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Louisiana Cancer and Lung Trust Fund Board

Louisiana Cancer Control Strategic Plan - 1997

Louisiana Cancer and Lung Trust Fund Board

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Tables

Introduction

The Louisiana Cancer and Lung Trust Fund Board was formed in 1980 and functions under Louisiana Revised Statute §§ 40:1299.80-89. Originally a part of the Department of Health and Hospitals, Office of Public Health, the Board was transferred to Louisiana State University Medical Center in 1995 and serves in an advisory capacity to the Governor in matters concerning cancer and its impact on the state. Its specific legislative mandates are two: to (1) establish policies for the operation of the statewide registry program for reporting cancer cases, and (2) establish criteria and guidelines to disburse monies appropriated by the legislature to be used solely for research on cancer and cardio-pulmonary diseases.

The Board is made up of medical professionals appointed by the Governor to serve at his pleasure. The current members of the Board, along with the institutions and agencies that each represents are listed below:

- Hans (J) Berkel, M.D., Ph.D. - LSUMC-Shreveport
- Charles L. Brown, Jr. M.D. - American Cancer Society
- Pelayo Correa, M.D. - LSUMC-New Orleans
- James R. Douglas, M.D. - American Heart Association
- Marcellus Grace, Ph.D. - Xavier University College of Pharmacy
- Carl G. Kardinal, M.D. - Leukemia Society of America
- Michael H. Martin, MPA - Mary Bird Perkins Cancer Center
- Carol M. Mason, M.D. - American Lung Association
- George H. Porter, III M.D. - Ochsner Medical Foundation

- John M. Rainey, M.D. - Acadiana Medical Research Foundation
- Lehrue Stevens, M.D. - Louisiana State Medical Society
- Roy S. Weiner, M.D. - Tulane University School of Medicine

This body is uniquely qualified to present an overview of the impact of cancer on the health of the citizens. It also is able to propose a strategic plan to lessen this impact. The following document addressed both of these issues.

All communications concerning this document, or other Board matters may be addressed to its primary office as follows:

Louisiana Cancer and Lung Trust Fund Board
Mr. Ray S. Whiting, Administrator
1600 Canal Street, Suite 800
New Orleans, LA 70112
Ph. 504-568-3335
Fax. 504-568-4283
E-mail: rwhiti@lsumc.edu

What is Cancer Control?

"Cancer Control" is defined by the National Cancer Institute (NCI) as follows:

> Cancer control is the reduction of cancer incidence, morbidity and mortality through an orderly sequence from research on interventions and their impact on defined populations, to the broad systematic applications of the results from research.

While the ideal might be to eliminate the threat of cancer, such as has been achieved with other diseases, the realistic approach at this time would be to bring cancer incidence and mortality into a more controlled situation. Cancer control therefore becomes an aggressive pro-active approach to directly reduce the incidence of cancer or achieve a diagnosis at the earliest possible stage. These goals can be carried out by:

Reducing the exposure to known risk factors for various cancers. These risk factors include, as discussed elsewhere, use of alcohol and tobacco, dietary and nutritional behaviors, as well as exposure to environmental factors. This requires preventive education to the public throughout an individual's lifespan. Such education must begin in the public school system, and continue to be provided through the combined efforts of public health programs, media campaigns, and the healthcare community.

As will be shown later, the incidence of lung cancer is much higher in Louisiana than elsewhere in the United States. An intense effort toward prevention of smoking is the only currently available solution to this problem.

The success of these campaigns can in part be measured by the Behavioral Risk Factor Surveillance Survey, which is conducted regularly by the Louisiana Office of Public Health.

Changing the stages of diagnosis. Louisiana has an overall cancer incidence rate lower than the national rates for all cancers combined. The most critical problem in Louisiana is a drastically higher mortality rate. To reduce this disparity, cancers must be diagnosed and treated at an earlier stage, When cancer is more amenable to aggressive intervention, resulting in increase cure rates and thus a lower mortality. This step calls for an increased effort towards early diagnosis and screening. Success in this area is measured by the data gathered by the Louisiana Tumor Registry and the Louisiana Office of Public Health, Vital Records department.

This Cancer Control Strategic Plan calls for the combined efforts of both public and private institutions and offers specific strategies to identified problems.

Thumbnail Sketch of Louisiana

Demographics

Population

In 1990, the population of Louisiana was 4,219,973, made up of approximately 68% whites, 30%

blacks and 2% of other racial backgrounds. In 1996, the estimated population was 4,342,334.(1) By 2000, it is expected to reach 4,477,836.(2)

Socio-Economic Status

In 1994, according to the Louisiana Department of Administration, 25.7% of Louisiana residents lived in poverty. This is one of the highest poverty rates in the nation.(3) By 1995, the U.S. Census Bureau showed that 19.7% of Louisiana residents lived in poverty, still one of the highest rates in the nation, exceeded only by North Carolina (19.9%), Alabama (20.1%), Mississippi (23.5%) and New Mexico (25.3%).

Socio-economic status bears on a person's access to higher education and adequate healthcare. It is a known fact that people with low literacy experience more severe health care problems compared to literate people. Without means of securing adequate healthcare, those living in poverty put a burden upon the state for their care.

Education and socio-economic status also relate to tobacco use, which is the primary cause of lung cancer. The section "Tobacco Use in Louisiana" shows that use is highest among the group least able to secure adequate health care, those lacking higher education, and/or adequate employment.

Health Care and Insurance

In 1994, Louisiana ranked 47th in access to primary care practitioners.(4) Without such access, individuals turn to hospital emergency rooms for treatment. The State of the State documents also report:

> According to the 1993 statistics from the U.S. Bureau of the Census, 23.9% of Louisiana residents were not covered by health insurance -- the highest percentage in the country....

The 1995 Statistical Abstract of the United States reports that in 1994, 19.2% of Louisianians were without health insurance.(5)

This creates a large burden on the state to provide, through its Charity Hospital system as well as through Medicaid and other governmental assistance, the treatment for a large segment of the citizenry. This is not the setting for either education about cancer risk factors, nor an atmosphere for early diagnosis of cancers.

The Impact of Cancer in Louisiana

What is Cancer?

Cancer is not a single disease, but a group of over 100 different diseases all marked by uncontrolled growth and proliferation of abnormal cells. If allowed to continue, these diseases result in death. There isn't a single cause for all of these different diseases. In fact, although some tumors share common risk factors, most cancers are caused by different factors.

Risk Factors

Several factors have been causally linked to the risk of developing cancer. These factors include genetic predisposition, hormonal differences, and immune conditions, as well as chemicals, radiation and viruses. Many cancers are linked to the use of tobacco, alcohol, and dietary factors. In Table 1, the proportion of cancers caused by the various risk factors is shown. Sometimes the various risk factors work in combination, creating a greater likelihood for cancer to occur. In spite of the similarity in the growth and spread of cancerous diseases, each type of cancer is unique in the suspected risk factors associated with their development.

Because many of the risks associated with cancer have been identified, reducing these risks is critical to reducing the incidence of cancer. Table 2 is a list of various cancers, along with associated risk factors and means of intervention or reducing the risks.

Second Leading Cause of Death

As shown in Table 3 cancer is the second leading cause of death in Louisiana. During the period 1988-92, over 83,000 new cancer cases were reported. Because cancer is reported by anatomical location, and because an individual may have more than one diagnosis of cancer (for example, lung cancer and

melanoma) there are more cases of cancer than individuals who have cancer.

In 1995, there were 39,539 deaths in Louisiana, 9,257 of which (23.5%) were caused by cancer. As shown in Table 4 cancer as cause of death has increased over the last forty years, from only 15.1% of all deaths in 1955 to 23.5% in 1995. This increase is thought to be largely due to the increase in lung cancer.

Cancer Trends

It is expected that 18,897 new incidents of cancer will be diagnosed in Louisiana in 1996. The expected site-specific numbers are shown in Table 5. Just over 30 percent of all new cancer cases are located in the lung and breast. These figures are based on previous trends, projected to the anticipated population.

In Table 2 are these same cancers mentioned, with risk factors and methods of early detection.

Selected Cancers Most Affecting Louisiana

Cancers affect different segments of the Louisiana population to different degrees (see Table 6). Black males are the hardest hit with lung cancer, having an incidence rate (age-adjusted per 100,000 population) of 131.4. This is higher than the national incidence rate (see Table 6), which for Black males is 124.3. When looking at the lung cancer mortality rates, however, Louisiana mortality for lung cancer among black males is significantly higher than the national rate; i.e., 124.9 in Louisiana versus 105.3 nationally.

Other significant cancer incidence rates include:

- white females have a breast cancer incidence rate of 94.1 per 100,000 population; black females have an incidence rate of 86.4;
- white males have the highest incidence rate of colorectal cancer at 53.5, followed by black males at 51.3; white females have the lowest incidence rate at 37.5, and black females have an incidence rate o 40.0.
- prostate cancer affects black males with an incidence rate of 140.9; white males have a prostate cance incidence rate of 115.4.

Table 7 shows age-adjusted incidence rates for all cancers combined, as well as for lung cancer, comparing Louisiana rates with those calculated for a large sample of US cities and states, by the Surveillance, Epidemiology and End Results (SEER) program. The latter is usually cited as the "national" rate.

In the category "all cancers combined" Louisiana incidence rates are lower than the national rates. However, looking at the mortality rates, there is a drastically different scenario. Louisiana mortality rates for "all cancers combined" is higher among white males (national 212.8, Louisiana 240.0), and black males (national 318.0, Louisiana 339.4) and females (national 168.0, Louisiana 175.6). For white women, national mortality rate is 140.0, and in Louisiana it is 140.6, just slightly higher.

When one considers just lung cancer mortality rates, compared to incidence rates, the numbers are even more alarming. While the Louisiana incidence rates are slightly higher than the national rates, the lung cancer mortality rates are drastically higher. The national mortality rate for black males with lung cancer is 105.3; in Louisiana that rate is 124.9. Among white males, the national lung cancer mortality rate is 72.5, while in Louisiana it is 91.3; for black females, it is 31.8 nationally and 33.8 in Louisiana; for white females, the national rate is also 31.8, but 35.8 in Louisiana. In each category the mortality rate for lung cancer is higher in Louisiana.

These statistics on the impact of cancer in Louisiana clearly point to those areas where effort is needed to change these striking trends.

Reduction of Cancer Mortality in Louisiana

Prevention and Early Detection

Prevention

Cancers caused by tobacco use (lung, head and neck, pancreas, bladder and esophagus cancers) or the excess use of alcoholic beverages (esophageal cancer and oral cancer) can, at least theoretically for the most part, be prevented. Lung cancer, 85-90% of which is smoking related, is one of the most preventable forms of cancer. Similarly, proper dietary and nutritional habits can aid in preventing cancers of the digestive tract. Certain skin cancers, caused by overexposure to UV rays in sunlight,

can be prevented by limiting outdoor exposure and applying UV-blockers. It is reported that only about 10% of cancers are caused by environmental or external factors such as pollutants and chemical exposures. Thus, it is easily seen that many cancers can be potentially prevented by altering human behavior. (See Table 1)

About two-thirds of cancers can be avoided if people:

- Did not use tobacco;
- Adopted healthy eating habits;
- Took precautions in exposure to the sun; and
- Minimized their intake of alcohol

Simply providing the information to the public (either in the public school system, as well as to adults using the public health services) does not always lead to individual adoption of risk-reduction behaviors. Educational materials often fail to match literacy levels or to address cultural differences in a way that makes risk-prevention relevant to the individuals most in need.

Prevention education is ideally begun in the elementary and secondary schools. Louisiana high school students are required to complete one-half unit of health education, but there is no standard state-wide health education curriculum; each parish determines the health curriculum presented in its public schools. Besides not having a state-wide curriculum, the state does not have the current means and resources to evaluate the content or quality of each parish health curriculum.

Early Detection and Screening

Screening examinations are available to detect cancers of the breast, tongue, mouth, colon, rectum, cervix, and prostate, as well as melanoma. When cancer is detected and treated early, the likelihood for survival is much higher. According to the American Cancer Society,

More than half of all new cancer cases occur in . . . screening-accessible cancer sites. The relative survival rate for these cancers when diagnosed in an early stage is about 80%. If all Americans participated in regular cancer screenings this rate could increase to more than 95%.[6]

The purpose of cancer screening is to diagnose an early stage tumor in people who do not yet have symptoms of the disease. When such early stage tumors are detected further medical tests can then be performed to diagnose the existence and extent of the disease. There are several cancers where screening can be successful:

Breast cancer

Mammography, combined with clinical breast exams, is the recommended screening method for breast cancer. The American Cancer Society's current recommendations are that women begin breast self-exams monthly at age 20; clinical physical examination every 3 years for women 20-40, and annually for women over 40. Mmamography is recommended to start at age 40.

Cervix cancer

Cervical cancer screening is done with the Papanicolaou (Pap) test, which diagnoses precancerous lesions of the cervix. Treatment of these lesions can prevent the development of "full-blown" cervical cancer. With diagnosis and treatment at the earliest stages, the likelihood of survival is nearly 100%. This inexpensive test is generally performed as part of a routine medical examination for women over 18. However, post-menopausal women do not visit their gynecologist and often fail to continue testing later in life.

Prostate cancer

Prostate screening is another common examination, although scientific evidence about its efficacy is inconclusive. The American Cancer Society recommends that digital rectal examinations and prostate-specific antigen tests are offered part of an annual medical check-up beginning at age 50, to men with a life-expectancy of ten years or more, as well as to younger men who at high risk (i.e., family history).

Colorectal cancer

Colorectal cancer screening and examinations should begin at age 50 for both men and women, with an annual fecal occult blood test and flexible sigmoidoscopy and digital rectal exam every 5 years; or a colonoscopy and digital rectal exam every ten years; or double contrast barium enema and digital rectal examination every five to ten years. Symptoms indicating need for earlier screening include:

history (personal or family) of colorectal cancer or adenomatous polyps, personal history of chronic inflammatory bowel disease, or families with hereditary colorectal cancer syndromes such as familial adenomatous polyposis and hereditary non-polyposis colon cancer.

Tobacco Use

Tobacco use is the single largest preventable cause of death in Louisiana. Therefore, any strategy to reduce the incidence of cancer, and in fact, improve overall health must address this monumental problem. The facts are clear:

- In 1994, 25.5% of the Louisiana population smoked.
- More men than women smoke.
- The percentage of smokers increases as income decreases; in fact, 31.8% of those earning less than $10,000 smoked.
- The percentage of smokers increases with unemployment; 44% of those out of work for a year or more smoke.
- Smoking as few as 100 cigarettes can lead to regular smoking; 53.4% of those who smoked 100 cigarettes continued to smoke regularly
- Tobacco experimentation usually begins before age 18.
- In 1994 20% of all deaths in Louisiana were attributable to smoking.

The economics of tobacco use is very unsettling as well:

- In 1994 total direct and indirect costs attributable to cigarette smoking was estimated at $1.45 billion.
- In 1994 tobacco tax revenues for Louisiana totaled between $116 to $121 million annual. This is about 7% of the total direct and indirect costs of tobacco use.

Thus, is it obvious that tobacco is addictive, expensive, and doesn't pay its own way.

Health Care Professionals

Health care professionals are the first line of defense in the war against cancer. They are a critical link in ensuring that people have access to timely screening and early diagnosis. Very few people seek regular screenings without a referral or recommendation from their doctor, yet many doctors fail to

provide adequate information or recommendations for screening, even when tests are offered free or for low cost.

Health care professionals need to be active participants in cancer prevention and control, but they often are not, citing lack of knowledge, time constraints and the demands of their daily caseloads. Further, a lack of consensus on screening guidelines, risk factors and treatment methods can affect health care decisions. Also, lack of services and reimbursement options for services limit the opportunity to provide adequate cancer prevention and screening services.

A significant factor in considering the high mortality cancer rates in Louisiana is the access to adequate health care. More than half of the parishes in the state have a critical shortage of health care providers (Figure 1 - Map of Louisiana Health Care Professional Shortages). In many of the rural areas, the ratio of health professionals is less than one physician for each 5,000 residents, yet in the metropolitan areas (particularly in New Orleans, Baton Rouge, Shreveport, Lafayette, and Lake Charles) where there are medical schools and teaching hospitals, the ratio is less than 3000:1.

Public Health

The Louisiana Office of Public Health (OPH) has been charged with the burden of protecting the health of its citizens. In targeting its resources toward cancer control and prevention, the following guidelines were established:

The focus of OPH resources should be toward cancers

1. which affect a large number of people;
2. that have a severe outcome;
3. that have interventions that are shown to either prevent the disease or prevent progress of early-diagnosed disease;
4. where cost of intervention is reasonable; and
5. where intervention or screening is acceptable to the population.

OPH has determined that lung, breast, cervical, colorectal, melanoma and other skin cancers meet these five criteria. It has also determined that the most common risk factors for these cancers (use of tobacco, dietary factors, and sun exposure) are appropriate for the focus of OPH attention, and that screening for breast, cervical, and colorectal cancers all fit the criteria.

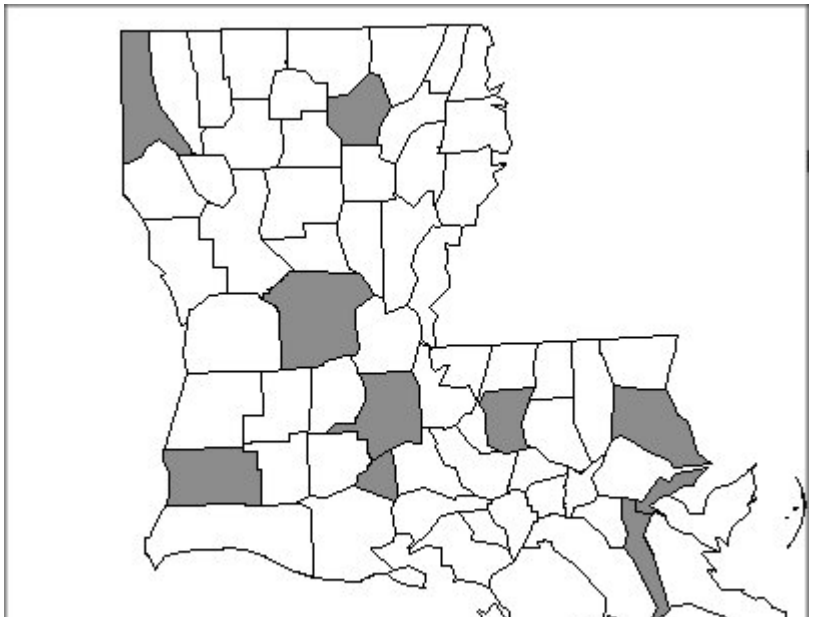
The strategies deemed most appropriate for pursuing primary and secondary prevention priorities include social marketing (i.e., health behaviors and appropriate screenings), community interventions, changing social policies (e.g., adoption of clinical screening recommendations, increased access to preventive services, and creating smoke-free and other environmentally healthy behaviors).

OPH is currently involved in the Women's Preventive Health Program, which is a collaborative project to increase the proportion of low-income and uninsured women who receive age-appropriate screening for breast, cervical and colorectal cancers and to increase the proportion of women who have healthy lifestyles. This target group is often beyond the age of menopause, and thus are no longer seeing a gynecologist on a regular basis. The five projects currently funded are in primarily urban areas.

Other projects include community-based peer programs to prevent adolescent tobacco use, and statewide initiatives to increase the proportion of the population who regularly engage in physical activity (following Surgeon General's recommendations for moderate physical activity) and who consistently consume at least five servings daily of fruits and vegetables (the "five-a-day" program).

Treatment Facilities

Timely access to diagnostic and treatment services is essential if cancer mortality rates are to be reduced. Besides training primary care physicians to routinely recommend appropriate screening, such diagnostic and screening facilities must be easily accessible for residents throughout the state. There are only 12 cities in Louisiana with cancer treatment facilities approved by the American College of Surgeons Commission on Cancer, offering a total of only twenty-eight ACOS-approved cancer programs. These are shown in the image to the right. Some of these are designated as community hospital comprehensive cancer programs, while others are designated as teaching



hospital cancer programs. Both categories provide a full range of services for diagnosis, but some treatment services may be referred elsewhere.

Of the twelve cities with ACOS approved cancer treatment facilities, only two cities (New Orleans and Shreveport) have Teaching Hospital Cancer Programs (THCP). Other than NCI-designated programs, only those ACOS facilities with the THCP designations have a requirement for conducting research. Also, teaching facilities are the only designation that requires residencies for training in appropriate areas, including medicine and surgery, as well as a variety of other specialties as needed, such as gynecology, pathology, diagnostic radiology or radiation oncology. These facilities are:

New Orleans:

- Medical Center of Louisiana at New Orleans (now under the supervision of LSU Medical Center)
- Ochsner Foundation Hospital
- Tulane University Hospital & Clinic
- Veterans Administration Medical Center

Shreveport:

- LSU Medical Center
- Overton Brooks VA Medical Center

A complete listing of these individual facilities is provided at Table 8.

Socio-Economic Status

Nearly one-fourth of Louisiana residents live below the poverty level. Lack of high school or college education, cultural barriers and socio-economic status have been found to play a significant part in the control of cancer morbidity and mortality. Studies have found that those of lower socio-economic status do not have access to adequate health care and engage in more high-risk behaviors (higher rates of smoking, poorer dietary habits, etc.) that contribute to increased risk for developing cancer. Also, because individuals of lower socio-economic status do not have access to regular preventive health care (such as with group medical insurance or HMO plans), when they do seek medical treatment, they use public hospital emergency rooms and are seen at a later stage of disease than if they had been able to seek treatment earlier.

Conclusions

There is no doubt that a comprehensive cancer control plan must be implemented within, and funded by the state of Louisiana. The Louisiana Cancer and Lung Trust Fund Board, as the designated cancer advisory body to the Governor, anticipates that this plan will be funded by the state, with the Board given responsibility and financial oversight for the implementation of the Plan. As a central body of cancer specialists, gathered from throughout the state, this strategic plan for cooperative effort will bring cancer control into a reality.

On the basis of the above facts concerning cancer control, the Board recommends the following steps to address the issues of exposure reduction and earlier diagnosis:

- Continued intense efforts to prevent adolescent use of tobacco (additional tobacco legislation)
- Encourage statewide use of mammography so that all eligible women have access to this technology.
- Continue and expand the current efforts toward early diagnosis of cervical and prostate cancer.

BUDGET

The following budget addresses these issues through the following actions:

- Create a data gathering office to obtain and correlate cancer control efforts of
-
    - Designated cancer centers
    - ACOS approved hospital cancer programs
    - Cancer control efforts of member institutions
    - Cancer control efforts of the Disease Prevention Centers in state hospital system
    - Cancer control efforts of the Office of Public Health
- Increase the Research efforts on cancers and behaviors identified above
- Enhance the data collecting efforts of the Louisiana Tumor Registry

BUDGET PROPOSAL TO IMPLEMENT CANCER CONTROL STRATEGIC PLAN

CURRENT

229,404	LCLTFB Budget
	Usual operating budget and salaries
	Administrator Salary
	Research
908,000	LTR Budget
1,137,404	Total

PROPOSED

170,625		LCLTFB Budget
	50,000	Usual operating budget and salaries
	35,625	Administrator Salary & Benefits
	60,000	Cancer Control Officer & Benefits (Position Title #A264, Project Coordinator)
	25,000	ACOS state-wide programs

1,588,000		LTR Budget
	150,000	Enough to get current (one-time
	958,000	Enough to remain current
	480,000	Enough to expand efforts 1. Mortality statistics and smaller geographic area analysis ($45,000) 2. Special analysis and projects; childhood cancer ($60,000) 3. Record linkage with Vital Records; passive follow up, survival data and analysis ($75,000) 4. Active follow up; recurrence, etc. ($150,000) 5. Analytic Unit ($150,000)
500,000		Research Budget
	300,000	Usual annual RFPs (See next page for analysis of historical funding short-fall)
	200,000	Special RFPs
2,248,625		Total

History of Grants and Funding Awards

The table below is self-explanatory, showing by fiscal year the number of grant applications submitted to the Board, and the number and funding actually awarded. Also shown is the amount of available research funds diverted from direct research to assist in Louisiana Tumor Registry enhancements.

Fiscal Year	Applications Submitted		Grants Awarded		Funding for Registry Enhancements	Total Funding for Research and Registry Enhancements
	#Apps	Funding Requested	Awards	Funding Awarded		
1984-85	43	$1,290,458	11	$186,943	0	$186,943
1985-86	26	$882,464	7	$181,279	0	$181,279
1986-87	30	$900,889	6	$165,940	23,589	$189,529
1987-88	0[(7)]	$20,000	1	$20,000	$140,475	$160,475
1988-89	17	$456,307	6	$134,995	$38,100	$173,095
1989-90	10	$255,711	6	$124,995	$38,100	$163,095
1990-91	14	$436,699	6	$136,497	$46,500[(8)]	$182,997
1991-92	22	$600,280	5	$97,829	$43,500	$141,329
1992-93	7	$296,770	5	$173,635	$43,500	$217,135
1993-94	9	$291,354	5	$185,736	$43,500	$229,236
1994-95	11	$489,240	4	$169,372	$43,500	$212,872

1995-96	6	$319,029	4	$154,632	$25,000[(9)]	$179,632
1996-97	10	$379,750	3	$155,900	$30,000[(10)]	$185,900
1997-98	8	$368,270	3	$152,000	$30,000[(11)]	$182,000
TOTALS	213	$6,987,221	72	$2,039,753	$545,764	$2,585,517
FUNDED		$2,039,753				
NOT FUNDED		$4,947,468				

Job Description - Cancer Control Officer

- Board's research efforts
- Assist Board in determining appropriate topics for RFP
- Review grant applications for completeness/appropriateness; assist investigators in targeting research projects
- Interact quarterly with principal investigators and their institutions upon awarding of grants
- Ensure project is on schedule
- Monitor budget for appropriateness
- Cancer control efforts of ACOS
- Determine current activities/programs of ACOS sites
- Assist ACOS sites to coordinate outreach efforts with public and teaching hospitals
- Assist ACOS sites to evaluate programs piloted intheteaching hospitals and adaptation and implementation
- Cancer control efforts of member institutions
- Determine the current cancer control aspects of each Board member institution
- Assist institutions in cooperative efforts on programs that overlap or complement
- Advise member institutions of legislative activities pertinent to cancer control
- Advice member institutions of funding opportunities for cancer control
- Cancer control efforts of Teaching Hospitals
- Interact with state hospital officials, and teaching hospital cancer directors

- Offer teaching hospital programs as pilots to be implemented in ACOS sites

Candidate for Cancer Control Officer will possess

- A Master of Public Health degree or equivalent, with an emphasis on Epidemiology, Public Health Administration, or related fields;
- Minimum three years cumulative experience in program management of public health, oncology, epidemiology or related fields
- A thorough understanding of the cancer control issues of Louisiana and its diverse population
- A commitment to cancer control efforts as outlined by the Board

Cancer Control Officer will:

- Maintain records of the Cancer Control Strategic Plan and its implementation
- Interact with healthcare officials, executives, and providers, in both public and private settings
- Maintain database of state-wide cancer control efforts
- Have a thorough understanding the Board's objectives in cancer control
- Visit ACOS sites as appropriate to maintain cooperative efforts, assist onsite development and implementation of DPC piloted programs for expansion into the private sector.
- Participate in regional and national conferences of state cancer control officers (or equivalents)
- Report to Chairman of the Board

Cancer Control Strategic Plan Schedule

Fiscal Year	Goals
1998	• Increase funding for the Board • Hire Cancer Control Program Coordinator • Increase funding for Louisiana Tumor Registry
1999	• Increased funding for Research • Implement Major (3-year) Projects • Complete Coordinator's Statewide Survey of Cancer Control Efforts in Louisiana; establish communications

2000	• Complete expansion of LTR data-gathering • Begin Coordinating Statewide Cancer Control Efforts (Urban areas-establish pilot programs)
2001	• Expand Private Sector implementation of Cancer Control Efforts (Rural areas- implement partnering of smaller facilities with major ACOS facilities in each region)
2002	• Statewide Cancer Control Symposium of all healthcare sectors: "Louisiana Cancer Control: A Model of Excellence" • Measure effectiveness of reaching goals • Determine next five-year goals

Notes:

1. Planning Section of the Office of Planning and Budget, Division of Administration, State of the State 1996. (http://www.doa.state.la.us./opb/96sos/96hhr2.htm), May 5, 1997

2. Center for Business and Economic Research, Northeast Louisiana University; Statistical Abstract of Louisiana, Population Projections-Louisiana and Parishes 19990-2010. (http://leap.nlu.edu/STAAB/CH0-2/T02-17.TXT). May 6, 1997.

3. Planning Section of the Office of Planning and Budget, Division of Administration, State of the State 1996 (http://www.doa.state.la.us./opb/96sos/), May 5, 1997

4. : Health and Human Resources: Health Care, State of the State 1996 (www.doa.state.la.us/opb/96sos/96hhr3.htm). May 5, 1997

5. Planning Section of the Office of Planning and Budget, Division of Administration; State of the State 1996. (http://www.doa.state.la.us./opb/96sos/), May 5, 1997.

6. Cancer Facts & Figures - 1997, American Cancer Society, 1997

7. No new applications were solicited for this time period; the $20,000 application and award represent the continuation funding for the establishment of the Louisiana Cancer Consortium, which was begun the previous year.

8. Includes $3,000 for a tumor registry consultant

9. A $25,000 commitment, to qualify for a 3:1 matching grant from CDC.

10. A $30,000 commitment, to qualify for a 3:1 matching grant from CDC.

11. A $30,000 commitment, to qualify for a 3:1 matching grant from CDC.

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Louisiana Cancer and Lung Trust Fund Board
Cancer Control Strategic Plan - Table 1

Table 1 - Proportion of Cancer Deaths Attributed to Different Factors	
Macro-Environmental Factors	
Pollution	2%
Industrial Products	<1%
Geophysical Factors	3%
Occupation	4%
Micro-Environmental Factors	
Tobacco	30%
Alcohol	3%
Diet	35%
Food additives	<1%
Reproductive factors	7%
Infection	10%?
Source: Adapted from: Doll, R and Peto, R. "The Causes of Cancer". Oxford University Press (1981)	

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Louisiana Cancer and Lung Trust Fund Board
Cancer Control Strategic Plan - Table 2

Table 2 - Selected Cancers, Risks, Interventions and Prevention

Type of Cancer	Risk Factors	Early Detection
Oral cavity	Cigar, cigarette or other tobacco use	Dental checkups can reveal abnormal tissue
Colorectum	Family history; sedentary lifestyle; high-fat or low-fiber diet.	Digital rectal exam; fecal occult blood test and sigmoidoscopy
Pancreas	Although little is known about cause or prevention, smoking is listed as a risk factor. Other studies suggest association with chronic pancreatitis, diabetes, or cirrhosis.	None.
Lung	Smoking is the greatest risk factor; other factors include exposure to industrial or organic chemicals, radiation exposure, air pollution, tuberculosis, and environmental tobacco smoke	No early detection method is available yet. Chest x-ray, sputum analysis and fiberoptic examination of the lungs help in diagnosis. Prevention of smoking is the most effective means of avoiding lung cancer. This includes early prevention among youth, as well as smoking cessation programs.
Melanoma	Excessive exposure to sun (ultraviolet radiation); light skin pigmentation; occupational exposure to coal tar, pitch, creosote, and other chemicals; family history of skin cancer	Changes in skin growths (size, shape, color, texture) or appearance of new growths; monthly self-examination of all skins surfaces;
Breast	Age; family history; early menarche or late menopause; long exposure to postmenopausal estrogens; recent use of oral contraceptives; not having children or having first live birth at a late age. Knowledge of risk factors has not been translated into preventive measures; best opportunity for reducing mortality is through early detection.	Monthly breast self-examination; regular mammography and physical examination of the breasts.
Cervix	Sexual behavior and sexually transmitted disease with certain types of human papillomavirus; early first intercourse, multiple sex partners; cigarette smoking; low socioeconomic status	Regular Pap tests

Prostate	Age (most are diagnosed after age 65); African-Americans have highest prostate cancer incidence rates in the world; disease is common in North America and Northwest Europe; family history; some studies indicate dietary fat may be a factor	Digital rectal exam annually after age 50; prostate-specific antigen blood test.
Bladder	Smoking; living in urban areas, some or work exposures (e.g., dye, rubber, or leather processing plants)	No early detection method available.
Leukemia	Causes are unknown; persons with Down's syndrome and other genetic abnormalities of higher than usual incidence rates; also linked to excessive exposure to ionizing radiation and certain chemicals; some forms of leukemia and lymphoma are causes by a retrovirus, human T-cell leukemia/lymphoma virus-I (HTLV-I)	None.
Source: American Cancer Society, 1997, Cancer Facts and Figures		

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Louisiana Cancer and Lung Trust Fund Board
Cancer Control Strategic Plan - Table 3

Table 3 - Ten Leading Causes of Death in Louisiana - 1992 & 1995

	1992 Total Deaths - 37,428		1995 Total Deaths - 39,539	
	Number	Percent	Number	Percent
Heart Disease	12060	32.2%	12086	30.6%
Malignant Neoplasms (Cancers)	8798	23.5%	9275	23.5%
Cerebrovascular Disease	2399	6.4%	2538	6.4%
Accidents and Adverse Effects	1748	4.7%	1819	4.6%
Chronic Obstructive Pulmonary Disease and Allied Conditions	1265	3.4%	1416	3.6%
Diabetes mellitus	1188	3.2%	1491	3.8%
Pneumonia and Influenza	995	2.7%	1022	2.6%
Homicide & Legal Intervention	786	2.1%	763	1.9%
AIDS	567	1.5%	729	1.8%
All Other Causes	7622	20.4%	8400	21.2%
Source: LA Office of Public Health, Vital Records				

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Louisiana Cancer and Lung Trust Fund Board
Cancer Control Strategic Plan - Table 4

Table 4 - Cancer as Percentage of All Deaths					
Cause of Death	1955	1965	1975	1985	1995
All Causes	24877	32113	33810	37041	39539
Cancer	3759	4837	6255	8235	9275
% from Cancer	15.1%	15.1%	18.5%	22.2%	23.5%
Source: LA Office of Public Health, Vital Records					

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Louisiana Cancer and Lung Trust Fund Board
Cancer Control Strategic Plan - Table 5

Table 5 - Estimated New Cancer Cases, 1996	
All sites combined	18,879
Oral cavity	449
Colorectum	2,193
Pancreas	465
Lung	3,261
Melanoma	550
Breast	2,510
Cervix	238
Prostate	2,800
Bladder	694
Leukemia	409
Source: Louisiana Tumor Registry	

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Louisiana Cancer and Lung Trust Fund Board
Cancer Control Strategic Plan - Table 6

Table 6- Annual Incidence of selected common cancers among different Louisiana populations - age-adjusted (U.S. 1970) per 100,000 population- 1988-92

	White		Black	
Type of Cancer	Male	Female	Male	Female
Lung	108.6	44.4	131.4	40.1
Breast	0.9	94.1	1.4	86.4
Prostate	115.4		140.9	
Colo-rectal	53.5	37.5	51.3	40.0
Cervical		7.6		16.9
Skin	12.8	7.0	2.9	1.4

Source: Cancer in Louisiana Volume 8

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Louisiana Cancer and Lung Trust Fund Board
Cancer Control Strategic Plan - Table 7

Table 7 - Comparison of Louisiana to National Incidence (I) and Mortality (M) Rates, all cancers combined and lung cancer -1988-92

		Whites				Blacks			
		Male		Female		Male		Female	
		I	M	I	M	I	M	I	M
Louisiana	All Cancers Combined	469.8	240.0	309.7	140.6	515.5	339.4	307.	175.6
	Lung Cancer	108.6	91.3	44.4	35.8	131.4	124.9	40.1	33.8
SEER/ U.S.	All Cancers Combined	484.2	212.8	351.4	140.0	585.5	318.0	337.3	168.0
	Lung Cancer	80.2	72.5	42.5	31.8	124.3	105.3	46.8	31.8

Sources: LA Office of Public Health, Vital Records; Louisiana Tumor Registry; Surveillance, Epidemiology and End Results program, Age-Adjusted SEER Incidence and U.S. Mortality Rates

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Louisiana Cancer and Lung Trust Fund Board
Cancer Control Strategic Plan - Table 8

Table 8 - American College of Surgeons Commission on Cancer Approved Cancer Treatment Facilities November 1996 (Designation acronyms explained in Table 9)

City, Parish	Site	Designation
Alexandria	Rapides Regional Medical Center 211 4th Street Alexandria, LA 71301-8421	COMP
	St. Frances Cabrini Hospital 3330 Masonic Drive Alexandria, LA 71301 318-487-1122	COMP
	VA Medical Center Shreveport Highway Alexandria, LA 71301 318-473-0010	COMP
Baton Rouge	Baton Rouge General Medical Center 3600 Florida Boulevard Baton Rouge, LA 70821 504-387-7000	COMP
	Mary Bird Perkins Cancer Center 4950 Essen Lane Baton Rouge, LA 70809 504-767-0847	ICP
	Our Lady of the Lake Regional Medical Center 5000 Hennessy Boulevard Baton Rouge, LA 70808 504-765-6565	COMP
	Woman's Hospital Goodwood at Airline Highway Baton Rouge, LA 70895 504-927-1300	SHCP
Covington	St. Tammany Parish Hospital 1202 South Tyler Covington, LA 70433 504-898-4000	CHCP
Lafayette	Lafayette General Medical Center	CHCP

	1214 Coolidge Avenue Lafayette, LA 70505 318-261-7991	
	Our Lady of Lourdes Regional Medical Center 611 St. Landry Lafayette, LA 70506 318-289-2000	CHCP
	University Medical Center 2390 West Congress Street Lafayette, LA 70502 318-261-6000	COMP
Lake Charles	Lake Charles Memorial Hospital 1701 Oak Park Boulevard Lake Charles, LA 70601 318-494-3000	COMP
	St. Patrick Hospital 524 South Ryan Street Lake Charles, LA 70605 318-436-2511	COMP
Metairie	East Jefferson General Hospital 4200 Houma Boulevard Metairie, LA 70011 504-454-4000	ChCP
Monroe	St. Francis Medical Center 309 Jackson Street Monroe, LA 71210 318-327-4000	COMP
New Orleans	Children's Hospital of New Orleans New Orleans LA 70118 504-899-9511	HACP
	Medical Center of Louisiana at New Orleans 1532 Tulane Avenue New Orleans, LA 70112 504-568-2311	THCP
	Memorial Medical Center 2700 Napoleon Avenue New Orleans, LA 70115 504-899-3000	COMP
	Ochsner Foundation Hospital 1516 Jefferson Highway New Orleans, LA 70121	THCP

	504-838-3000	
	Touro Infirmary 1401 Foucher Street New Orleans, LA 70115 504-897-7011	COMP
	Tulane University Hospital and Clinic 1415 Tulane Avenue New Orleans, LA 70112 504-588-5263	THCP
	VA Medical Center 1601 Perdido Street New Orleans, LA 70145 504-589-5258	THCP
Opelousas	Opelousas General Hospital 520 Prudhomme Lane Opelousas, LA 70570 318-948-3011	CHCP
Shreveport	LSU Medical Center 1501 Kings Highway Shreveport, LA 71130 318-675-5000	THCP
	Overton Brooks VA Medical Center 510 East Stoner Avenue Shreveport, LA 71101 318-424-6089	THCP
	Schumpert Medical Center 915 Margaret Place Shreveport, LA 71120 318-227-4500	COMP
Slidell	Slidell Memorial Hospital 1001 Gause Boulevard Slidell, LA 70458 504-643-2200	CHCP
West Monroe	Glenwood Regional Medical Center 503 McMillan Road West Monroe, LA 71294 318-329-4200	COMP

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Louisiana Cancer and Lung Trust Fund Board
Cancer Control Strategic Plan - Table 9

Table 9 - Categories of Cancer Programs Approved by the ACOS Commission on Cancer

Category (Acronyms)	Services Available	Qualifications of Staff	Residencies Present	Fellowships in Oncology	Research	Conference Requirements
NCIP Comprehensive Cancer program (NCI-designated program)	Full range for diagnosis and treatment of cancer	Major specialty board, including those in oncology, where offered	Optional	Advanced oncologic fellowship programs that lead to board eligibility	Required	Weekly
THCP Teaching Hospital Cancer Program	Full range for diagnosis and treatment of cancer. Radiation therapy may be conducted elsewhere	Major specialty boards, including those in oncology, where offered	At least four, which must include medicine, surgery, and any two of the following: gynecology, pathology, diagnostic radiology, radiation oncology or an oncologic fellowship that leads to board eligibility	Optional	Required	Weekly
COMP[1] Community Hospital Comprehensive Cancer Program (greater than 300 new cases/year	Full range for diagnosis and treatment of cancer, but patients may need referral for portion of treatment	Major specialty boards, including those in oncology, where offered	Optional	Optional	Optional	Weekly

- A community hospital accessioning greater than 300 new cancer cases each year has the choice of being designated a Community Hospital Comprehensive Cancer Program or a Community Hospital Cancer Program. The hospital must meet the conference requirements of the category chosen for a minimum of one year prior to a survey or a category change.

CHCP Community Hospital Cancer Program	Full range for diagnosis and treatment of cancer, but patients may need referral for portion of treatment	Major appropriate specialties represented or available	Optional	Optional	Optional	Monthly
HACP[2] Hospital Associate Cancer Program	Limited resources for diagnosis and treatment of cancer	Individual consideration	Optional	Optional	Optional	Monthly
SHCP[3] Special Hospital Cancer Program	By individual consideration, as appropriate to the institution	Individual consideration	Optional	Optional	Optional	Monthly
ICP Integrated Cancer Program	Full range for diagnosis and treatment of cancer, combining resources of partnership	Individual consideration	Optional	Optional	Optional	Weekly or monthly, as appropriate to hospital partner
FCCP Freestanding Cancer Center Program	Limited to two or three treatment modalities	Individual consideration	Optional	Optional	Optional	Monthly
■ A Hospital Associate Cancer Program accessions 100 or fewer new cases per year ■ A special Hospital Cancer program accessions at least 15 new cases per year. This category is generally reserved for institutions that serve a particular patient population, e.g., Children's Hospitals.						
AFCP[4] Affiliate Hospital Cancer Program	Limited resources with access to parent institution	Individual consideration	None	None	None	Between four and six meetings annually
	Comprehensive,	Major specialties	Optional	Optional	Optional	As appropriate to

MCO[5] Managed Care Organization	Population-based system	available through organization or by contract				individual hospital category

- An Affiliate Cancer Program accessions fewer than 50 new cases per year. If the annual caseload exceeds 50 patients with cancer, the hospital should apply independently for the Hospital Associate Cancer Program.
- The Managed Care Organization category was created by the Commission in an ongoing effort to be responsive and flexible to the changes in health care delivery systems. An MCO employs its own physician group which provides care at facilities owned or operated by the MCO. In addition, it provides direction and support to its facilities.

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