and services.

Strategy 2: Encourage hospitals, treatment centers and other cancer facilities to achieve ACoS approved status or an equivalent standard of care.

Strategy 3: Publicize the benefits of and increase access to navigation services.

Objective 3: Educate health care providers, caregivers, survivors, payers, and policy/decision makers about access to care issues.

Strategy 1: Advocate to the public, payors, and policy makers to increase funding for cancer screenings and treatment.

Strategy 2: Convene a meeting of health care professionals, survivors, researchers, and others to develop an advocacy strategy about unmet cancer screening and treatment needs among underserved populations.

Strategy 3: Develop educational opportunities for policy and decision makers about policies that promote access to care for underserved populations.

Strategy 4: Recruit, and include in the partnership, individuals and organizations representing populations experiencing disparities in cancer control and treatment.

Survivorship

According to the CDC, the term "cancer survivors" refers to individuals who have been diagnosed with cancer and the people in their lives who are affected by the diagnosis, including family members, friends and caregivers.²⁴

Due to advances in the early detection and treatment of cancer, people are living many years after a diagnosis. In January 2007, about 11.7 million people with a previous diagnosis of cancer were living in the United States.²³ Approximately 66 percent of people diagnosed with cancer are expected to live at least five years after diagnosis.²⁵ However, disparities in health care impact survival. Low-income men and women who have inadequate or no health insurance coverage are more likely to be diagnosed with cancer at later stages, when survival times are shorter.²⁶

Cancer survivors may face physical, emotional, social, spiritual, and financial challenges as a result of their cancer diagnosis and treatment. Pediatric cancer survivors and their families face challenges brought on by late effects, secondary cancers and psychosocial issues across the lifespan from childhood. Public health professionals strive to address survivorship and quality of life issues such as the coordination of care, patient-provider communication, health promotion, support services, palliative care and fertility preservation. In light of these concerns, public health initiatives aimed at understanding and preventing secondary disease, recurrence, and the long-term physical and psychosocial effects of treatment are essential.

Cancer survivors are at risk for recurrence and for developing second cancers due to the effects of treatment, unhealthy lifestyle behaviors, underlying genetics or risk factors that contributed to the first cancer.²⁷

Survivorship Goals, Objectives and Strategies

Goal 1: Increase access to survivorship and palliative care programs, especially among diverse, underserved and underinsured populations.

Objective 1: Increase knowledge of cancer survivors and their families about survivorship, rehabilitative, psychosocial, supportive, and palliative care.

Strategy 1: Increase access to local, state, and national support programs via resource centers, libraries, and navigation programs.

Strategy 2: Educate health care providers about multi-cultural needs, and identify existing resources and opportunities.

Strategy 3: Develop and encourage survivorship and palliative care programs through clinical practice guidelines, training, and accreditation.

Objective 2: Increase access to and utilization of the full spectrum of supportive care (exercise, nutrition, spiritual, psychological, rehabilitative, behavioral, and social services.)

Strategy 1: Increase access to and publicity of available free or low cost survivorship clinic, health and wellness programs, and rehabilitation.

Strategy 2: Encourage hospitals, treatment centers, and other cancer facilities to focus on survivorship and palliative care issues.

Strategy 3: Increase access to and publicize benefits of these services with medical staff and the community.

Objective 3: Educate survivors, policy and decision makers to ongoing survivorship, palliative care, and quality of life issues.

Strategy 1: Advocate for increased federal and state funding for survivorship clinics, programs and services.

Strategy 2: Convene a meeting of health care professionals, cancer survivors, researchers, and programmatic staff with the goal of developing strategies to educate policy makers about the unmet needs for cancer survivors.

Strategy 3: Develop educational opportunities for survivors and decision makers of insurance carriers and health plans regarding policies that promote timely access to quality care regardless of persons' ability to pay or coverage.

Objective 4: Develop, enhance, and use survivorship surveillance data to define the scope, needs, and health behaviors of the cancer survivor population.

Strategy 1: Utilize the BRFSS and NHIS survivorship modules.

Strategy 2: Use cancer registry data to define and implement interventions for follow-up treatment and care among cancer survivors.

Strategy 3: Use and contribute to evidence base of survivorship interventions and disseminate results via peer-reviewed journals, internal reports to partnership and targeted presentations.

Data and Surveillance

Surveillance data can be used to identify and prioritize at-risk populations for prevention strategies, early detection programs and research. Cancer surveillance data can enable health professionals to identify risk factors for cancer, to determine incidence and mortality rates by population group, to evaluate the cancer burden at a local and state level and to compare this information to the nation. Successful utilization of these data for the purpose of improving the health of the public involves at least three broad activities. First, the registry must generate cancer data that are complete, comprehensive, timely and of high quality. Second these data must be used to chart the progress of cancer control and prevention in Illinois, and to support research into the causes of cancer and cancer outcomes, as well as the success of early detection and treatment strategies. Third, results of these studies must be made available to the public at large, health professionals and policy makers. A valuable tool for advancing cancer research is a system for quickly identifying new cancer cases promptly after diagnosis. Commonly called “rapid case ascertainment,” such systems, which involve close collaboration between cancer registries and academic investigators, facilitate research which depends upon promptly enrolling newly diagnosed cancer patients into research studies. Many states have such systems in place and cancer research in Illinois would be greatly advanced if the state were to collaborate with its university partners to establish and maintain a rapid case ascertainment system.

Data and Surveillance Goals, Objectives and Strategies

Goal 1: Ensure adequate funding for the Illinois State Cancer Registry.

Objective 1: Develop a plan to identify sustainable funding for the Illinois State Cancer Registry to maintain its gold certification.

Strategy 1: Review all potential mechanisms and sources of funding for ISCR.

Strategy 2: Reach out to potential funders and make the case for the importance of short-term funding to enable ISCR to maintain its gold certification.

Objective 2: Develop a plan of action to secure funding on an ongoing basis and over the long term.

Strategy 1: Assess the impact of state laws, regulations and policies on ISCR funding.

Strategy 2: Develop a position paper on ISCR funding and the impact of state funding policies on ISCR.

Goal 2: Increase the visibility of cancer data utilization reported by ISCR by increasing collaboration and accessibility of ISCR data to support research aimed at improving public health.

Objective 1: Identify the research needs of ISCR and how potential collaborators might work with ISCR to meet those needs.

Strategy 1: Assess what additional research results ISCR would like to be able to provide to the public if resources were available.

Strategy 2: Determine public needs from the registry in terms of information about cancer in the community or state.

Strategy 3: Create an inventory of potential resources to ISCR that could aid in meeting the above strategies.

Strategy 4: Work with ISCR on a plan to meet the research goals identified.

Objective 2: Improve the accessibility of ISCR data to the research community.

Strategy 1: Recruit additional partners from data-using institutions into the Illinois Cancer Partnership.

Strategy 2: Assess the research environment and identify organizational impediments to collaboration.

Strategy 3: Assess whether state laws, regulations and policies provide a barrier to data accessibility.

Strategy 4: Draft and disseminate a position paper that identifies barriers and potential solutions to increase availability of ISCR data.

Goal 3: Support rapid case ascertainment (RCA) to better connect newly diagnosed cancer patients with research studies.

Objective 1: Convene a working group of state and private partners to develop a broadly acceptable plan for RCA.

Strategy 1: Understand the laws and rules at the state, to determine impact on the objective, and what changes should be proposed.

Strategy 2: Draft a plan for RCA activities to include roles of participating partners.

Strategy 3: Identify leadership and subordinate roles.

Strategy 4: Identify personnel needs and training requirements.

Strategy 5: Discuss and secure required financial support for the program.

Strategy 6: Determine ownership of data.

Research and Clinical Trials

According to the American Cancer Society, only 4 percent of adults with cancer take part in clinical trials. Research from the National Cancer Institute suggests that barriers to enrollment include: lack of awareness of clinical trials as a treatment option and misinformation about the process, lack of access, fear and distrust of research, and financial and personal concerns. Health care providers, and their understanding of, and comfort with the process of clinical trials, play a key role in patients' participation in trials.

Research and Clinical Trials Goals, Objectives and Strategies

Goal 1: Raise awareness of cancer research among policy makers and the general public.

Objective 1: Increase knowledge about cancer prevention and treatment in clinical trials.

Strategy 1: Investigate funding opportunities for clinical trials awareness programs.

Strategy 2: Develop, adapt, implement, evaluate, and disseminate programs to educate providers to improve provider awareness of clinical trials and their competence for recruitment to clinical trials.

Goal 2: Monitor the geographic distribution throughout Illinois of persons participating in therapeutic cancer clinical trials.

Objective 1: Establish a process for obtaining annual statewide accrual information for therapeutic cancer clinical trials.

Strategy 1: Establish baseline accrual information for therapeutic trials in 2009 by January 2012.

Strategy 2: Review yearly therapeutic accrual numbers on an annual basis.

HOW TO HELP THE ILLINOIS CANCER PARTNERSHIP FIGHT CANCER

The Illinois Cancer Partnership (ICP) has addressed six major cancer-related priority focus areas in this plan; 1) Primary Prevention, 2) Early Detection, 3) Access to Care, 4) Survivorship, 5) Data and Surveillance, and 6) Research and Clinical Trials. In order to accomplish the plan goals and objectives, the ICP needs the involvement of a broad range of citizens, including individuals, informal groups, and corporate entities, to help implement the goal strategies within their communities where people live, work and play. With the help of these groups, and by working together, this plan can be used as a tool to reduce the burden of cancer.

There are many ways organizations and individuals can support the goals and objectives of the ICP. The following approaches can be implemented to achieve outcome objectives.

Hospitals

- Acquire and maintain American College of Surgeons-Commission on Cancer Accreditation.
- Establish coordinated care process with community physicians.
- Establish palliative care and survivorship programs.
- Increase access to and utilization of patient navigation programs.
- Provide cancer awareness information to medical staff, employees and patients.
- Ensure cancer cases are reported in a timely manner to the ISCR.
- Provide meeting space for cancer support groups.
- Collaborate to sponsor community screening and education programs.

Local Health Departments

- Provide cancer awareness information to employees and community residents.
- Facilitate healthy lifestyle campaigns.
- Work with community residents to assess needs and develop evidence-based intervention programs.
- Work with hospitals and health care providers to promote prevention programs, screening programs and case reporting.
- Provide space for cancer survivor support groups.
- Implement community-based programs to address cancer risk factors.

Community-based Organizations

- Provide cancer awareness information to staff and clients.
- Promote cancer screening among clients.
- Collaborate to provide community prevention programs.

- Encourage participation in clinical trials.

Professional Organizations

- Provide cancer awareness information to employees and members.
- Promote cancer screening among employees, members and clients.
- Encourage participation in clinical trials.
- Collaborate to provide community prevention programs.

Employers

- Enforce the Smoke-free Illinois Act.
- Provide healthy foods in vending machines and cafeterias.
- Encourage employees to increase physical activity through work site wellness programs.
- Collaborate with health care providers to host screening events.
- Promote healthy behaviors.
- Provide health and dental insurance coverage with wellness incentives.

Schools and Universities

- Include cancer prevention messages in health classes.
- Provide healthy foods in vending machines and cafeterias.
- Increase physical education requirements.
- Enforce the Smoke-free Illinois Act and make all campuses smoke-free.

Faith-based Organizations

- Provide cancer prevention and screening information to members.
- Encourage healthy food policies for events.
- Open your building for walking clubs in cold weather.
- Encourage congregation to get cancer screening tests on time .
- Assess feasibility of establishing a health ministry program.
- Offer space for faith-based cancer support groups.

Health Care Providers

- Ensure patients get appropriate cancer screening tests.
- Refer patients to smoking cessation assistance and nutrition programs.
- Report cancer cases in a timely manner.
- Encourage patients to enroll in clinical trials.
- Make earlier referrals to hospice for end-of-life care.
- Educate patients about risks and early detection.
- Refer chronically ill patients to palliative care programs if available.
- Discuss individualized follow-up care with cancer survivors.

Policy and Decision-Makers

- Become knowledgeable about cancer burden data in Illinois communities.
- Support funding for comprehensive cancer control.
- Support additional funding for the ISCR.
- Sponsor or support legislation that promotes cancer prevention and control.
- Ensure that all residents have access to quality health care services.

Individuals

- Avoid all tobacco and secondhand smoke.
- Consume the recommended servings of fruits and vegetables daily and maintain a healthy weight.
- Increase daily physical activity of adults and children.
- Understand recommended health screenings and commit to being screened.
- Advocate for cancer prevention and control legislation.
- If diagnosed with cancer, consider enrolling in a clinical trial.
- Support and care for those who are diagnosed with cancer.
- Volunteer with a hospital, health department, faith community, or local cancer control group.
- Join the ICP and participate in one or more work groups.

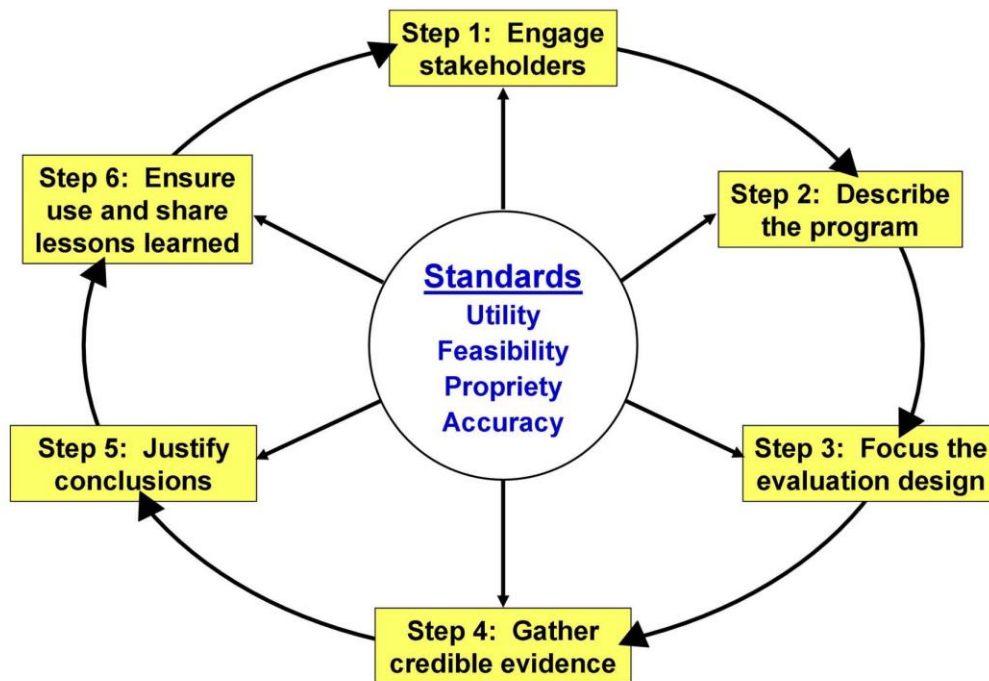
PLAN EVALUATION AND IMPLEMENTATION

Evaluation

The strategies and implemented interventions will be continually monitored and evaluated to determine their effectiveness in achieving the plan goals and objectives. The evaluation activities will include both implementation processes and outcomes measurement. The ICP and other stakeholders will be involved in the implementation process and will be responsible for collecting and reporting outcome data to evaluate progress toward the intended outcomes of the intervention strategies.

Graphic 8 illustrates the CDC's Framework for Program Evaluation. The CDC developed the evaluation framework and procedures for use as a systematic means to improve and account for public health actions and for achieving measurable outcomes.²⁸

Graphic 8: CDC Framework for Program Evaluation



Source: Adapted from the U.S. Centers for Disease Control and Prevention (CDC), Framework for Program Evaluation²⁸

The CDC Framework for Program Evaluation summarizes and organizes steps and standards for effective program evaluation as described in the following paragraphs. The steps and standards are used together throughout the evaluation process. For each step, there is a sub-set of standards that are used as criteria for judging the quality of program evaluation efforts in public health.²⁸

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

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

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

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

Step 5: Justify conclusions. The evaluation conclusions are justified when they are linked to the evidence gathered and judged against agreed-upon values or standards set by the stakeholders. Stakeholders must agree that conclusions are

justified before they will use the evaluation results with confidence. Justifying conclusions on the basis of evidence includes standards, analysis and synthesis, interpretation, judgment and recommendations.

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

According to the CDC, this “evaluation framework consists of a set of 30 standards that assess the quality of evaluation activities to determine whether a set of evaluative activities are well-designed and working to their potential. These standards, adopted from the Joint Committee on Standards for Educational Evaluation, answer the question, "Will this evaluation be effective?" The standards are recommended as criteria for judging the quality of program evaluation efforts in public health.²⁹

The 30 standards are organized into the following four groups:

1. **Utility standards** ensure that an evaluation will serve the information needs of intended users.
2. **Feasibility standards** ensure that an evaluation will be realistic, prudent, diplomatic and frugal.
3. **Propriety standards** ensure that an evaluation will be conducted legally, ethically and with due regard for the welfare of those involved in the evaluation, as well as those affected by its results.
4. **Accuracy standards** ensure that an evaluation will reveal and convey technically adequate information about the features that determine worth or merit of the program being evaluated.²⁹

Implementation

In order to achieve the goals outlined in the state plan, the strategies must be implemented. The state plan will serve to mobilize individuals, organizations, institutions and communities committed to fighting cancer. These groups can use this plan to select strategies for implementation consistent with their missions. Effective implementation of these diverse strategies will require an ongoing, coordinated and

collaborative effort. All partners must embrace the state plan to make a true impact on cancer prevention and control in Illinois.

Plan of Action – Implementation and Sustainment:

- Begin implementation of selected strategies within three months of state plan ratification.
- Identify work groups to lead priority areas, goals, recommendations and strategies.
- Identify strategies to be implemented first.
- Develop written inter-organizational linkages.
- Develop an evaluation mechanism.
- Identify, coordinate and secure funding opportunities.
- Expand partnerships and collaborations.
- Continuously review progress by tracking activities and measuring results.
- Develop and implement a resource plan.

ILLINOIS CANCER CONTROL INITIATIVES

Illinois is active in addressing the burden of cancer through the following programs and activities.

Comprehensive Cancer Control Program

The Illinois Comprehensive Cancer Control Program located in the Illinois Department of Public Health, integrates and coordinates a wide range of cancer related activities through a broad partnership of public, private and nonprofit sector stakeholders with a common mission to save lives and reduce the overall burden of cancer.

Illinois Comprehensive Cancer Control Plan

The Illinois Comprehensive Cancer Control Plan provides a framework for action to reduce the burden of cancer in Illinois by providing an organized approach to cancer prevention and control efforts for the entire state.

Illinois Cancer Partnership

The Illinois Cancer Partnership is a broad-based, multi-organizational partnership that integrates public, private and nonprofit sectors in a collaborative effort with common goals and objectives that promotes cancer prevention, reduces cancer deaths and minimizes the burden of cancer for all individuals throughout the state. Their mission is to reduce the incidence, morbidity and mortality of cancer and enhance survivorship in Illinois. The partnership provides leadership and advocacy for:

- Identifying statewide needs for cancer prevention and control.
- Identifying interventions and resources.
- Coordinating activities.
- Promoting the availability of sufficient workforce, equipment and services.
- Seeking financial resources to fund plan initiatives.
- Supporting efforts to increase awareness and share strategies to reduce the burden of cancer.

Community Initiative Cancer Coalition Grants

Illinois state grants are provided to local health departments and regional coalitions to partner with health care providers, citizens and community and faith-based groups to educate the public on cancer prevention, healthy lifestyle choices and the importance of cancer screening and early detection.

Illinois Tobacco Quitline

The Illinois Department of Public Health funds the Illinois Tobacco Quitline, which is operated by the American Lung Association, to provide no-cost tobacco cessation counseling services. Cessation services are available in 150 languages including services to people who are hard of hearing or hearing impaired.

Illinois Breast and Cervical Cancer Program

The Illinois Breast and Cervical Cancer Program offers free mammograms, breast exams, pelvic exams, and Pap tests to eligible women. Even if a woman has already been diagnosed with cancer, she may receive free treatment if she qualifies. Since the program was launched in Illinois in 1995, more than 102,000 women have been screened for breast and cervical cancers.

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ACRONYM LIST

ACS	American Cancer Society
ACoS	American College of Surgeons
BRCA	Breast Cancer Mutation
BRFSS	CDC's Behavioral Risk Factor Surveillance System
CBE	Clinical Breast Exam
CCC	Comprehensive Cancer Control
CDC	Centers for Disease Control and Prevention
DRE	Digital Rectal Exam
FOBT	Fecal Occult Blood Test
GIS	Geographic Information System
HFS	Illinois Department of Health and Family Services
ICP	Illinois Cancer Partnership
IOM	Institute of Medicine
ISCR	Illinois State Cancer Registry
NCI	National Cancer Institute
NHIS	National Health Interview Survey
NIH	National Institutes of Health
PSA	Prostate-Specific Antigen
RCA	Rapid Case Ascertainment
SGR	Report of the Surgeon General
UV	Ultra Violet

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Illinois Cancer Partnership Executive Committee

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Cindy Davidsmeyer
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Sarah Page

Nomathemba Pressley

Lizbeth Swords

Shaan Trotter

Resource Management

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Pamela Balmer

Co-chair: Julie Janssen

Claudia Nash

Partnering Organizations

Advocate Christ Medical Center
American Cancer Society - DuPage County
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Inc.
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American Lung Association of Illinois
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Registry
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Illinois State Medical Society
Hope Light Foundation
Human Kinetics
Illinois Academy of Family Physicians
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Ingalls Memorial Hospital
Jo Daviess County Health Department
John H. Stroger Jr., Hospital of Cook
County
Leukemia and Lymphoma Society, Illinois
Chapter
Logan County Department of Public Health

Macoupin County Public Health
Department

McDonough District Hospital

Partnering Organizations (Continued)

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Sangamon County Department of Public
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Illinois University

Siteman Cancer Center, Washington
University School of Medicine

Southern Illinois Healthcare

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Southern Illinois University, School of
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Division of Epidemiology and
Biostatistics

University of Illinois College of Medicine at
Peoria

University of Illinois Extension

Us TOO International Prostate Cancer
Education and Support Network

Wellness House

Winnebago County Health Department

RESOURCES FOR CANCER-RELATED INFORMATION

The following websites are for awareness and educational purposes only. Inclusion in this listing does not imply endorsement of a particular website, its content or organization.

All-Cancers Websites

URL

American Cancer Society (ACS)	www.cancer.org
American College of Surgeons (ACoS)	www.facs.org
American Society of Clinical Oncology (ASCO)	www.cancer.net/patient/Survivorship
Cancer Care	www.cancercare.org
Cancer Control P.L.A.N.E.T.	http://cancercontrolplanet.cancer.gov/
National Cancer Institute (NCI)	www.cancer.gov
National Children's Cancer Society	www.children-cancer.org
U.S. Centers for Disease Control and Prevention (CDC)	www.cdc.gov/cancer

Cancer Specific Websites (Illinois Top 10 and selected cancers)

Breast Cancer

Susan G. Komen for the Cure	www.komen.org
National Breast Cancer Foundation	www.nationalbreastcancer.org
National Breast Cancer Organization	www.y-me.org

Cervical Cancer

Foundation for Women's Cancer	www.foundationforwomenscancer.org
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Colon Cancer

Susan Cohan Colon Cancer Foundation	www.coloncancerfoundation.org
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Kidney Cancer

Kidney Cancer Association	www.kidneycancer.org
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Leukemia and Lymphoma

Leukemia and Lymphoma Society	www.lls.org
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Liver Cancer

Search All-Cancers Websites

Lung Cancer

Lung Cancer Alliance

www.lungcanceralliance.org

lungCANCER.org

www.lungcancer.org

Myeloma Cancer

Leukemia and Lymphoma Society

www.lls.org

International Myeloma Foundation

www.myeloma.org

Oral Cancer

National Institute of Dental and

Craniofacial Research

www.nidcr.nih.gov

Oral Cancer Foundation

www.oralcancerfoundation.org

Ovarian Cancer

National Ovarian Cancer Coalition

www.ovarian.org

Ovarian Cancer National Alliance

www.ovariancancer.org

Foundation for Women's Cancer

www.foundationforwomenscancer.org

Pancreatic Cancer

Pancreatic Cancer Action Network

www.pancan.org

Prostate Cancer

Us TOO International

www.ustoo.com

Prostate Cancer Foundation

www.pcf.org

Skin Cancer

Skin Cancer Foundation

www.skincancer.org

Testicular Cancer

Testicular Cancer Resource Center

<http://tcr.acor.org/>

Cancer Patients and Survivors Websites

American Cancer Society

www.cancer.org

American Society of Clinical Oncology
(ASCO)

www.cancer.net/patient/Survivorship

Lance Armstrong Foundation

www.livestrong.org

National Coalition for Cancer Survivorship

www.canceradvocacy.org

Patient Resource Cancer Guide	www.patientresource.net
Planet Cancer (young adults age 15-39)	www.planetcancer.org
Survivor Alert (for young adults)	www.survivoralert.org

Financial Assistance Websites

American Cancer Society (ACS)	www.cancer.org
Cancer Care	www.cancercare.org/financial
Division of Specialized Care for Children (Illinois Title V Program)	http://www.uic.edu/hsc/dscc
Illinois Department of Human Services	www.dhs.state.il.us
Illinois Healthcare for All Kids	www.allkids.com
Illinois Housing Development Authority	www.ihda.org
Leukemia and Lymphoma Society	www.lls.org
National Children’s Cancer Society	www.children-cancer.org
Partnership for Prescription Assistance	www.pparx.org

Insurance Assistance Websites

Illinois Comprehensive Health Insurance Plan	www.chip.state.il.us
Illinois Department of Insurance	www.insurance.illinois.gov
Illinois Health Connect	www.illinoishealthconnect.com
Patient Advocate Foundation–The National Underinsured Resource Directory	www.patientadvocate.org

Cancer Screening Websites

Guidelines for the Early Detection of Cancer (ACS)	www.cancer.org
Screening and Testing to Detect Cancer (NCI)	http://www.cancer.gov/cancertopics/screening
U.S. Preventive Services Task Force	http://www.uspreventiveservicestaskforce.org/

Cancer Related Data Websites

Cancer Facts and Figures 2011 (ACS)	www.cancer.org/Rese
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	<u>arch/CancerFactsFigures/CancerFactsFigures/cancer-facts-figures-2011</u>
Illinois Behavioral Risk Factor Surveillance System (BRFSS)	<u>http://app.idph.state.il.us/brfss/</u>
Illinois Cancer Registry	<u>www.idph.state.il.us/cancer/statistics.htm</u>
Surveillance, Epidemiology and End Results (SEER)	<u>http://seer.cancer.gov/</u>
State Cancer Profiles	<u>www.statecancerprofiles.cancer.gov</u>

Appendix A: Cancer Incidence

Cancer Incidence: Top 10 most commonly diagnosed cancers by sex, all races, Illinois, 1992-2006								
Male/All Races, 1992-1996			Male/All Races, 1997-2001			Male/All Races, 2002-2006		
Cancer Sites	Count	Percent	Cancer Sites	Count	Percent	Cancer Sites	Count	Percent
All Sites	138,789	100.0	All Sites	147,739	100.0	All Sites	156,268	100.0
Prostate	40,084	28.9	Prostate	41,408	28.0	Prostate	42,773	27.4
Lung and Bronchus	24,833	17.9	Lung and Bronchus	24,766	16.8	Lung and Bronchus	24,369	15.6
Colon and Rectum	16,384	11.8	Colon and Rectum	17,876	12.1	Colon and Rectum	17,789	11.4
Urinary Bladder	8,680	6.3	Urinary Bladder	9,625	6.5	Urinary Bladder	10,447	6.7
Non-Hodgkin Lymphoma	5,393	3.9	Non-Hodgkin Lymphoma	6,036	4.1	Non-Hodgkin Lymphoma	6,546	4.2
Kidney and Renal Pelvis	3,837	2.8	Kidney and Renal Pelvis	4,623	3.1	Kidney and Renal Pelvis	6,069	3.9
Leukemia	3,997	2.9	Leukemia	4,413	3.0	Melanoma of the Skin	5,129	3.3
Oral Cavity and Pharynx	4,086	2.9	Oral Cavity and Pharynx	4,365	3.0	Leukemia	4,675	3.0
Melanoma of the Skin	2,834	2.0	Melanoma of the Skin	4,074	2.8	Oral Cavity and Pharynx	4,659	3.0
Pancreas	2,964	2.1	Pancreas	3,434	2.3	Pancreas	3,855	2.5
Female/All Races, 1992-1996			Female/All Races, 1997-2001			Female/All Races, 2002-2006		
Cancer Sites	Count	Percent	Cancer Sites	Count	Percent	Cancer Sites	Count	Percent
All Sites	132,779	100.0	All Sites	144,384	100.0	All Sites	149,722	100.0
Breast	40,360	30.4	Breast	44,074	30.5	Breast	42,264	28.2
Lung and Bronchus	16,715	12.6	Lung and Bronchus	18,614	12.9	Lung and Bronchus	20,529	13.7
Colon and Rectum	17,125	12.9	Colon and Rectum	18,083	12.5	Colon and Rectum	17,509	11.7
Corpus and Uterus, NOS	7,997	6.0	Corpus and Uterus, NOS	8,270	5.7	Corpus and Uterus, NOS	8,982	6.0
Non-Hodgkin Lymphoma	5,056	3.8	Non-Hodgkin Lymphoma	5,503	3.8	Non-Hodgkin Lymphoma	5,730	3.8
Thyroid	2,335	1.8	Thyroid	3,131	2.2	Thyroid	4,735	3.2
Ovary	4,777	3.6	Ovary	4,653	3.2	Ovary	4,633	3.1
Melanoma of the Skin	2,319	1.7	Melanoma of the Skin	3,109	2.2	Melanoma of the Skin	4,026	2.7
Pancreas	3,227	2.4	Pancreas	3,713	2.6	Pancreas	3,973	2.7
Kidney and Renal Pelvis	2,610	2.0	Kidney and Renal Pelvis	3,221	2.2	Kidney and Renal Pelvis	3,906	2.6

Source: Illinois Department of Public Health, Illinois State Cancer Registry, November 2008

Appendix B: Cancer Mortality

Cancer Mortality: Top 10 cancer causes of death by sex, all races, Illinois, 1992-2006								
Male/All Races, 1992-1996			Male/All Races, 1997-2001			Male/All Races, 2002-2006		
Cancer Sites	Count	Percent	Cancer Sites	Count	Percent	Cancer Sites	Count	Percent
All Cancers	64,628	100.0	All Cancers	61,794	100.0	All Cancers	61,794	100.0
Lung and Bronchus	21,006	32.5	Lung and Bronchus	18,917	30.6	Lung and Bronchus	18,917	30.6
Prostate	7,629	11.8	Colon and Rectum	6,320	10.2	Colon and Rectum	6,320	10.2
Colon and Rectum	7,018	10.9	Prostate	6,283	10.2	Prostate	6,283	10.2
Pancreas	2,934	4.5	Pancreas	3,457	5.6	Pancreas	3,457	5.6
Non-Hodgkin Lymphoma	2,632	4.1	Leukemia	2,707	4.4	Leukemia	2,707	4.4
Leukemia	2,622	4.1	Non-Hodgkin Lymphoma	2,392	3.9	Non-Hodgkin Lymphoma	2,392	3.9
Esophagus	2,025	3.1	Esophagus	2,194	3.6	Esophagus	2,194	3.6
Stomach	1,858	2.9	Urinary Bladder	1,855	3.0	Urinary Bladder	1,855	3.0
Urinary Bladder	1,716	2.7	Kidney and Renal Pelvis	1,721	2.8	Kidney and Renal Pelvis	1,721	2.8
Kidney and Renal Pelvis	1,564	2.4	Liver	1,623	2.6	Liver	1,623	2.6
Female/All Races, 1992-1996			Female/All Races, 1997-2001			Female/All Races, 2002-2006		
Cancer Sites	Count	Percent	Cancer Sites	Count	Percent	Cancer Sites	Count	Percent
All Cancers	60,293	100.0	All Cancers	60,029	100.0	All Cancers	60,029	100.0
Lung and Bronchus	13,212	21.9	Lung and Bronchus	14,872	24.8	Lung and Bronchus	14,872	24.8
Breast	10,691	17.7	Breast	9,235	15.4	Breast	9,235	15.4
Colon and Rectum	7,203	11.9	Colon and Rectum	6,380	10.6	Colon and Rectum	6,380	10.6
Pancreas	3,198	5.3	Pancreas	3,636	6.1	Pancreas	3,636	6.1
Ovary	3,118	5.2	Ovary	3,157	5.3	Ovary	3,157	5.3
Non-Hodgkin Lymphoma	2,471	4.1	Non-Hodgkin Lymphoma	2,248	3.7	Non-Hodgkin Lymphoma	2,248	3.7
Leukemia	2,133	3.5	Leukemia	2,165	3.6	Leukemia	2,165	3.6
Corpus and Uterus, NOS	1,477	2.4	Corpus and Uterus, NOS	1,621	2.7	Corpus and Uterus, NOS	1,621	2.7
Myeloma	1,354	2.2	Myeloma	1,185	2.0	Myeloma	1,185	2.0
Stomach	1,171	1.9	Stomach	1,144	1.9	Stomach	1,144	1.9

Source: Surveillance, Epidemiology and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: Mortality - All COD, Public-Use with State, Total U.S. (1969-2006), and Mortality - All COD, Public-Use with State, National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released May 2009. Underlying Mortality data provided by NCHS (www.cdc.gov/nchs)



Contact Information:

Illinois Comprehensive Cancer Control Program
Illinois Department of Public Health
535 West Jefferson Street
Springfield, Illinois 62761
217-782-3300 (Phone)
217-782-1235 (FAX)