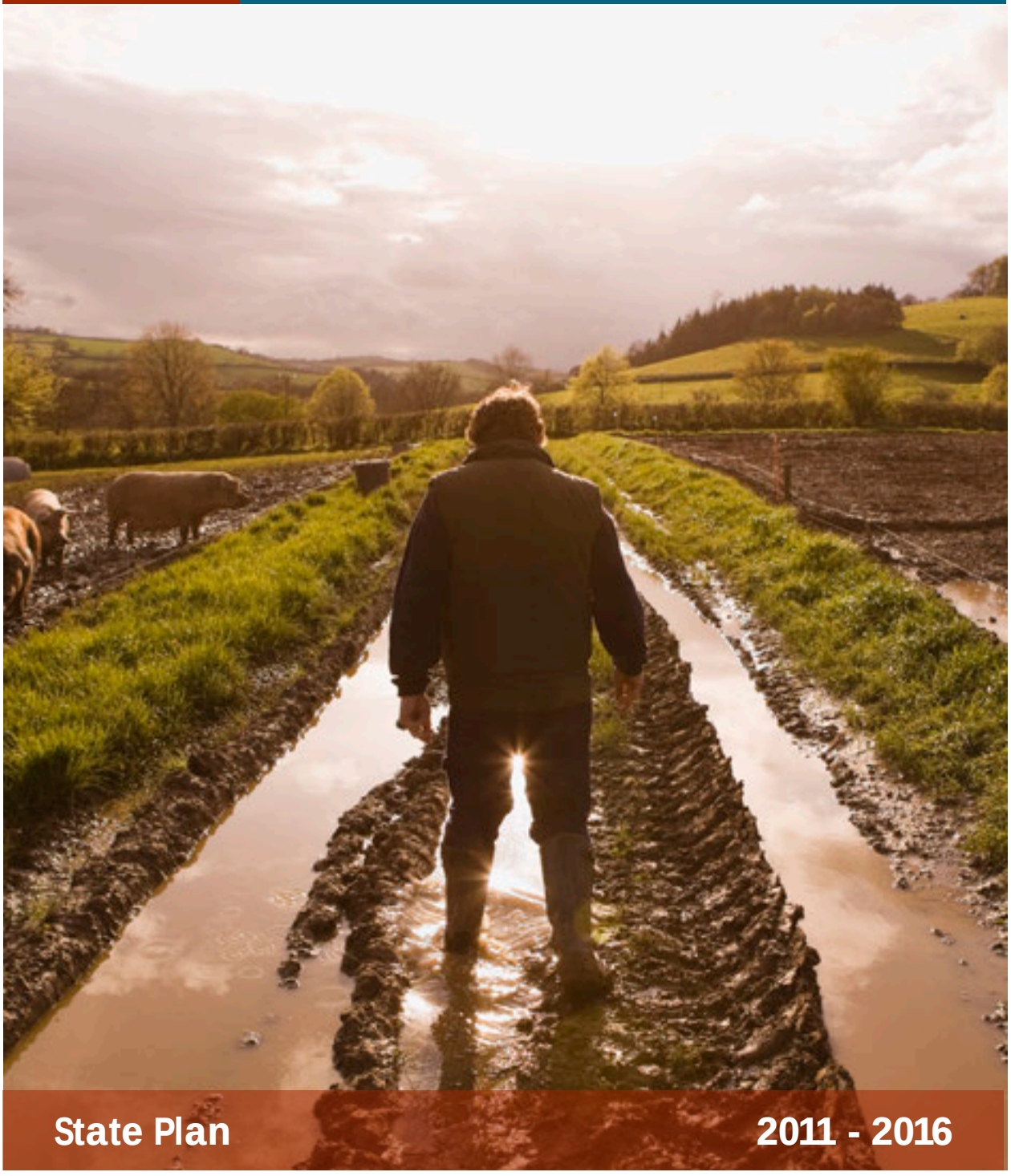
Nebraska Comprehensive Cancer Control



State Plan **2011 - 2016**

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Acknowledgements

The first Nebraska Cancer Plan was developed by a core planning team of partners from across Nebraska in 2003-2004. The Plan was published and distributed in August 2004, and implementation began in fall 2004. This revision builds upon the first Nebraska Cancer Plan. Many partners across Nebraska provided input into this revision. Partners responded to a state plan survey, provided suggestions at the spring and fall partnership meetings and on the 2009 Cancer Caravan en route from Omaha to Scottsbluff. The members of the Advisory Committee also provided input during the quarterly Advisory Committee meetings and through various electronic communications. Very active partners in plan implementation also had face to face meetings with staff. It is estimated that over half of the 360 NC2 partners participated in the plan revision process.

Implementation of the Nebraska Cancer Plan depends upon collaboration among our many statewide partners. So, too, revising the Cancer Plan resulted from collaboration and the identification of new resources with different skill sets. Two students from the University of Nebraska College of Journalism and Mass Communications, Lincoln, worked with Nebraska Comprehensive Cancer Control Program (NE CCCP) and Nebraska Cancer Coalition (NC2) during 2010; both were involved in developing the new logos for NE CCCP and NC2, assisting in managing the 2010 Cancer Summit and helping put this plan together. **Thanks to Alanna Nunn and Kelsey Satra!** Thanks to two masters in public health CAPSTONE students for reviewing other state plans to identify trends and new approaches being taken in other states, tribes and territories. **Thanks to Parveen Ghani and Farida Ebrahim!** Farida also assessed the data sections of other cancer plans and provided input along with DHHS staff; thanks to **Brian Rettig and Ming Qu**. Thanks also to **Elizabeth Green**, **NE CCCP**, who proofread the plan. Thanks to **Maisun Allahiq** and **Robby DeFrain** for layout and graph design. A special thanks to **each NC2 Partner** who is now poised to implement new strategies and activities to further implement the Nebraska Cancer Plan. And thank you to **June Ryan** for her tireless leadership and enthusiasm.

Dedication

The Nebraska Cancer Plan is dedicated to the people of Nebraska whose lives have been touched by cancer.

Nebraska Cancer Coalition (NC2)

In 2010, the Nebraska Cancer partners filed paperwork to become incorporated as a 501(c)(3) non-profit entity. At the same time, the partnership name was changed from Nebraska C.A.R.E.S to Nebraska Cancer Coalition (NC2). Some of the reasons for these changes include the following:

- Increased ability to generate resources:
  - apply for grants not available to state government programs;
  - request foundation and other financial resources;
  - accept donor contributions; and
  - bring on part time staff resources for a specific project or time period.
- Increased ability for advocacy and policy, environment and systems changes.
- Increased capacity to expand the partnership.
  - Experience in other states has shown that some organizations will join a non-profit partnership entity and not join a loosely structured, government-run partnership; and
  - Experience also has shown that organizations will join an entity that they feel will be more responsive to their needs than a government-run partnership.
- Increased capacity to plan and host meetings, accept registrations and pay expenses using Generally Accepted Accounting Principles.
- Increased capacity to implement the Nebraska Cancer Plan.

A Memorandum of Understanding (MOU) was developed between NC2 and the Nebraska Comprehensive Cancer Control Program (NE CCCP). This document outlines the relationship and respective roles and responsibilities of the two entities as well as joint roles and responsibilities. The intention is for the relationship to be seamless while at the same time enhancing Nebraska's capacity to maintain a statewide partnership, develop and implement a state cancer plan and meet the overall goal of reducing the burden of cancer in Nebraska. The roles of NC2 and NE CCCP are included in the appendix.

Significance for the Partners:

All individuals and organizations that were Nebraska C.A.R.E.S partners became NC2 partners. The Advisory Committee became the Board of Directors and was expanded to include the following directors: Alan G. Thorson, M.D., F.A.C.S., Chair; Stephen J. Lemon, M.D., F.A.C.S, Vice Chair; Kim Bland, R.N., OCN, CRNP, Secretary; and Roger Howard, Treasurer.

Guiding Principles were developed and include the following:

- NC2 and NE CCCP will always work in collaboration.
- NC2 and NE CCCP will utilize conflict management tools as needed.
- NC2 and NE CCCP will not knowingly compete with each other or with any partner.
- NC2 and NE CCCP will work to achieve a common goal of reducing the burden of cancer in Nebraska, e.g. reducing cancer incidence and mortality over time.

Other Nebraska State Plans

Since the initial comprehensive cancer state plan was developed and implemented, other Nebraska Department of Health and Human Services (DHHS) programs and coalitions developed strategic and state plans. NC2 partners and NE CCCP staff participated in each of the following planning processes to advocate for the inclusion of cancer prevention and control, to provide input regarding evidence-based strategies and promising practices, and to plan how NC2 and NE CCCP might help with plan implementation.

- Health Disparities and Health Equity State Plan
- Healthy Communities Strategic Plan
- Nebraska Breast Cancer Plan
- Nutrition and Activity for Health State Plan
- Tobacco Disparities State Plan

These plans are incorporated by reference in this Nebraska Cancer Plan. Appropriate components of the above plans will be included in annual work plans developed jointly by NC2 partners and NE CCCP staff.

Other Program Collaboration

NE CCCP has historically collaborated with other Nebraska DHHS programs. This collaboration will continue with the following Division of Public Health partners:

- Community Health and Performance Management
  - Health Disparities and Health Equity
  - Healthy Communities
  - Rural Health
- Disease Prevention and Health Promotion
  - Cardiovascular Health
  - Diabetes Prevention and Control
  - Nutrition and Activity for Health
  - Oral Health and Dentistry
  - Preventive Health and Health Services Block Grant
  - Tobacco Prevention and Control
- Lifespan Health Services
  - Women's and Men's Health
  - Every Woman Matters (Breast and Cervical Cancer Early Detection Program)
  - Nebraska Colon Cancer Screening Program
- Public Health Support
  - Epidemiology
  - Geographic Information Systems
  - Health Statistics
  - Nebraska Cancer Registry

Other Nebraska State Departments

Over the past two years, NE CCCP has developed an effective working relationship with the Nebraska Department of Education, Health, Physical Education and Health Sciences Unit. This collaboration will continue as it provides a way in which to promote school health policy that is consistent with cancer prevention and control.

Executive Summary

In 2008, more than 8,930 Nebraska residents were diagnosed with cancer and 3,377 died from the disease. Four types of cancer –lung, breast, prostate and colorectal cancer – account for 53% of all cancer cases and 50% of cancer deaths. More than two-thirds of all cancer deaths could be prevented with the adoption of a healthier lifestyle and improved screening.

The number of cancer survivors is projected to grow with earlier diagnosis, improved treatment and an aging population.

Nebraska was awarded a grant from the Centers of Disease Control and Prevention (2001) to form a comprehensive cancer control program and to write a state cancer plan. One of the primary responsibilities of the program was to implement the priorities identified in the state plan by forming partnerships with the cancer community of health care professionals, survivors, individuals and organizations.

In 2010, the partnership entity of the comprehensive cancer control program became a 501(c)3 non-profit program known as the Nebraska Cancer Coalition (NC2). And in 2011, the state cancer plan was updated to focus on the following goals:

- Emphasize primary prevention to reduce cancer risks
- Address public health needs of cancer survivors
- Reduce cancer disparities to achieve health equity
- Promote early detection and appropriate screening
- Increase access to cancer care

By working together, coordinating resources and implementing the cancer plan, we will continue to reduce the burden of cancer among Nebraska residents. Please join us in this important work on behalf of all Nebraskans!

To join in our efforts or to learn more, please visit the Nebraska Cancer Coalition (NC2) at www.necancer.org.

Introduction

Comprehensive Cancer Control

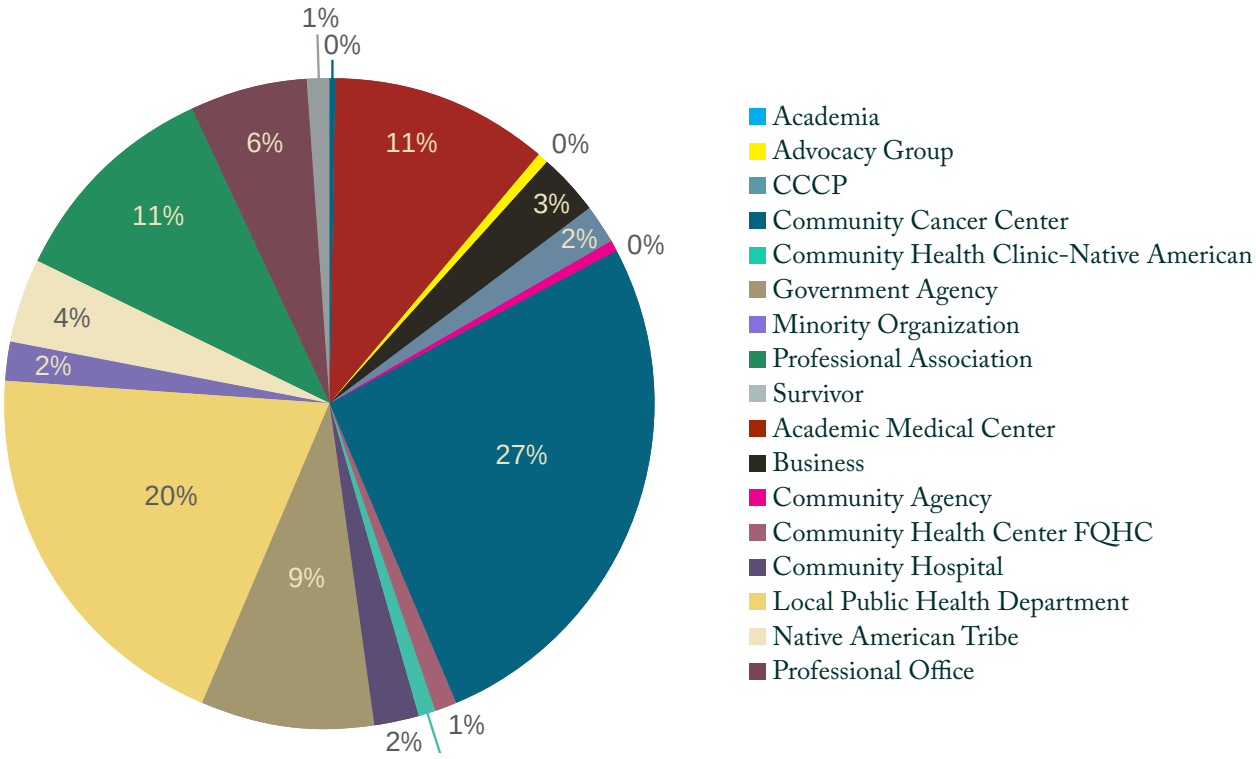
Comprehensive Cancer Control is an integrated, coordinated approach to reducing the impact of cancer. The program model includes assessment of cancer data, policy implementation, research, education, programs, services, and evaluation. The model anticipates the building of a statewide partnership, the development of a state cancer plan and the implementation of the plan by the partners. Today, the Centers for Disease Control and Prevention (CDC) funds 67 states, tribes and territories for comprehensive cancer control.

Nebraska's Comprehensive Cancer Control Program

The Nebraska Department of Health and Human Services (DHHS) began receiving funds from the Centers for Disease Control (CDC) to develop a comprehensive cancer control program. The partnership evolved in August 2002 with the first partner meeting. By January 2004, the partnership had grown to nearly 130 persons representing 100 groups and organizations across Nebraska.

Now in 2011, the partnership includes 360 individuals representing nearly 160 Nebraska groups and organizations as represented by the following figure.

NE CCCP Partnership 2011



During 2002-2004, partners developed the first comprehensive cancer control plan. The plan was finalized and shared with partners in June 2004; the plan was unveiled to the public in August 2004. The plan was intended to be a flexible document, allowing for incorporation of needs and interests of the partners. The six primary goals were addressed during the past six years; however, implementation strategies varied as new champions for a specific goal were identified. The number of partners implementing the plan has continued to increase throughout this implementation time period. In developing this plan revision, several questions were posed to the partners: Have we made a difference? If so, what specific actions should we continue? If not, what should we do instead?

Accomplishments from 2001 to 2010 related to the Nebraska Cancer Plan:

- We addressed **health disparities**.
  - We reframed the issue of health disparities to include uninsured and under-insured as well as minority populations;
  - We provided information to help inform partners and the public about how the population in Nebraska is changing.

- We advocated to CDC and others that rural populations also experience health disparities.
- We collaborated within DHHS and with outside agencies to make a difference in reducing health disparities.
- **Bottom Line**: This issue continues to be a national, state, and local issue requiring all programs and services to focus on "Equal treatment for all."

- We focused on **prevention** before it became the national headliner that it now is.
  - We provided financial support for a shared nutritionist position with the NE Cardiovascular Health Program.
  - The nutrition and physical activity staff became the Nutrition and Activity for Health Program, funded by CDC and staffed with 4.5 full time equivalent positions. This program has an annual budget of $727,000 and in 2010, received an ARRA grant valued at $320,000.
  - We participated in developing the initial Nutrition and Activity for Health Plan and the subsequent plan update in 2010-2011.
  - The NE CCCP Manager sits on the NAFH steering committee, participating in strategic planning, partner collaboration and other key activities.
  - In the tobacco area, the most significant accomplishment was the passage of the statewide Clean Air legislation.
  - **Bottom line**: More needs to be done at the national, state and local level to prevent cancer and other chronic diseases, especially in the areas of tobacco control, nutrition, physical activity and obesity prevention.

- We promoted **cancer screening and early detection**
  - Breast Cancer screening rates (e.g. had a mammogram in the past two years) dropped from 75.1% in 2001 to 72.7% in 2008
  - Cervical Cancer screening rates (had a pap test in the past three years) dropped from 88.2% in 2000 to 78.8% in 2008.
  - Colorectal cancer screening rates increased from 38% in 2001 to 60.1% in 2009.
  - Partners supported two Nebraska Dialogue for Action events, nine national Dialogue for Action events, Screen for Life, the Stay in the Game social marketing campaign with Husker Sports Network, two Boxer 500 and one Rollin' to Colon events.
  - Partners achieved policy and systems change by:
    - increasing funds for Every Woman Matters;
    - obtaining state funding for Stay in the Game;
    - gaining mandatory health insurance program coverage for colorectal cancer screening and passing the statewide Nebraska Clean Air legislation and passing numerous local clean air ordinances.
  - **Bottom line**: Significant progress was made in colorectal cancer screening but we lost ground in screening for breast and cervical cancer. Clearly, more work needs to be done.

- We built an internal DHHS infrastructure:
  - The NE CCCP manager's full time position was filled with the same person since June 2002.

- The community health manager full time position was filled with two persons over 95% of the time the position was approved and funded.
- The program was located in the Office of Disease Prevention and Health Promotion.
- The program hosted three masters in public health CAPSTONE students and five other senior college students to complete internships; program staff provided public health orientation to five other students.
- The program shared a position with the UKMC which contracted with the National Cancer Institute (NCI) for the Cancer Information Services (CIS) Partnership Program; this position was filled with three different persons during the six years of the partnership (filled 100% of the time.)

- We built a partnership infrastructure and in 2010 revised that infrastructure.
  - We adopted the name and logo: C.A.R.E.S Cancer Awareness, Research, Education and Service to identify the program and partnership.
  - In 2010, we formed a 501(c)(3) non-profit entity to manage the partnership and selected a new name Nebraska Cancer Coalition (NC2).
  - The NE CCCP remains the DHHS "program" for comprehensive cancer control.
  - We have had consistent partnership leadership from 2001 to 2010. In the first year, co-chairs shared leadership responsibilities; when Eva Serenil stepped down after one year due to family illness, Alan G.Thorson, M.D., continued as Chair. Similarly, numerous work group leaders have held their leadership positions over the past six years.

- We leveraged funding to expand resources beyond the CDC annual grants
  - The program applied for and received funding for sun safety ($30K/year x 5 years); Dialogue for Action ($120K in-kind); C-Change policy development ($10K);
  - NC2 has the capacity to acquire resources not available to the program. In 2010, NC2 was "adopted" by the Family, Career and Community Leaders of America (FCCLA) students in Nebraska and raised funds.
  - Annual "in kind" resources from partners each year has far exceeded the 10% match required for the grant ($25K to $31K annually);
  - Partners provided cash supports for the Stay in the Game colon cancer social marketing campaign.

Burden of Cancer

Nebraska Demographics

Nebraska is the fifteenth largest state in the nation in terms of land surface. The state spans nearly 500 miles from east to west and approximately 250 miles from north to south. The two largest cities in Nebraska are Omaha and Lincoln, both located in the southeastern part of the state.

The 2010 Census reports became available in March, 2011. These reports show that Nebraska added 115,078 people over the past decade to reach a total population of 1,826,341. This growth rate translates to a 6.7% increase compared to an 8.4% increase during the previous decade. Twenty four of the state's 93 counties gained population during the last decade while 69 primarily rural counties continued to lose population. More than half of all Nebraskans now live in three eastern counties: Douglas, Sarpy or Lancaster. Sarpy County grew by 30% over the last decade, the highest rate for any of the counties.

A quick analysis of the population of the top twenty cities in Nebraska reveals a dramatic challenge for addressing the burden of cancer in the state. Only two cities could be considered "large" and there is only one city over 50,000 but less than 250,000. In 2010, Omaha broke the 400,000 population barrier, and Lincoln topped 250,000. La Vista had the largest percentage growth rate among the state's top 20 cities, showing a 35% growth rate. The Metro Omaha area grew to 865,350 or about a 13% increase over the past decade. Three cities in the top 20 rankings lost population: York, Alliance, and Beatrice. Most of Nebraska's 93 counties experienced a loss of population.

Top 20 Nebraska Cities by Population 2010 U.S. Census

	City	Population	County
1	Omaha	408,958	Douglas
2	Lincoln	258,379	Lancaster
3	Bellevue	50,137	Sarpy
4	Grand Island	48,520	Hall
5	Kearney	30,787	Buffalo
6	Fremont	26,397	Dodge
7	Hastings	24,907	Adams
8	North Platte	24,733	Lincoln
9	Norfolk	24,210	Madison
10	Columbus	22,111	Platte
11	Papillion	18,894	Sarpy
12	LaVista	15,758	Sarpy
13	Scottsbluff	15,039	Scotts Bluff
14	South Sioux City	13,353	Dakota
15	Beatrice	12,459	Gage
16	Lexington	10,230	Dawson
17	Gering	8,500	Scotts Bluff
18	Alliance	8,491	Box Butte
19	Blair	7,990	Washington
20	York	7,766	York

Source: 2010 U.S. Census

The Hispanic population in Nebraska grew by almost 73,000 in the past decade, as shown in table below. This figure represents a 77.3% gain over the 2000 census and accounts for more than 60% of the total population growth in the past ten years. In contrast, the rest of the population grew by only 2.6% over the same time span. In some cities, the proportion of Hispanic population doubled or nearly doubled, e.g. Crete, Wakefield, South Sioux City. Significant changes were seen in many other communities. Wilber, for example, long regarded as the Czech Capitol of the state, now has one in ten residents as Hispanic; ten years ago, the ratio was closer to two out of every 100 residents.

Growth of Hispanic Population in Nebraska

	2000	2010
Hispanic Population	94,425	167,405
Nebraska population	1,711,263	1,826,341

Source: 2010 U.S. Census

Nebraska is also an arrival site for refugees in the United States. In 2009 over 800 refugees came to Nebraska according to the U.S. Department of Health and Human Services Administration for Children and Families. In addition to refugees who come directly to Nebraska there are many more refugees who re-locate to Nebraska from other arrival sites. The majority of the 2009 arrivals came from Myanmar (formerly known as Burma).

According to the 2010 Census, the Omaha white-only population decreased by 16,000; whites now comprise 68% of the city's residents compared to 75% ten years ago. The Hispanic population grew 82% to 53,553. African Americans continue to be the top minority group in Omaha at 55,128 persons or about 13.5% of the population. During the last decade, Omaha's nonwhite population grew by 34,655.

Nebraska Cities above 1,000 Population with the Greatest Percentage Hispanic Population

Cities	Overall 2010 Population	2010 Hispanic Population	Percent 2010	Percent 2000
Schuyler	6,211	4,060	65%	45%
Lexington	10,230	6,138	60%	51%
Madison	2,438	1,189	49%	34%
South Sioux City	13,353	6,047	45%	25%
Terrytown	1,198	505	42.2%	44%
Crete	6,960	2,484	36%	14%
Wakefield	1,451	488	33.6%	17%
Gibbon	1,833	593	32.4%	21%
Dakota City	1,919	562	29%	20%
Scottsbluff	15,039	4,371	29%	24%

Source: 2010 U.S. Census; Mark Anderson and Sheila Story, Lincoln Journal Star; March 2, 1011.

Nebraska's population by race did not substantially change over the past decade.

Race	Percent of Population
White alone	86.1
Black or African American alone	4.5
American Indian and Alaska Native alone	1.0
Asian alone	1.8
Native Hawaiian and Other Pacific Islander alone	0.1
Some Other Race alone	4.3
Two or More Races	2.2

In 2006, Nebraska's population age 65 and older represented about 13% of the population. It is expected that by 2015, the age 65+ population will make up 14% of the state's population and by 2030, this age group will comprise 21% of the Nebraska population. (OASDI Beneficiaries by State and County, 2006. Social Security Administration. Projections of the Population, By Age and Sex, of States: 1995 to 2025. United States Census Bureau. Ranking of States by Projected Percent of Population age 65 and Over: 2000, 2010, and 2030. United States Census Bureau.) These projected changes in age demographics suggest significant work is needed to reduce the cancer incidence and mortality, especially for those cancers for which age is a major risk factor.

Additionally, many Nebraska communities are losing their inhabitants; one of every three of the 93 counties is a frontier county (fewer than six people per square mile) according to the Office of Rural Health. Living in a frontier county often means there are no nearby medical services leaving inhabitants medically underserved.

To reflect these demographic changes the Nebraska Comprehensive Cancer Control program is adjusting priorities to continue to promote health equity, reduce disparities and reach out to especially vulnerable populations like recent immigrants, refugees and Nebraskans living in underserved areas.

The Cost of Nebraska's Cancer Burden

The economic burden of cancer is the financial cost associated with

a. expenditures for cancer preventive, screening and treatment services,
b. the economic cost associated with time and effort spent by patients and their families undergoing cancer treatment, and
c. the economic cost associated with lost productivity due to cancer-related disability and premature death.

According to the National Institutes of Health (NIH), the total cost of cancer for the entire U.S. in 2010 was $263.8 billion. This figure includes $102.8 billion for direct medical costs and $161 billion for indirect costs. Indirect costs may further be broken into indirect morbidity costs ($20.9 billion) and indirect mortality costs ($140.1 billion). For Nebraska the cost of cancer is estimated at $1.53 billion per year. Direct and indirect costs are shown in the table below.

Estimated Cost of Cancer in Nebraska 2010	
Direct costs	$595 million
Indirect costs: morbidity	$121 million
Indirect costs: mortality	$811 million

Policy, Environment and Systems Change

Policy, environment and systems changes have been shown to substantially impact disease burdens in the areas of cardiovascular health, diabetes and other chronic diseases. The previous cancer plan only minimally addressed issues of policy, environment and systems change. As comprehensive cancer control has evolved over the past ten years, these issues have become more approachable, in part because there has been a corresponding increase in the number of evidence-based strategies. Changes in the national and state economy as well as maturing of the comprehensive cancer control programs have resulted in increased advocacy and the need to address policy issues.

Cancer Trends in Nebraska

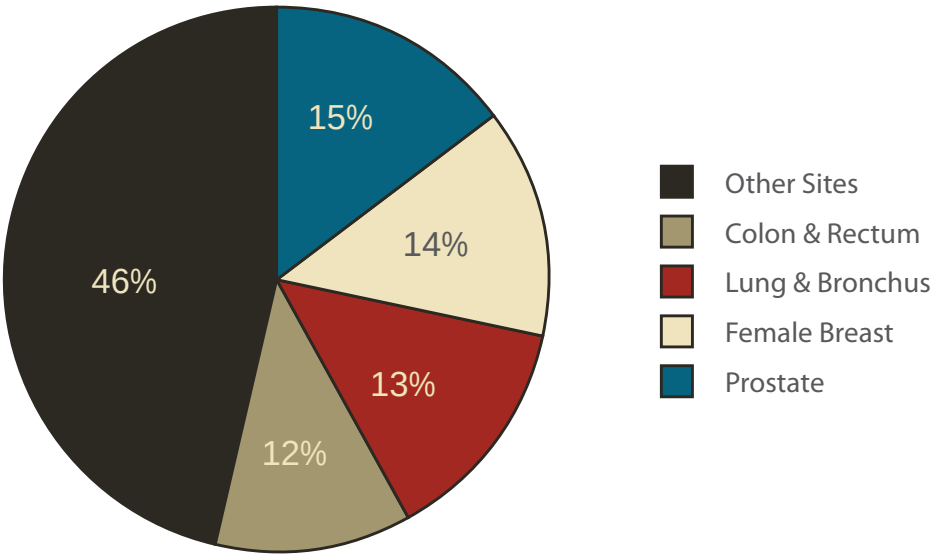
The Nebraska Cancer Registry, managed by the Nebraska DHHS, gathers data used to describe cancer incidence, mortality, treatment, and survival in Nebraska. These data are especially useful for analysis of trends and to compare Nebraska's cancer experience to the rest of the nation. A brief overview of cancer trends is included in this plan. More detailed data and reports are available from the Nebraska Cancer Registry at http://www.hhs.state.ne.us/ced/cancer/data.htm The brief overview of cancer incidence and mortality below suggests that there are many areas of potential focus for the NC2 and NE CCCP.

Incidence

The Nebraska Cancer Registry recorded 8,930 diagnoses of malignant cancer among Nebraska residents in 2008. This number is lower than the 9,256 number of cancer diagnoses in 2007; however, recent registry experience suggests that as the registry continues to find cases, the final count of 2008 cases will probably increase by about 2-4%.

Primary Site	Number
Prostate	6628
Female Breast	6172
Lung & Bronchus	6074
Colon & Rectum	5265
Other Sites	20856

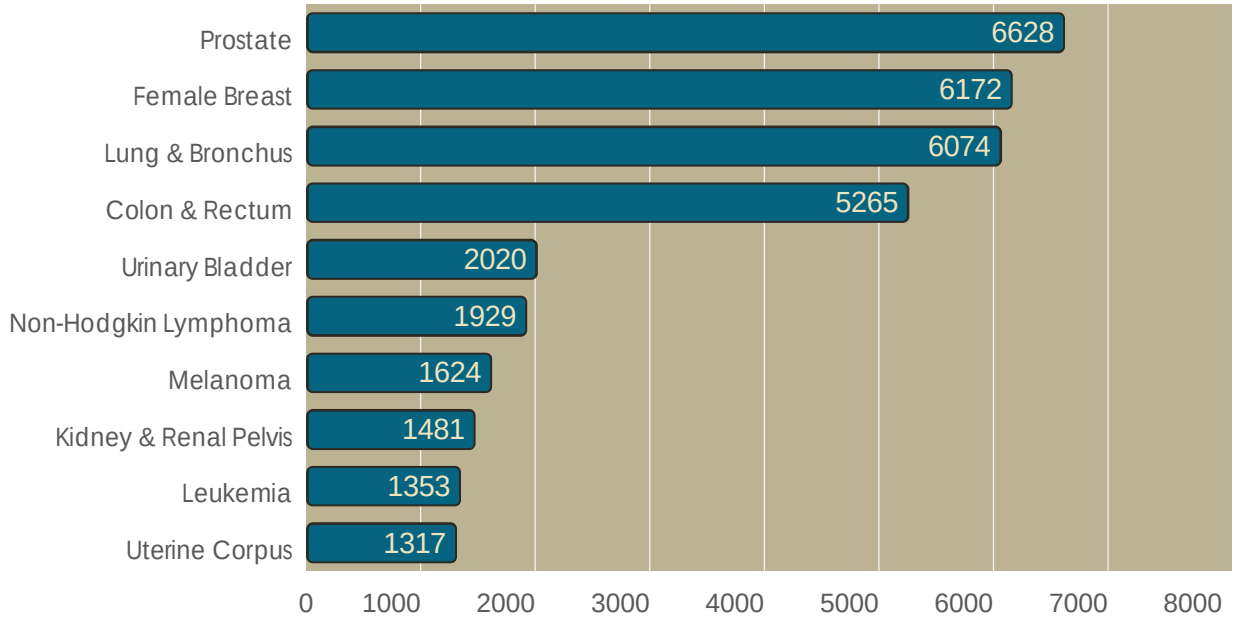
Distribution of Malignant Cancer Diagnoses, by Primary site, Nebraska, 2004-2008



Nebraska's top ten cancer sites are shown in the table and chart below.

Primary Site	Number
Uterine Corpus	1317
Leukemia	1353
Kidney & Renal Pelvis	1481
Melanoma	1624
Non-Hodgkin Lymphoma	1929
Urinary Bladder	2020
Colon & Rectum	5265
Lung & Bronchus	6074
Female Breast	6172
Prostate	6628

Leading Cancer Sites by Number of Malignant Diagnoses, Nebraska 2004-2008.



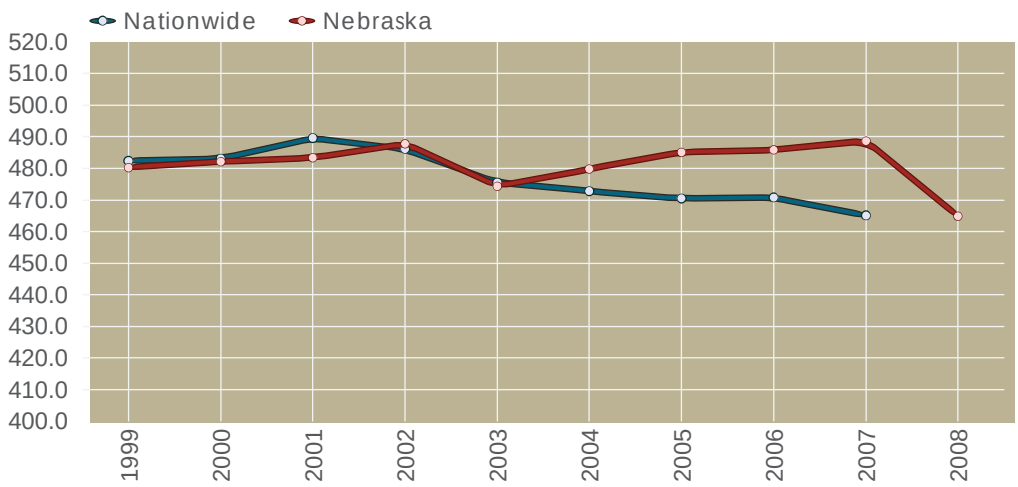
The incidence of cancer in Nebraska is similar to the incidence of cancer for Americans as a whole.

The Nebraska and U.S. cancer incidence rates are shown in the table below; the U.S. rate is given for 2007, the most recent rate available.

Nebraska and U.S. Cancer Incidence Rates	
Nebraska Incidence Rate (2008)	484.9 cases per 100,000 population
U.S. Incidence Rate (2007)	465.1 cases per 100,000 population.

The cancer incidence trend for Nebraska and the U.S. are shown in the table below. Since 2003, the Nebraska cancer incidence rate has been somewhat higher than the U.S. rate but the gap appears to have been narrowed with the 2008 data.

Cancer (All Sites) Incidence Rates, Nebraska and the U.S., 1999-2008.



The leading cancer sites from 1997 through 2008 have consistently included breast, prostate, lung & bronchitis, and colon & rectum. Again, in 2008, cancers of the lung, breast, prostate, colon and rectum occurred most frequently, accounting for more than half (52.7%) of all cancer diagnoses.

Cancer incidence varies considerably across racial and ethnic groups. For example, African American men have higher rates of prostate cancer than men in other racial and ethnic groups. Hispanic women have higher rates of breast cancer than women in other groups.

Cancer Incidence Rates for Top Ten Primary Sites by Race and Ethnicity, Nebraska, 1999-2008

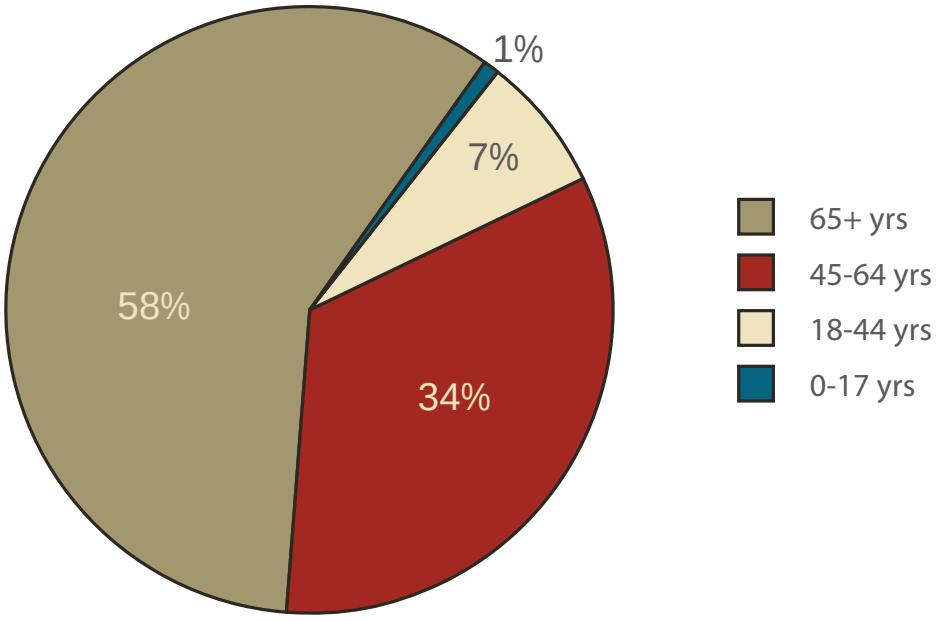
Rank	White	African American	Native American	Asian/Pacific Islander	Hispanic
1	Prostate	Prostate	Lung/Bronchus	Colon/Rectum	Female Breast
2	Female Breast	Lung/Bronchus	Female Breast	Lung/Bronchus	Colon/rectum
3	Lung/Bronchus	Female Breast	Colon/Rectum	Female Breast	Lung/Bronchus
4	Colon/Rectum	Colon/Rectum	Prostate	Prostate	Prostate
5	Urinary Bladder	Kidney/Renal Pelvis	Kidney/Renal Pelvis	Liver/ Intrahepatic Bile Duct	Kidney/Renal Pelvis

Nebraska Cancer Registry, 2008 Draft Report

The age distribution of malignant cancer diagnoses in Nebraska show that persons age 65 and older are more likely to be diagnosed with cancer.

Age	Number
0-17 yrs	376
18-44 yrs	3281
45-64 yrs	15058
65+ yrs	26280

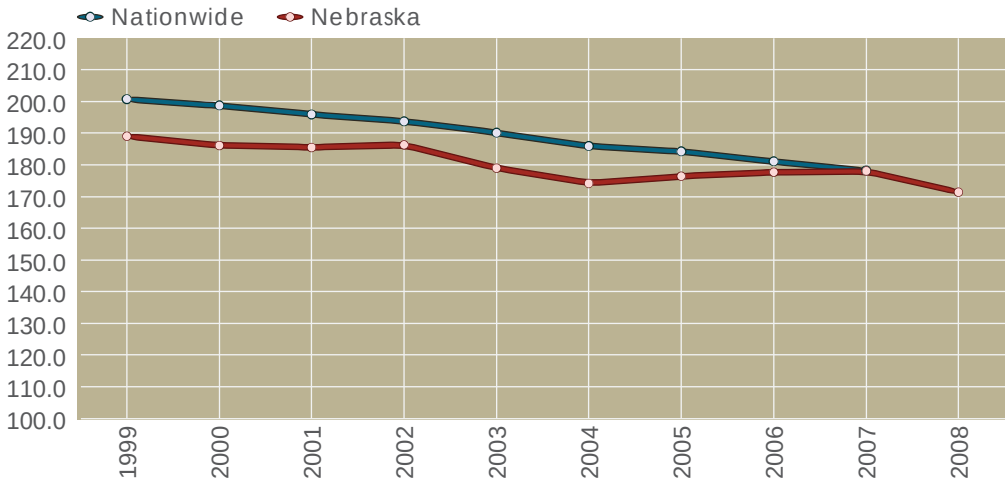
Age Distribution of Malignant Cancer Diagnoses, Nebraska, 2004-2008



Mortality

In 2008, there were 3,377 cancer deaths in Nebraska, a number that translates into a rate of 171.4 cancer deaths per 100,000 population. The Nebraska cancer mortality rates have been lower than the U.S. rates until 2007 when the U.S. rate and the Nebraska rate were nearly identical as shown in the Chart below. The rate of death due to cancer in Nebraska has decreased from 189.0 cases per 100,000 population in 1999 to 171.4 cases per 100,000 population in 2008. (Could the implementation of our first Nebraska Cancer Plan be making a difference?)

Cancer (All Sites) Mortality Rates, Nebraska and the U.S., 1999-2008.



A comparison of the most recent state and U.S. mortality rates for the past five years shows that Nebraska has lower rates of cancer mortality from the oral cavity, stomach, liver, and uterine cervix and higher rates of cancer deaths of the uterine corpus and brain. By primary site, cancers of the lung, breast, prostate, colon and rectum accounted for just under half (49.6%) of Nebraska's cancer deaths.

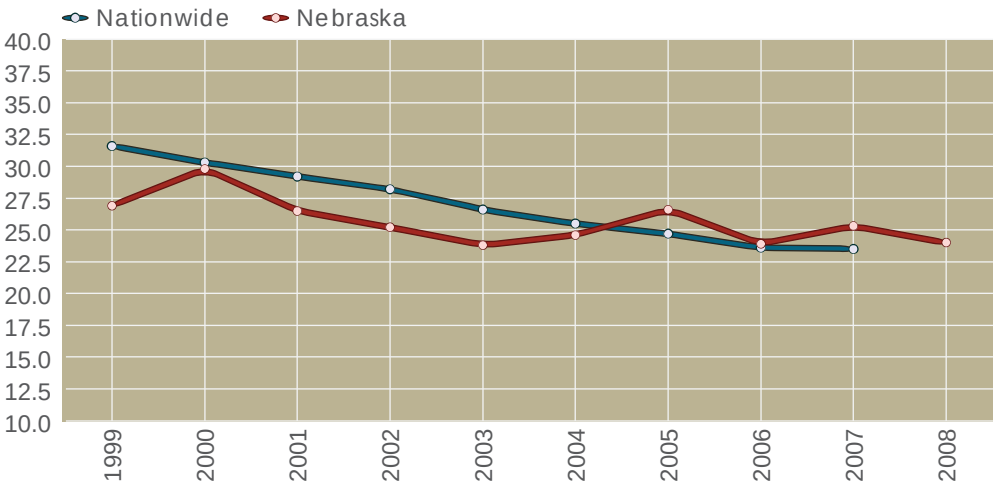
During the five-year period 2004-2008, age was the primary predictor of cancer death as shown in the table below.

Cancer Mortality: Percentage Distribution by All Sites and Age at Death
Nebraska 2004-2008

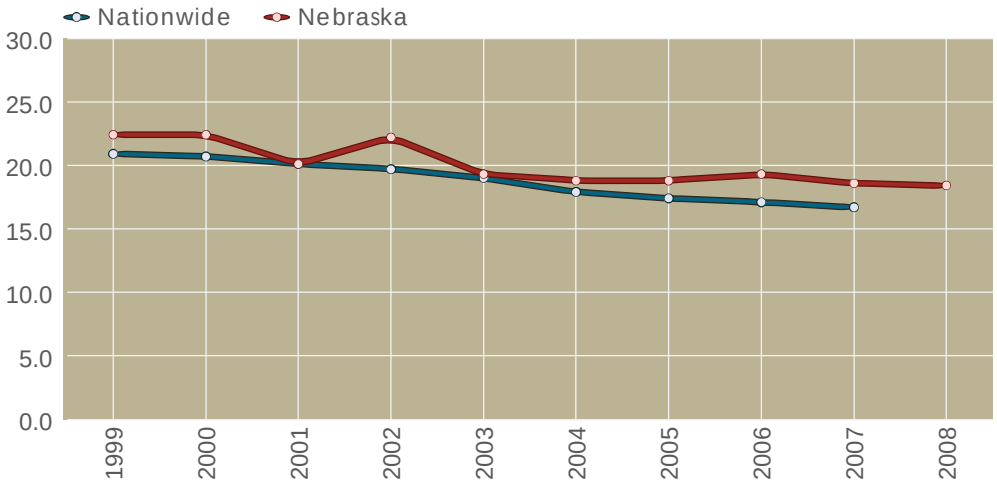
	0-17 years	18-44 years	45-64 years	65+ years
All Sites	.4%	2.7%	23.3%	73.6%

As evidenced by the two charts below, both Nebraska and the U.S. have made some progress in reducing the rates of prostate cancer death and colon/rectal cancer death. In Nebraska, prostate cancer mortality rates have decreased from 26.9 cases per 100,000 population in 1999 to 24.0 cases in 2008. Similarly, colorectal cancer mortality rates have decreased from 22.4 cases per 100,000 population to in 1999 to 18.4 cases per 100,000 population in 2008. Increasing colorectal cancer screening rates has been a key initiative throughout the 2005-2010 Nebraska Cancer Plan implementation phase.

Prostate Cancer Mortality Rates, Nebraska and the U.S., 1999-2008



Colon and Rectum (Colorectal) Cancer Mortality Rates, Nebraska and the U.S. 1999-2008



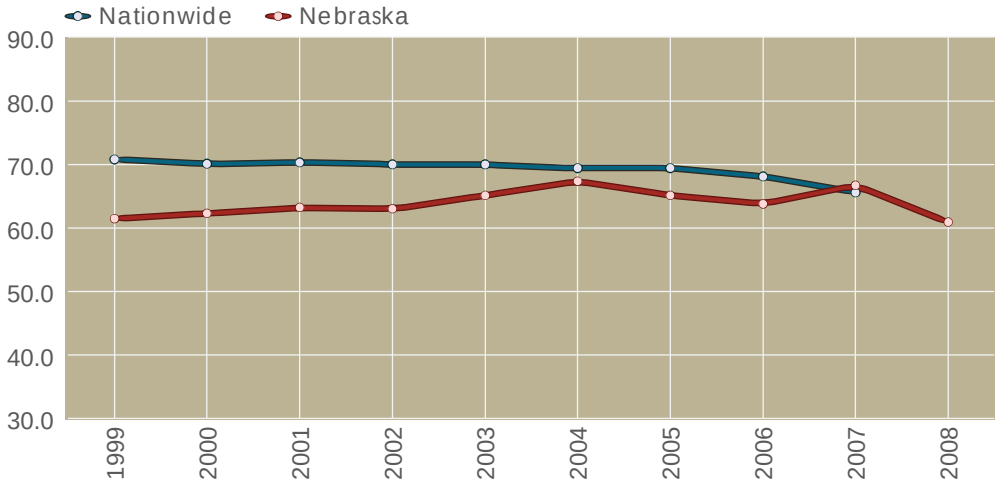
Incidence and Mortality for Selected Primary Sites

Lung and Bronchus

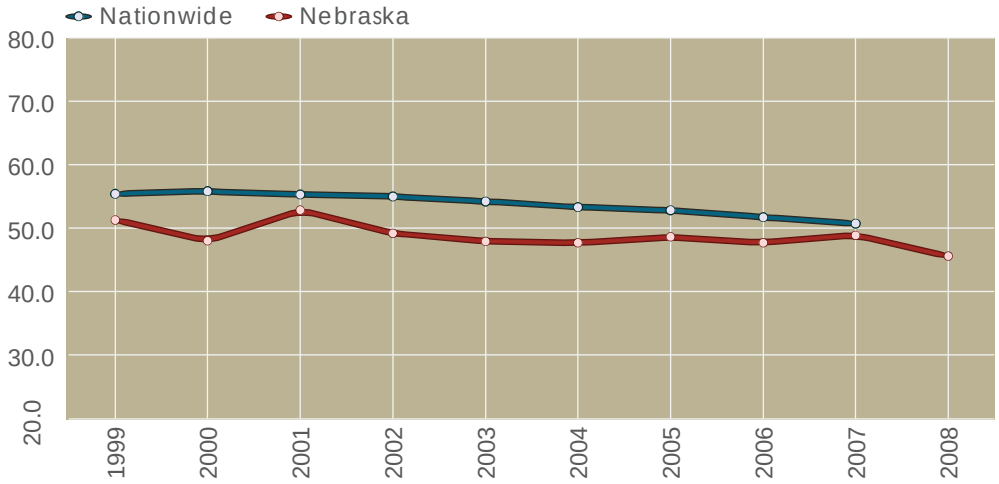
Although lung cancer was only the third most frequently diagnosed cancer among Nebraska residents in 2008, it was the year's leading cause of cancer mortality, accounting for more than 25% of the state's cancer deaths. During the past five years (2004-2008) lung cancer has averaged over 1,200 diagnoses and 900 deaths in Nebraska per year. The high number of lung cancer deaths is due to the small number of cases that are detected at an early stage; as a result, fewer than 20% of people who are diagnosed with lung cancer survive five years or more.

Cigarette smoking is the major cause of lung cancer and causes about 85% of lung cancer deaths. Implementation of Nebraska's Clean Air Bill is expected to make some impact on the smoking rates and ultimately the incidence and mortality rates; in the meantime, other state and local policy initiatives are indicated.

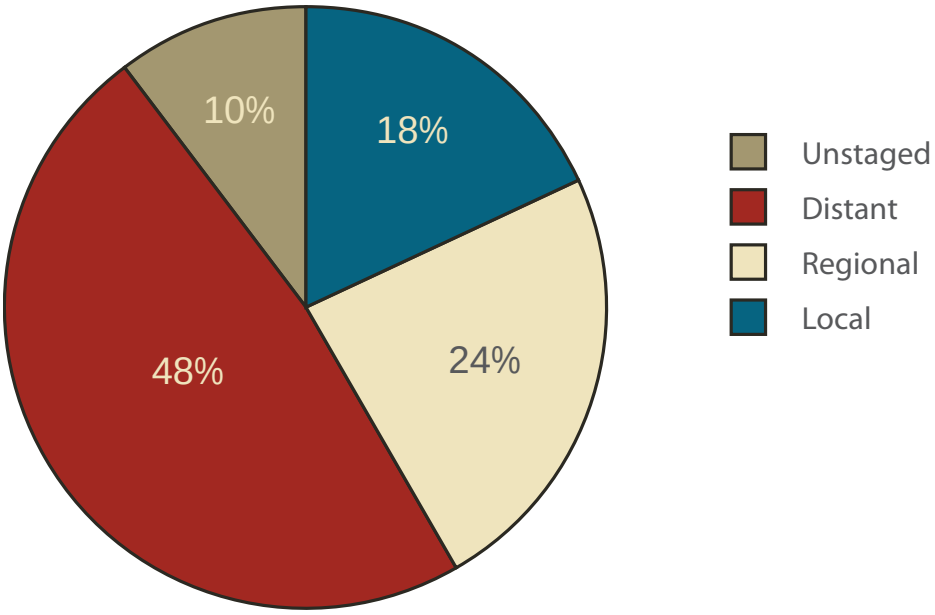
Lung and Bronchus Cancer, Incidence Rates: Nebraska and the U.S. 1999-2008



Lung and Bronchus Cancer, Mortality Rates, Nebraska and the U.S., 1999-2008



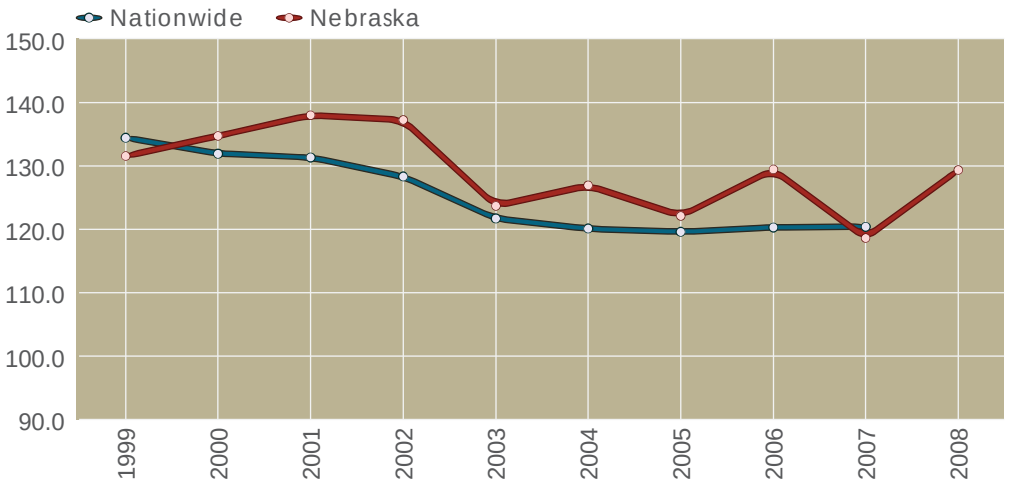
Lung and Bronchus Cancer, Percent of Cases, by Stage of Disease at Diagnosis, Nebraska, 2004-2008



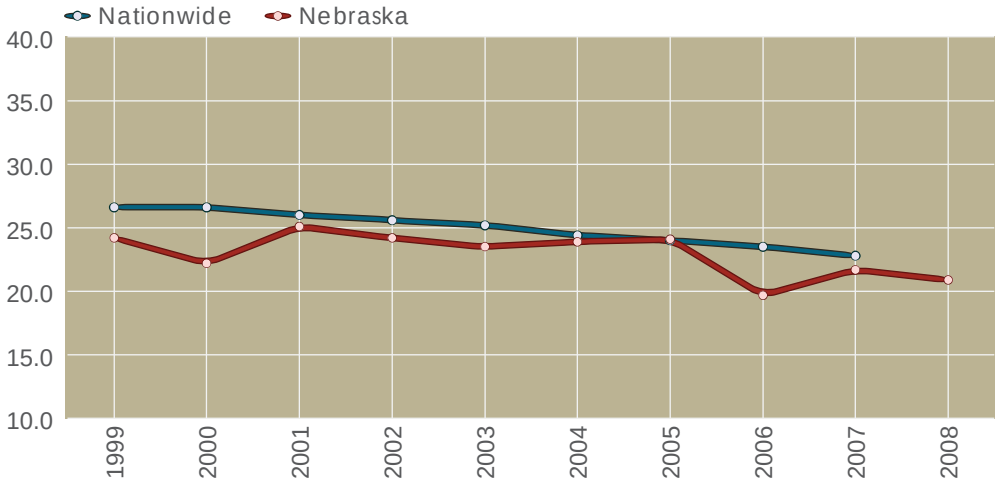
Female Breast Cancer

Breast cancer is the most common malignancy among women and the second most frequent cause of female cancer deaths. Between 2004 and 2008, 6,172 Nebraska women were diagnosed with malignant breast cancer (and another 1,348 women were diagnosed with in-site breast cancer) and 1,181 women died from it. Since 1990, the rate of breast cancer deaths in Nebraska and the nation has declined significantly. During the same time period, the rate of malignant breast cancer diagnoses has also declined. Implementation of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP and in Nebraska Every Woman Matters) and the decreasing use of post-menopausal hormone replacement therapy have attributed to this decline. One important risk factor for breast cancer is age, with fewer than 20% of all malignancies occurring among women under age 50. Early detection of breast cancer has resulted in over half (51%) of female breast cancers being diagnosed at local stage.

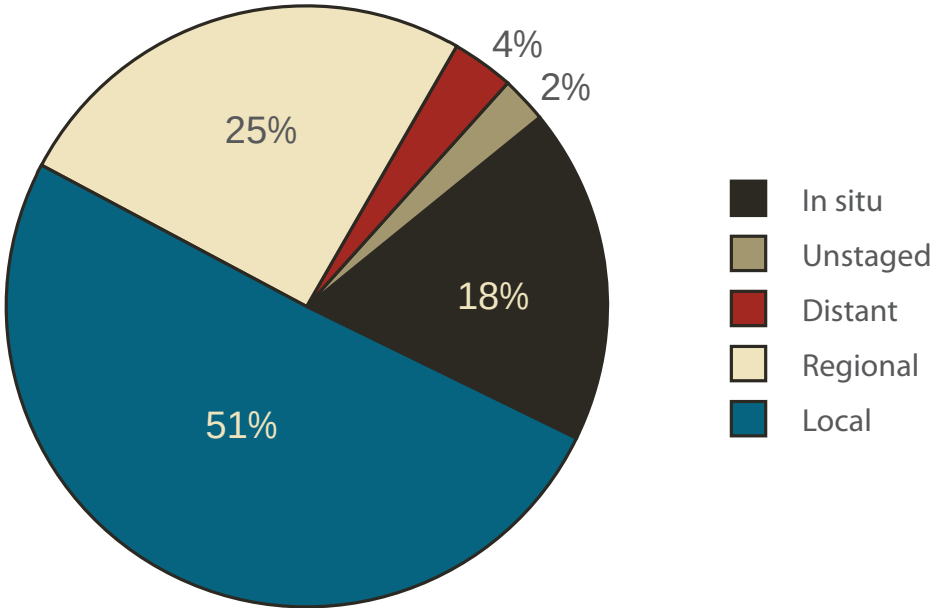
Female Breast Cancer Incidence Rates, Nebraska and the U.S., 1999-2008



Female Breast Cancer Mortality Rates, Nebraska and the U.S., 1999-2008



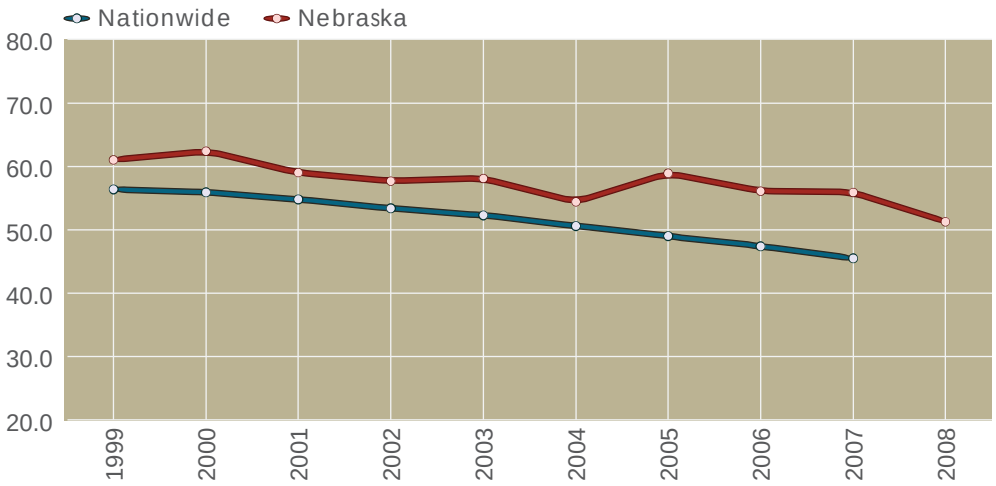
Female Breast Cancer, % of Cases, by Stage of Disease at Diagnosis



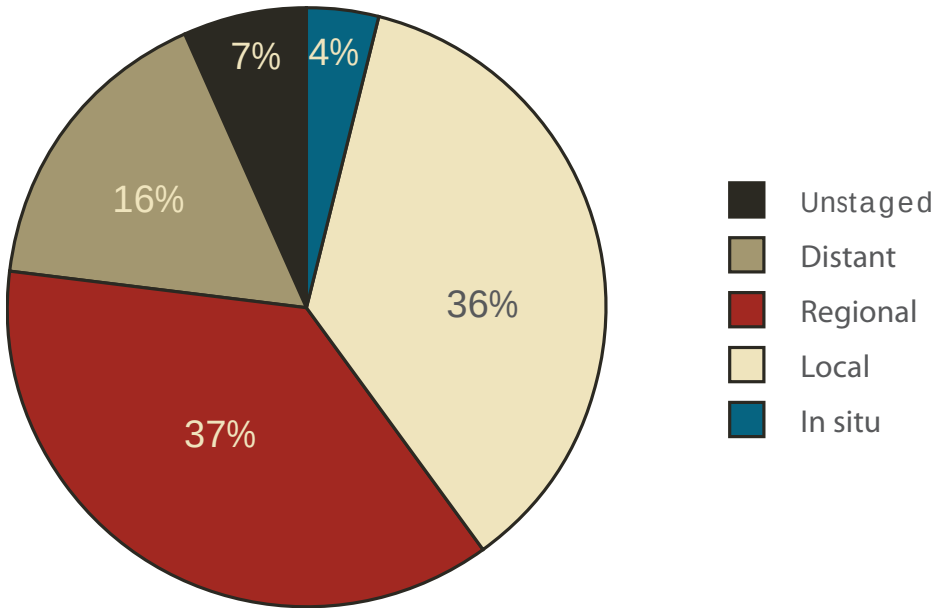
Colorectal Cancer

In 2008, colorectal cancer was the fourth most frequently diagnosed cancer among Nebraska residents, accounting for 1,001 new malignancies. It was the second cause of cancer death in the state, accounting for 369 deaths. Seventy percent (70%) of colorectal cancer cases occurred in persons who were 65 or older at diagnosis. Other risk factors include a personal or family history of colorectal cancer or polyps, a personal history of chronic inflammatory bowel disease, and certain hereditary colorectal cancer syndromes. Modifiable risk factors include physical inactivity, obesity, smoking, a high-fat diet (especially fat from animal sources) and heavy alcohol use. As indicated in the chart below, Nebraska's colorectal cancer incidence rate since 1999 has been higher than the national colorectal cancer incidence rate, although the incidence rates for both Nebraska and the U.S. have been declining. Mortality rates were discussed earlier in this report. In part, due to increased screening, the number of cases diagnosed at local and regional stages now account for seventy-three% (73%) of all cases diagnosed.

Colorectal Cancer Incidence Rates, Nebraska and the U.S., 1999-2008



Colorectal Cancer Percentage of Cases, by Stage of Disease at Diagnosis, Nebraska 2004-2008



Cancer and Heart Disease

Cancer is the leading cause of death for some groups of Nebraska residents. For persons under age 75, cancer claims more lives than heart disease; after age 75, this pattern is reversed as shown in the table and figure below.

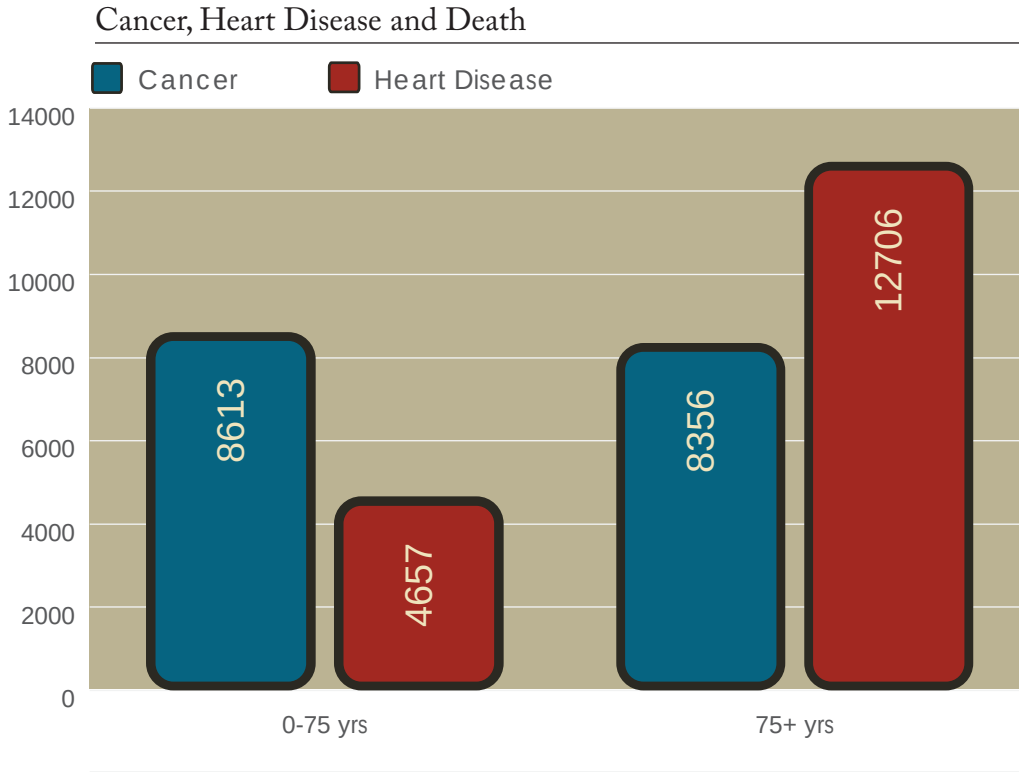
Cause of Death	0-75 yrs	75+ yrs	TOTAL
Cancer	8613	8356	16969
Heart Disease	4657	12706	17363

Male

Cause of Death	<75	75+	TOTAL
Cancer	4736	4130	8866
Heart Disease	3141	5287	8428

Female

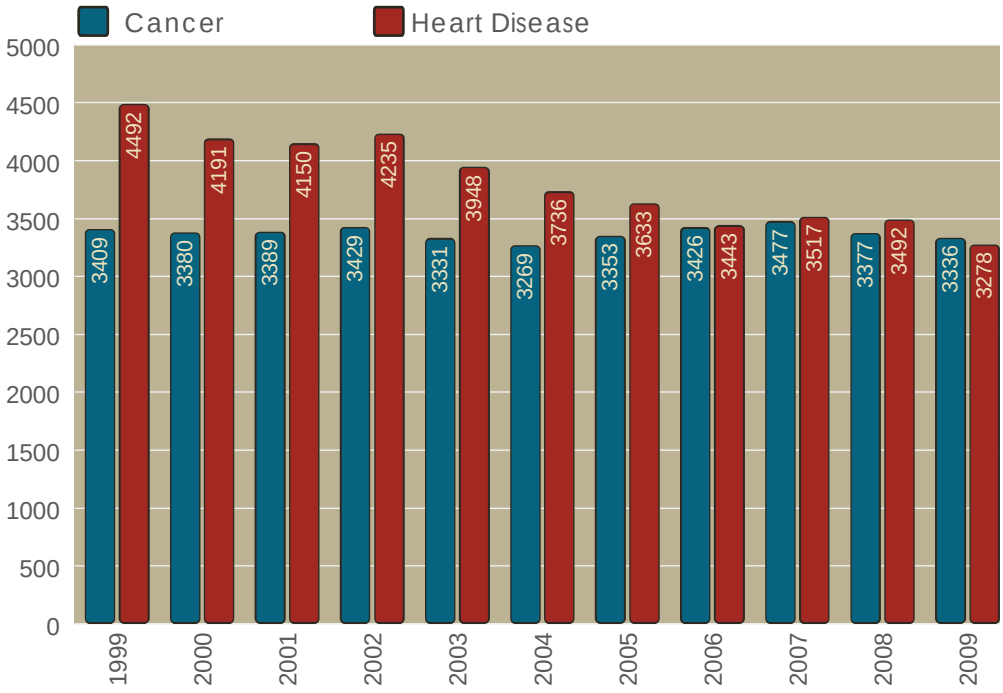
Cause of Death	<75	75+	TOTAL
Cancer	3877	4226	8103
Heart Disease	1516	7419	8935



In terms of actual numbers, cancer deaths exceeded heart disease deaths for the first time in 2009. This trend is expected to continue, in part because much progress has been made in diagnosing and treating heart disease early.

Year	Cancer	Heart Disease
1999	3409	4492
2000	3380	4191
2001	3389	4150
2002	3429	4235
2003	3331	3948
2004	3269	3736
2005	3353	3633
2006	3426	3443
2007	3477	3517
2008	3377	3492
2009	3336	3278

Annual Number of Deaths, Heart Disease and Cancer, Nebraska 1999-2009



Risk Factors

Tobacco

The American Cancer Society reports that tobacco use is the most preventable cause of death in our society, accounting for at least 30% of all cancer deaths. Use of tobacco is responsible for as many as 87% of all lung cancers. There is ample evidence that secondhand smoke, smokeless tobacco, pipe tobacco, cigars, and cigarettes cause cancer. Exposure to secondhand smoke also causes other health problems such as respiratory illness and asthma attacks. Oral cancer occurs several times more frequently among smokeless tobacco users than non-users.

According to the most recent data from the Nebraska Behavioral Risk Factor Surveillance System (BRFSS), the prevalence of cigarette smoking among Nebraska adults has decreased from 21.2% of the adult population in 2000 to 16.7% in 2009. Nebraska youth who smoked on one or more of the past 30 days in 2001 was 30.5% compared to 18.4% in 2009. Data from the 2008 Nebraska Behavioral Risk Factor Surveillance System (BRFSS) suggests that Nebraska males (20.1%) are more likely to smoke than females (16.7%). Younger adults (ages 18-24) exhibit the highest smoking rates (27.6%) with the lowest being among the 65+ age group (7.7%). The sharp decline in the smoking rate after age 65 may be due to increased mortality attributable to smoking-related diseases. BRFSS fact sheets are included in the Appendix. More specific and timely information is available from the Tobacco Free Nebraska Program's website at http://www.dhhs.ne.gov/tfn/tfnpubrep.htm

Nutrition and Physical Activity

Diet, obesity, and physical activity are also important modifiable determinants of cancer risk. The American diet is estimated to account for about one-third of all U.S. cancer deaths. The greatest concern with the American diet today is the consumption of too much saturated fat and too few vegetables, fruits, and whole grains. In Nebraska, less than one in four adults who participated in the 2010 BRFSS reported that they consumed recommended servings of fruits and vegetables per day; this was slightly more than the one in five who reported this consumption level in the 1990 survey. The statistics for youth are similarly disappointing. According to the 2001 Nebraska YRBS, only 18% of the state's high school students reported that they had eaten at least five servings of fruits and vegetables per day during the past seven days.
Obesity is known to increase the risk of developing cancers of the breast among post-menopausal women, cervix, endometrium, ovary, and gall bladder among women, cancer of the colon among both men and women and cancers of the prostate among men. Obesity may also be a risk factor for cancers of the pancreas and esophagus. In Nebraska, 59% of adults who participated in the 2001 BRFSS in were overweight or obese; in 2009, rate was 65% who reported being overweight (37%) or obese (28%).

Physical inactivity is strongly associated with increased risk of developing colon and breast cancers and may also increase the risk for cancers of the pancreas, prostate, lung, endometrium, ovary, and testes. Physical activity levels among both adolescents and adults are strikingly low. In fact, only 68% of Nebraska adults surveyed in the 2009 BFRSS reported that they had engaged

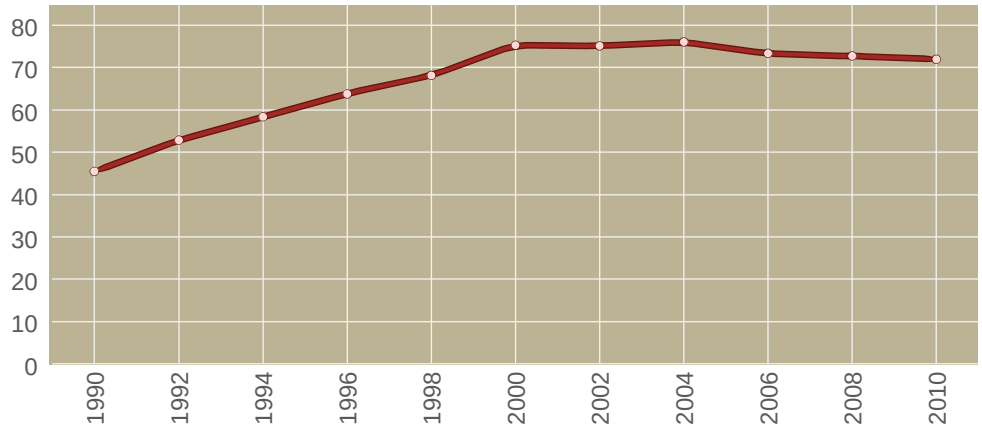
in recommended leisure-time physical activity during the past month; this percentage has been decreasing in recent years. The 2001 Nebraska YRBS shows that one-fourth of youth surveyed had not participated in moderate or vigorous physical activity during the past seven days, fewer than half attended any physical education classes and more than half watched two or more hours of television on an average school day.
The Nebraska Comprehensive Cancer Control Program is working closely with the Nutrition and Activity for Health (NAFH) Program in the Nebraska Department of Health and Human Services to identify opportunities for collaboration. See the BRFSS Data Fact Sheets in the Appendix. More comprehensive and current information is available on the NAFH website: http://www.dhhs.ne.gov/NAFH/

Cancer Screening

Screening tests are currently available for detecting breast, cervical, colon and rectal cancers. The research arena is working hard to improve these screening modalities and to develop new ones, especially for lung and bronchus cancers.

Breast Cancer
During the decade of the 1990s, breast cancer mortality began to decline substantially in Nebraska and the nation; this is due in part to the increased use of screening mammography and state level policies supporting treatment after diagnosis of breast cancer. The 2008 BRFSS Fact Sheet notes that approximately 1 in 4 women ages 40+ reported not having a mammogram in the past two years, as seen in the chart below.

Percentage of Nebraska Women 40+ Who Have Had a Mammogram in Past Two Years, 1990-2010



Women with some college reported a higher frequency (76.5%) of having a mammogram in the past two years than women with no high school diploma or GED (54.5%). There is some evidence that completion of annual mammograms is on the decline both nationally and in Nebraska. The Office of Women's and Men's Health, Every Woman Matters Program has put together a work group to develop the first Nebraska Breast Cancer Plan. This plan provides a

framework and work plan for the next five years and is integrated into this Nebraska Cancer Plan.

Cervical Cancer
Throughout the United States, cervical cancer incidence and mortality have fallen drastically during the past several decades, as a result of the introduction and widespread adoption of the Pap test as a means to screen for the disease. The Pap test is a simple procedure that can detect cervical cancer and pre-cancerous lesions, and can be performed by a health care professional as part of a pelvic exam.

The results from the 2008 Nebraska BRFSS show that only about 1 in 5 Nebraska women ages 18+ reported not having a Pap test in the past 3 years. Women with more income and with more education were more likely to have had a pap test in the past three years.

Colorectal Cancer
In 2008, colorectal cancer was the fourth most frequently diagnosed cancer among Nebraska residents, accounting for over 1,001 new cases. It was the second leading cause of cancer death in the state. The 2009 BRFSS Fact Sheet indicates that the screening rate for Nebraska adults age 50+ who reported ever having a sigmoidoscopy or colonoscopy increased from 38% in 2001 to 60.1% in 2009. Nebraska also has narrowed the gap between national screening rates and Nebraska rates. Significant progress was made in screening for colorectal cancer during the 2005-2010 plan implementation phase as indicated by the increased screening rates, the development and funding of a Nebraska Colon Cancer Screening Program, the Stay in the Game Campaign, Rollin' to Colon, Boxer 500 and other activities.

Prostate Cancer
Prostate cancer screening remains controversial. The U.S. Preventive Services Task Force recently concluded again that there is insufficient evidence to promote routine screening for all men and inconclusive evidence that screening improves health outcomes. Two screening tests are commonly used: prostate-specific antigen (PSA) test and digital rectal exam (DRE).

The next section of this plan presents the priorities, goals, objectives and activities for the next plan period, e.g. 2011-2016. These priorities match the nation cancer prevention and control priorities. Annually, a specific work plan and evaluation plan will be developed and distributed to the partnership. As in the past, the plan should be considered to be flexible to meet the evolving needs of the partners and to be adopted to current issues, trends and developments.

Priorities & Goals

1. Priority:

Emphasize primary prevention to reduce cancer risks

Goal 1A: Reduce the impact of tobacco use and exposure on cancer incidence and mortality

Objective A:
Decrease the percentage of youth (grades 9 – 12) who use tobacco products 20.1% in 2016.

What will be measured	Baseline	Timeframe
Percent decrease	22.3% NE YRBS 2009	By 2016

Objective B:
Decrease the percentage of adults who smoke cigarettes to 16.0% in 2016.

What will be measured	Baseline	Timeframe
Percent decrease	16.7% NE BRFSS 2010	By 2016

Objective C:
Decrease the percentage of adult males who use smokeless tobacco to 3.0% in 2015.

What will be measured	Baseline	Timeframe
Percent decrease	5.0% NE BRFSS 2008	2015

Objective D:
Increase the number of policies to ensure smoke free public housing.

What will be measured	Baseline	Timeframe
Increase in state or local policies	TBD	By 2016

Objective E:
Increase the proportion of adult Nebraskans that are protected from secondhand smoke in homes to 88.0% in 2016.

What will be measured	Baseline	Timeframe
Percent increase	85.0% in 2009 NE Adult Tobacco Survey/Social Climate Survey	By 2016

Objective F:
Increase the proportion of adult Nebraskans that are protected from secondhand smoke in cars from to 83.0% in 2016.

What will be measured	Baseline	Timeframe
Increase in state or local policies	80.2% in 2009 NE Adult Tobacco Survey/Social Climate Survey	By 2016

Strategies:

i. Support Tobacco Free Nebraska annual work plans and collaborate to achieve common goals.
ii. Implement community wide mass media campaigns and support the Tobacco Free Nebraska Program (TFN).
iii. Increase provider to patient education.
iv. Support implementation of the TFN Health Disparities State Plan.
v. Challenge employers to provide tobacco cessation programs as part of benefits plans.
vi. Collaborate with the DHHS Office of Oral Health and Dentistry and the UNL College of Dentistry.
vii. Collaborate with communities and local health care systems regarding development and implementation of tobacco-free campus policies.
viii. Increase callers to the Nebraska Tobacco Quit Line.

Goal 1B: Healthy Eating and Physical Activity

Objective A:
Increase percent of adolescents who report eating fruits two or more times a day and vegetables three or more times a day to 7.9%, in accordance with the Healthy People 2020 goal of ten percent improvement.

What will be measured	Baseline	Timeframe
Percent increase	6.9% NE YRBS 2009	By 2016

Objective B:
Increase percentage of Nebraska adults who daily consume 5 or more servings of fruits and vegetables to 31% in accordance with the Healthy People 2020 goal of ten percent improvement.

What will be measured	Baseline	Timeframe
Percent increase	21% NE BRFSS 2009	By 2016

Objective C:
Decrease the percentage of Nebraska youth (ages 10-17) who are overweight or obese to 41% in accordance with the Healthy People 2020 goal of ten percent improvement.

What will be measured	Baseline	Timeframe
Percent decrease	31% NCHS 2007	By 2016

Objective D:
Decrease the percentage of Nebraska adults who are overweight or obese (BMI of 25 or greater) to 55% in accordance with the Healthy People 2020 goal of ten percent improvement.

What will be measured	Baseline	Timeframe
Percent decrease	65% NE BRFSS 2009	By 2016

Objective E:
Increase the percentage of Nebraska adolescents who report being physically active at least 60 minutes daily during the past seven days to 27.7% in accordance with the Healthy People 2020 goal of ten percent improvement.

What will be measured	Baseline	Timeframe
Percent increase	17.7% NE YRBS 2009	By 2016

Objective F:
Increase the percentage of Nebraska adults who meet the 2008 Physical Activity Guidelines to 78% in accordance with the Healthy People 2020 goal of ten percent improvement.

What will be measured	Baseline	Timeframe
Percent decrease	68% NE BRFSS 2009	By 2016

Objective G:
Decrease the incidence of Melanoma to 18.9, the national level.

What will be measured	Baseline	Timeframe
Incidence	23.5 Nebraska Cancer Registry	By 2016

Strategies:

i. Support the implementation of the Nebraska Nutrition & Activity for Health State Plan.
ii. Expand coordinated school health policies with the Nebraska Department of Education.
iii. Support efforts to increase physical activity during the school day.
iv. Implement community-wide social media campaigns.
v. Increase worksite wellness programs that incorporate healthy eating components.
vi. Build relationships with DHHS Environmental Health Unit and identify collaboration opportunities.
vii. Survey district health departments to assess their sun safety needs, provide resources as needed.
viii. Apply for skin cancer prevention funding.
ix. Review the New Dietary Guidelines and implement as necessary.

2. Priority:

Address public health needs of cancer survivors

Goal 2A: Optimize continuity of care for cancer survivors during and beyond initial treatment

Objective A:
Increase percentage of cancer survivors who have insurance that pays for all or part of their cancer treatment to 100%.

What will be measured	Baseline	Timeframe

Percent Increase	91% BRFSS 2009	By 2016

Objective B:
Decrease percentage of cancer survivors who report ever being denied health or life insurance coverage because of their cancer to 0%.

What will be measured	Baseline	Timeframe
Percent Decrease	7% BRFSS 2009	By 2016

Goal 2B: Increase coordination of services and expand provider knowledge of survivorship issues

Objective A:
Conduct a baseline survey to assess the gaps in survivorship services.

What will be measured	Baseline	Timeframe
Completion of survey	No survey	By 2012

Objective B:
Provide ongoing support during the next 5 years for quality of life training for health care professional on improving palliative care, survivorship, rehabilitation and end-of-life care.

What will be measured	Baseline	Timeframe
Support Resources	0	By 2016

Objective C:
Increase the percentage of cancer survivors who report participating in a clinical trial to 17%.

What will be measured	Baseline	Timeframe
Percent increase	7% BRFSS 2009	By 2016

Strategies:

i. Support the implementation of the National Action Plan for Survivorship developed by the Lance Armstrong Foundation.
ii. Promote Patient Navigation services.
iii. Continue and expand survivorship module in Nebraska BRFSS.
iv. Provide training and education opportunities at statewide cancer summits.
v. Support cancer centers' training in survivorship rehabilitation programs.
vi. Promote professional education on clinical trials.
vii. Work towards a state wide network of clinical trials in collaboration with ACoS to increase the number of participants and create effective mechanisms to screen patients for enrollment.
viii. Raise Pain and Policy Studies Group pain management report card grade from B+ to an A.
ix. Convene ad hoc group of Nebraska caregivers with expertise in survivorship to discuss current survivorship programs, gaps and current trends.
x. Promote increased participation in tumor sample collections for individual, family and research purposes.
xi. Support development of Cancer Corners across Nebraska.

3. Priority:

Reduce cancer disparities to achieve health equity

Goal 3A:

Reduce barriers to care

Notes: Minority groups are defined as: Hispanic/Latino, African American, and Native American.
Underserved populations include persons who are uninsured, under-insured and persons with access to care issues.

Objective A:
Conduct review of cancer screening in Nebraska with a focus on minority/ underserved populations.

What will be measured	Baseline	Timeframe
Creation of review mechanism	TBD	By 2014

Objective B:
Evaluate transportation, insurance and other barriers to cancer screening/early detection, diagnosis, treatment, palliative care and end of life care and develop a plan for aggressively addressing these barriers.

What will be measured	Baseline	Timeframe

Completion of review and creation of a plan	No plan	By 2012

Objective C:
Increase the percentage of adults who live in Nebraska who have health insurance to 93%.

What will be measured	Baseline	Timeframe
Percent increase	83% Nebraska Health Information Project	By 2016

Objective D:
Increase the percent of adults in Nebraska who participate in early screening and detection to 82.7% for breast cancer, 88.8% for cervical cancer, and to 70.1% for colorectal cancer.

What will be measured	Baseline	Timeframe
Percent increase	CRC: 60.1% Breast 82.7% Cervical 88.8%	By 2016

Objective E:
Increase the percentage of physicians who discuss prostate cancer screening with Nebraska African American men by ten percent.

What will be measured	Baseline	Timeframe
Percent increase	TBD—after survey complete	By 2016

Note: Survey Lincoln/Omaha physicians most likely to reach African American men to establish baseline.

Strategies:

i. Support the work of the community cancer coalitions in their outreach efforts to enroll eligible persons in the Nebraska Colon Cancer Program or otherwise obtain colon cancer screening tests as appropriate to their age and health status.
ii. Support the EWM Program in its efforts to reach to North Omaha African American women for breast and cervical cancer screening.
iii. Collaborate with the Northern Plains Comprehensive Cancer Control Program in its efforts to prevent and control cancer among Native Americans in Nebraska. Note that NP CCCP was previously the Aberdeen Area Tribal Chairman's Health Board or AATCHB.

iv. Provide strong and effective leadership in advocating for policies and programs to ensure access of racial/ethnic minorities to comprehensive health services in Nebraska.
v. Provide clinical seminar(s) on prostate cancer screening.
vi. Distribute information to partners/local health departments/cancer coalitions about potential sources of payment for cancer screening, diagnosis, treatment and palliative care.
vii. Establish refugee screening events to provide screening and education.
viii. Review CDC Health Disparities and Inequalities Report.

4. Priority:

Promote early detection and appropriate screening

Goal 4A: Increase screening rates

Objective A:
Reduce Nebraska's breast cancer mortality rate to 18 per 100,000 women.

What will be measured	Baseline	Timeframe
Rate decrease	19.2 Nebraska Cancer Registry, 2009	By 2016

Objective B:
Increase breast cancer screening rates for women with incomes below $35,000/yr to 70%.

What will be measured	Baseline	Timeframe
Rate increase	59% Every Woman Matters	By 2016

Objective C:
Increase breast cancer screening rates for rural women to 76%.

What will be measured	Baseline	Timeframe
Rate increase	70% BRFSS	By 2016

Objective D:
Increase the percentage of adults in Nebraska who receive appropriate colon cancer screening to 80%.

What will be measured	Baseline	Timeframe
Percent increase	60.1% NE BRFSS 2009	By 2016

Note: Goal was set in agreement with Nebraska Colon Cancer Screening program's goal which was set by the CDC.

Objective E:
Increase percent of women who received a pap smear in the last three years to 88.8%.

What will be measured	Baseline	Timeframe
Percent increase	78.8% NE BRFSS 2008	By 2016

Objective F:
Increase percentage of Nebraska adolescents ages (13-17) who receive the HPV vaccine to 43.9%.

What will be measured	Baseline	Timeframe
Percent increase	33.9% CDC National Immunization Survey, 2009	By 2016

Objective G:
Promote new screening guidelines as recommended (e.g. lung cancer screening).

What will be measured	Baseline	Timeframe
Changes to U.S.PSTF recommendation	Current recommendations	By 2016

Note: The United States Preventive Services Task Force-U.S.PSTF- is the non-governmental organization that establishes guidelines for preventive health services, including all cancer screening

Strategies for cancer detection and screening:

i. Collaborate with DHHS Office of Women's and Men's Health on cancer initiatives.
ii. Collaborate with DHHS Office of Reproductive Health on cancer initiatives.
iii. Support and sustain the Nebraska Colon Cancer Program.
iv. Support and sustain the Every Woman Matters Program.
v. Support the development and work of community cancer coalitions.

vi. Continue to work with the statewide partnership on implementing cancer control initiatives.
vii. Represent Nebraska at the National Dialogue for Action.
viii. Support the Patient Navigation programs in promoting appropriate screening.
ix. Promote effective use of resources among partners through collaboration.

5. Priority:

Increase access to cancer care

Goal 5A:

Education and expansion of collaboration efforts

Objective A:
Evaluate geographic distribution of cancer care services across Nebraska to identify gaps and create a plan to begin to address gaps.

What will be measured	Baseline	Timeframe
Completion of review & creation of plan	No plan	By 2014

Objective B:
Create and distribute to healthcare professionals (other than oncologists) an optimal cancer screening and care guide.

What will be measured	Baseline	Timeframe
Creation of resource	No resource	By 2014

Objective C:
Increase capacity to support collaborative clinical trial work in Nebraska.

What will be measured	Baseline	Timeframe
Contractor to lead clinical trial activities	No contractor	By 2016

Objective D:
Maintain current level of Cancer Center Accreditation.

What will be measured	Baseline	Timeframe

Number of cancer Centers with accreditation	12 out of 13 cancer centers	By 2016

Objective E:
Increase the number of cancer centers that have an accredited breast cancer program.

What will be measured	Baseline	Timeframe
Number of accredited programs	0 out of 13 cancer centers	2016

Note: In collaboration with Good Samaritan Hospital, St. Elizabeth Regional Medical Center and St. Francis Medical Center Cancer Centers, the ACS and the ACoS.

Strategies:

i. Build relationship with Veterans Administration Hospitals to increase continuity of care.
ii. Support use of regional tumor boards.
iii. Assess location of services through GIS mapping.
iv. In collaboration with the cancer centers, NC2 intends to contract with an individual to lead clinical trial activities.

Conclusion & Call to Action

When the initial Comprehensive Cancer Control Plan was written in 2003-04, who would have thought that in only five years Nebraska would experience a decrease in colon cancer mortality from 20 cases per 100,000 to 18.9 per 100,000? Or that cancer control advocates would be joining with tobacco prevention and control advocates to enact a statewide clean air bill—the strongest legislation in the nation at that time. Who would have thought that Nebraska would host two state Dialogue for Action strategic planning meetings or convene a lung cancer clinical symposium? Who would have thought that Nebraska would invite two national American Cancer Society presidents to keynote annual cancer summits? Or that with the Every Woman Matters and Nebraska Colon Cancer Programs, we would have three buses drive from Omaha to Scottsbluff, picking up supporters along the way for the fall conference? Who would have guessed that there would be a Stay in the Game media campaign, a Rollin' to Colon or a Boxer 500? In 2002, who would have thought that Nebraska would decide to develop a non-profit partnership organization or contract with grant writers? We will never know the full role that the Nebraska Comprehensive Cancer Control Program has played in making these events and activities possible, but we can believe that having the Nebraska Cancer Plan has provided a focus and direction for increased collaboration. Our more than 150 groups and organizations have demonstrated commitment, idea-generation and cooperation toward achievement of many goals; they have provided resources, energy and suggestions for improvement. They have carried the cancer prevention and control messages deeper into their own groups and organizations, in part by recommending additional colleagues and peers as partners.

As we file the initial plan and prepare to implement the revised Nebraska Cancer Plan, we should celebrate the successes and accomplishments, for there have been many. We should also pause

to review the current burden of cancer and consider the work that still remains to be done. Too many Nebraska families still experience the high costs of cancer; each day, new cancer cases are diagnosed and loss of life occurs. There is a place at the intervention table for anyone who believes in cancer prevention and control. We want—and need—your input, cooperation and commitment.

For more information or to become an involved partner, please contact one of the following persons or organizations:

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Appendix

Roles and Responsibilities

Nebraska Comprehensive Cancer Control Program — NE CCCP

Maintain relationship with CDC

- Develop/submit annual grant
- Prepare/submit grant-related reports
- Complete/submit performance measures
- Develop/submit an annual budget
- Develop/submit annual work plan
- Develop/submit evaluation reports
- Gather and maintain data and reports

Maintain relationships with other DHHS programs

- Cardiovascular Health Program
- Colon Cancer Screening Program
- Community Wellness Program
- Communities Putting Prevention to Work
- Diabetes Prevention Program
- Every Woman Matters
- Nutrition and Activity for Health
- Office of Women's and Men's Health
- Office of Minority Health/Health Equity
- Oral Health Program
- Public Health Support Unit/Cancer Registry
- Tobacco Free Nebraska
- Others as appropriate to annual work plan

Facilitate relationship between NE CCCP and NC2

- Develop contract with NC2 when funds are available
- Participate in regular meetings with NC2 Director or Designee
- Participate in regular meetings with NC2 Chair and Director
- Facilitate development of an annual work plan between NE CCCP and NC2

Maintain effective NC2 members relationships

- Co-Host Annual Cancer Summit
- Implement Cancer Plan with select coalition members depending on project

Nebraska Cancer Coalition — NC2

Manage statewide coalition organization

- Maintain current coalition list
- Schedule and host quarterly meetings
- Recruit and orient new coalition members
- Provide coalition list to NE CCCP
- Prepare E-news
- Plan/host Spring Partnership Meeting
- Prepare/conduct annual coalition member satisfaction survey

Seek funding to support plan implementation

- Identify possible funding opportunities
- Identify potential partners
- Develop and submit applications for grants, foundation and other funds
- Manage projects and funds with coalition members
- Distribute evaluation reports to NE CCCP
- and coalition members

Maintain effective relationships with NE CCCP

- Schedule and participate in meetings with NE CCCP
- Schedule and participate in meetings with NE CCCP and Coalition Chair
- Participate in development of an annual work plan with NE CCCP
- Carry out contract terms and submit status and other reports as required

NE CCCP and NC2 must both be involved in the following:

- Updating of State Cancer Plan
- Implementation of State Cancer Plan
- Selecting, awarding and managing mini grants (funding requested in 2010-2011 budget to CDC)
- Selection of potential partners for grants obtained by NC2
- Planning and convening annual Cancer Summit and Spring Partnership

Staffing:

- It is anticipated that NE CCCP will be staffed with 2 full time equivalencies
- It is anticipated that NC2 will be staffed with at least a .2 full time equivalency; additional staffing may be added as work plan and budget indicate. A focus area for 2011 is to obtain grant writer(s) and a policy specialist.

Healthy People 2020 Summary of Objectives - Cancer

Number	Objective Short Title
C–1	Overall cancer deaths
C–2	Lung cancer deaths
C–3	Female breast cancer deaths
C–4	Uterine cervix cancer deaths
C–5	Colorectal cancer deaths
C–6	Oropharyngeal cancer deaths
C–7	Prostate cancer deaths
C–8	Melanoma deaths
C–9	Invasive colorectal cancer
C–10	Invasive uterine cervical cancer
C–11	Late-stage female breast cancer
C–12	Statewide cancer registries
C–13	Cancer survival
C–14	Mental and physical health-related quality of life of cancer survivors
C–15	Cervical cancer screening
C–16	Colorectal cancer screening
C–17	Breast cancer screening
C–18	Receipt of counseling about cancer screening
C–19	Prostate-specific antigen (PSA) test
C–20	Ultraviolet irradiation exposure

Topic Area: Cancer

- C–1: Reduce the overall cancer death rate.
  - Target: 160.6 deaths per 100,000 population.
  - Baseline: 178.4 cancer deaths per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population).
  - Target setting method: 10 percent improvement.

    Data source: National Vital Statistics System (NVSS), CDC, NCHS.

- C–2: Reduce the lung cancer death rate.
  - Target: 45.5 deaths per 100,000 population.
  - Baseline: 50.6 lung cancer deaths per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population).
  - Target setting method: 10 percent improvement.

    Data source: National Vital Statistics System (NVSS), CDC, NCHS.

- C–3: Reduce the female breast cancer death rate.
  - Target: 20.6 deaths per 100,000 females.
  - Baseline: 22.9 female breast cancer deaths per 100,000 females occurred in 2007 (age adjusted to the year 2000 standard population).
  - Target setting method: 10 percent improvement.

    Data source: National Vital Statistics System (NVSS), CDC, NCHS.

- C–4: Reduce the death rate from cancer of the uterine cervix.
  - Target: 2.2 deaths per 100,000 females.
  - Baseline: 2.4 uterine cervix cancer deaths per 100,000 females occurred in 2007 (age adjusted to the year 2000 standard population).
  - Target setting method: 10 percent improvement.

    Data source: National Vital Statistics System (NVSS), CDC, NCHS.

- C–5: Reduce the colorectal cancer death rate.
  - Target: 14.5 deaths per 100,000 population.
  - Baseline: 17.0 colorectal cancer deaths per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population).
  - Target setting method: Modeling/projection.

    Data source: National Vital Statistics System (NVSS), CDC, NCHS.

- C–6: Reduce the oropharyngeal cancer death rate.
  - Target: 2.3 deaths per 100,000 population.
  - Baseline: 2.5 oropharyngeal cancer deaths per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population).
  - Target setting method: 10 percent improvement.

    Data source: National Vital Statistics System (NVSS), CDC, NCHS.

- C–7: Reduce the prostate cancer death rate.
  - Target: 21.2 deaths per 100,000 males.
  - Baseline: 23.5 prostate cancer deaths per 100,000 males occurred in 2007 (age adjusted to the year 2000 standard population).
  - Target setting method: 10 percent improvement.

    Data source: National Vital Statistics System (NVSS), CDC, NCHS.

- C–8: Reduce the melanoma cancer death rate.
  - Target: 2.4 deaths per 100,000 population.
  - Baseline: 2.7 melanoma cancer deaths per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population).
  - Target setting method: 10 percent improvement.

    Data source: National Vital Statistics System (NVSS), CDC, NCHS.

- C–9: Reduce invasive colorectal cancer.
  - Target: 38.6 new cases per 100,000 population.
  - Baseline: 45.4 new cases of invasive colorectal cancer per 100,000 population were reported in 2007 (age adjusted to the year 2000 standard population).
  - Target setting method: Modeling/projection.

    Data sources: National Program of Cancer Registries (NPCR), CDC; Surveillance, Epidemiology and End Results (SEER) Program, NIH, NCI.

- C–10: Reduce invasive uterine cervical cancer.
  - Target: 7.1 new cases per 100,000 females.
  - Baseline: 7.9 new cases of invasive uterine cancer per 100,000 females were reported in 2007 (age adjusted to the year 2000 standard population).
  - Target setting method: 10 percent improvement.

    Data sources: National Program of Cancer Registries (NPCR), CDC; Surveillance, Epidemiology and End Results (SEER) Program, NIH, NCI.

- C–11: Reduce late-stage female breast cancer.
  - Target: 41.0 new cases per 100,000 females.
  - Baseline: 43.2 new cases of late-stage breast cancer per 100,000 females were reported in 2007 (age adjusted to the year 2000 standard population).
  - Target setting method: Modeling/projection.

    Data sources: National Program of Cancer Registries (NPCR), CDC; Surveillance, Epidemiology and End Results (SEER) Program, NIH, NCI.

- C–12: Increase the number of central, population-based registries from the 50 States and the District of Columbia that capture case information on at least 95 percent of the expected number of reportable cancers.
  - Target: 51 (50 States and the District of Columbia).
  - Baseline: 42 States had central, population-based registries that captured case information on at least 95 percent of the expected number of reportable cancers in 2006.
  - Target setting method: Total coverage.
  - Data sources: National Program of Cancer Registries (NPCR), CDC; Surveillance, Epidemiology and End Results (SEER) Program, NIH, NCI.
- C–13: Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis.
  - Target: 72.8 percent.
  - Baseline: 66.2 percent of persons with cancer were living 5 years or longer after diagnosis in 2007.
  - Target setting method: 10 percent improvement.

    Data source: Surveillance Epidemiology and End Results (SEER) Program, NIH, NCI.

- C–14: (Developmental) Increase the mental and physical health-related quality of life of cancer survivors.

  Potential data source: National Health Interview Survey (NHIS), CDC, NCHS.

- C–15: Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines.
  - Target: 93.0 percent.
  - Baseline: 84.5 percent of women ages 21 to 65 years received a cervical cancer screening based on the most recent guidelines in 2008 (age adjusted to the year 2000 standard population).
  - Target setting method: 10 percent improvement.

    Data Source: National Health Interview Survey (NHIS), CDC, NCHS.

- C–16: Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines.
  - Target: 70.5 percent.
  - Baseline: 54.2 percent of adults ages 50 to 75 years received a colorectal cancer screening based on the most recent guidelines in 2008 (age adjusted to the year 2000 standard population).
  - Target setting method: Modeling/projection.

    Data source: National Health Interview Survey (NHIS), CDC, NCHS.

- C–17: Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines.
  - Target: 81.1 percent.
  - Baseline: 73.7 percent of females ages 50 to 74 years received a breast cancer screening based on the most recent guidelines in 2008 (age adjusted to the year 2000 standard population).
  - Target setting method: 10 percent improvement.
  - Data source: National Health Interview Survey (NHIS), CDC, NCHS.
- C–18: Increase the proportion of adults who were counseled about cancer screening consistent with current guidelines.
  - C–18.1 Increase the proportion of women who were counseled by their providers about mammograms.
    - Target: 76.8 percent.
    - Baseline: 69.8 percent of women ages 50 to 74 years were counseled by their providers about mammograms in 2008 (age adjusted to the year 2000 standard population).
    - Target setting method: 10 percent improvement.

      Data source: National Health Interview Survey (NHIS), CDC, NCHS.

  - C–18.2 Increase the proportion of women who were counseled by their providers about Pap tests.
    - Target: 65.8 percent.
    - Baseline: 59.8 percent of women ages 21 to 65 years were counseled by their providers about Pap tests in 2008 (age adjusted to the year 2000 standard population).
    - Target setting method: 10 percent improvement.

      Data source: National Health Interview Survey (NHIS), CDC, NCHS.

- C–18.3 (Developmental) Increase the proportion of adults who were counseled by their providers about colorectal cancer screening.

  Potential data source: National Health Interview Survey (NHIS), NCHS, CDC.

- C–19: (Developmental) Increase the proportion of men who have discussed with their health care provider whether or not to have a prostate-specific antigen (PSA) test to screen for prostate cancer.

  Potential data source: National Health Interview Survey (NHIS), CDC, NCHS.

- C–20: Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn.
  - C–20.1 (Developmental) Reduce the proportion of adolescents in grades 9 through 12 who report sunburn.

    Potential data source: Youth Risk Behavior Surveillance Survey (YRBSS), CDC.

  - C–20.2 (Developmental) Reduce the proportion of adults ages 18 years and older who report sunburn.

    Potential data source: National Health Interview Survey (NHIS), NCHS, CDC.

  - C–20.3 Reduce the proportion of adolescents in grades 9 through 12 who report using artificial sources of ultraviolet light for tanning.
    - Target: 14.0 percent.
    - Baseline: 15.6 percent of adolescents in grades 9 through 12 reported using artificial sources of ultraviolet light for tanning in 2009.
    - Target settin method: 10 percent improvement.

      Data source: Youth Risk Behavior Surveillance Survey (YRBSS), CDC.

  - C–20.4 Reduce the proportion of adults ages 18 and older who report using artificial sources of ultraviolet light for tanning.
    - Target: 13.7 percent.
    - Baseline: 15.2 percent of adults ages 18 and older reported using artificial sources of ultraviolet light for tanning in 2008 (age adjusted to the year 2000 standard population).
    - Target setting method: 10 percent improvement.

      Data source: National Health Interview Survey (NHIS), NCHS, CDC.

- C–20.5 Increase the proportion of adolescents in grades 9 through 12 who follow protective measures that may reduce the risk of skin cancer.
  - Target: 11.2 percent.
  - Baseline: 9.3 percent of adolescents in grades 9 through 12 followed protective measures that may reduce the risk of skin cancer in 2009.
  - Target setting method: 20 percent improvement.

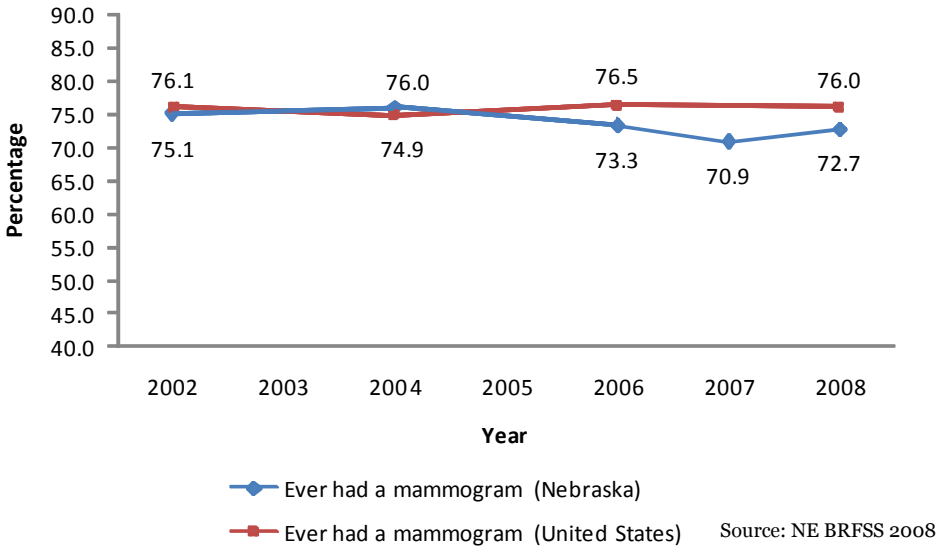
    Data source: Youth Risk Behavior Surveillance Survey (YRBSS), CDC.

- C–20.6 Increase the proportion of adults ages 18 years and older who follow protective measures that may reduce the risk of skin cancer.
  - Target: 80.1 percent.
  - Baseline: 72.8 percent of adults ages 18 years and older followed protective measures that may reduce the risk of skin cancer in 2008 (age adjusted to the year 2000 standard population).
  - Target setting method: 10 percent improvement.

    Data source: National Health Interview Survey (NHIS), CDC, NCHS.

Breast cancer screening among Nebraska women, 2008

Figure 1: Percentage of Nebraska women ages 40+ years who reported having a mammogram in the past 2 years, by year, 2002-2008

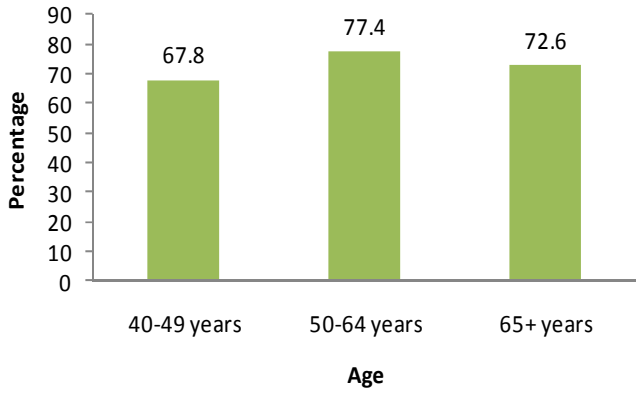


Source: NE BRFSS 2008

2008 NE BRFSS Quick Facts

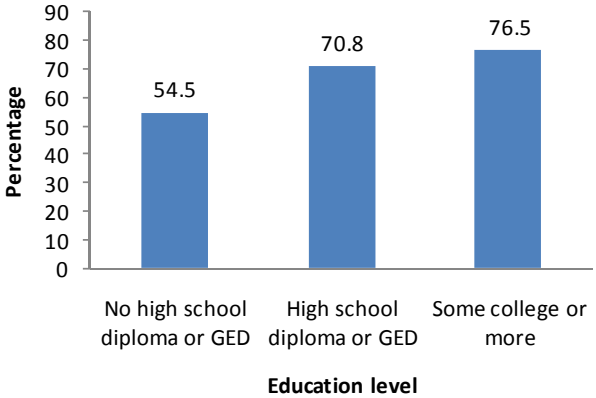
- Approximately 1 in 4 Nebraska women ages 40+ years reported not having a mammogram in the past 2 years.
- Women ages 40-49 years and those who had no high school diploma or GED education were less likely to report having a mammogram in the past 2 years compared to older women and women with a higher education level, respectively.

Figure 2: Percentage of Nebraska women ages 40+ years who reported having a mammogram in the past 2 years, by age, 2008



Source: NE BRFSS 2008

Figure 3: Percentage of Nebraska women ages 40+ years who reported having a mammogram in the past 2 years, by education level, 2008



Source: NE BRFSS 2008

Breast cancer is the most common cancer diagnosed among Nebraska women, and the second most frequent cause of female cancer deaths in the state.

(Source: Cancer Incidence and Mortality in Nebraska: 2007).

Breast cancer screening means checking a woman's breasts for cancer before there are signs or symptoms of the disease. Three main tests are used to screen the breasts for cancer:

- Mammogram: A mammogram is an X-ray of the breast. Mammograms are the best method to detect breast cancer early when it is easier to treat and before it is big enough to feel or cause symptoms. Women age 40 years or older should have a screening mammogram every one to two years.
- Clinical breast exam: A clinical breast exam is an examination by a doctor or nurse, who uses his or her hands to feel for lumps or other changes.
- Breast self-exam: A breast self-exam is when you check your own breasts for lumps, changes in size or shape of the breast, or any other changes in the breasts or underarm (armpit).

Although having regular mammograms can lower the risk of dying from breast cancer, having a clinical breast exam or a breast self-exam have not been found to decrease risk of dying from breast cancer. The best way to find breast cancer is with a mammogram.

Every Woman Matters is a program that can help women ages 40-64 years who meet income eligibility requirements pay for screening mammograms. For more information, visit www.dhhs.ne.gov/womenshealth/ewm

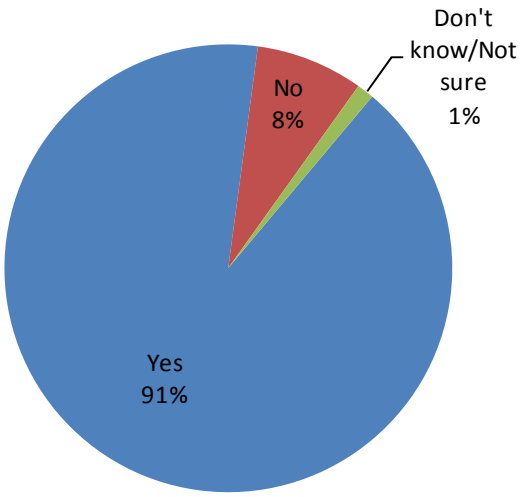
For more information about breast cancer screening, contact:

Nebraska Comprehensive Cancer Control
301 Centennial Mall South, P.O. Box 95026
Lincoln, NE 68509-5026
Phone: 402-471-4411
Fax: 402-471-6446
www.dhhs.ne.gov/NebraskaCARES

The Nebraska Behavioral Risk Factor Surveillance System (BRFSS) has been conducting surveys annually since 1986 for the purpose of collecting data on the prevalence of major health risk factors among adults residing in the state. Information gathered in these surveys can be used to target health education and risk reduction activities throughout the state in order to lower rates of premature death and disability.
The data presented in this report come from approximately 16,000 landline telephone BRFSS surveys conducted in Nebraska in 2008. Prevalence estimates are based on weighted data rather than raw numbers of responses to a question. The weights adjust for over– or under-sampling of age/gender groups.

To learn more about the Nebraska Behavioral Risk Factor Surveillance System, or to view additional reports, visit: www.dhhs.ne.gov/brfss

Figure 1: Percentage of cancer survivors who reported having health insurance that paid for all or part of their cancer treatment, 2009

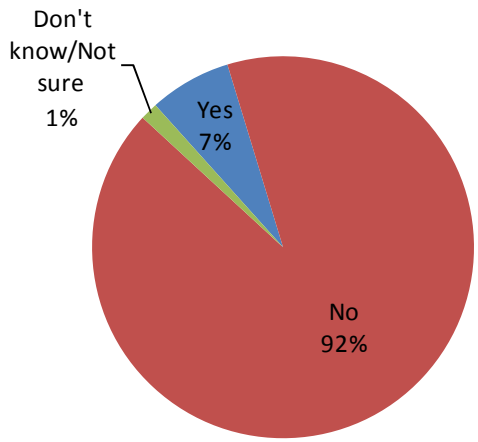


Source: NE BRFSS 2009

2009 NE BRFSS Quick Facts

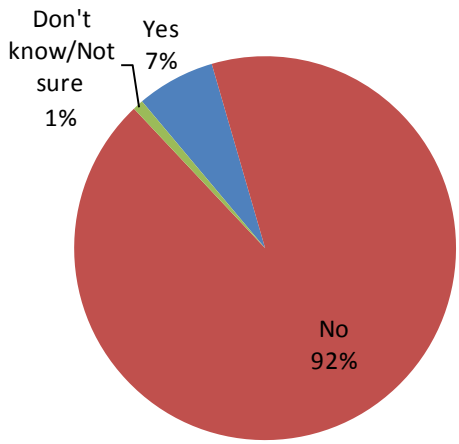
- Only 1 in 3 Nebraska cancer survivors reported ever receiving a written summary of all their cancer treatments from a doctor, nurse or other health professional.
- Fewer than 3 in 5 Nebraska cancer survivors reported ever receiving instructions about the place and person for routine cancer check-ups after completing cancer treatments. Of those who reported receiving these instructions, only one third reported that they were written down or printed on paper.
- Fewer than 1 in 10 Nebraska cancer survivors reported currently having physical pain caused by their cancer or cancer treatment. Of those who reported currently having pain, nearly one-third reported that their pain was not under control.

Figure 2: Percentage of cancer survivors who reported ever being denied health or life insurance coverage because of their cancer, 2009



Source: NE BRFSS 2009

Figure 3: Percentage of cancer survivors who reported participating in a clinical trial as part of their cancer treatment, 2009



Source: NE BRFSS 2009

Promoting Health After a Cancer Diagnosis

Cancer survivors are at greater 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. The following factors can help maintain health and improve survival and quality of life after a cancer diagnosis:

- Quitting tobacco use: Smoking is a preventable risk factor for cancer recurrence and additional cancers.
- Being active and maintaining a healthy weight: Obesity may be related to poorer survival after breast, prostate, and colorectal cancer. Regular physical activity may improve quality of life after a cancer diagnosis.
- Discussing follow-up care with a health care provider: Important topics to discuss include: A follow-up plan of care that includes a schedule of recommended follow-up visits, screenings, and medical tests and specifies which providers will be responsible for care; possible delayed effects of treatment; the importance of seeking timely care in response to certain signs or symptoms; emotional wellness after cancer and identifying available resources for additional support, if necessary; lifestyle changes recommended for improving health and wellbeing after cancer; and developing an effective support system that meets survivors' medical and emotional needs.

For more information about promoting health after a cancer diagnosis, visit www.cdc.gov/cancer/survivorship

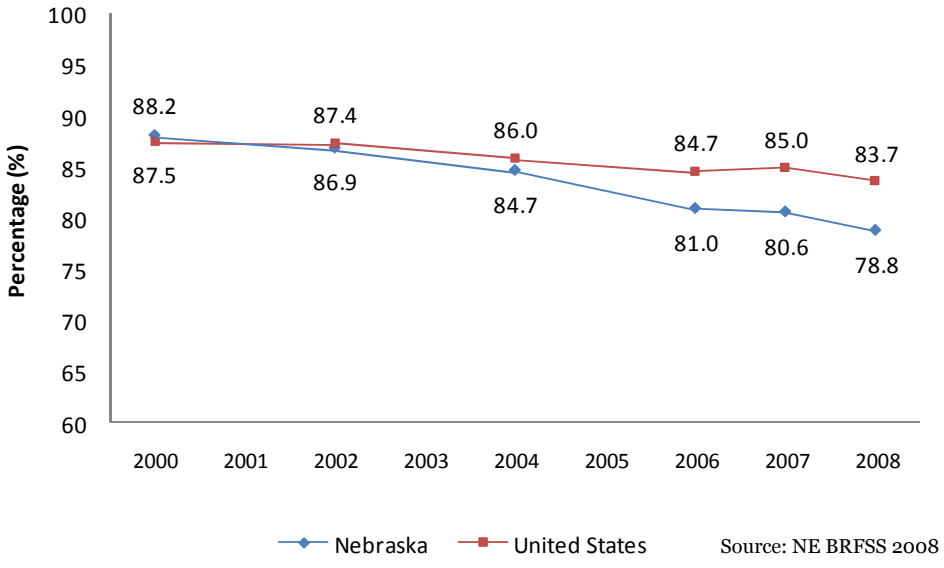
Additional resources on cancer survivorship include A National Action Plan for Cancer Survivorship: Advancing Public Health Strategies available at www.cdc.gov/cancer/survivorship/pdf/plan.pdf and the Institute of Medicine's From Cancer Patient to Cancer Survivor: Lost in Transition.

For more information about cancer survivorship, contact:

Nebraska Comprehensive Cancer Control
301 Centennial Mall South, P.O. Box 95026
Lincoln, NE 68509-5026
Phone: 402-471-4411
Fax: 402-471-6446
www.dhhs.ne.gov/NebraskaCARES

Cervical cancer screening among Nebraska women, 2008

Figure 1: Percentage of Nebraska women ages 18+ years who reported having a Pap test in the past 3 years, by year, 2000-2008

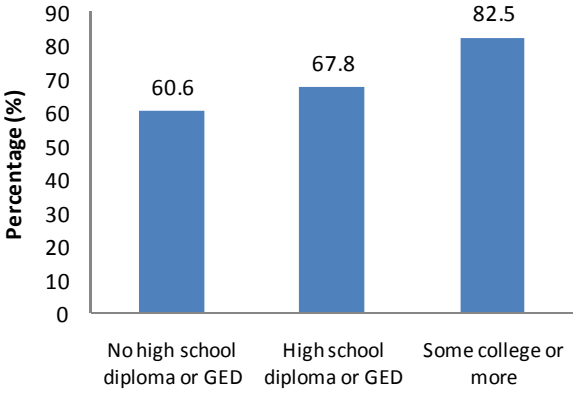


Source: NE BRFSS 2008

2008 NE BRFSS Quick Facts

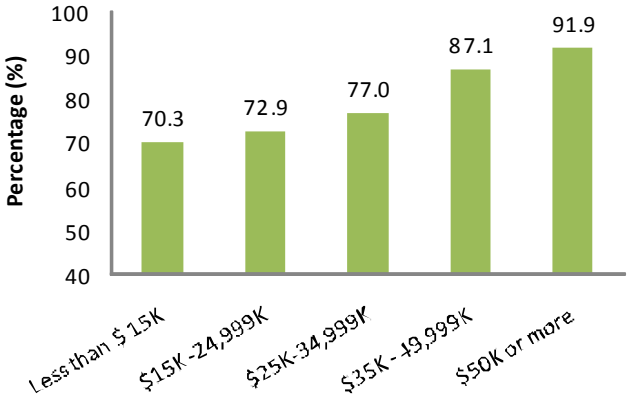
- Approximately 1 in 5 Nebraska women ages 18+ years reported not having a Pap test in the past 3 years.
- Women who had no high school diploma or GED education or earned less than $15K/year were less likely to report having a Pap test in the past 3 years compared to women with a higher education level and higher income level, respectively.

Figure 2: Percentage of Nebraska women ages 18+ years who reported having a Pap test in the past 3 years, by education level, 2008



Source: NE BRFSS 2008

Figure 3: Percentage of Nebraska women ages 18+ years who reported having a Pap test in the past 3 years, by income level, 2008



Source: NE BRFSS 2008

Almost all cervical cancers are caused by human papillomavirus (HPV). HPV usually causes no symptoms and will often go away on its own; however, if it does not, there is a chance that, over time, it may cause cervical cancer.

The most important thing a woman can do to avoid getting cervical cancer is to have regular screening tests.

- Cervical cancer is the easiest female cancer to prevent, with regular screening tests and follow-up. It is also highly curable when found and treated early.
- The Pap test (or Pap smear) looks for pre-cancers, or cell changes, on the cervix that might become cervical cancer if they are not treated appropriately. Women should start getting regular *Pap tests at age 21, or within three years of first having sex*.
- Women ages 30 years or older whose Pap tests are normal have a very low chance of getting cervical cancer in the next few years. For that reason, such women may not need another screening test for up to three years. However, it is important to visit a doctor regularly for a checkup that may include a pelvic exam.

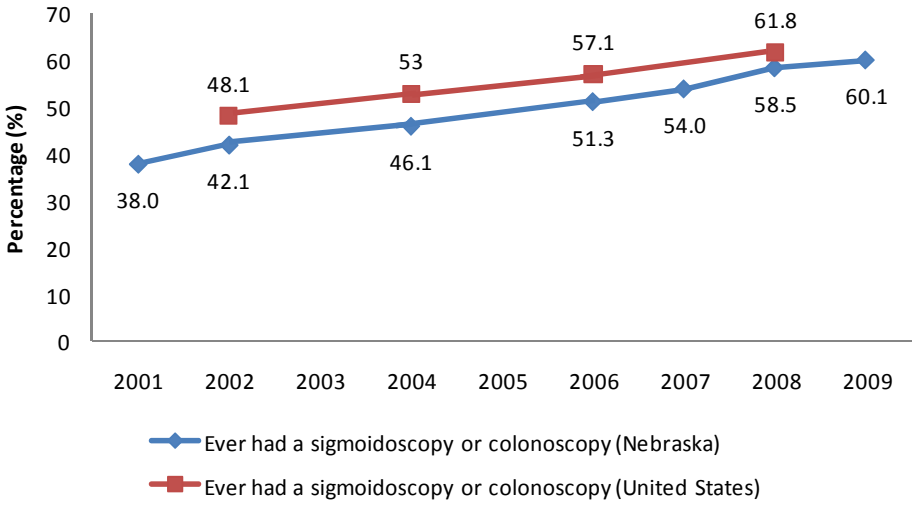
Every Woman Matters is a program that can help women ages 40-64 years who meet income eligibility requirements pay for Pap tests. For more information, visit www.dhhs.ne.gov/womenshealth/ewm

For more information about cervical cancer screening, contact:

Nebraska Comprehensive Cancer Control
301 Centennial Mall South, P.O. Box 95026
Lincoln, NE 68509-5026
Phone: 402-471-4411
Fax: 402-471-6446
www.dhhs.ne.gov/NebraskaCARES

Colorectal cancer screening among Nebraska adults, 2009

Figure 1: Percentage of Nebraska adults age 50+ years who reported ever having a sigmoidoscopy or colonoscopy, by year, 2001-2009

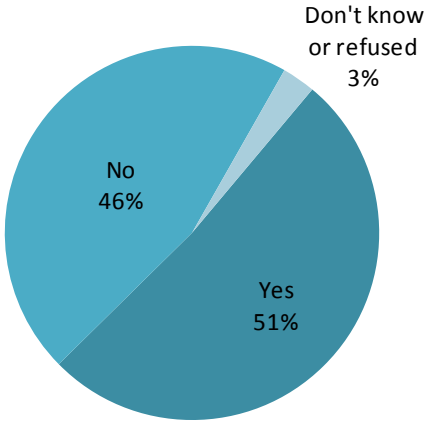


Source: NE BRFSS 2009

2009 NE BRFSS Quick Facts

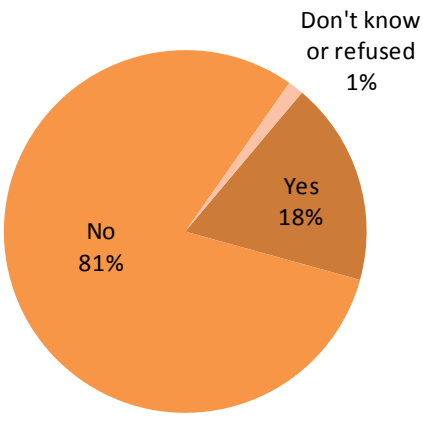
- Only 3 in 5 Nebraska adults age 50+ years reported ever having a sigmoidoscopy or colonoscopy.
- Only half of Nebraska adults age 50+ reported having a sigmoidoscopy or colonoscopy in accordance with recommended guidelines*.
- Fewer than 1 in 5 Nebraska adults age 50+ years reported having a blood stool test in the past 2 years.

Figure 2: Percentage of adults age 50+ years who reported having a sigmoidoscopy within past 5 years or a colonoscopy within past 10 years, 2009



Source: NE BRFSS 2009

Figure 3: Percentage of adults age 50+ years who reported having a blood stool test in the past 2 years, 2009



Source: NE BRFSS 2009

Colorectal cancer is the fourth most frequently diagnosed cancer among Nebraska residents, and the second leading cause of cancer mortality in the state. (Source: Cancer Incidence and Mortality in Nebraska: 2007)

Regular screening, beginning at age 50, is the key to preventing colorectal cancer.

*Recommended colorectal cancer screening tests and intervals:

- **High-sensitivity fecal occult blood test (FOBT)**, which checks for hidden blood in three consecutive stool samples, should be administered every year.
- **Flexible sigmoidoscopy**, where physicians use a flexible, lighted tube (sigmoidoscope) to inspect visually the interior walls of the rectum and part of the colon, should be administered every five years.
- **Colonoscopy**, where physicians use a flexible, lighted tube (colonoscope) to inspect visually the interior walls of the rectum and the entire colon, should be administered every 10 years.

The U.S. Preventive Services Task Force (U.S.PSTF) recommends screening for colorectal cancer using high-sensitivity fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 50 years and continuing until age 75 years.

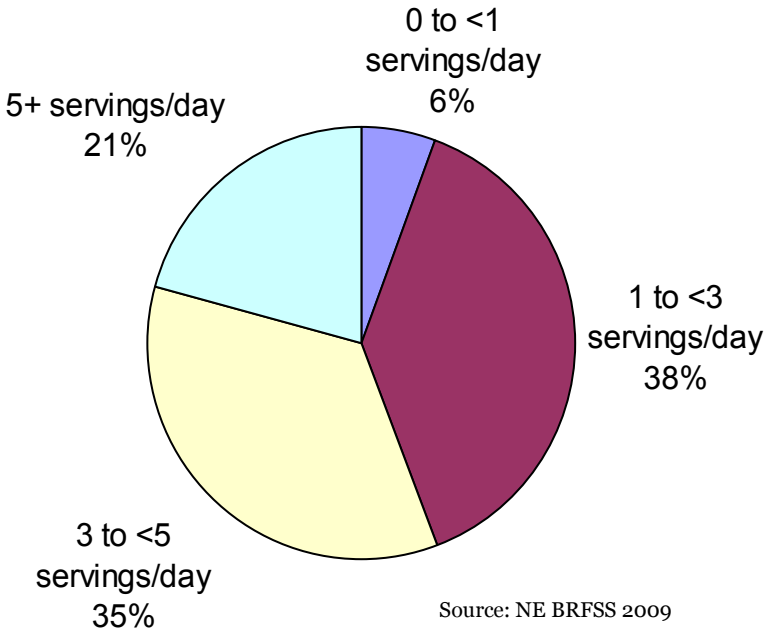
The Nebraska Colon Cancer Screening Program provides colorectal cancer screening tests to Nebraskans who are under– or uninsured. For more information, visit www.dhhs.ne.gov/crc

For more information about colorectal cancer screening, contact:

Nebraska Comprehensive Cancer Control
301 Centennial Mall South, P.O. Box 95026
Lincoln, NE 68509-5026
Phone: 402-471-4411
Fax: 402-471-6446
www.dhhs.ne.gov/NebraskaCARES

Fruit & vegetable intake among Nebraska adults, 2009

Figure 1: Percentage of adults consuming 5 or more servings of fruits and vegetables per day in 2009

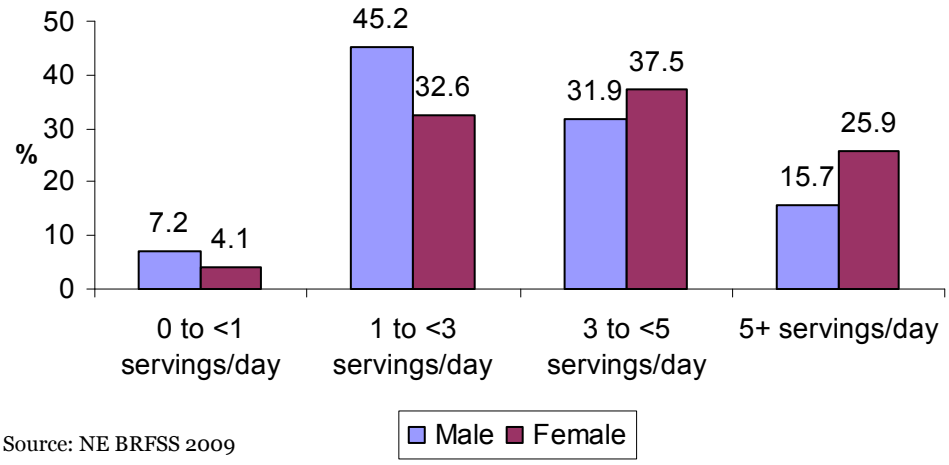


Source: NE BRFSS 2009

2009 NE BRFSS Quick Facts

- Less than 1 in 4 adults consumed 5+ servings of fruits and vegetables per day in 2009
- Women are more likely to consume 5+ servings of fruits and vegetables per day, on average, compared to men
- According to the 2005 Dietary Guidelines for Americans: 1 serving fruit or vegetable= 1/2 cup

Figure 2: Percentage of adults consuming 5 or more servings of fruits and vegetables per day in 2009, by gender



Source: NE BRFSS 2009

2005 Dietary Guidelines for Americans

- Women need at least 7-9 servings (3.5-4.5 cups) of fruits and vegetables per day
- Men need at least 9-10 servings (4.5-5 cups) of fruits and vegetables per day

Fresh, frozen, dried, or canned fruits and vegetables count toward your daily fruit and vegetable goal. Look for fruit without added sugar or syrups and vegetables without added salt, butter, or cream sauces. To find out how many fruits and vegetables you need each day, as well as tips for incorporating more fruits and vegetables into your diet, visit www.fruitsandveggiesmatter.gov

Compared to people who only eat small amounts of fruits and vegetables, those who eat more generous amounts tend to have reduced risk of chronic diseases, including:

- Stroke
- Type 2 diabetes
- Some types of cancer
- Cardiovascular disease and hypertension

Most fruits and vegetables are naturally low in calories and provide essential nutrients and dietary fiber.

Interested in helping to create policies and environments supportive of healthy eating in your community? Check out the Nebraska Physical Activity and Nutrition State Plan, available at www.hhs.state.ne.us/hew/hpe/nafh/Docs/PANstateplan.pdf

For more information about healthy eating, contact:

Nutrition and Activity for Health
301 Centennial Mall South, P.O. Box 95026
Lincoln, NE 68509-5026
Phone: 402-471-2101
Fax: 402-471-6446
www.dhhs.ne.gov/nafh

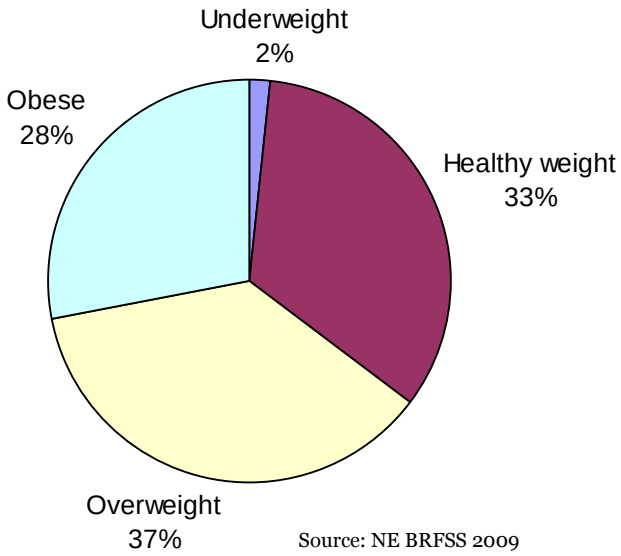
Overweight and obesity among Nebraska adults, 2009

Figure 1: Percentage of Nebraska adults who were overweight or obese in 2009

- Overweight and obesity are determined by an individual's body mass index (BMI) which is calculated as: weight in kilograms ÷ (height in meters)^2

BMI categories:

- Underweight: <18.5
- Healthy weight: 18.5-24.9
- Overweight: 25.0-29.9
- Obese: ≥30

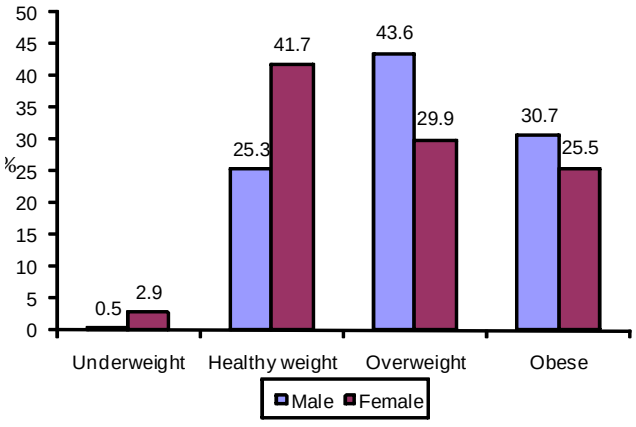


Source: NE BRFSS 2009

2009 NE BRFSS Quick Facts

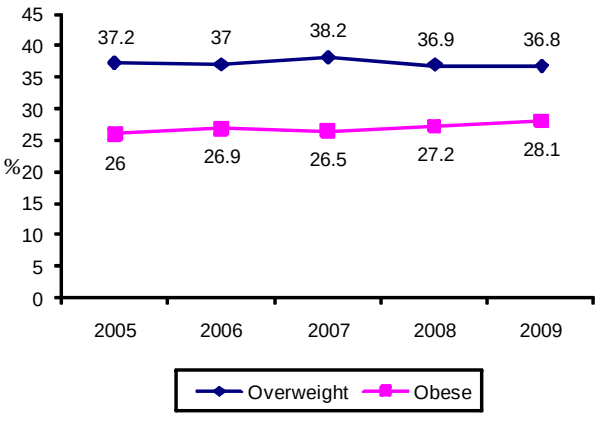
- Nearly 2 in 3 adults were overweight or obese
- Males were more likely to be overweight than females
- The percentage of adults who are overweight and obese has remained relatively stable since 2005

Figure 2: Percentage of adults who were overweight or obese in 2009, by gender



Source: NE BRFSS 2009

Figure 3: Percentage of adults who were overweight or obese in 2005 to 2009, by year



Source: NE BRFSS 2005-2009

Steps to Achieving a Healthy Weight

1. Assess your body mass index using an online BMI calculator
   - Available at www.cdc.gov/healthyweight/assessing
2. If you are already at a healthy weight, prevent weight gain by:
   - Choosing a healthy eating plan according to the Dietary Guidelines for Americans, available at www.cdc.gov/healthyweight/healthy_eating
   - Engaging in 150 minutes of moderate-intensity aerobic activity, or 75 minutes of vigorous-intensity aerobic activity, or an equivalent combination of the two, each week, and
   - Weighing yourself on a regular basis and taking appropriate action if you notice significant weight gain
3. If you are overweight or obese, lose weight by:
   - Reducing your caloric intake by 500—1000 calories per day to lose no more than 1 to 2 pounds per week, and
   - Engaging in physical activity most days of the week (about 60—90 minutes at moderate intensity)

Overweight and obese individuals are at increased risk for many health conditions, including:

- Hypertension
- Type 2 diabetes
- Coronary heart disease
- Stroke
- Osteoarthritis
- Sleep apnea
- Some cancers

Even a modest weight loss, such as 5 - 10% of your total body weight, is likely to produce health benefits!

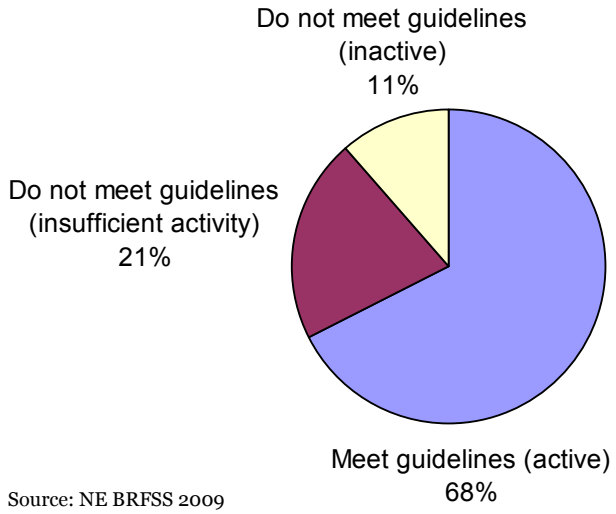
Interested in helping to create policies and environments supportive of healthy eating in your community? Check out the Nebraska Physical Activity and Nutrition State Plan, available at www.hhs.state.ne.us/hew/hpe/nafh/Docs/PANstateplan.pdf

For more information about obesity prevention, contact:

Nutrition and Activity for Health
301 Centennial Mall South, P.O. Box 95026
Lincoln, NE 68509-5026
Phone: 402-471-2101
Fax: 402-471-6446
Website: www.dhhs.ne.gov/nafh

Physical activity among Nebraska adults, 2009

Figure 1: Percentage of Nebraska adults meeting 2008 Physical Activity Guidelines in 2009



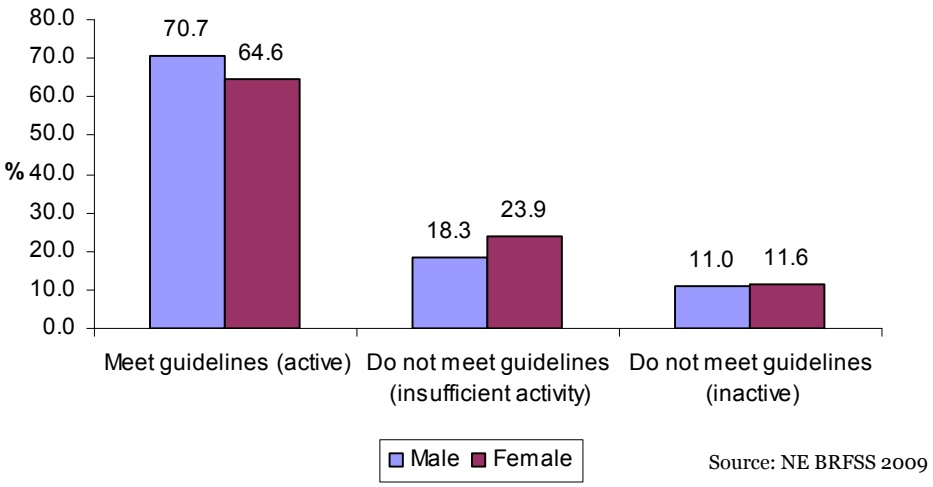
Source: NE BRFSS 2009

2008 Physical Activity Guidelines for Americans

(adults ages 18-64 years)

- Muscle-strengthening activities on 2 or more days PLUS
- 150 minutes per week of moderate physical activity OR
- 75 minutes per week of vigorous physical activity OR
- An equivalent combination of moderate and vigorous physical activity
- **Moderate physical activity** causes small increases in breathing or heart rate. A person should be able to talk, but not sing, during the activity.
- **Vigorous physical activity** causes large increases in breathing or heart rate. A person will not be able to say more than a few words without pausing for a breath during the activity.

Figure 2: Percentage of Nebraska adults meeting 2008 Physical Activity Guidelines in 2009, by gender



Source: NE BRFSS 2009

2009 NE BRFSS Quick Facts

- Nearly 1 in 3 adults did not meet recommended guidelines for physical activity
- Males were slightly more likely to meet recommended guidelines for physical activity than women

Regular physical activity can help

- Control your weight
- Reduce your risk of cardiovascular disease
- Reduce your risk for type 2 diabetes and metabolic syndrome
- Reduce your risk of some cancers
- Strengthen your bones and muscles
- Improve your mental health and mood
- Improve your ability to do daily activities and prevent falls, if you're an older adult
- Increase your chances of living longer

Interested in helping to create policies and environments supportive of healthy eating in your community? Check out the Nebraska Physical Activity and Nutrition State Plan, available at www.hhs.state.ne.us/hew/hpe/nafh/Docs/PANstateplan.pdf

Moderate Intensity	Vigorous Intensity
• Walking briskly (3 miles per hour or faster, but not racewalking)	• Race walking, jogging, or running
• Water aerobics	• Swimming laps
• Bicycling slower than 10 miles per hour	• Tennis (singles)
• Tennis (doubles)	• Aerobic dancing
• Ballroom dancing	• Bicycling 10 miles per hour or faster
• General gardening	• Jumping rope
	• Heavy gardening (continuous digging or hoeing)
	• Hiking uphill or with a heavy backpack

For more information about physical activity, contact:

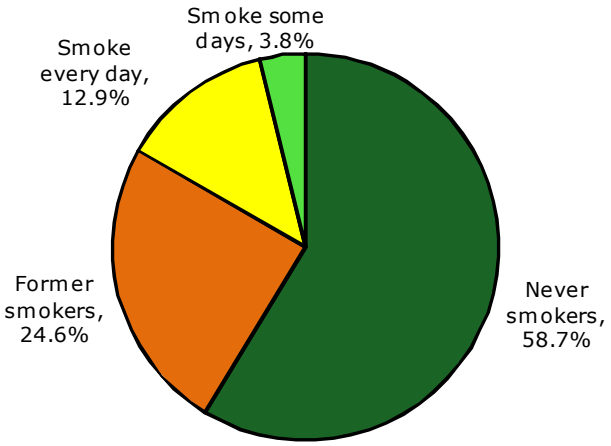
Nutrition and Activity for Health
301 Centennial Mall South, P.O. Box 95026
Lincoln, NE 68509-5026
Phone: 402-471-2101
Fax: 402-471-6446
www.dhhs.ne.gov/nafh

Nutrition & Activity FOR HEALTH
PREVENTION WORKS

Smoking among Nebraska adults, 2009

Figure 1: Percentage of Nebraska adults who are current, former, or never smokers, 2009

- **Current Smokers:** Adults who have smoked at least 100 cigarettes in their lifetime, and smoke everyday or some days.
- **Former Smokers:** Adults who have smoked at least 100 cigarettes in their lifetime, but do not currently smoke.
- **Never Smokers:** Adults who have smoked less than 100 cigarettes in their lifetime.



2009 NE BRFSS Quick Facts

- About 1 in 6 adults reported currently smoking cigarettes.
- The percentage of adults who reported smoking has decreased since 2000.
- Smoking was reported more by males, those with less than a high school education, and those with an income less than $15k/year.

Figure 2: Current smoking among Nebraska adults, by year, 2000-2009

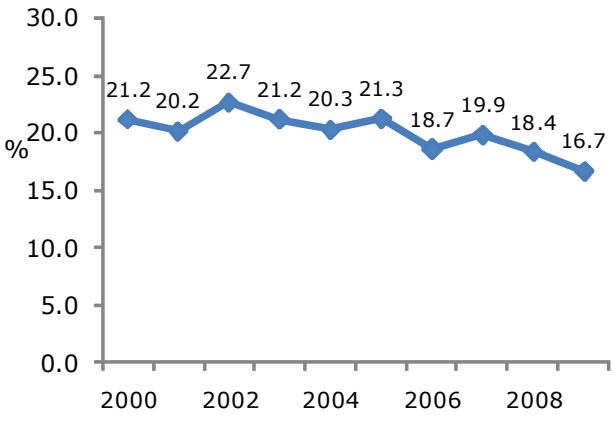
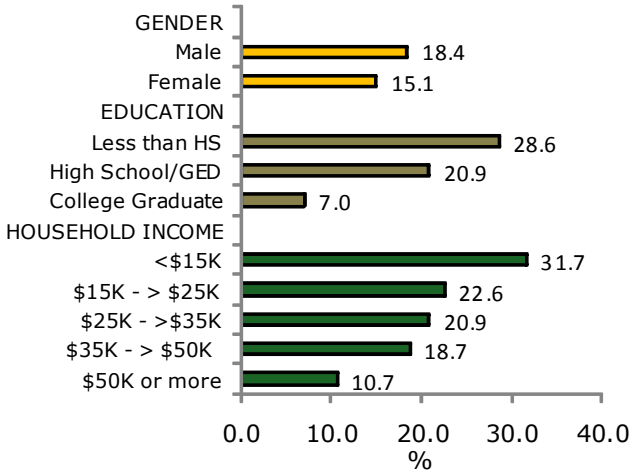


Figure 3: Smoking prevalence among Nebraska adults, by gender, education, and income, 2009



Smoking contributes to a variety of health conditions, including:

- Cancer, including cancer of the lung, kidney, pancreas, cervix, stomach, esophagus, and uterus
- Cardiovascular disease, including heart diseases, atherosclerosis, aortic aneurysm
- Respiratory diseases including bronchitis, emphysema, chronic airway obstruction

If you've tried to quit in the past, don't give up.

Most people who quit successfully don't succeed on their first try. Think of your past attempts as practice.

It's never too late to quit!

Steps to quitting smoking for good...

- Make a plan before you quit.
- Think about why you want to stop smoking and what's preventing you from quitting.
- Learn why you smoke.
- Plan for change and set up the support you need.
- Medications have helped many people quit for good.
- Check with your doctor before starting any nicotine replacement therapy.
- Exercise and relaxation techniques are great alternatives to smoking.

The Nebraska Tobacco Quitline can help you quit tobacco for good.

Call 1-800-QUIT-NOW (1-800-784-8669)

For more information, visit www.quitnow.ne.gov

For more information contact:

Tobacco Free Nebraska
P.O. Box 95026
Lincoln, NE 68509-5026
Phone: 402-471-2101
Fax: 402-471-1371
www.dhhs.ne.gov/tfn

TOBACCO FREE NEBRASKA

for a great state of health

United States Preventative Services Task Force Recommended Guidelines

Breast Cancer Screening Guidelines

Until recently, the U.S.PSTF recommended that all women begin having an annual mammogram beginning at age 40. Their current recommendation, which has raised much discussion in the professional realm, is that women aged 50 to 74 years receive biennial screening mammography. In Nebraska, the Every Woman Matters Program continues to provide breast cancer screening services beginning at age 40. Women with a family History (e.g. grandmother, mother, aunts or sisters) should talk with their primary care providers who will often recommend screening beginning at age 30.

U.S.PSTF Screening for Breast Cancer

Cervical Cancer Screening Guidelines

All women should begin cervical cancer screening about 3 years after they begin having vaginal intercourse, but no later than 21 years old and continue to do so until age 65.

Screening should be done every year with a Pap test. Beginning at age 30, women who have had 3 normal Pap test results in a row may get screened every 2 to 3 years. Women who have had a total hysterectomy may also choose to stop having Pap tests, unless the surgery was done as a treatment for cervical cancer or pre-cancer. Women who have had a hysterectomy without removal of the cervix should continue to have Pap tests.

U.S.PSTF Screening for Cervical Cancer

Colorectal Cancer Screening Guidelines

Other than family history, the greatest risk factor for colon and/or rectal cancer is advancing age. Persons under age 50 with a family history of colon and/or rectal cancer should talk with their primary care providers and may want to consider genetic counseling. Beginning at age 50 both men and women should follow one of these testing schedules:

- colonoscopy every 10 years,
- annual screening with a sensitive FOBT,
- or flexible sigmoidoscopy every 5 years with a midinterval sensitive FOBT

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NE CCCP & NC2 2012-2013 Joint Workplan

Priority:

Emphasize primary prevention to reduce cancer risks

Goal: **Reduce the impact of tobacco use and exposure on cancer incidence and mortality**

Strategies:

1. Support the Tobacco Free Nebraska annual work plans and collaborate to achieve common goals
2. Implement community wide mass media campaigns and support the Tobacco Free Nebraska Program (TFN).

Goal: **Healthy Eating and Physical Activity**

Strategies:

3. Support the implementation of the Nebraska Nutrition & Activity for Health State Plan.
4. Expand coordinated school health policies with the Nebraska Department of Education.
5. Support efforts to increase physical activity during the school day.
6. Increase worksite wellness programs that incorporate healthy eating components.
7. Educate on the dangers of indoor tanning.
8. Survey district health departments to assess their sun safety needs, provide resources as needed.

Priority:

Address Public Health needs of Cancer Survivors

Goal: **Optimize continuity of care for cancer survivors during and beyond treatment.**

Goal: **Increase coordination of services and expand provider knowledge of survivorship issues.**

Strategies:

9. Support the implementation of the National Action Plan for Survivorship developed by the Lance Armstrong Foundation.
10. Continue and expand survivorship module in Nebraska BRFSS.
11. Provide training and education opportunities at statewide cancer summits.
12. Convene ad hoc group of Nebraska caregivers with expertise in survivorship to discuss current survivorship programs, gaps and current trends.
13. Promote increased participation in tumor sample collections for individual, family and research purposes.
14. Support development of Cancer Corners across Nebraska.

Priority:

Reduce cancer disparities to achieve health equity

Goal: Reduce barriers to care

Strategies:

15. Support the work of the community cancer coalitions in their outreach efforts to enroll eligible persons in the NCP or otherwise obtain colon cancer screening tests as appropriate to their age and health status.
16. Support the EWM Program in its efforts to reach to North Omaha African American women for breast and cervical cancer screening.
17. Collaborate with the Northern Plans Comprehensive Cancer Control Program in its efforts to prevent and control cancer among Native Americans in Nebraska.
18. Provide clinical seminar(s) on prostate cancer screening.
19. Establish refugee screening events to provide screening and education.

Priority:

Promote early detection and appropriate screening.

Goal: Increase screening rates

Strategies:

20. Collaborate with DHHS Office of Men and Women's Health on cancer initiatives.
21. Collaborate with DHHS Office of Reproductive Health on cancer initiatives.
22. Support and sustain the Nebraska Colon Cancer Program.
23. Support and sustain the Every Woman Matters Program.
24. Support the development and work of community cancer coalitions.
25. Continue to work with the statewide partnership on implementing cancer control initiatives.
26. Represent Nebraska at the National Dialogue for Action.

Priority:

Increase access to cancer care

Goal: Education and Expansion of collaboration efforts

Strategies:

27. Support use of regional tumor boards.

Evaluation Plan

June 2011-June 2012 2011-2016 Cancer Plan Priorities

- Emphasize primary prevention to reduce cancer risk (Tobacco, Healthy Eating/Physical Activity)
- Address public health needs of cancer survivors
- Reduce cancer disparities to achieve health equity
- Promote early detection and appropriate screening
- Increase access to cancer care

The purpose of this Evaluation Plan is to provide a framework and work plan for evaluating the work of the Nebraska Comprehensive Cancer Control Program (NE CCCP) and the Nebraska Cancer Coalition (NC2) as these two entities implement the Nebraska Cancer Plan 2011-2016. This Evaluation Plan is based on the Comprehensive Cancer Control Branch Program Evaluation Toolkit, June 2010, and is intended to meet National Comprehensive Cancer Control Program Evaluation criteria and requirements.

Rationale: Evaluation is an important component of comprehensive cancer control planning and implementation. Evaluation determines whether our two entities are moving forward in meaningful ways to implement the cancer plan in ways that make a difference. Evaluation is also important to inform stakeholders if their organization is doing what the stakeholders have agreed is to be done.

Stakeholders: The Nebraska Cancer Coalition or NC2 is comprised of more than 400 persons representing about 150 groups and organizations that have come together to plan and implement cancer prevention and control strategies to make a difference in Nebraska. All stakeholders want to know that their organization is effective and that it is selecting achievable outcomes. Some stakeholders want more than that; they want to know that the resources that they are dedicating to comprehensive cancer control are making a difference in their own organization as well as the broader NC2 coalition. Each year NC2 and NE CCCP select specific goals, objectives and activities presented in the Nebraska Cancer Plan as focal areas for their work. Some stakeholders will be involved more than others in each year's plan of work and similarly, some stakeholders will be more engaged in the evaluation work plan.

Based on the June 2011-June 2012 plan of work, the following stakeholders are likely to be most interested in the evaluation plan for this period.

Evaluation Stakeholders	What Stakeholders Want to Know
PRIORITY: Emphasize primary prevention to reduce cancer risk **Goal:** Reduce the impact of tobacco use and exposure on cancer incidence and mortality	
Advocacy and Communication Group	Have we maintained support for the statewide smoke-free worksite law? Have we identified and taken action on local policy, systems and environmental change efforts? Has the tax on tanning beds remained in effect? Is it time to pursue additional policy initiatives?
All NC2 Partners	As a group, did we include tobacco cessation programs as part of our benefit plans? Have we maintained support for the statewide smoke-free worksite law?
American Cancer Society	Have we maintained support for the statewide smoke-free worksite law?
American Lung Association	Have we maintained support for the statewide smoke-free worksite law?
Consumer Focused Group	Have we maintained support for the statewide smoke-free law? To what extent have we moved from smoke-free to tobacco free policy, environment, systems change? Have we implemented the NAFH work plan? The breast cancer work plan? What outcomes have we experienced?
Data and Surveillance Group NE Cancer Registry	Have we moved the numbers in the desired direction? Have we supported the use of data as it has become available?
Coordinated school health project	Have we increased number of policies to implement coordinated school health projects?

Evaluation Stakeholders	What Stakeholders Want to Know
DHHS Worksite Wellness Group	Have we been successful in getting worksites to adopt tobacco cessation as part of benefit plans? Have we completed the worksite wellness toolkit? To what extent has it been used?
District Health Departments	What difference did having a healthy community grant make? What did we learn? What worked? How many persons were appropriately served?
Nebraska Clean Air Policy Group	Have we maintained support for the statewide smoke-free worksite law?
Office of Oral Health & Dentistry	Have we collaborated on at least one activity with NC2 and/or NE CCCP?
Patient Focused Group	Have we had the desired outcomes in patient navigation, clinical trials and palliative care? What have we learned? Have we obtained any new resources for these topic areas?
Tobacco Free Nebraska Program	Have we maintained support for the statewide smoke-free worksite law? How have NC2 and NE CCCP supported implementation of our annual work plans? Have our partners advocated for a tax increase on tobacco products? Have we challenged employers to provide tobacco cessation benefits as part of plan benefits?
UNL College of Dentistry	Have we collaborated on at least one activity with NC2 and/or NE CCCP?
Goal: Improve Healthy Eating and Physical Activity Habits	
Advocacy and Communications Group	Have schools expanded the use of coordinated school health policies?
DHHS Environmental Health Unit	Have we collaborated on at least one activity with NC2 and/or NE CCCP?

Evaluation Stakeholders	What Stakeholders Want to Know
District Health Departments	What difference did having a healthy community grant make? What did we learn? What worked? How many persons were appropriately served?
NAFH Program	How have NC2 and NE CCCP contributed to the implementation of our State Plans? Has NC2 supported our efforts to increase physical activity during the school day? How has NC2 supported the passage of the breast feeding bill?
NE Department of Education	Have schools expanded the use of coordinated school health policies?
PRIORITY: Address Public Health Needs of Cancer Survivors **Goal:** Optimize continuity of care for cancer survivors during and beyond treatment. **Goal:** Increase coordination of services and expand provider knowledge of survivorship issues	
Cancer Summit Planning Committee	Did we include a cancer survivor training component in the annual cancer summit?
Cancer Centers	Did we implement any new components of the LAF National Action Plan for Survivorship?
CHS Cancer Centers	Did we develop cancer corners and how effective are they in providing community resources?
Advocacy & Communications Group	Were we successful in raising the Pain and Policy Studies Group report card grade to A?
NC2 Survivorship Work Group	Did we promote implementation of the LAF National Action Plan for Survivorship?

Evaluation Stakeholders	What Stakeholders Want to Know
District Health Departments	What public health approaches have been taken? What outcomes have been realized? What resources or additional information do we need?
NE CCCP	Did we continue and/or expand the survivorship module? What were the results? Did we build an effective relationship with the University of Montana? Did we develop and implement a model for creating a clinical trials network? What were the challenges and opportunities? What are the next steps? Was our support of the development of cancer corners useful? What did we learn? What are the next steps? Did we write this up as a success story, if applicable? Did we share our experiences with other state/tribe/territory cancer programs?
Nebraska Chair, ACoS CoC PL Program	What were our accomplishments and challenges in developing a statewide network of clinical trials collaboration? Did we build an evaluation component into the NC2 contract for a resource to work on clinical trials network development? Did we increase the number of clinical trials participants? What are the next steps? Who might we target for expansion of this project?
PRIORITY: Reduce cancer disparities to achieve health equity. **Goal:** Reduce barriers to care.	
Community Cancer Coalitions	Did the number of enrollees in NCP increase? What activities were most successful? What did we learn? What were the challenges and opportunities? What are the next steps? How did NC2 and/or NE CCCP support our coalition efforts throughout the year?
Cancer Corners	Testing and promotion of a new community education model

Evaluation Stakeholders	What Stakeholders Want to Know
Creighton University Cancer Center	Was Creighton CC partner in reaching the North Omaha AA women for breast & cervical cancer screening? If not, why not? If so, what did we learn?
EWM	Did the number of enrollees from north Omaha increase? What did we learn? What are the challenges and opportunities?
Northern Plains Comprehensive Cancer Control Program	What activities were conducted and were they considered successful (as defined in the specific projects to be determined by NP CCCP and NE CCCP)?
NE CCCP	Did the number of enrollees in NCP increase? What activities were most successful? What did we learn? What were the challenges and opportunities? Did the number of enrollees from North Omaha increase? What did we learn? What are the challenges and opportunities? Did we review the CDC Health Disparities and Inequalities Report? What did we learn and apply in addressing Nebraska's health disparities? Did our applications make the desired differences in increasing access to services? What partners did we engage in attempting to reduce cancer disparities to achieve health equity?
NE Colon Cancer Screening Program	Did the number of enrollees in NCP increase? What activities were most successful? What did we learn? What were the challenges and opportunities?
UNMC College of Public Health	Was UNMC CPH a partner in reaching the North Omaha AA women for breast & cervical cancer screening? If not, why not? If so, what did we learn?
PRIORITY: Promote early detection and appropriate screening. **Goal:** Increase screening rates.	

Evaluation Stakeholders	What Stakeholders Want to Know
American Cancer Society	Was our MOU effective in promoting CRC screening? What did we learn from our efforts throughout the year? What will we do the same/differently in future years?
Boxer 500	Have we increased enrollment into NCP, increased CRC screening and increased awareness?
Community Cancer Coalitions	How many FOBT kits were distributed? # tested positive; # colonoscopies; what worked.
DHHS Women's and Men's Health	Did we collaborate on at least one activity? What did we learn? What are the next steps?
DHHS Office of Reproductive Health	Did we collaborate on at least one activity? What did we learn? What are the next steps?
DHHS Every Women Matters Program	What resources are available for EWM? If resources are inadequate, what changes will be made? Did enrollments increase? Did changes we made in the program work as intended? Was the MOU with ACS and NE CCCP useful? Why or why not?
NC2	What cancer control initiatives did we promote or support? What difference did they make?

Evaluation Stakeholders	What Stakeholders Want to Know
NE CCCP	Did we collaborate with OM/W Health on at least one activity? What did we learn? What are next steps? Did we have representation at the National Dialogue? What did we learn? What are next steps? Did we interact with the Colon Cancer Alliance? What did we learn? What are next steps? Have the screening rates moved in the desired direction? What are the screening trends? What are the gaps between Nebraska and U.S. data? Are gaps narrowing where they should? What resources are available? Is there any action we should take to increase resources?
NE Colon Cancer Program	What resources are available for NCP? If resources are not adequate, what changes will be made? Did enrollments increase? Did changes we made in the program work as intended? How many persons were diagnosed with colorectal cancer? How did our positive test rate compare to the U.S. rate? Was the MOU with ACS and NE CCCP useful? Why or why not? What activities did we implement with Husker Sports Network and did they have the desired outcomes? Is there support for Stay in the Game for another year, e.g. (2012-2013)?
Pool Cool project	Increased awareness and application of sun safety behaviors
Rollin to Colon	Increased enrollment into NCP, increased CRC screening and increased awareness

Evaluation Stakeholders	What Stakeholders Want to Know
PRIORITY: Increase access to cancer care. **Goal:** Education and expansion of collaboration efforts.	
NCI Cancer Centers	Were we able, with NC2 support, to contact with an individual to lead clinical trials work?
NE CCCP	Did we prepare and distribute GIS maps of cancer services?

Evaluation Stakeholders	How to Engage Stakeholders	When to Engage Stakeholders	Stakeholder areas of expertise, interests and availability
All NC2 Partners	Benefits Challenge Share Worksite survey results	Fall Summit E-news	Leverage in their organizations
American Cancer Society	Quarterly meetings Input into project development MOU re: breast cancer MOU re: colorectal cancer Patient focused activities	Already engaged; ongoing meetings	Statewide availability; policy and program expertise; similar goals Knowledge about tobacco cessation, prevention & control; patient treatment and support expertise

Evaluation Stakeholders	How to Engage Stakeholders	When to Engage Stakeholders	Stakeholder areas of expertise, interests and availability
American Lung Association	Arranged meeting w/ ACS	August 2011	Policy expertise; knowledge about tobacco cessation, prevention & control
Cancer Summit Planning Committee	Present intent to include survivorship content	Spring 2012	Tobacco issues; advocacy, policy, environment and systems change
Cancer Centers	Project specific	TBD	Cancer treatment, palliative care, survivorship
CHI Cancer Centers	Already engaged	Ongoing	Cancer corner project capacity building, pilot and expansion projects
Community Cancer Coalitions	Already engaged	Ongoing	Community outreach; cancer screening
DHHS Environmental Health Unit	Meet and Greet Meeting	July 2011	Environmental health
DHHS Women's and Men's Health	Quarterly meetings		Men's and women's health including cancer prevention, treatment, public services
DHHS Office of Reproductive Health	Quarterly meetings	September 2011	Women's health issues
DHHS Worksite Wellness WG	Monthly meetings	Ongoing	Worksite wellness; business capacity

Evaluation Stakeholders	How to Engage Stakeholders	When to Engage Stakeholders	Stakeholder areas of expertise, interests and availability
Every Women Matters Program	Quarterly meetings	Ongoing	Breast & cervical cancer care
District Health Departments	Healthy Community program	Ongoing	Public health strategies
NAFH Program	Advisory committee Periodic topical meetings	Ongoing	Nutrition, physical activity and obesity prevention; breast feeding
NC2	Monthly meetings	Ongoing	Collaboration and effective resource use
NC2 Advocacy & Communications	Periodic meetings Email		Policy, environment and systems change at state and local levels
NE Colon Cancer Program	Quarterly meetings	Ongoing	Public colorectal cancer screening
NE Department of Education	Periodic meetings	Ongoing	Coordinated school health programming
Nebraska Chair, ACoS CoC PL Program	Emails	Ongoing	Quality inpatient treatment
Office of Oral Health & Dentistry	Initial meet & greet	August 2011	Oral health including cancer prevention
Tobacco Free Nebraska Program	Quarterly meetings	Ongoing	Tobacco prevention and control

Evaluation Stakeholders	How to Engage Stakeholders	When to Engage Stakeholders	Stakeholder areas of expertise, interests and availability
UNL College of Dentistry	Initial meet & greet	September 2011	Oral health

Program Background and Description

I. Key Comprehensive Cancer Control (CCC) Program Components--The building blocks for cancer planning and control as developed by the Centers for Cancer Prevention and Control National Comprehensive Cancer Control Program include the following components which are best viewed along a continuum of continuous planning, implementing and evaluating:

- Building/enhancing infrastructure
- Mobilizing support
- Utilizing data and research
- Building partnerships
- Assessing, addressing the cancer burden
- Developing and implementing a cancer plan
- Conducting evaluation

II. Stage of Development--The Nebraska Comprehensive Cancer Control Program (NE CCCP) was established in August, 2002. It completed the initial planning process and released its first Nebraska Cancer Plan in June 2004. The plan implementation process started early in 2004 and continues into 2012 and beyond. The planning process and the implementation process occur on an overlapping continuum with planning and implementation overlapping. NC2 partners developed the initial and revised cancer plan as a flexible document to allow for directional changes when new champions are identified, new data and trends information is available and when partners provide a convincing reason to revise our cancer plan and work plan.

III. Program Context --The Nebraska Comprehensive Cancer Control Program and its partners formed a non-profit entity in 2010 known as Nebraska Cancer Coalition or NC2. These two entities have entered into a Memorandum of Understanding and have identified separate and joint responsibilities. To the extent possible, the goal is to operate a seamless system with the two entities

working very closely together. The NC2 organization is comprised of about 150 groups and organizations represented by about 400 individuals; NC2 also includes cancer survivors and their family members.

NE CCCP receives funding from the national Centers for Disease Prevention and Control (CDC) National Comprehensive Cancer Control Program. No funds are received from Nebraska state government; however, partners contribute significant in-kind resources primarily employee time, expertise, organization space, meals and other refreshments. NC2 was formed, in part, to seek additional funding through grant applications, foundation funding and other similar sources. NC2 has selected at least two board directors who have considerable experience matching charitable organizations or families with non-profit entities. In addition, NC2 has contracted with a part time grant writer and may contract with others in the future.

Nebraska as a state offers an environment of collaboration and cooperation. This is unique in comparison to some other states, tribes or territories where "getting people to the table" may be more challenging. NE CCCP and NC2 staff continue to build important mutually beneficial relationships to extend the pool of partners who may engage in cancer prevention and control activities.

IV. Evaluation Design and Methods Matrix

Focus	Evaluation Questions	Indicators	Data Collection Sources	Data Collection Methods	Data Collection Timing	Data Analysis
The CCC component you will evaluate	What you want to know	The type of data you will need to address the evaluation question	Where you will get the data	How you will get the data	When you will collect the data	How you will organize and interpret the data
Emphasize primary prevention to reduce cancer risk (Tobacco, Healthy Eating/Physical Activity)						
TFN collaboration	How/when did we collaborate on what projects	project assignments project notes	NE CCCP files	We will collect it as we work together	Ongoing throughout the year	Review collaboration outcomes; present in end of year report to partners

Promote cigarette tax increase	Was a cigarette tax increase introduced? Passed?	Cigarette tax increase bill introduced/ passed by NE legislature.	State legislative bill action summaries	Find on NE Legislative website	End of Legislative Sessions 2011/2012	Status of bill introduction and passage
Support statewide smoke-free worksite law	Was legislation introduced to reduce/negate clean air act	Bill(s) were or were not introduced	State legislative bill website	Find on NE Legislative website	End of Legislative Sessions 2011/2012	Status of existing legislation
NAFH state plan implementation	Did we address one or more of 4 annual work plan priorities?	Included in NAFH work plan	NAFH data collection system	NAFH data collection system	June 2011 and June 2012	Review collaboration outcomes; present in year-end report to partners
Expand coordinated school health policies	Were actions taken to expand CSH policies effective?	CHS policy outcomes, e.g. # of new policies	Dept of Education data collection sources	Dept of Education reporting requirements on schools	June 2011 and June 2012	Analysis w/ DOE and NAFH; present in year-end reports
Environmental Health Unit collaboration	How/when did we collaborate on what projects	Project assignments Project notes	NE CCCP files	We will collect it as we work together	December 2011 and June 2012	Analysis w/ EH Unit; present in year-end reports
Introduce/pass breast feeding bill	Was bill introduced? Result?	Bill was or was not introduced and passed.	State Legislative bill action summaries.	Fine on NE Legislative website	End of Legislative Sessions 2011/2012	Status of legislation.

The CCC component you will evaluate	What you want to know	The type of data you will need to address the evaluation question	Where you will get the data	How you will get the data	When you will collect the data	How you will organize and interpret the data
Emphasize primary prevention to reduce cancer risk (Tobacco, Healthy Eating/Physical Activity)						
Continue/ expand BRFSS survivorship module	Did we continue and did we expand the module?	BRFSS reports	From the BRFSS program reports	Obtain from DHHS BRFSS program staff	June 2011, 2012	Review BRFSS reports and ask for their input if needed to develop report
Provide survivorship training at Summit	Yes or no, we provided survivorship training	Conference planning minutes	NC2 and NE CCCP program files and conference agenda	We keep the data	November 2011	Include in annual evaluation report
Develop a clinical trials network	Did we take actions to develop a network? Were the outcomes what we planned?	Project files and notes	NC2 and Ne CCCP program files	We will maintain the data and NC2 will manage a contract with an oncology professional	June 2011, 2012	We will build in an evaluation and report component into the contract
Raise PPS Group report card grade to A from B+	Did we take actions to change the grade?	Project files and notes	NC2 and NE CCCP program files	We will maintain them	June 2011, 2012	We will include in annual evaluation report to partners

Cancer Corner development	What were the results of the pilot? Did we find resources to expand the project?	Project files and notes	NC2 and NE CCCP program files	We will maintain it	June 2011, 2012	We will evaluate project with CC partners based on their eval plan. We will include in annual evaluation report to partners
Reduce cancer disparities to achieve health equity						
Support community cancer coalitions	What actions did we take? Outcomes?	Project files and notes	NC2 and Ne CCCP program files	We will maintain it	June 2011, 2012	Quarterly review with ACS, NCP and NE CCCP
GPTHCB CCCP collaboration	What joint projects did we plan and do? Outcomes?	Project files and notes; NP CCCP meeting minutes	NE CCCP program files	We will maintain it	December 2011, June 2012	Quarterly review with NP CCCP
The CCC component you will evaluate	What you want to know	The type of data you will need to address the evaluation question	Where you will get the data	How you will get the data	When you will collect the data	How you will organize and interpret the data
Identify possible actions re: CDC Health Disparities and Inequalities Report	What activities did we plan and implement? What were the outcomes	Program files and notes	NE CCCP and NC2 files	We will maintain it	December 2011, June 2012	We will develop a project action plan that includes an evaluation component
Promote early detection and appropriate screening						

Collaboration: -OMWH -ORH -NCP -EWM -CC Coalitions -Dialogue	How/when did we collaborate on what projects	project assignments project notes	NE CCCP files	We will collect it as we work together	Ongoing throughout the year	Review collaboration outcomes; present in end of year report to partners
Implement Community Coalition initiatives	How/when did we collaborate on what projects	project assignments project notes	NE CCCP files	We will collect it as we work together	Ongoing throughout the year	Review collaboration outcomes; present in end of year report to partners
Increase access to cancer care						
Complete GIS mapping of resources	Did we develop resource maps? How were they distributed and used?	Project assignments and files	Ne CCCP files	We will maintain the files	September 2011, June 2012	We will develop a report that includes the maps
Clinical trials initiative	Did we take actions to develop a network? Were the outcomes what we planned?	Project files and notes	NC2 and Ne CCCP program files	We will maintain the data and NC2 will manage a contract with an oncology professional	June 2011, 2012	We will build in an evaluation and report component into the contract

Red activities designate policy initiatives

I. Dissemination and Utilization of Findings

The following checklist will be used to ensure effective preparation and distribution of evaluation reports.

- ☐ Provide interim and final reports to intended users in time for use.
- ☐ Tailor the report content, format, and style for the audience(s) by involving audience members.
- ☐ Include an executive summary.
- ☐ Summarize the description of the stakeholders and how they were engaged.
- ☐ Describe essential features of the program (e.g., in appendices).
- ☐ Explain the focus of the evaluation and its limitations.
- ☐ Include an adequate summary of the evaluation plan and procedures.
- ☐ Provide all necessary technical information (e.g., in appendices).
- ☐ Specify the standards and criteria for evaluative judgments.
- ☐ Explain the evaluative judgments and how they are supported by the evidence.
- ☐ List both strengths and weaknesses of the evaluation.
- ☐ Discuss recommendations for action with their advantages, disadvantages, and resource implications.
- ☐ Ensure protections for program clients and other stakeholders.
- ☐ Anticipate how people or organizations might be affected by the findings.
- ☐ Present minority opinions or rejoinders where necessary.
- ☐ Verify that the report is accurate and unbiased.
- ☐ Organize the report logically and include appropriate details.
- ☐ Remove technical jargon.
- ☐ Use examples, illustrations, graphics, and stories.

II. Dissemination Strategy Matrix—While we expect some partners to be more interested in our evaluation reports than others, our experience is that all partners want to know what we have done and whether it made the desired difference. We will be sure that partners listed earlier in this evaluation plan document participate in completing the evaluation reports.

Evaluation Topic	Audience	Format and Channel for Sharing Findings	Timeline	Responsible Person
Promote cigarette tax increase	All Partners	Annual Report	June 2012	June
Support statewide smoke-free worksite law	All Partners	Annual Report	June 2012	June
NAFH state plan implementation	All Partners	Annual Report	June 2012	June
Expand coordinated school health policies	All Partners	Annual Report	June 2012	June
Introduce/pass breast feeding bill	All Partners	Annual Report	June 2012	Jennie
Continue/expand BRFSS survivorship module	All Partners	Annual Report	June 2012	Liz
Provide survivorship training at Summit	All Partners	Annual Report	June 2012	June
Develop a clinical trials network	All Partners	Annual Report	June 2012	June
Raise PPS Group report card grade to A from B+	All Partners	Annual Report	June 2012	June
Cancer Corner development		Cancer Summit	Oct 2011	June

GPTHCB CCCP collaboration	All Partners	Annual Report	June 2012	June
Identify possible actions re: CDC Health Disparities and Inequalities Report	All Partners	Annual Report	June 2012	June
Collaboration: -OMWH; -ORH; -NCP; -EWM -CC Coalitions; -Dialogue; -Environmental Health	All Partners	Annual Report	June 2012	June
Implement Community Coalition initiatives	All Partners	Annual Report	June 2012	June
Complete GIS mapping of resources	All Partners	Annual Report	June 2012	June

III. Checklist for Ensuring Utilization of Evaluation Results

- ☐ Share and discuss results at stakeholder meeting.
- ☐ Discuss prioritization of recommendations for program improvement with stakeholders.
- ☐ Discuss how we will implement recommendations for program improvement with stakeholders.
- ☐ Discuss ways stakeholders can apply evaluation findings to improve their organizational practices or CCC-related interventions.
- ☐ Include evaluation results and points of discussion in stakeholder meeting notes.
- ☐ Review evaluation findings and recommendations in regularly scheduled staff meetings.
- ☐ Identify action steps staff members can take to implement recommendations.
- ☐ Identify a program staff member to coordinate, document, and monitor efforts to implement improvement recommendations
- ☐ Identify a program staff member to coordinate, document, and monitor efforts.

Building Blocks of Comprehensive Cancer Control Planning
(as explained in Part II of the "Guidance for Comprehensive Cancer Control Planning")

Objectives	Planning Activities							Outcomes	Planning Goal
Enhance Infrastructure Part II, Section 3	Assess infrastructure needs and capacity	Gain buy-in from leadership of coordinating agency	Identify/ hire dedicated coordinator/ staff	Create core planning group	Involve cancer-related coordinating agency staff	Develop work plan to guide the planning process	Coordinate and monitor process (e.g., staff work groups)	Management and administrative structures and procedures developed Planning products produced, disseminated and archived	
Mobilize Support Part II, Section 4	Assess current level of support	Secure funds and in-kind resources for planning	Build support among the public and private sectors	Publicize efforts of the partnership	Develop approaches for funding plan strategies	Reassess partnership representation and coverage for implementation		Partnership develops priorities for allocation of existing resources Gaps in resources and level of support identified	P
Utilize Data/Research Part II, Section 5	Build linkages to registry and other data agencies and sources	Identify available data/ research	Review data and research as the basis for plan objectives and strategies	Assess data gaps	Conduct data collection as feasible	Identify or collect baseline data against which to measure outcomes		Planning and research data reviewed for needs assessment and strategy development Data/research gaps identified	L A
Build Partnerships Part II, Section 6	Identify, contact, and invite potential partners	Assess partner interest and capacity	Prepare for first partnership meeting	Agree on goals, vision and decision-making process with partners	Establish partnership leadership	Create work groups	Assess partner satisfaction Develop ways for new members to join & non-members to provide input	Original members remain committed as new members join Partnership/subcommittee meetings held and attended.	N
Assess/Address Cancer Burden Part II, Section 7	Organize partnership around areas of interest	Determine critical areas of burden and high-risk populations	Assess gaps in strategies already in place	Create measurable goals and objectives for plan	Identify possible intervention strategies	Prioritize goals, objectives and strategies	Identify implementing organizations for plan strategies	Target areas for cancer prevention and control selected and prioritized	
Conduct Evaluation Part II, Section 8	Identify resources and staff for evaluation	Define planning evaluation questions	Document the planning process	Identify emerging challenges, solutions, and outcomes of the planning process		Provide TA/ training on evaluation to partners	Create evaluation plan for implementation	A strategy for assessing planning process, monitoring implementation, and measuring outcomes in place	

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Nebraska Comprehensive Cancer Control

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