



Idaho Comprehensive Cancer Strategic Plan 2016-2020

Contents

- Executive Summary 4
- The Current State of Cancer in Idaho 4
- CCAI Board of Directors..... 5
- Introduction 6
 - Cancer in Idaho 6
 - Causes of Cancer..... 6
 - Cancer Survivorship 7
- Purpose of the Plan..... 8
 - Vision 9
 - Values..... 9
 - Mission 9
 - Goals 9
- Idaho Demographics 10
- Healthcare Workforce Development... 11
- The Burden of Cancer in Idaho 13
 - Cost..... 13
 - Cancer and Health Equity..... 14
 - Policy, System, and Environmental Change 16
 - Physical Access 17
 - Financial Access 17
- Idaho Data and Surveillance 18
- Needs Assessment 19
- What Can You Do? 20
- Cancer Plan Priority Areas 22
 - Prevention..... 22
 - Early Detection and Screening 22
 - Treatment..... 23
 - Quality of Life and Survivorship..... 25
- At a Glance – Goals of the Idaho Comprehensive Cancer Plan 27

GOALS

Prevention

- Goal 1:** Reduce the incidence and mortality of tobacco-related cancers 28
- Goal 2:** Increase access to healthy food options and opportunities for physical activity..... 29
- Goal 3:** Increase protective behaviors from sun and other ultraviolet radiation exposure..... 30
- Goal 4:** Increase the vaccination rate for vaccines shown to reduce the risk of cancer 31
- Goal 5:** Reduce cancer risk related to environmental carcinogens..... 32

Early Detection and Screening

- Goal 6:** Reduce breast cancer deaths and rate of late stage diagnosis through screening and early detection 33
- Goal 7:** Reduce deaths and numbers of new cases of cervical cancer through screening and early detection 34
- Goal 8:** Reduce the numbers of deaths and new cases of colorectal cancers through screening and early detection..... 35
- Goal 9:** Monitor the development and implementation of screening and early detection methods for other cancers 36

Treatment

- Goal 10:** Increase timely access to quality cancer diagnostic and treatment services for all Idahoans..... 37
- Goal 11:** Increase opportunities to access and participate in cancer treatment clinical trials..... 38
- Goal 12:** Increase provider utilization of evidence-based treatment guidelines 39

Quality of Life and Survivorship

- Goal 13:** Improve the physical and mental health of cancer survivors 40
- Goal 14:** Improve access and referrals to palliative care services for cancer patients..... 41

References..... 42

Abbreviations 43

Executive Summary

The Current State of Cancer in Idaho

In 2016, it is estimated that more than 8,000 Idahoans will hear the words “You have cancer.”¹ In 2014, 2,791 Idahoans died from cancer.² Almost every Idahoan, whether connected through friends or family members, has been affected by cancer. Cancer places a huge economic burden on individuals and the state. It is estimated that the total annual cost associated with cancer in the state is over \$1 billion.³

The Comprehensive Cancer Alliance for Idaho (CCAI) is a partnership between many dedicated individuals and organizations from healthcare and professional organizations, cancer-related and other non-profit organizations, cancer survivors and individuals touched by cancer. CCAI was formed to achieve its goals through the development and implementation of an Idaho Comprehensive Cancer Plan.

This comprehensive five year plan (2016-2020) was developed with input from four regional CCAI meetings held throughout the state in the Fall of 2014. Each region had at least one need unique to that area but the overarching issues were consistent throughout the largely rural state. CCAI’s Board of Directors continues to coordinate efforts to address the cancer burden by strengthening alliances and encouraging collaboration within the state.

This plan addresses a broad spectrum of cancer control areas, including prevention and risk reduction, early detection and screening, treatment, quality of life and survivorship.

The goals and objectives in the Idaho Comprehensive Cancer Plan are intended as long term goals and most are not expected to be achieved within one year. However, an annual addendum to the plan will be published by the CCAI Board of Directors to help ensure that we are moving in the right direction, to celebrate small successes and help determine what goals might need more attention over the course of the next year.



In 2016,
approximately
8,000
Idahoans will hear the
words, “**You have
cancer.**”

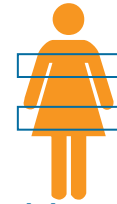
In 2014,
2,791
Idahoans died
from cancer.

The total annual cost
associated with
cancer in Idaho is
estimated to be over
\$1 billion

In 2014,
approximately
78,000
Idahoans lacked
insurance and
coverage for
preventive screenings.

Although Idaho has made some progress in a few areas since the last cancer plan was published, the state still remains at or near the bottom of the rankings for many cancer screenings and high on some rankings such as skin cancer diagnosis. To date, the state has not opted to expand Idaho's Medicaid program which leaves an estimated 78,000 Idahoans without insurance and coverage for preventive screenings at this time (2014 data).⁴

It is the vision of the CCAI Board of Directors to share and educate beyond just the CCAI membership in hopes that together as a community we can work to achieve these goals. Everyone feels the impact of cancer and everyone can take part in some way to help Idaho decrease our cancer risks, diagnoses and deaths.



Idaho ranked last among U.S. states and the District of Columbia for cervical cancer screening.

Idaho ranked 50th among U.S. states and the District of Columbia for breast cancer screening.

Source: American Cancer Society: Statistics at a Glance. http://cancerstatisticscenter.cancer.org/?_ga=1.207635290.932034519.1452090199#state/Idaho. 2016.

CCAI Board of Directors (current as of January 2016)

Jennifer Poole, President, American Cancer Society, Cancer Action Network

Tina Schaal, Vice President, American Cancer Society

Chris Johnson, Treasurer, Cancer Data Registry of Idaho

Jodi Weak, Secretary, Susan G. Komen, Idaho Montana

Stacey Carson, Past President, Idaho Hospital Association

Laura Brown, Leukemia & Lymphoma Society

Charlene Cariou, Comprehensive Cancer Control Program, Idaho Department of Health and Welfare

Luke Cavener, American Cancer Society, Cancer Action Network

Karyn Goodale-Durham, South Central Public Health District

Vicky Jekich, St. Luke's Mountain States Tumor Institute

Alicia Rosales, St. Luke's Mountain States Tumor Institute

Linda Rowe, Qualis Health

Ex Officio Members:

Casey Suter, Project Filter, Idaho Department of Health and Welfare

JamieLou Delavan, Project Filter, Idaho Department of Health & Welfare

Susan Bordeaux, Women's Health Check, Idaho Department of Health and Welfare


Introduction

Cancer in Idaho


Cancer is a term that includes more than 100 different diseases, each characterized by the uncontrolled growth and spread of abnormal cells. Cancer is the second leading cause of death in the United States and has been the leading cause of death in Idaho since 2008.⁵ About 22% of all deaths in Idaho each year are from cancer.⁵ Nearly one in two men and 30 to 40 percent of women in the United States will be diagnosed with cancer sometime in their life.⁶ Each year in Idaho, there are approximately 8,000 new cases of cancer (invasive and in situ) and 2,700 cancer deaths.¹ Although cancer may occur at any age, it is a disease of aging. Nearly 80% of cancers are diagnosed in persons ages 55 and older.⁶ Because the population is aging, the number of new cancer cases and cancer deaths that occur each year will continue to increase unless the trend is reversed by significant improvements in prevention, early detection and treatment. Total annual cancer cases will likely double in the United States by 2050.⁷



Causes of Cancer

Cancer is caused both by external factors such as tobacco use, exposure to chemicals, radiation and infectious organisms and by internal factors such as genetics, hormonal factors and immune conditions. These causal factors may act together or in sequence to initiate or promote carcinogenesis. Ten or more years often pass between exposure to external factors and detectable cancer.⁶ A large proportion of cancers could be prevented, such as all cancers caused by tobacco use and heavy alcohol consumption.⁶

Cancer is the
2nd 
leading cause of death
in the U.S.

Cancer is the
leading 
cause of death in
Idaho since 2008.

In Idaho, 
approximately
22%
of all deaths each year
are from cancer.

Each year, there are
approximately
8,000 
new cases of cancer
(invasive and in situ)
and
2,700 
cancer deaths.

Nearly **80%** of cancers are diagnosed
in persons ages **55 and older**.

Cancer Survivorship

The term cancer survivor refers to a person who has been diagnosed with cancer from the time of diagnosis throughout his or her life.⁸ It is estimated that nearly 14.5 million Americans with a history of cancer, including 66,600 in Idaho, were alive on January 1, 2014.⁹ People are living longer after a cancer diagnosis due to advances in early detection and treatment. That means the number of cancer survivors is expected to increase at a faster rate than incidence, to approach 18 million in the United States by 2022.¹⁰ Sixty-four percent of cancer survivors have survived at least five years after diagnosis; 40% have survived 10 years or more; and 15% have survived 20 years or more.⁹

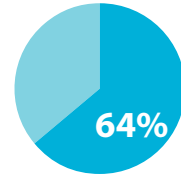
The ten most commonly diagnosed cancers among Idahoans are listed in Table 1.

Table 1. Ten Most Commonly Diagnosed Cancers Among Idahoans (2013)

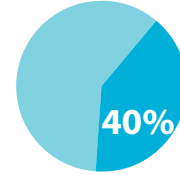
Males	Females
Prostate	Breast
Lung and Bronchus	Lung and Bronchus
Colorectal	Colorectal
Melanoma of the Skin	Corpus Uteri
Kidney and Renal Pelvis	Melanoma of the Skin
Leukemia	Thyroid
Oral Cavity and Pharynx	Non-Hodgkin's Lymphoma
Non-Hodgkin's Lymphoma	Leukemia
Bladder	Pancreatic
Pancreatic	Ovarian

Source: Johnson CJ, Carson SL. Cancer in Idaho, 2013. Boise, ID: Cancer Data Registry of Idaho; December 2015.

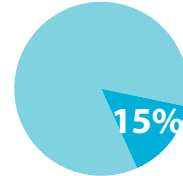
Cancer Survivorship



Survived at Least 5 Years After Diagnosis



Survived at Least 10 Years After Diagnosis



Survived at Least 20 Years After Diagnosis

Purpose of the Plan

The Idaho Comprehensive Cancer Plan aims to reduce the cancer burden across the state and improve the lives of all Idahoans. As the statewide action plan for cancer initiatives, the Idaho Comprehensive Cancer Plan identifies the challenges and issues that affect our state and presents a set of goals, objectives and strategic actions to help inform and guide communities and partners in the fight against cancer.

The *State of Cancer in Idaho* is a supplemental document that will be updated annually. It will provide annual data and state-access updates and identify the annual focus and priority area(s).



The CCAI was founded in 2002 and became a 501(c)3 non-profit organization in May 2010. The CCAI members and Board of Directors consist of healthcare professionals, representatives from state agencies, cancer-related non-profit organizations, insurance providers and cancer survivors. One of the primary functions of the CCAI is to develop, maintain and monitor the Idaho Comprehensive Cancer Plan.

While the plan was developed by the alliance, no one organization or individual can be responsible for all the work contained within this document. Effective strategies for cancer prevention and control require a concerted effort across disciplines. The plan is a guide for community members, policy makers, advocates and health care professionals to use as they engage in actions and initiatives to ease the burden of cancer in Idaho.



Comprehensive Cancer
Alliance of Idaho Website:
www.ccaidaho.org

Vision

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

Values

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

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

Mission

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

Goals

To fulfill its mission, the goals of CCAI shall be to:

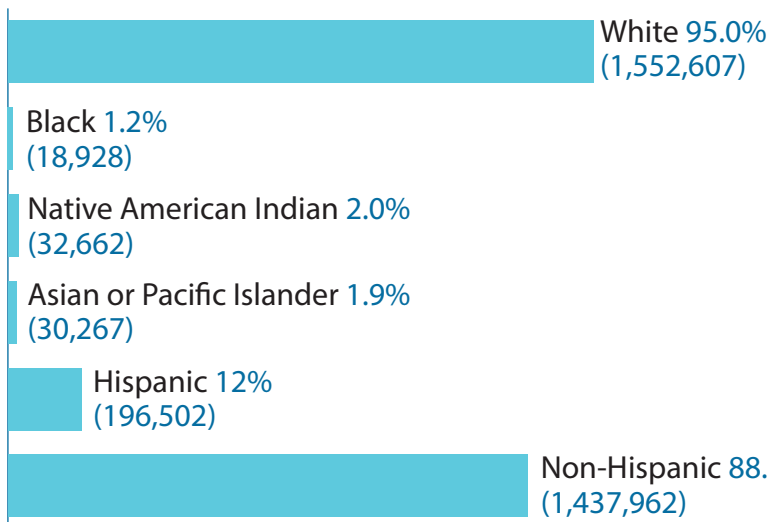
- Decrease the incidence of preventable cancers.
- Decrease preventable cancer deaths.
- Improve the quality of life for people in Idaho affected by cancer.

Idaho Demographics

Idaho is a large geographical state of 82,413 square miles with high desert areas, forests, rugged mountains, open plains and large valleys. Idaho has 44 counties. Of those, nine are classified as urban with a population center of at least 20,000; 19 counties are classified as rural with six persons or more per square mile; and 16 counties are classified as frontier with less than six people per square mile.¹¹

In 2014, the state population was 1,634,464, with the following distribution by race and ethnicity.¹¹ (See Figure 2.)

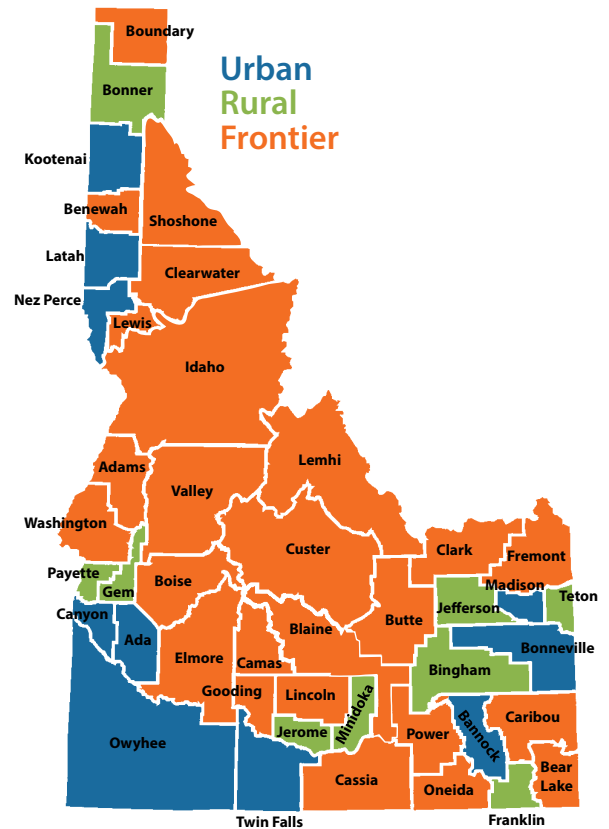
Figure 2. Population Distribution in Idaho (2014)



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

Source: U.S. Bureau of the Census. Idaho Resident Population, Estimate July 1, 2014. Internet Release Date June 30, 2015.

Figure 1. Classification of Idaho Counties



Healthcare Workforce Development

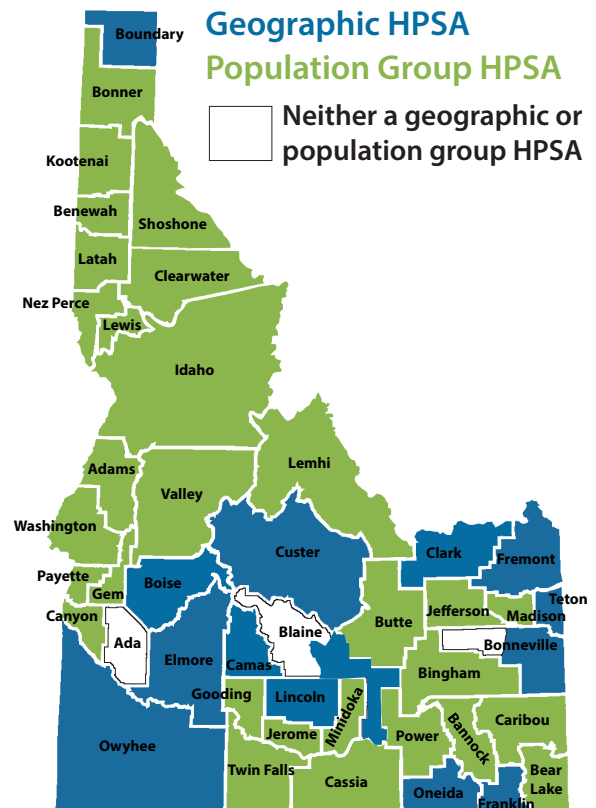
Idaho is the 11th largest state in the nation, and ranks 39th in population with 1,634,464 people (2014 estimates).¹²

On average, there are about 20 persons per square mile in the state of Idaho.¹² Most of Idaho's communities are small, widespread and scattered over mountain ranges. Traversing great distances over precarious roads, combined with health professional shortages, makes accessing healthcare a challenge for much of the rural population.

Across Idaho, almost one in six adults (16.4%) reported having healthcare access limited by cost.¹³ The American Community Survey conducted by the U.S. Bureau of the Census shows that 15.5% of the Idaho's population is living below the federal poverty level.¹⁴ Forty-two percent of all households in Idaho headed by females with related children under 18 years of age residing with them have incomes below the federal poverty level.¹⁴ Idaho stands slightly higher than the 2014 national average of 39.8% in this statistic, ranking 31st in the nation.¹⁴ Additionally, in 2014, Idaho's average unemployment rate was 4.8%, ranking Idaho 14th in the country.¹⁵

Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration (HRSA) as having shortages of primary care, dental care or mental health providers. HPSAs may be geographic (a county or service area), population (e.g., low income or Medicaid eligible) or facilities (e.g., federally qualified health centers, or state or federal prisons). Figures 3 and 4 provide some detail about HPSAs and healthcare access in Idaho.¹⁶

Figure 3. Idaho Primary Care Health Professional Shortage Area Service Areas



Source: Idaho Primary Care Health Professional Shortage Area Service Areas. Bureau of Rural Health and Primary Care, Division of Health, Department of Health and Welfare, July 2015.

Barriers to Health Access in Idaho






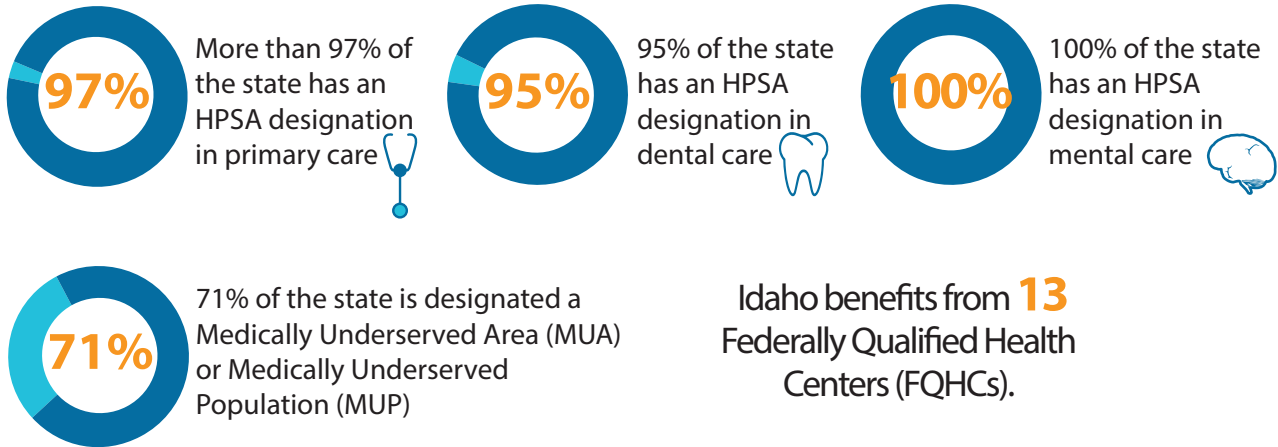
-  Lack of primary, dental and mental healthcare within reasonable geographic and economic reach
- 
- 
-  Increasing cost of healthcare
-  Lack of health insurance

Figure 4. HPSAs and Healthcare Access in Idaho

Health Professional Shortage Area Designations in Idaho



Idaho's Ranking in Lack of Population Access to Health Services



Idaho's Ranking in Population Access to Physicians

68 primary care physicians/100k population
48th out of 50 states

159 physicians in patient care/100k population
49th out of 50 states

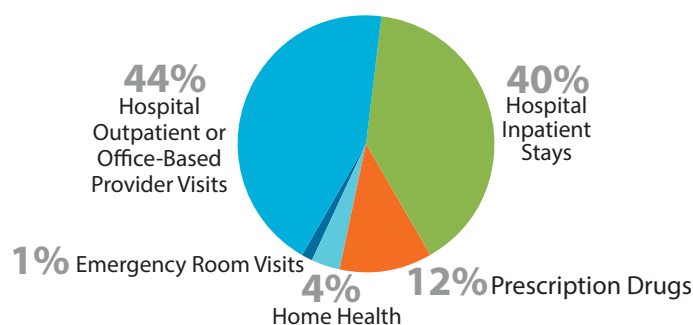
Sources: Health Resources and Services Administration, HRSA Data Warehouse <http://datawarehouse.hrsa.gov/Tools/Analyzers/hpsafind.aspx>, State Population and HPSA Designation Population Statistics, U.S. Dept. of Health and Human Services, 2013, and the American Medical Association, 2011

The Burden of Cancer in Idaho

Cost

The cost of cancer care is substantial. The Centers for Disease Control and Prevention (CDC) Chronic Disease Cost Calculator (version 2) estimates the total cost of cancer in the United States at \$205 billion in 2015 (in 2010 dollars) with the average cost per person at \$11,140.³ In Idaho, the estimated cost of cancer in 2015 is \$1 billion with the average cost per person at \$11,260, slightly higher than the national average.³

Figure 5. Percent Distribution of Cancer Treatment by Type of Service (U.S. 2013)



Source: Agency for Healthcare Research and Quality. Total Expenses and Percent Distribution for Selected Conditions by Type of Service: United States, 2013. Medical Expenditure Panel Survey Household Component Data. Generated interactively (December 08, 2015).

The economic burden, both to society and the individual, is increased by indirect “costs” including lost earnings and reduced work productivity. The total for both direct and indirect cancer related costs in Idaho was estimated at \$732 million in 2010.³

Cancer is among the most expensive conditions to treat. Cost of cancer care varies by the type of cancer, stage at diagnosis, patient age and the presence or absence of other diseases. Individuals face financial challenges because of lack of insurance or underinsurance, resulting in out-of-pocket expenses including high deductibles, copayments, coverage caps and limits on prescription drug coverage. Costs for cancer treatment have risen substantially over time and are estimated to increase by 76.3% and 91% in the U.S. and Idaho, respectively, from 2010-2020 (see Table 2).³

Table 2. Medical Cost Projections for Cancer Treatment, U.S. Overall and Idaho (2010-2020)

Year	U.S. Overall (in millions)	Idaho (in millions)
2010	\$154,769	\$732
2015	\$205,504	\$1,008
2020	\$272,918	\$1,398
% Increase 2010-2020	76.3%	91.0%

Source: Chronic Disease Cost Calculator [computer program]. Version 2. Atlanta, GA: Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion; 2015.

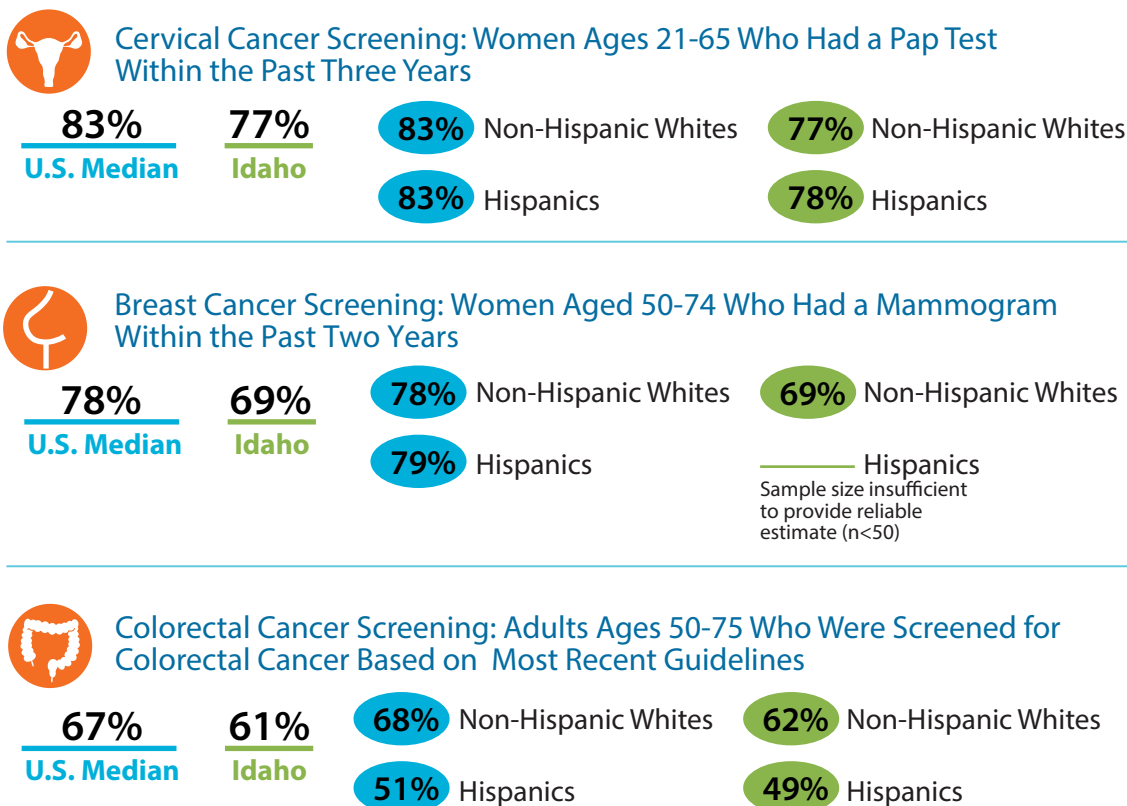
Cancer and Health Equity

Cancer health disparities exist in Idaho and can have an impact on an individual's access to and use of screening, treatment and survivorship services, leading to the potential for increased incidence and mortality rates for specific groups.

Various factors can create an adverse difference in cancer incidence, mortality and survivorship. Eliminating or addressing these disparities are an overarching goal of this plan. The factors that can contribute to disparities include health insurance status, race and ethnicity, age and socioeconomic status (income and education level).

The National Cancer Institute defines **cancer health disparities** as adverse differences in cancer incidence (new cases), cancer prevalence (all existing cases), morbidity (cancer-related health complications), cancer mortality (deaths), cancer survivorship, and burden of cancer or related health conditions that exist among specific population groups.¹⁷

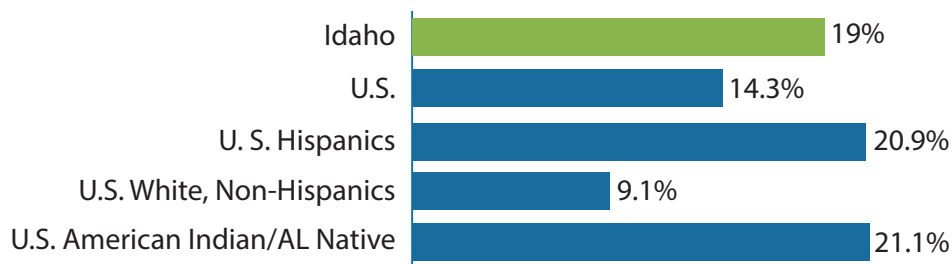
Figure 6. Screening Rates in Idaho (2014)



Note: Cervical cancer screening data includes pregnant women as part of the denominator.

Source: National Cancer Screening Rates, 2014. Idaho Behavioral Risk Factor Surveillance System (BRFSS), 2015.

Figure 7. Adults Ages 18-64 Without Health Insurance (2014)



Sources: The Kaiser Commission on Medicaid and the Uninsured. The Uninsured: A Primer Key Facts About Health Insurance And The Uninsured In The Era Of Health Reform. Supplemental Tables. November 2015. <http://files.kff.org/attachment/supplemental-tables-the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-the-era-of-health-reform>.

Table 3. Incidence Rates of Certain Cancers by Socioeconomic Factors (U.S. 2007-2011)

Low Education	High Education	Areas with High Rates of Uninsured	Areas with Low Rates of Uninsured
Cervix	Breast	Cervix	Melanoma of skin
Colon and rectum	Melanoma of skin	Colon and rectum	Prostate
Esophagus	Prostate	Uterus	Thyroid
Kidney and renal pelvis		Esophagus	
Larynx		Liver and bile duct	
Lung and bronchus		Lung and bronchus	
		Oral cavity and pharynx	

Source: Cancer Health Disparities. (2008, March 11). <http://www.cancer.gov/about-nci/organization/crhd/cancer-health-disparities-fact-sheet#q>.

Policy, System, and Environmental Change

Creating long term changes that have an impact on cancer rates takes a three point approach—public policy, healthcare systems and physical environments. Idaho continues to make slow but steady progress on policy changes. In 2015, the Idaho legislature passed a bill to prohibit children 13 and under from using indoor tanning beds and requiring written parental consent for minors aged 14-17. Working with employers to create healthy workplaces and communities, Idaho is seeing progress on making all workplaces smoke-free.

As of 2015, Idaho has not expanded Medicaid to persons up to 138% of federal poverty guidelines, which would help cover the gap of an estimated 78,000 Idahoans without healthcare coverage.⁴ Idaho does not offer Medicaid coverage for childless adults and has the fifth lowest income level eligibility for parents among the 22 states that have not adopted Medicaid expansion.¹⁸

Health system change has included electronic medical records, improved reminder systems, patient navigation, and development of cancer treatment summaries and survivorship plans. Continued work is needed to increase access to care outside of normal work hours and outside of the more urban centers. Southwest Idaho has two hospitals with mobile mammography programs and Eastern Idaho has one mobile mammography program, but rural and frontier areas of the state have little to no access to mobile mammography.

Environmental change often overlaps with policy on many levels. Many public parks across the state are smoke-free or have smoking restrictions. Idaho employers are adopting workplace wellness programs, tobacco free worksites and providing healthier vending machine options.

Figure 8. Cancer and Health Disparities

Medically underserved, low income and minority populations are more likely to:



Be diagnosed with and die from preventable cancers.

Be diagnosed with late-stage disease for cancers detectable through screening at an early stage.



Receive no treatment, or treatment that does not meet accepted standards.



Die of cancers that are generally curable.

Suffer from cancer without the benefit of pain control and other palliative care.

Source: Making Cancer Health Disparities History. A Report of the Trans-HHS Cancer Health Disparities Progress Review Group. 2004.

Physical Access

The Commission on Cancer (CoC), a program of the American College of Surgeons (ACoS), recognizes cancer care programs for their commitment to providing comprehensive, high quality and multidisciplinary patient centered care. As of 2016, there are six cancer treatment centers in Idaho accredited by the CoC:

- Kootenai Health, Coeur D'Alene
- Portneuf Medical Center, Pocatello
- Saint Alphonsus Regional Medical Center, Boise
- St. Joseph Regional Medical Center, Lewiston
- St. Luke's Magic Valley Medical Center, Twin Falls
- St. Luke's Regional Medical Center, Boise

All of Idaho's major population centers have specialized cancer treatment services. Some of the facilities offer cancer services at additional locations including satellite offices, making comprehensive cancer services available to more Idahoans. However, many Idahoans live in rural areas and need to travel long distances or to other states for treatment.

Financial Access

There are many financial barriers for Idahoans across the continuum of care. Idaho has not addressed the needs of approximately 78,000 residents who are unable to afford healthcare coverage. Medicaid expansion and other potential coverage programs continue to be discussed but nothing has been implemented.

Figure 9. CoC-Accredited Cancer Treatment Centers in Idaho



Source: American College of Surgeons. Cancer Treatment Centers. <https://www.facs.org/search/cancer-programs?state=ID>

Idaho Data and Surveillance

Multiple sources of data are used to track cancer incidence, prevalence, survival and mortality and morbidity among different population groups.

The Cancer Data Registry of Idaho (CDRI)

CDRI collects incidence and survival data on all cancer patients who reside in Idaho or who are diagnosed or treated in Idaho. CDRI has been designated as a gold standard registry by the North American Association of Central Cancer Registries (NAACCR) for timeliness, completeness, and quality.

www.idcancer.org

The Centers for Disease Control and Prevention's National Program of Cancer Registries (NPCR)

The NPCR supports central cancer registries in 45 states (including Idaho), the District of Columbia, Puerto Rico and the U.S. Pacific Island Jurisdictions. These data represent 96% of the U.S. population.

www.cdc.gov/cancer/npcr

Surveillance, Epidemiology, and End Results (SEER) Program

Part of the National Cancer Institute, the SEER program consists of several population-based cancer registries throughout the U.S. The U.S. Cancer Statistics Incidence and Mortality Web-based Report (USCS) contains the official federal statistics on cancer incidence (newly diagnosed cases) from each registry that meet data quality criteria. USCS data are combined from NPCR and SEER and are used in this document for comparison purposes and rankings.

<http://seer.cancer.gov>

The Behavioral Risk Factor Surveillance System (BRFSS)

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

www.cdc.gov/brfss

The Youth Risk Behavior Surveillance System (YRBS)

The YRBS focuses on the behaviors related to the leading causes of mortality and morbidity among youth grades 9 through 12. The questionnaire is administered in the classrooms of Idaho's public schools, usually in odd numbered years (2011, 2013).

www.cdc.gov/healthyyouth/data/yrbs/index.htm

The School Health Policies and Practices Study* (SHPPS)

SHPPS is a national survey periodically conducted to assess school health policies and practices at the state, district, school and classroom levels.

www.cdc.gov/healthyyouth/data/shpps/index.htm

The National Adult Tobacco Survey (NATS)

NATS is a stratified, national, landline and cell phone survey of non-institutionalized adults aged 18 years and older residing in the 50 states or D.C. NATS results are used to assess the prevalence of tobacco use among adults, the factors promoting and impeding tobacco use and for evaluating both national and state-specific tobacco control programs.

www.cdc.gov/tobacco/data_statistics/surveys/nats

Needs Assessment

In order to ensure that cancer control efforts were appropriate and relevant for Idahoans, the ICCCP conducted an assessment on the cancer screening behaviors and beliefs of Idahoans aged 50 and older. In this assessment, regional focus groups conducted in 2013 sought to identify insights into key cancer screening motivators, or lack thereof, in obtaining recommended screenings for breast, cervical, colorectal, prostate and skin cancer (See Table 4).

The assessment results have informed ongoing cancer control efforts throughout the state and should continue to be used for development and implementation of various cancer prevention and early detection interventions.

Table 4. Key Findings: Cancer Screening Behaviors and Beliefs Assessment

Key Finding	Implication
Men and women have differing relationships with healthcare and varying amounts of knowledge about it.	A “one size fits all” approach to cancer screening messaging is not working. Messages should be customized to each gender to address their underlying emotions and motivations.
There is little awareness of colonoscopy alternatives.	Some people are forgoing colorectal cancer screening entirely in order to avoid a colonoscopy.
Among those who have not had a colonoscopy, there is little awareness that the colonoscopy procedure is done with medication and is not painful.	There is little education and awareness about the colonoscopy procedure itself and what to expect during the procedure.
The perceived cost of colonoscopies (both out-of-pocket costs and time required for screening) is a significant barrier.	Even among those with insurance, cost is a barrier because people do not know how much of the procedure will be covered. Moreover, the perceived time required is a hidden cost. If programs exist that offer reduced cost colonoscopies to those without insurance, no knowledge of such programs exist among the general public.

What can you do?

The CCAI, through the Idaho Comprehensive Cancer Plan, aims to reduce the burden of cancer in Idaho and pursue the coalition mission that “Every Idahoan deserves the opportunity for proper cancer prevention and detection; state-of-the-art cancer treatment; and the highest possible quality of life which we are committed to provide through a data-driven, coordinated, comprehensive cancer plan.” We can’t do it alone. We need the coordination and collaboration of statewide stakeholders and resources to successfully implement this plan. Below are some ideas about how you can help.

As a Hospital



- Review, support or participate in implementing Idaho Comprehensive Cancer Plan activities.
- Ensure that cancer cases are reported in a timely manner.
- Collaborate to sponsor navigation and survivorship programs.
- Collaborate to sponsor community screening and education programs.
- Implement tobacco-free policies at your facility.
- Include cancer prevention messages in health classes.
- Provide healthy foods in vending machines and cafeterias.
- Encourage employees to get cancer screening tests on time.

As a Public Health Department



- Review, support or participate in implementation of Idaho Cancer Comprehensive Plan activities.
- Support policy, environmental and systems changes for cancer control.
- Provide cancer prevention awareness information and screening programs to citizens.
- Provide navigation services for clients.
- Collaborate in community prevention campaigns.
- Work with physicians to promote screening programs and case reporting.
- Provide cancer prevention information to members.
- Learn how to provide healthy potlucks and meeting meals.
- Provide space for physical activity programs.
- Encourage employees to get cancer screening tests on time.

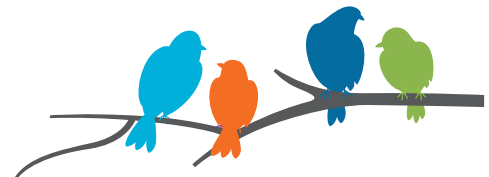
*"Hope" is the thing with
feathers*

That perches in the soul

*And sings the tune
without the words*

*And never stops — at
all....*

Emily Dickinson, c.1861



As a Community-Based Organization

- Review, support or participate in implementation of Idaho Comprehensive Cancer Plan activities.
- Support policy, environmental and systems changes for cancer control.
- Promote or provide cancer prevention awareness information and screening programs for clients.
- Encourage participation in clinical trials.
- Collaborate to provide community prevention programs.

As an Employer

- Implement tobacco-free policies at your facility.
- Provide healthy foods in vending machines and cafeterias.
- Encourage employees to increase physical activity.
- Collaborate with community partners to host education or screening events.
- Implement worksite wellness programs to educate on and to encourage employees to have regular cancer screenings.

As an Individual

- Stop using tobacco products or never start.
- Eat more fruits and vegetables and maintain a healthy weight.
- Increase your daily physical activity.
- Know when to be screened and do it on schedule.
- Support comprehensive tobacco-free environment policies.
- If diagnosed with cancer, consider enrolling in a clinical trial.
- Show your support and care for those who are diagnosed.
- Volunteer with your hospital, health department, faith community or local community-based organization.

Cancer Plan Priority Areas

In order to most effectively organize the Idaho Comprehensive Cancer plan, the 2016-2020 goals have been separated into priority areas. These areas focus on the prevention, early detection and treatment of cancer, and increasing the quality of life for cancer survivors.

Prevention

Cancer is the leading cause of death in Idaho. While not all cancers are preventable, many of the known risk factors can be decreased or eliminated through personal behaviors.

Some behaviors that have been shown to reduce the risk of cancer include eliminating the use of all tobacco products and exposure to secondhand smoke, engaging in physical activity, and maintaining a healthy weight. Other personal factors linked to cancer prevention are protection from natural ultraviolet (UV) radiation and avoiding UV exposure from artificial sources, such as tanning beds and sun lamps; following recommended vaccination guidelines; and reducing exposure to environmental carcinogens.

Through healthy lifestyle practices and other policy-driven and systematic changes, we will reduce the burden of cancer in Idaho.

Early Detection and Screening

Secondary prevention efforts can have a significant impact on the cancer burden in Idaho by reducing overall new cases and deaths from the disease. Detecting a cancer at its earliest stage, or even as a precancerous lesion, can act as a “preventive” measure by not allowing the disease to progress to a later stage when treatment regimens are not as effective. The recommended age to begin screening, as well as the methodologies used, varies by each cancer type as well as other factors. The CCAI has identified the early detection and screening of cancer as a priority area for cancer control efforts in Idaho.

Routine screenings for the following cancer types are currently recommended for the general population by the United States Preventive Services Task Force (USPSTF):

- Breast cancer
- Cervical cancer
- Colorectal cancer

The USPSTF also recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years who have a 30 pack-a-year smoking history and currently smoke or have quit within the past 15 years. CCAI also encourages routine oral cancer screenings as recommended by a clinician.

Treatment

Cancer treatment can entail surgery, radiation, chemotherapy and other modalities. Cancer treatment varies by type of cancer, stage at diagnosis, age, general health and personal decision factors. Successful treatment involves a partnership between healthcare providers, patients and family/caregivers. Patients who fully understand their treatment program tend to experience greater satisfaction with their care and are more likely to complete treatment. When patients understand the nature and risks of their cancer diagnosis and potential risks and benefits of treatment, they can make informed decisions that are consistent with their personal preferences and values.

When cancer is found, a patient's survival and quality of life can depend on the availability of timely, quality treatment. However, approximately 19% of adult Idahoans aged 18-64 do not have health insurance, which may reduce some cancer treatment options. Access to care may be further compromised by geographic barriers; Idaho is the 14th largest of the 50 United States and ranks 44th in population density. Other barriers, including those based on culture, language, age or socioeconomic status, may impact the quality of care received.

The accessibility, availability and quality of cancer treatment are broad and complicated issues, yet there are significant and identifiable areas where action can be taken, including:

- Current programs and services of all types, from health-care clinics to public health organizations, must collaborate to share information and best practices and to streamline service delivery.
- Barriers must be reduced or eliminated.
- A skilled workforce must be available to provide treatment to Idahoans in every part of the state.
- Individuals living with cancer must be empowered to be active participants in their own care.
- High quality research must be a consistent priority.

High quality cancer diagnostic results help inform all areas of patient care planning, including staging, treatment, palliation, rehabilitation and surveillance for late effects and recurrent disease. An accurate diagnosis can also determine if a patient's family members are at higher risk for the disease, which calls for a more thorough family history and/or genetic testing so that a patient's relatives may be referred to appropriate counseling, screening and follow-up services. Quality follow-up care is an essential component of the cancer prevention and control continuum.

Changes in detection and treatment methodologies, clinical recommendations and healthcare industry practices often present challenges in getting the best care to patients. Facilities accredited by the ACoS Commission on Cancer offer a full range of medical services along with a multidisciplinary team approach to patient care.

As of 2016, there are six CoC-accredited cancer programs in Idaho. Some essential elements of these programs include:

- Access to state-of-the-art clinical services and equipment for all phases of the cancer prevention and control continuum: primary prevention, screening/early detection, diagnostics, treatment, rehabilitation and support services

- A multidisciplinary team approach to coordinate patient care
- Up-to-date clinical trials and treatment information for patients
- A cancer registry and database that follows patients throughout life
- Ongoing monitoring and evaluation of patient outcomes

Quality of Life and Survivorship

Thanks to significant advances in cancer treatment and improvements in early detection, the number of cancer survivors in the U.S. is growing rapidly. There are over 66,000 cancer survivors in Idaho. Today, a diagnosis of cancer is no longer a death sentence. Patients are living longer with the disease and are frequently disease free. Cancer survivors are now dealing with cancer as a chronic illness or with the chronic side effects of treatment. The growing number of cancer survivors has created a shift in modern cancer care that has an increased focus on quality of life for survivors both during and after treatment. This includes a focus on physical health as well as mental health throughout the continuum of care. Oncologists are encouraged to engage their patients in shared decision making as it relates to issues of survivorship and long term disease management or palliation.

The National Comprehensive Cancer Network (NCCN) published clinical best practice guidelines for survivorship in 2013. In 2014 the American Society for Clinical Oncology (ASCO) followed suit. Both organizations have also published guidelines for palliative care and symptom management that are readily used in cancer care today. The guidelines highlight the important interface between physical health and mental health with special attention to not only disease surveillance and pain management but also assessment and referral for anxiety, depression, sexual function, nutrition and physical activity. A growing body of research supports the inclusion of these issues as part of the quality of life discussion with patients both during and after treatment for cancer.

Survivorship is
the process of
living
with,
through
or
beyond
cancer.

The Institute of Medicine recommends that every patient receive a survivorship care plan. The Commission on Cancer requires all accredited cancer centers to offer these care plans to patients upon completion of cancer treatment. These care plans must be comprehensive in nature and meet all of the minimum requirements set forth by ASCO.

In addition to the new guidelines and recommendations for survivorship care, there is an increasing effort to improve palliative care programs and access to hospice services for cancer patients with high symptom burden and/or limited life expectancy. The published clinical guidelines for palliative care and symptom management should guide this care. Efforts to improve the quality of life of cancer patients should be accompanied by discussions about advanced care planning and include the implementation of an advanced directive for every patient. These discussions are often difficult to conduct and require that clinicians and staff be trained and comfortable with the subject. Staff should be able to answer questions and direct patients to reputable community resources and organizations.

With the growing number of cancer survivors in Idaho, healthcare providers, community organizations, researchers, health plan administrators and advocates must be prepared to meet the unique and often challenging needs of this population. With the landscape of healthcare requirements, guidelines and recommendations ever changing, it is important that the CCAI offer an opportunity for healthcare partners to collaborate and receive the latest education on best practices. There are many different models for providing survivorship and palliative care to improve the quality of life of cancer survivors in Idaho and through collaboration and education this goal can be achieved.

Links to Guidelines

Agency for Healthcare Research and Quality: www.guideline.gov

American Cancer Society (ACS): www.cancer.org

American College of Obstetricians and Gynecologists: www.acog.org

American Society of Clinical Oncology (ASCO) - Institute for Quality: www.instituteforquality.org/

American College of Surgeons Commission on Cancer: <https://www.facs.org/quality-programs/cancer>

American Society for Colposcopy and Cervical Pathology: www.asccp.org/consensus.shtml

Institute of Medicine: <http://iom.nationalacademies.org/>

National Cancer Institute (NCI): www.cancer.gov

National Comprehensive Cancer Network (NCCN): www.nccn.org

At a Glance – Goals of the Idaho Comprehensive Cancer Plan

Prevention – Prevent Cancer from Occurring

Goal 1	Reduce the incidence and mortality of tobacco-related cancers
Goal 2	Increase access to healthy food options and opportunities for physical activity
Goal 3	Increase protective behaviors from sun and other ultraviolet radiation exposure
Goal 4	Increase the vaccination rate for vaccines shown to reduce the risk of cancer
Goal 5	Reduce cancer risk related to environmental carcinogens

Early Detection and Screening – Detect Cancer at Its Earliest Stages

Goal 6	Reduce breast cancer deaths and rate of late stage diagnosis through screening and early detection
Goal 7	Reduce deaths and numbers of new cases of cervical cancer through screening and early detection
Goal 8	Reduce the numbers of deaths and new cases of colorectal cancers through screening and early detection
Goal 9	Monitor the development and implementation of screening and early detection methods for other cancers

Treatment – Treat All Cancer Patients by Using the Most Appropriate and Effective Therapy

Goal 10	Increase timely access to quality cancer diagnostic and treatment services for all Idahoans
Goal 11	Increase opportunities to access and participate in cancer treatment clinical trials
Goal 12	Increase provider utilization of evidence-based treatment guidelines

Quality Of Life – Optimize the Quality of Life for Every Person Affected by Cancer

Goal 13	Improve the physical and mental health of cancer survivors
Goal 14	Improve access and referrals to palliative care services for cancer patients

PREVENTION

Goal 1: Reduce the incidence and mortality of tobacco-related cancers

Objectives	<ul style="list-style-type: none"> • Reduce cigarette smoking by adults. • Reduce tobacco use by adolescents. • Reduce use of smokeless tobacco products by adults. 		
Measures	Measure	Baseline	Target
	1.1 Percentage of adults who are current smokers (age adjusted to the year 2000 standard population)	16.5% BRFSS 2014	12.0% HP2020
	1.2 Percentage of adolescents in grades 9 through 12 who used cigarettes, chewing tobacco, snuff, or cigars in the past 30 days	17.0% YRBS 2015	13.6% CCAI (20%)
	1.3 Percentage of adult males aged 18+ who are current users of smokeless tobacco products such as chewing tobacco, snuff and snus (age adjusted to the year 2000 standard population)	9.4% BRFSS 2014	7.5% CCAI (20%)
Strategic Actions	<ul style="list-style-type: none"> • Support and promote implementation of policy, systems, and environmental change and other evidence-based strategies that decrease tobacco use and initiation and exposure to secondhand smoke. • Evidence-based strategies may include: <ul style="list-style-type: none"> ◊ Promoting and implementing tobacco-free environment policies ◊ Conducting youth- and adult-focused counter-marketing campaigns statewide ◊ Increasing prices of cigarettes and other tobacco products ◊ Supporting expanded access to and promoting use of comprehensive tobacco cessation programs and services • Improve health professional knowledge, practice behaviors and system support related to increasing provision of or referral to tobacco cessation services. • Conduct statewide messaging campaigns about the dangers of tobacco use. • Support and promote implementation of evidence-based strategies to decrease disparities in gender, racial/ethnic populations, LGBT people and rural communities related to tobacco use. 		

PREVENTION

Goal 2: Increase access to healthy food options and opportunities for physical activity

<h3>Objectives</h3>	<ul style="list-style-type: none"> • Increase the proportion of adults who meet the recommended physical activity guidelines. • Increase the proportion of adults who are at a healthy weight. • Increase the proportion of adolescents who meet current federal physical activity guidelines for aerobic physical activity. 														
<h3>Measures</h3>	<table border="1"> <thead> <tr> <th>Measure</th> <th>Baseline</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td>2.1 Percentage of Idaho adults aged 18+ who engage in the recommended level of weekly physical activity (age adjusted to the year 2000 standard population)</td> <td>18.4% BRFSS 2013</td> <td>22.1% CCAI (20%)</td> </tr> <tr> <td>2.2 Percentage of adults aged 20+ who are at a healthy weight (BMI \geq 18.5 and \leq 25.0; age adjusted to the year 2000 standard population)</td> <td>32.5% BRFSS 2014</td> <td>35.8% CCAI (10%)</td> </tr> <tr> <td>2.3 Percentage of adolescents in grades 9 through 12 who meet physical activity guidelines for aerobic physical activity</td> <td>27.9% YRBS 2013</td> <td>31.6% HP2020</td> </tr> </tbody> </table>	Measure	Baseline	Target	2.1 Percentage of Idaho adults aged 18+ who engage in the recommended level of weekly physical activity (age adjusted to the year 2000 standard population)	18.4% BRFSS 2013	22.1% CCAI (20%)	2.2 Percentage of adults aged 20+ who are at a healthy weight (BMI \geq 18.5 and \leq 25.0; age adjusted to the year 2000 standard population)	32.5% BRFSS 2014	35.8% CCAI (10%)	2.3 Percentage of adolescents in grades 9 through 12 who meet physical activity guidelines for aerobic physical activity	27.9% YRBS 2013	31.6% HP2020		
Measure	Baseline	Target													
2.1 Percentage of Idaho adults aged 18+ who engage in the recommended level of weekly physical activity (age adjusted to the year 2000 standard population)	18.4% BRFSS 2013	22.1% CCAI (20%)													
2.2 Percentage of adults aged 20+ who are at a healthy weight (BMI \geq 18.5 and \leq 25.0; age adjusted to the year 2000 standard population)	32.5% BRFSS 2014	35.8% CCAI (10%)													
2.3 Percentage of adolescents in grades 9 through 12 who meet physical activity guidelines for aerobic physical activity	27.9% YRBS 2013	31.6% HP2020													
<h3>Strategic Actions</h3>	<ul style="list-style-type: none"> • Support the implementation of policy, systems and environmental change and other evidence-based strategies that increase access to healthy foods and physical activity opportunities to influence individual behavior change and reduce the risk of cancer related to obesity. • Evidence-based strategies may include supporting and promoting: <ul style="list-style-type: none"> ◊ The implementation of evidence-based school and youth community programs that promote good nutrition, physical activity and healthy weight ◊ The implementation of evidence-based worksite and adult community programs that promote good nutrition, physical activity and healthy weight ◊ Built environment and policy approaches designed to provide opportunities for people to be more physically active and have easy access to healthy foods ◊ Improvements to health professional knowledge, practice behaviors, and system support related to increasing provision of or referral to counseling and services that promote nutrition and physical activity guidelines and obesity reduction and control • Support and promote the adoption of the <i>Let's Move</i> Initiative. 														

PREVENTION

Goal 3: Increase protective behaviors from sun and other ultraviolet radiation exposure

Objectives

- Reduce the proportion of adolescents in grades 9 through 12 who use artificial sources of ultraviolet light for tanning.
- Reduce the proportion of adults aged 18 years and older who use artificial sources of ultraviolet light for tanning.
- Reduce the proportion of adults aged 18 years and older who become sunburned.

Measures

Measure	Baseline	Target
3.1 Percentage of adolescents in grades 9 through 12 who report using artificial sources of ultraviolet light for tanning	9.0% YRBS 2015	7.2% CCAI (20%)
3.2 Percentage of adults aged 18+ who report using artificial sources of ultraviolet light for tanning (age adjusted to the year 2000 standard population)	5.6% BRFSS 2014	4.5% CCAI (20%)
3.3 Percentage of adults who report having a red or painful sunburn that lasted a day or more in the past 12 months (age adjusted to the year 2000 standard population)	52.0% BRFSS 2014	46.8% CCAI (10%)

Strategic Actions

- Implement policy, systems, and environmental change and other evidence-based strategies that increase the adoption of ultraviolet radiation safety behaviors.
- Evidence-based strategies may include:
 - ◊ Advocating for eliminating the use of tanning beds
 - ◊ Implementing evidence-based school, worksite and community programs that promote sun safety
 - ◊ Conducting statewide awareness campaigns on the link between solar radiation and risk of skin cancer (settings such as parks, schools, daycare centers, worksites and beaches)
 - ◊ Improving health professional knowledge, practice behaviors and system support related to skin cancer rates and sun safety

PREVENTION

Goal 4: Increase the vaccination rate for vaccines shown to reduce the risk of cancer

Objectives	<ul style="list-style-type: none"> • Increase the percentage of youth and young adults who have completed the recommended HPV vaccine series according to national guidelines. • Promote hepatitis B vaccination and adoption of CDC recommendations for hepatitis screening. 		
Measures	Measure	Baseline	Target
	4.1 Percentage of adolescent females aged 13-17 years who completed 3 doses of the HPV vaccine	38.3% NIS-Teen 2014	80.0% HP2020
	4.2 Percentage of adolescent males aged 13-17 years who completed 3 doses of the HPV vaccine	17.2% NIS-Teen 2014	80.0% HP2020
	4.3 Percentage of newborns receiving hepatitis B vaccine (Hepatitis B vaccine administered from birth through age 3 days; children in the 2014 NIS born in January 2011 through May 2013)	75.4% NIS-Child 2014	85.0% HP2020
Strategic Actions	<ul style="list-style-type: none"> • Implement policy, systems and environmental change and other evidence-based strategies that address infectious disease causes related to cancer. • Improve health professional knowledge, practice behaviors and system support related to increasing provision of, or referral to, immunizations against HPV and hepatitis B. • Evidence-based strategies may include: <ul style="list-style-type: none"> ◊ Enhancing access to vaccination services through home visits, cost reductions and vaccination programs in nontraditional settings ◊ Increasing community demand through incentives, reminder systems and vaccine requirements for childcare, schools and colleges ◊ Implementing provider or system-based intervention that includes immunization information tests, provider assessments and feedback and standing orders • Improve health professional knowledge, practice behaviors and system support related to increased use of HPV and hepatitis B vaccines. 		

PREVENTION

Goal 5: Reduce cancer risk related to environmental carcinogens

Objective Measure

- Increase the proportion of persons living in homes that have been tested for radon.

Measure	Baseline	Target
5.1 Percentage of adults living in households ever been tested for radon (age adjusted to the year 2000 standard population)	20.7% BRFSS 2014	24.8% CCAI (20%)

Strategic Actions

- Implement evidence-based policies, programs and systems changes to share information among the public, researchers, regulatory agencies and industry about environmental carcinogens, specifically radon.
- Advocate for evidence-based epidemiologic and environmental monitoring and research across the life course (in utero and childhood, workplace, and multi-generational exposures).
- Improve health professional knowledge, practice behaviors and systems support related to known and emerging environmental carcinogens.

Smokers are nearly **25 times** more likely to be harmed by radon than non-smokers.

What is radon?

Radon comes from the natural breakdown of uranium in soil, rock and water and gets into the air. The greatest exposure occurs at home, where people spend most of their time.

How does radon cause cancer?

Radon gas in the air breaks down into particles that attach themselves to dust, which are then inhaled into the lungs. There, the radon can damage cells and cause cancer. Radon can be a higher risk for people with certain lung conditions such as asthma, emphysema, and whose lungs have been damaged by scarring (fibrosis).

Smoking and exposure to radon increases the risk of getting lung cancer. The chances of getting lung cancer from radon depend mostly on:

- How much radon is in the home
- The amount of time spent in the home
- Whether a person is a smoker or has ever smoked

EARLY DETECTION AND SCREENING

Goal 6: Reduce breast cancer deaths and rate of late stage diagnosis through screening and early detection

Objectives	<ul style="list-style-type: none"> • Increase the proportion of women who receive breast cancer screening according to national guidelines. • Reduce late stage female breast cancer. • Reduce the rate of female breast cancer. 		
Measures	Measure	Baseline	Target
	6.1 Percentage of women aged 50 to 74 who had a mammogram within the past two years (age adjusted to the year 2000 standard population)	68.9% BRFSS 2014	81.1% HP2020
	6.2 Age-adjusted rate per 100,000 females of breast cancer diagnoses at late stage (regional and distant)	42.4 CDRI 2013	38.1 CCAI (10%)
	6.3 Age-adjusted mortality rate, female breast cancer	20.5 BVRHS 2014	18.5 CCAI (10%)
Strategic Actions	<ul style="list-style-type: none"> • Promote the use of evidence-based strategies to increase access to care. Evidence-based strategies may include: <ul style="list-style-type: none"> ◊ Increasing hours of operation ◊ Increasing access to transportation services ◊ Increasing mobile and other alternative screening opportunities ◊ Increasing access to insurance coverage ◊ Promoting investments in and increasing availability of patient navigation services ◊ Using best practice models for increasing collaboration among service providers to ensure continuum of care (access to treatment) ◊ Ensuring appropriate follow-up for those who receive abnormal breast-cancer screening results • Promote using evidence-based interventions to provide education on breast cancer. • Promote screening guidelines and awareness of insurance coverage options, including for all underserved populations. • Support the provision of education and screening services through emerging models of healthcare delivery. • Support the implementation of clinical system changes to increase utilization of evidence-based cancer screening. Strategies include: <ul style="list-style-type: none"> ◊ Electronic health records ◊ Provider and client reminder systems ◊ Assessment of compliance (offering or delivering screening to clients) for providers and/or practices • Identify disparate populations and support evidence-based interventions to increase screening and decrease mortality. • Collaborate with statewide organizations and partners to support and/or facilitate education to healthcare providers on breast cancer screening best practices. 		

EARLY DETECTION AND SCREENING

Goal 7: Reduce deaths and numbers of new cases of cervical cancer through screening and early detection

Objectives

- Increase the proportion of women who receive cervical cancer screening according to national guidelines.
- Reduce the rate of invasive cervical cancer.

Measures

Measure	Baseline	Target
7.1 Percentage of women aged 21-65 who have had a Pap test within the past three years (age adjusted to the year 2000 standard population)	76.3% BRFSS 2014	93.0% HP2020
7.2 Age-adjusted rate per 100,000 females of invasive cervical cancer diagnoses	5.2 CDRI 2013	4.7 CCAI (10%)
7.3 Age-adjusted cervical cancer mortality rate per 100,000 females	2.0 BVRHS 2014	1.6 CCAI (20%)

Strategic Actions

- Promote the use of evidence-based strategies to increase access to care. Evidence-based strategies may include:
 - ◊ Increasing hours of operation
 - ◊ Increasing access to transportation services
 - ◊ Increasing mobile and other alternative screening opportunities
 - ◊ Increasing access to health insurance coverage
 - ◊ Promoting investments in and increasing availability of patient navigation services
 - ◊ Using best practice models for increasing collaboration among service providers to ensure continuum of care (access to treatment)
 - ◊ Ensuring appropriate follow-up for those who receive abnormal cervical cancer screening results
- Promote using evidence-based interventions to provide education on cervical cancer and promote screening guidelines and awareness of insurance coverage options among all underserved populations.
- Support the provision of education and screening services through emerging models of healthcare delivery.
- Support the implementation of clinical system changes to increase utilization of evidence-based cancer screening. Strategies include:
 - ◊ Electronic health records
 - ◊ Provider and client reminder systems
 - ◊ Assessment of compliance (offering or delivering screening to clients) for providers and/or practices
- Identify disparate populations and support evidence-based interventions to increase screening.
- Collaborate with statewide organizations and partners to support and/or facilitate education to healthcare providers on cervical cancer screening best practices.

EARLY DETECTION AND SCREENING

Goal 8: Reduce the numbers of deaths and new cases of colorectal cancers through screening and early detection

Objectives	<ul style="list-style-type: none"> • Increase the proportion of adults who receive colorectal cancer screening according to national guidelines. • Reduce the rate of invasive colorectal cancer. • Reduce the colorectal cancer death rate. 		
Measures	Measure	Baseline	Target
	8.1 Percentage of adults aged 50-75 who reported receiving a colorectal cancer screening based on the most recent guidelines, which include a blood stool test in the past year, sigmoidoscopy in the past 5 years and blood stool test in the past 3 years, or a colonoscopy in the past 10 years (age adjusted to the year 2000 standard population)	60.9% BRFSS 2014	80% 80% by 2018
	8.2 Age-adjusted rate per 100,000 of invasive colorectal cancer incidence	35.1 CDRI 2013	31.6 CCAI (10%)
	8.3 Age-adjusted mortality rate, colorectal cancer	12.8 BVRHS 2014	11.5 CCAI (10%)
Strategic Actions	<ul style="list-style-type: none"> • Promote the use of evidence-based strategies to increase access to care, including: <ul style="list-style-type: none"> ◊ Increasing hours of operation ◊ Increasing access to transportation services ◊ Increasing mobile and other alternative screening opportunities ◊ Increasing access to insurance coverage ◊ Promoting investments in and increasing availability of patient navigation services ◊ Using best practice models for increasing collaboration among service providers to ensure continuum of care (access to treatment) ◊ Ensuring appropriate follow-up for those who receive abnormal colorectal cancer screening results • Promote using evidence-based interventions to provide education on colorectal cancer and promote screening guidelines and awareness of insurance coverage options for all underserved populations. • Support the provision of education and screening services through emerging models of healthcare delivery. • Support the implementation of clinical system changes to increase use of evidence-based cancer screening. Strategies include: <ul style="list-style-type: none"> ◊ Electronic health records ◊ Provider and client reminder systems ◊ Assessment of compliance (offering or delivering screening to clients) for providers and/or practices • Identify disparate populations and support evidence-based interventions to increase screening and decrease mortality. • Collaborate with statewide organizations and partners to support and/or facilitate education to healthcare providers on colorectal cancer screening best practices. • Develop, evaluate and promote new technologies that will increase public demand and use of screening. 		

EARLY DETECTION AND SCREENING

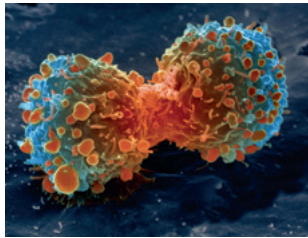
Goal 9: Monitor the development and implementation of screening and early detection methods for other cancers

Objectives

- Disseminate updates to USPSTF cancer screening recommendations. Specific cancer screenings to address include:
 - ◊ Lung Cancer
 - ◊ Oral Cancer
 - ◊ Prostate Cancer
- Disseminate information on novel methods for screening and early detection, including imaging technologies, genomics and proteomics.

Strategic Actions

- Collaborate with statewide organizations and partners to support and/or facilitate education to healthcare providers on updated and emerging cancer screening best practices from the USPSTF.



"Lung cancer cell during cell division-NIH" by United States: National Institutes of Health. Licensed under Public Domain via Commons - https://commons.wikimedia.org/wiki/File:Lung_cancer_cell_during_cell_division-NIH.jpg#/media/File:Lung_cancer_cell_during_cell_division-NIH.jpg

Imaging technologies: Medical Imaging is a broad term that encompasses nuclear, computer and magnetic sciences-based technologies that provide oncologists and cancer fighting researchers with high resolution, multidimensional views of human anatomical structures.

Genomics: Genomics aims to understand the structure of genes, including mapping genes and sequencing the DNA. Genomics examines the molecular mechanisms and the interplay of genetic and environmental factors in disease.

Proteomics: a branch of biotechnology concerned with analyzing the structure, function and interactions of the proteins produced by the genes of a particular cell, tissue, or organism.

TREATMENT

Goal 10: Increase timely access to quality cancer diagnostic and treatment services for all Idahoans

Objectives	<ul style="list-style-type: none"> • Increase the proportion of adults with health care coverage. • Reduce the proportion of adults with cost-related barriers to care. • Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis. 		
Measures	Measure	Baseline	Target
	10.1 Percentage of Idaho adults aged 18-64 with health care coverage (age adjusted to the year 2000 standard population)	79.3% BRFSS 2014	95.2% CCAI (20%)
	10.2 Percentage of Idahoans who could not see a doctor due to cost sometime in past year (age adjusted to the year 2000 standard population)	16.4% BRFSS 2014	13.1% CCAI (20%)
	10.3 5-year relative survival ratio, adjusted for age and primary site mix (NAACCR cancer survival index)	63.6 CDRI 05-11	65.6 CCAI (Best states)
Strategic Actions	<ul style="list-style-type: none"> • Support legislative and policy solutions to increase the percentage of adult Idahoans with any kind of healthcare coverage. • Promote availability of culturally competent patient navigators and community health workers in both clinic and community settings across the continuum of cancer care. • Support the implementation of evidence-based policy and systems change to increase and improve delivery of care and reduce structural and financial barriers. • Support the implementation of evidence-based interventions related to diagnosis, treatment and palliation to decrease disparities in racial/ethnic populations, populations with less education, underserved adolescents and young adults, and underserved geographic areas of the state. • Report cancer patient relative survival ratios by primary site category and stage at diagnosis. 		

TREATMENT

Goal 11: Increase opportunities to access and participate in cancer treatment clinical trials

Objectives	<ul style="list-style-type: none"> • Increase the proportion of cancer patients who enroll in treatment-related clinical trials. 								
Measures	<table border="1"> <thead> <tr> <th data-bbox="367 369 1118 432">Measure</th> <th data-bbox="1118 369 1295 432">Baseline</th> <th data-bbox="1295 369 1479 432">Target</th> </tr> </thead> <tbody> <tr> <td data-bbox="367 432 1118 562">11.1 Percentage of cancer patients who enroll in treatment-related clinical trials</td> <td data-bbox="1118 432 1295 562">TBA CDRI 2015</td> <td data-bbox="1295 432 1479 562">50% Pediatric 5% Adults CCAI</td> </tr> </tbody> </table>	Measure	Baseline	Target	11.1 Percentage of cancer patients who enroll in treatment-related clinical trials	TBA CDRI 2015	50% Pediatric 5% Adults CCAI		
Measure	Baseline	Target							
11.1 Percentage of cancer patients who enroll in treatment-related clinical trials	TBA CDRI 2015	50% Pediatric 5% Adults CCAI							
Strategic Actions	<ul style="list-style-type: none"> • Promote the expansion of geographic (community) reach of clinical trials to provide patients and physicians with local access to novel therapeutics and cancer treatments. • Support the development, implementation and evaluation of education and advocacy plans to increase infrastructure resources for clinical trials, focusing on: <ul style="list-style-type: none"> ◊ Systems and technologies to support personalized medicine ◊ Use of electronic health records and health information exchanges ◊ Maintaining a user friendly database of current clinical trials 								

TREATMENT

Goal 12: Increase provider utilization of evidence-based treatment guidelines

Objectives

- Promote awareness, education and advocacy efforts aimed at increasing the number of patients who receive high quality care.
- Monitor Idaho performance on American College of Surgeons Commission on Cancer (CoC) standards for Cancer Program Practice Profile Report (CP3R) treatment standards.

Strategic Actions

- Increase awareness and advocate for leadership in Idaho for the CoC Liaison Program State Chair. <https://www.facs.org/quality-programs/cancer/clp/statechresource/statecontact>
- CCAI will communicate at least twice per year with CoC hospital cancer committee chairs regarding strategic plan activities and progress for the entire plan.
- Actively promote adoption of quality standards of care according to national guidelines (CoC, NCCN, etc.)
- Promote the increased collection and use of biomarker data for targeted cancer treatment.

QUALITY OF LIFE

Goal 13: Improve the physical and mental health of cancer survivors

Objectives

- Increase the proportion of cancer survivors who receive survivorship care plans.
- Decrease the proportion of cancer survivors who report poor physical health.
- Decrease the proportion of cancer survivors who report poor mental health.
- Decrease the proportion of cancer survivors who report being a current smoker.
- Decrease the proportion of cancer survivors who report no physical activity outside of work in the past month.
- Increase the proportion of cancer survivors who report eating 5+ fruits and vegetables per day.

Measures

	Measure	Baseline	Target
13.1	Proportion of cancer patients receiving survivorship care plans	TBA CoC Hospitals 2015	75% CoC
13.2	Percentage of cancer survivors who report poor physical health 14+ of last 30 days (age adjusted to the year 2000 standard population)	29.0% BRFSS 2011- 2012	26.1% CCAI (10%)
13.3	Percentage of cancer survivors who report poor mental health 14+ of last 30 days (age adjusted to the year 2000 standard population)	28.6% BRFSS 2011- 2012	25.7% CCAI (10%)
13.4	Percentage of cancer survivors who are current smokers (age adjusted to the year 2000 standard population)	31.3% BRFSS 2011- 2012	28.1% CCAI (10%)
13.5	Percent of cancer survivors who report no physical activity outside of work (age adjusted to the year 2000 standard population)	20.0% BRFSS 2011- 2012	23.3% CCAI (10%)
13.6	Percent of cancer survivors who report consuming 5+ servings fruit and vegetables per day (age adjusted to the year 2000 standard population)	20.0% BRFSS 2011- 2012	22.0% CCAI (10%)

Strategic Actions

- Encourage the inclusion of the Survivorship Module in the Idaho Behavioral Risk Factor Surveillance System at least every 3 years.
- Increase the access and accuracy of survivorship care plans that are available to health professionals throughout the state of Idaho.
 - ◊ Create an Idaho Survivorship Care Plan template to be distributed to all partners in the state.
- Improve health professional knowledge, practice behaviors and system support related to increasing provision of, or referral to, mental and physical health screening and support services.
 - ◊ Support a yearly Survivorship Conference for collaboration.
 - ◊ Disseminate local and national education opportunities through the listserv to all CCAI Stakeholders.
- Work with community and healthcare organizations to provide health behavior education.

QUALITY OF LIFE

Goal 14: Improve access and referrals to palliative care services for cancer patients

<h3>Objectives</h3>	<ul style="list-style-type: none"> • Work with the Idaho Health Care Directive Registry to evaluate and monitor progress on Idahoans who complete advanced directives. • Collaborate with Honoring Choices Idaho to move forward the Idaho Community Initiative on Advanced Care Planning and report outcomes as the program moves forward. • Increase the proportion of cancer patients whose physical pain caused by cancer or cancer treatment is under control. 											
<h3>Measures</h3>	<table border="1"> <thead> <tr> <th>Measure</th> <th>Baseline</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td>14.1 Access to palliative care in hospitals</td> <td>B Grade CAPC 2015</td> <td>A Grade CCAI</td> </tr> <tr> <td>14.2 Proportion of cancer patients whose physical pain caused by cancer or cancer treatment is under control</td> <td>TBA BRFSS</td> <td>TBA</td> </tr> </tbody> </table>	Measure	Baseline	Target	14.1 Access to palliative care in hospitals	B Grade CAPC 2015	A Grade CCAI	14.2 Proportion of cancer patients whose physical pain caused by cancer or cancer treatment is under control	TBA BRFSS	TBA		
Measure	Baseline	Target										
14.1 Access to palliative care in hospitals	B Grade CAPC 2015	A Grade CCAI										
14.2 Proportion of cancer patients whose physical pain caused by cancer or cancer treatment is under control	TBA BRFSS	TBA										
<h3>Strategic Actions</h3>	<ul style="list-style-type: none"> • Improve health professional knowledge, practice behaviors and system support related to increasing provision of, or referral to, palliative care services. <ul style="list-style-type: none"> ◊ Support a yearly Palliative Care Conference for collaboration ◊ Disseminate local and national education opportunities through the listserv to all CCAI Stakeholders • Work with community partners to implement education and resources around palliative and end of life care. • Include CCAI members in community initiatives regarding advance directives. 											

References

1. C.J. Johnson, S.L. Carson. *Annual Report of the Cancer Data Registry of Idaho: Cancer in Idaho, 2013*, accessed January 2016, <https://www.idcancer.org/ContentFiles/AnnualReports/Cancer%20in%20Idaho%202013.pdf>.
2. C.J. Johnson, S.L. Carson. *Cancer in Idaho, 2014, Preliminary Data*, accessed January 2016, <http://www.idcancer.org/ContentFiles/AnnualReports/Cancer%20in%20Idaho%202014%20Preliminary.pdf>.
3. *Chronic Disease Cost Calculator, Version 2*; online calculator.
4. "The Coverage Gap," accessed January 17, 2016, <http://closethegapidaho.org/the-coverage-gap>.
5. Idaho Health Statistics, Fact Sheets & Reports, Vital Statistics Fact Sheet, accessed December 2015, <http://healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/FactSheetsandReports/tabid/916/Default.aspx>.
6. *Cancer Facts & Figures 2015*, prepared by the American Cancer Society, 2015.
7. B.K. Edwards, H.L. Howe, L.A. Ries, M.J. Thun, H.M. Rosenberg, R. Yancik, P.A. Wingo, A. Jemal, and E.G. Feigal, Annual Report to the Nation on the status of cancer, 1973–1999, featuring implications of age and aging on U.S. cancer burden. *Cancer*, no. 94 (2002): 2766–2792. doi: 10.1002/cncr.10593.
8. "Survivorship Definitions," accessed January 10, 2016, <http://cancercontrol.cancer.gov/ocs/statistics/definitions.html>.
9. *Cancer Treatment and Survivorship Facts & Figures 2014-2015*, prepared by the American Cancer Society, <http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-042801.pdf>.
10. R. Siegel, C. DeSantis, K. Virgo, K. Stein, A. Mariotto, T. Smith, D. Cooper, T. Gansler, C. Lerro, S. Fedewa, C. Lin, C. Leach, R. S. Cannady, H. Cho, S. Scoppa, M. Hachey, R. Kirch, A. Jemal, and E. Ward, Cancer treatment and survivorship statistics, 2012. *CA: A Cancer Journal for Clinicians* (2012), 62: 220–241. doi: 10.3322/caac.21149
11. U.S. Census Bureau. State and County QuickFacts, accessed December 2015, <http://www.census.gov/quickfacts/table/POP060210/16,00http://quickfacts.census.gov/qfd/states/16000.html>.
12. State Facts for Students, accessed January 16, 2016, <http://www.census.gov/schools/facts/idaho.html>
13. Idaho Behavioral Risk Factors. Results from the 2014 Behavioral Risk Factor Surveillance System, accessed December 2015, <http://healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/BehavioralRiskFactorSurveillanceSystem/tabid/913/Default.aspx>.
14. Poverty Rates by State, 2014, accessed January 2016, http://nwlc.org/wp-content/uploads/2015/08/compiled_state_poverty_table_2014_final.pdf
15. State of Idaho Resident Labor Force, accessed January 2016, <http://lmi.idaho.gov/publications/2015/LAUS/statewide-unemployment-rates.pdf>.
16. Health Resources and Services Administration, HRSA Data Warehouse, accessed January 2016, <http://datawarehouse.hrsa.gov/Tools/Analyzers/hpsafind.aspx>.
17. "Where Are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children, and Pregnant Women," accessed October 28, 2015, <http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>.
18. Cancer Health Disparities, (2008), accessed December 8, 2015, <http://www.cancer.gov/about-nci/organization/crchd/cancer-health-disparities-fact-sheet#q1>.

APPENDIX

Abbreviations

ACoS – American College of Surgeons

AHRQ – Agency for Healthcare Research and Quality

ASCO – American Society of Clinical Oncology

BRFSS – Behavioral Risk Factor Surveillance System

BVRHS – Bureau of Vital Records and Health Statistics

CAPC – Center to Advance Palliative Care

CCAI – Comprehensive Cancer Alliance for Idaho

CDRI – Cancer Data Registry of Idaho

CoC – Commission on Cancer

CP3R – Cancer Program Practices Profile Report

FQHC – Federally Qualified Health Center

HP2020 – Health People 2020

HPSA – Health Professional Shortage Areas

ICCCP – Idaho Comprehensive Cancer Control Program

IDHW – Idaho Department of Health and Welfare

LDCT – Low dose computed tomography

MUA – Medically Underserved Area

MUP – Medically Underserved Population

NAACCR – North American Association of Central Cancer Registries

NATS – National Adult Tobacco Survey

NCCN – National Comprehensive Cancer Network

NPCR – National Program of Cancer Registries

SEER – Surveillance, Epidemiology and End Result Program

SES – Socioeconomic Status

SHPPS – School Health Policies and Practices Study

USCS – U.S. Cancer Statistics Incidence and Mortality Web-Based Report

USPSTF – United States Preventive Services Task Force

UV – Ultraviolet Radiation

YRBS – Youth Risk Behavior Survey

NOTES

NOTES

NOTES

This publication was supported by the Grant or Cooperative Agreement Number, DP003881, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

January 2016

