COMPREHENSIVE CANCER CONTROL IN CALIFORNIA

2004

California Dialogue on Cancer

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Foreword from the California Dialogue on Cancer

An estimated 138,000 Californians will be diagnosed with cancer in 2004 and 53,800 will die from the disease. In the coming years, cancer is expected to strike three out of four California families. The diverse populations in our state bring additional challenges in combating the disease.

Comprehensive cancer control is based on the idea that people and organizations working together to identify problems and develop solutions will lead to better use of limited resources and generation of new resources through new partnerships.

Comprehensive cancer control will reduce the cancer burden on all California citizens by integrating and coordinating approaches for reducing the incidence, morbidity, and mortality of cancer through effective prevention, early detection, treatment, rehabilitation, and palliation efforts.

The California Dialogue on Cancer (CDOC) was formed to provide guidance for comprehensive cancer control activities in California. The development of the state plan is the first step in the ongoing process of implementing comprehensive cancer control. CDOC will be the lead organization in implementation of the plan via working committees specifically formed to address specific strategies and tactics as well as cross-cutting issues.

The California Comprehensive Cancer Plan is a strategic plan of action, developed by dedicated individuals and organizations concerned with the burden of cancer on California citizens. In particular, the American Cancer Society and the California Department of Health Services have assisted in coordinating the process that led to this plan.

This process included:

I Establishing a Steering Committee for initial guidance in determining overarching issues and the plan's framework.

II Developing an outline of the plan which resulted in a first rough draft.

III Following completion of the first draft of the plan, convening a meeting of cancer control stakeholders in California to further develop the plan. This stakeholders group was comprised of individuals with expertise in the field and representatives from a broad spectrum of government, health care, business, labor, and community-based organizations. This meeting was attended by over 175 individuals representing more than 75 organizations. This was the process of building our strategic partnerships.

IV The document resulting from this stakeholders meeting was distributed to participants for further review, revision, and finalization. In addition, cross-cutting issues were identified and to be addressed during the implementation process.

This formal plan blends community participation with the science of cancer control, examines the barriers and gaps in cancer control efforts and identifies measurable goals, strategies and tactics needed for the future. The impact of cancer is greater on some people than others. Therefore, recognition of the state's multicultural population is a primary component of this plan of action.

Successful implementation requires the continued support and assistance of many different partners including the state legislature, state and local health agencies, community-based organizations and grassroots efforts. Additional resources will also be needed to support of plan strategies.

We are extremely thankful for all those individuals and organizations who have assisted in developing this agenda for the future. This plan is an end product of the planning process and an important milestone toward reducing the cancer burden on Californians; however, it is just one step in a longer, sustained, comprehensive cancer control process. Every partner organization involved is vital to continuing successful implementation of California's Cancer Control plan, and we look forward to working together on this critical endeavor.

Executive Summary

California Confronts Cancer

Cancer is second only to heart disease as a cause of death in California across all population groups, except for Asian/Pacific Islander women where it is the leading cause of death. In the coming years, cancer is expected to strike three out of four California families.

Significant talent and resources have been directed into the effort to control cancer in our state. As a result, California has created a world-class cancer surveillance system and registry. Although encouraged by its progress in controlling cancer, the state is at an important juncture where a comprehensive plan can coordinate control efforts and optimize resources during difficult financial times. A comprehensive plan will also engender greater collaboration and consensus among stakeholders as to what could and should be achieved.

In March 2003, California convened the California Comprehensive Cancer Control Plan Stakeholders Meeting with over 200 participants including state leaders, members of the public, not-for-profit organizations, health, medical, and business communities, the research community, national leaders, survivors, caregivers, and advocates. This meeting resulted in development of the initial draft of California's plan.

The meeting was an inaugural event sponsored by the California Dialogue on Cancer (CDOC), the overarching organization that will take on issues of structure, growth, and outcomes for cancer control in California.

The Cancer Burden in California

Mirroring the rest of the nation, the burden of cancer does not fall equally on all Californians. Californians who are poor, lack health insurance, and lack access to adequate cancer care carry an unequal burden of cancer. The risk of developing cancer varies considerably by race/ethnicity.

Measures of cancer incidence, mortality, survival, and other pertinent data are used as a resource to originate and evaluate comprehensive cancer control as an evidence-based public health program. Evidence-based programs ensure that limited resources are directed toward efforts that will lead to the most meaningful and applicable results.

Cross-Cutting Issues in Cancer Control

In order to implement the comprehensive cancer control plan and achieve its goals, cross-cutting issues, which cut across the full spectrum of cancer control, are highlighted.

- Access to Quality Care
- Prevention
- Survivorship, Palliative Care, and Quality of Life
- Surveillance and Evaluation
- The Cost of Cancer
- Public Policy and Legislation
- Research
- The Environment and Cancer

The Unequal Burden of Cancer

California's large multicultural and diverse population also often encounters barriers to optimal cancer care. Disparities exist in knowledge, access, treatment, and survival and result in risk of high cancer incidence, mortality, poor cancer survival, and poor quality of life. Efforts specifically directed to the state's diverse and low-income populations will continue to overcome gaps in its cancer control programs.

Top Strategies to Achieve Goals and Objectives

Key strategies and tactics for making progress in California's efforts to control cancer were developed by participants at the March 2003 Stakeholders Meeting described above. Listed below are the top strategies identified for colorectal, breast, prostate, and lung cancer as well as for the two leading risk factors for cancer overall, i.e. tobacco use, poor nutrition and physical inactivity.

Colorectal Cancer - Top Strategies to Achieve Goals and Objectives

1. By January 1, 2006, develop and support proactive colorectal cancer advocacy groups that will, in turn, support community, state, and national agendas for increasing awareness of colorectal cancer issues.

2. By January 1, 2006, develop and support evidence-based, culturally sensitive public awareness campaigns that focus on the importance of colorectal cancer screening, prevention, and early detection through media, community outreach, and through a collaboration among health care providers and community and voluntary organizations.
3. By January 1, 2006, work toward universal insurance coverage for colorectal cancer screening and treatment.

Breast Cancer - Top Strategies to Achieve Goals and Objectives

1. By January 1, 2006, begin to conduct statewide tracking of women's breast cancer health care.
2. By January 1, 2006, provide education for health professionals, policy makers, and consumers, including diverse populations, regarding breast cancer risk assessment and risk reduction through a variety of materials and mechanisms developed to increase cultural competency and communication skills.
3. By January 1, 2006, develop a coordinated system and resources to provide access for patients to breast cancer detection, diagnosis, and treatment services which ensures quality of life throughout the continuum of cancer care including recovery and palliative care.

Prostate Cancer - Top Strategies to Achieve Goals and Objectives

1. By January 1, 2006, educate the public, health professionals, and policy makers regarding major issues relating to prostate cancer including its risks, treatment options and associated quality of life issues, fears, beliefs and perceptions about the cancer and its treatment, lack of trust in the health care system among diverse groups, the need for easier access to prostate cancer detection and care, and lack of accurate, unbiased information conveniently accessible to men within and outside the health care system.
2. By January 1, 2006, increase state funding for prostate cancer control research that includes basic, translational, clinical, and health services, quality of life, and outcomes research.
3. By January 1, 2006, ensure consistent funding of existing prostate cancer mandates and programs for the low income, uninsured, and underinsured, and ensure that programs are culturally and linguistically appropriate for ethnic communities.

Lung and Oral Cancer and Tobacco Control - Top Strategies to Achieve Goals and Objectives

1. Prevent or control tobacco use by funding and implementing the Tobacco Education and Research Oversight Committee Master Plan to strengthen the California Tobacco Control Program structure (community-based and school-based programs and tobacco-related disease research).
2. Integrate evidence-based and efficacious smoking and smokeless tobacco cessation services into the state's school systems, community-based organizations, public health programs, and health care plans and institutions.
3. Improve current and develop new technologies for screening, early diagnosis, and treatment of lung, oral cancer, and other tobacco-related cancers (e.g. cervical, stomach, pancreatic), and improve the quality of life measures at all stages of the patient's health care and balance of life.

Nutrition, Obesity, Physical Activity, and Cancer - Top Strategies to Achieve Goals and Objectives

Based on the model provided by the successful tobacco prevention campaign in California, identify current funding streams and mobilize new resources to at least a comparable level of California's Tobacco Control Program. Create a similar statewide infrastructure to change state norms regarding healthy dietary and physical activity behaviors as follows:

1. Develop a statewide infrastructure that provides leadership, management, planning, information and intervention dissemination, resource development training, and coordination.
2. Institute environmental and policy change.
3. Implement mass communication strategies.

The individuals and organizations who have contributed to this end product of the planning process are welcomed as a partner in developing this agenda into the future.

This process of building partnerships continues with The California Dialogue on Cancer (CDOC) providing guidance for comprehensive cancer control implementation activities in California via working committees specifically formed to address specific strategies and tactics as well as cross-cutting issues.

Chapter 1

Comprehensive Cancer Control in California

COMPREHENSIVE CANCER CONTROL IN CALIFORNIA

GOALS

1. By 2010, reduce the cancer mortality rate by 40 percent in California, from a baseline of 178.3 deaths per 100,000 persons.

2. By 2010, reduce the cancer incidence rate by 20 percent in California, from a baseline of 445.5 new cases per 100,000 persons.

California Confronts Cancer

California has made enormous strides in cancer control over the past twenty years, particularly during the last decade as cancer incidence and mortality rates have declined, in some cases dramatically.

Between 1988 and 1999, overall California cancer mortality rates decreased 17 percent among men and 12 percent among women. The relatively smaller decline among women is likely driven by a lag in reducing their lung cancer-related mortality.

During 1988-1999, Cancer Mortality Rates in California Decreased Significantly Among African Americans (11 Percent), non-Hispanic Whites (13 Percent), Hispanics/Latinos (12 Percent), and Asian/Pacific Islanders (15 Percent).

Much, however, remains to be done. An estimated 138,300 Californians will be diagnosed with cancer in 2004 and 53,700 will die from the disease (1). Cancer is second only to heart disease as a cause of death in California across all population groups, except for Asian/Pacific Islander women where it is the leading cause of death. In the coming years, cancer is expected to strike three out of four California families. The population is aging, births and population migration are growing, and even now California has the highest percentage of uninsured residents in the U.S., (nearly 25 percent). These are large, albeit surmountable, barriers to saving lives from cancer.

There are more cancer survivors alive now than ever. Nearly 885,000 Californians are alive today who have a personal history of cancer, and this is not by chance. Vast talent and resources have been directed into the effort to control cancer in our state. As a result, California has created a world-class cancer surveillance system and registry. Concurrently, research, clinical, and public health cancer control programs recast research findings into practical interventions to benefit all Californians.

What is a Successful Cancer Control Program?

California's Tobacco Control Program, certainly a model for the rest of the nation, demonstrated what is needed to control and ultimately eliminate cancer, in this case lung and other tobacco-related cancers. California has experienced a dramatic decline in lung cancer deaths compared to the rest of the U.S. over the past 15 years (1). However, when the full impact of the program hits in the future (because cancer does take some time to develop), the decline in lung cancer incidence and mortality will be nothing less than awesome.

What Makes this Program Work?

Number one, it is comprehensive. The program is organized at the grass roots level across the state and involves coalitions in every county and the three cities in the state that have a health department, as well as a broad spectrum of government, voluntary, health care, business, labor, and community-based organizations. Recognition of and sensitivity to the state's multicultural population is crucial, and the program's ethnic networks are essential partners that participate throughout the program.

Secondly, public policy, particularly at the local level, is a major intervention tool that brings about social change. Third, an aggressive media campaign frames the issues and helps to focus and legitimize program efforts in the public's eye. Fourth, multiple strategies are used to get the job done.

To sustain the program, a viable infrastructure emphasizes both vertical (state and local) and horizontal connections (training, technical assistance, clearinghouse, ethnic networks, cessation helpline, evaluation, media and public relations) that benefit the entire program. This horizontal and vertical integration is key to its success. Highly skilled staff and courageous leadership at all program levels provide the program's support.

Programs like this, as with all cancer control programs, cannot be done with a minimal and uncertain budget. Political and social will are essential to fund and sustain programs at necessary levels if results are expected. Sustainability of adequate program funding is difficult as it fluctuates with the ebb and flow of legislative decisions and budget constraints. (See Chapter 7, "Lung and Oral Cancer and Tobacco Control," for more detailed information on California's tobacco control program.)

California's Plan

Although California should be and is encouraged by its progress in controlling cancer, the state is at an important juncture where a comprehensive plan can coordinate control efforts and optimize resources during difficult financial times. In addition, many of the strategies and tactics presented in this plan will have health benefits extending far beyond cancer to additional leading causes of mortality such as heart disease and diabetes.

A comprehensive plan will also engender greater collaboration and consensus among stakeholders as to what could and should be achieved. These stakeholders include state leaders, members of the public, not-for-profit organizations, health, medical, and business communities, the research community, national leaders, survivors, caregivers, and advocates, all who will help create this visionary blueprint for California.

Developing a comprehensive cancer control plan is a tall order for California whose urban-rural mix, ethnic diversity, and geographic size have resulted in a complex population larger than that of the country of Canada. California, must be up to the challenge.

Overarching Principles of California's Plan

California's plan is about science, delivery, and impact, in other words, what we know must be applied to what we do, and if we don't know, we must find out. When the California Comprehensive Cancer Control Steering Committee met in June of 2002, members deliberated on these issues and resolved that the following ten core principles be considered in creating the plan.

The committee felt this plan must address:

1) Cancer in general, and selected site-specific areas.
2) Equal access to quality care for all resulting in minimal disparities in cancer outcomes.
3) Quality cancer surveillance and data collected across all population sub-groups.
4) Culturally appropriate awareness, information, and interventions that span the diversity of California
5) Continued and expanded investment in research across the research continuum from prevention to applied public health (translational) research.
6) Greatly expanded funding needed to achieve successful cancer control outcomes.
7) The relationship of poverty and the environment to the development of cancer.
8) All aspects of the cancer continuum from prevention and risk reduction to palliative care, survivorship and end of life considerations including physical, psychological, social, and spiritual dimensions that are crucial to cancer patients and their families.
9) Strong collaboration among cancer control groups that include both traditional and non-traditional partners.
10) Focus on opportunities and interventions that will have the biggest impact for the greatest number of people.

The California Dialogue on Cancer

In 2002, two leading California cancer control organizations that have collaborated over many years spearheaded the beginning of the planning process: the California Division of American Cancer Society and California Department of Health Services (DHS). Although California already has major, individual cancer control programs in place, no formal comprehensive plan has been developed since 1983.

A Comprehensive Cancer Control Steering Committee was organized and met June 7, 2002, to begin the planning process which would ultimately lead to the development of a draft plan. This distinguished committee was composed of numerous and diverse representatives from academia, corporate California, health care and insurance industries and institutions, consumer and advocacy groups, and others with an interest in cancer control. (See Appendix A)

In March 2003, California convened the California Comprehensive Cancer Control Plan Stakeholders Meeting to introduce the Steering Committee's thoughts on a draft plan to a large statewide coalition, to gain constituent participation, and to begin a massive reconstruction effort for cancer control program growth. Over 200 meeting participants examined the science of cancer control, its practice, funding, assets, gaps in cancer control efforts, barriers to close the gaps, and then identified priority strategies and tactics needed to overcome the barriers and produce successful cancer control outcomes. This meeting was the inaugural event sponsored by the California Dialogue on Cancer, the overarching organization that will take on issues of structure, growth, and outcomes for cancer control in California.

This plan is the first step.

Chapter II

The Cancer Burden in California

The Cancer Burden in California

Comprehensive cancer control programs, should, as should all public health-oriented programs, be evidence-based to ensure that limited resources are directed toward efforts that will lead to the most meaningful and applicable results.

Key characteristics of evidence-based programs include:

- Intervention approaches developed are based on the best possible scientific information.
- Problem solving is multi-disciplinary.
- Theory and systematic planning approaches are followed.
- Sound evaluation principles are followed.
- Results are disseminated to others who need to know.

California has the ultimate resource to base its plan of action on and to use for evaluating the plan in the California Cancer Registry (CCR) and the Cancer Surveillance Section's Survey Research Group. In order to set the stage for the remainder of this plan, pertinent data from the Registry and the Survey Research Group are summarized below.

Cancer in California

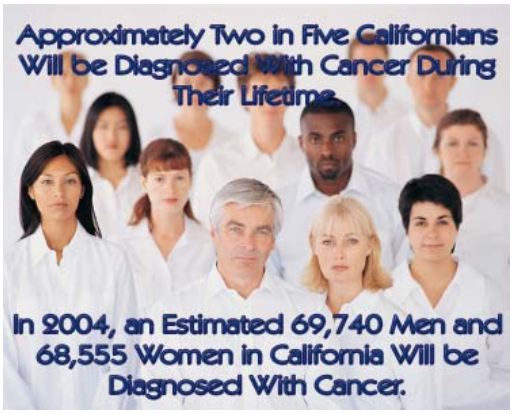


Table 1 shows the expected number of new cases per year for the ten leading causes of cancer. Among men, the most frequently diagnosed cancer is prostate, while breast cancer is the most frequently diagnosed cancer among women. Lung and colorectal cancers are second and third most frequently diagnosed cancers among both men and women.

Table 1
Estimated Number of New Cancer Cases per Year, by Gender and Site (Ten Leading Causes of Cancer Incidence), California, All Race/Ethnicity Groups Combined, 2004-2010

Cancer Site	Annual Number of New Cases	
	Men	Women
Breast	135	22,415
Prostate	22,265	-
Lung	9,300	8,215
Colon	5,030	5,310
Urinary bladder	4,215	1,360
Melanoma	3,355	2,345
Non-Hodgkins Lymphomas	3,035	2,520
Uterine corpus	-	3,520
Rectum	2,320	1,825

Source: California Cancer Registry (11/02)
Prepared by the California Department of Health Services, Cancer Surveillance Section.

Cancer is the second leading cause of death among all Californians, and one in four deaths in California is attributable to cancer. Among Asian/Pacific Islander women, however, cancer is the leading cause of death in California. While overall cancer mortality rates have been declining, the absolute number of cancer-related deaths is expected to increase because California's population is aging and growing in size. During 2004, approximately 27,080 men and 26,610 women will die from cancer in this state (1).

Table 2
Estimated Number of Cancer Deaths per Year, by Gender and Site (Ten Leading Causes of Cancer Death), California, All Race/Ethnicity Groups Combined, 2004-2010

Cancer Site	Annual Number of Deaths	
	Men	Women
Lung	7,530	6,445
Female breast	-	4,195
Prostate	2,925	-
Colon	2,165	2,250
Pancreas	1,395	1,525
Non-Hodgkins Lymphomas	1,175	1,000
Leukemias	1,205	935
Ovary	-	1,515
Liver	945	460

Source: California Cancer Registry (11/02)
Prepared by the California Department of Health Services, Cancer Surveillance Section.

In most race/ethnic groups, prostate, lung and colorectal cancer are among the top four cancers for males, while breast, lung and colorectal cancer are among the top four cancers for females. Risk varies considerably among the four-race/ethnic groups and variation exists even within Asian subgroups.

Table 3 and 4 show the five most common cancers and number of new cases for the period 1996-2000, among men and women, respectively. Prostate cancer was the most common cancer for men in most ethnic groups, but lung cancer was the most common cancer for Cambodian and Vietnamese men. Lung cancer also was the most frequently diagnosed cancer among Korean men.

Table 2 shows the annual expected number of deaths for the most frequent causes of cancer death. Lung cancer will kill more California men than prostate and colon cancers combined, and as many women as breast cancer and colon cancer combined.

Mirroring the rest of the nation, the burden of cancer does not fall equally on all Californians, and the risk of developing cancer varies considerably by race/ethnicity. Among men, African-American men have the highest incidence and mortality from cancer, followed by non-Hispanic whites. Among women, non-Hispanic white women have the highest incidence of cancer, but African-American women have the highest mortality. Although Hispanic and Asian/Pacific Islander men and women are at lower risk of developing many cancers, they have higher rates of other cancers, including liver, stomach and cervical cancer. Asian/Pacific Islanders and Hispanics are two to three times more likely than non-Hispanic whites to develop stomach cancer, and are from two to five times more likely to develop liver cancer. Hispanic women also have twice the risk of being diagnosed with invasive cervical cancer relative to non-Hispanic white women.

Table 3
Five Most Common Cancers and Number of New Cases by Detailed Race/Ethnicity, California, 1996-1999, Men

	Men				
Rank	1	2	3	4	5
African American	Prostate 8,443	Lung 3,801	*C&R 2,291	**NHL 691	Oral 754
American Indian	Prostate 56	Lung 50	*C&R 41	Kidney 16	Stomach 14
Asian Indian	Prostate 305	*C&R 93	**NHL 68	Lung 67	Leukemia 64
Cambodian	Lung 44	Liver 38	*C&R 22	**NHL 16	Leukemia 13
Chinese	Prostate 1,337	*C&R 984	Lung 969	Liver 497	Oral 343
Filipino	Prostate 1,720	Lung 1,126	*C&R 700	**NHL 302	Liver 235
Hawaiian	Prostate 46	Lung 31	*C&R 27	Bladder 12	**NHL 10
Hispanic	Prostate 11,214	*C&R 4,221	Lung 3,771	**NHL 2,291	Leukemia 1,861
Japanese	Prostate 807	*C&R 577	Lung 386	Stomach 230	Bladder 165
Korean	Lung 293	Stomach 273	*C&R 262	Prostate 192	Liver 176
Laotian	Liver 53	Lung 41	Stomach 23	*C&R 16	Oral 14
Non-Hispanic White	Prostate 67,413	Lung 35,371	*C&R 26,203	Bladder 17,456	Melanoma 13,220
Vietnamese	Lung 408	Liver 343	Prostate 277	*C&R 238	Stomach 147

Source: California Cancer Registry (11/02)
*C&R = Colon and Rectum
**NHL = Non-Hodgkin's Lymphoma
Prepared by the California Department of Health Services, Cancer Surveillance Section.

Table 4
Five Most Common Cancers and Number of New Cases by Detailed Race/Ethnicity, California, 1996-1999, Women

Women					
Rank	**1**	**2**	**3**	**4**	**5**
African American	Breast 5,865	Lung 2,503	*C&R 2,485	Uterus 816	Pancreas 647
American Indian	Breast 77	Lung 39	*C&R 31	Uterus 24	Ovary 19
Asian Indian	Breast 373	Ovary 64	*C&R 61	Uterus 58	**NHL 44
Cambodian	Breast 48	Cervix 28	Lung 24	Thyroid 19	*C&R 15
Chinese	Breast 1,774	*C&R 901	Lung 649	Ovary 289	Stomach 263
Filipino	Breast 2,427	*C&R 606	Lung 470	Thyroid 400	Uterus 386
Hawaiian	Breast 70	Lung 29	Uterus 19	*C&R 18	Ovary 8
Hispanic	Breast 11,216	*C&R 3,384	Cervix 2,836	Lung 2,587	Uterus 2,071
Japanese	Breast 1,211	*C&R 587	Lung 337	Stomach 199	Uterus 192
Korean	Breast 415	*C&R 249	Stomach 181	Lung 149	Cervix 108
Laotian	Lung 31	Breast 30	Cervix 23	Stomach 16	*C&R 16
Non-Hispanic White	Breast 78,061	Lung 32,283	*C&R 25,868	Uterus 13,471	Ovary 9,369
Vietnamese	Breast 519	*C&R 215	Lung 194	Cervix 158	Thyroid 121

Source: California Cancer Registry (11/02)
*C&R = Colon and Rectum
**NHL = Non-Hodgkin's Lymphoma
Prepared by the California Department of Health Services, Cancer Surveillance Section.

Similarly, breast cancer is the most frequently diagnosed cancer among all women except Laotian women, among whom lung cancer is the most frequent cancer. Cancer of the cervix does not appear among the top ten cancers for all California women combined, but is among the top five cancers for Cambodian, Hispanic, Korean and Laotian women.

Similarly, liver cancer is not one of the top cancers for all California men combined, but is one of the top five cancers for Cambodian, Chinese, Korean, Laotian, and Vietnamese men. Stomach cancer is one of the top five cancers for American Indian men, Chinese women, Japanese men and women, Korean men and women, Laotian men and women, and Vietnamese men.

Although not among the top five sites, African-American men and women have twice the risk of developing multiple myeloma, and cancers of the stomach or liver compared to non-Hispanic whites. African-American women have a 50 percent higher risk of developing invasive cervical cancer, and African-American men are 60 percent more likely to be diagnosed with prostate cancer compared to non-Hispanic whites.

Chances of Being Diagnosed Early and Surviving Cancer Also Vary by Race/Ethnic Group in California.

Table 5 shows the proportion of Californians diagnosed with early stage (*in situ* or localized) breast, prostate, cervix, colorectal cancer and

Table 5
Percent of Cancers Diagnosed at Early Stage, by Race/Ethnicity, California, 1999

	Percent Early Stage			
	African American	**Asian Pacific Islander**	**Hispanic**	**Non-Hispanic White**
Breast (female)	61	69	62	70
Prostate (male)	64	70	70	71
Cervix (female)	41	46	50	53
Colorectal (male)	41	41	40	43
Colorectal (female)	41	39	36	41
Melanoma (male)	--	80	80	90
Melanoma (female)	--	84	89	92

Source: California Cancer Registry (11/02)
Prepared by the California Department of Health Services, Cancer Surveillance Section.

melanoma, by race/ethnicity during 1999. Through screening, these cancers can be diagnosed at an early stage. Yet fewer than half of colorectal cancers are diagnosed early in men and women of all race/ethnic groups, and fewer than half of cervix cancers in African-American and Asian women, despite the availability of effective screening programs. Incidence rates of more advanced breast cancer (Stages III and IV) were higher among African-American women than among non-Hispanic white women.

Survival from Cancer Varies by Type, but for Most Cancers Survival is Associated With Stage at Diagnosis.

Table 6
Five-Year Relative Survival by Stage at Diagnosis, California, 1993-1999

Cancer Type	All Stages	Localized	Regional	Distant
Female breast	87%	97%	77%	18%
Cervix uteri	70%	91%	52%	13%
Uterus	86%	96%	67%	18%
Ovary	54%	95%	79%	32%
Prostate	98%	100%	94%	33%
Testis	94%	99%	95%	69%
Oral & Pharynx	59%	79%	49%	28%
Colon & Rectum	63%	91%	66%	9%
Pancreas	5%	15%	6%	2%
Lung & Bronchus	14%	48%	20%	3%
Melanoma	88%	93%	52%	14%
Bladder	68%	80%	36%	7%
Hodgkin's Disease	82%	--	--	--
NHL**	52%	--	--	--
Leukemia	44%	--	--	--
Childhood (0-19)	73%	--	--	--
Adult (20+)	38%	--	--	--

Source: California Cancer Registry (11/02)
Follow-up is through December 2000
**NHL = Non-Hodgkin's Lymphoma
Prepared by the California Department of Health Services, Cancer Surveillance Section.

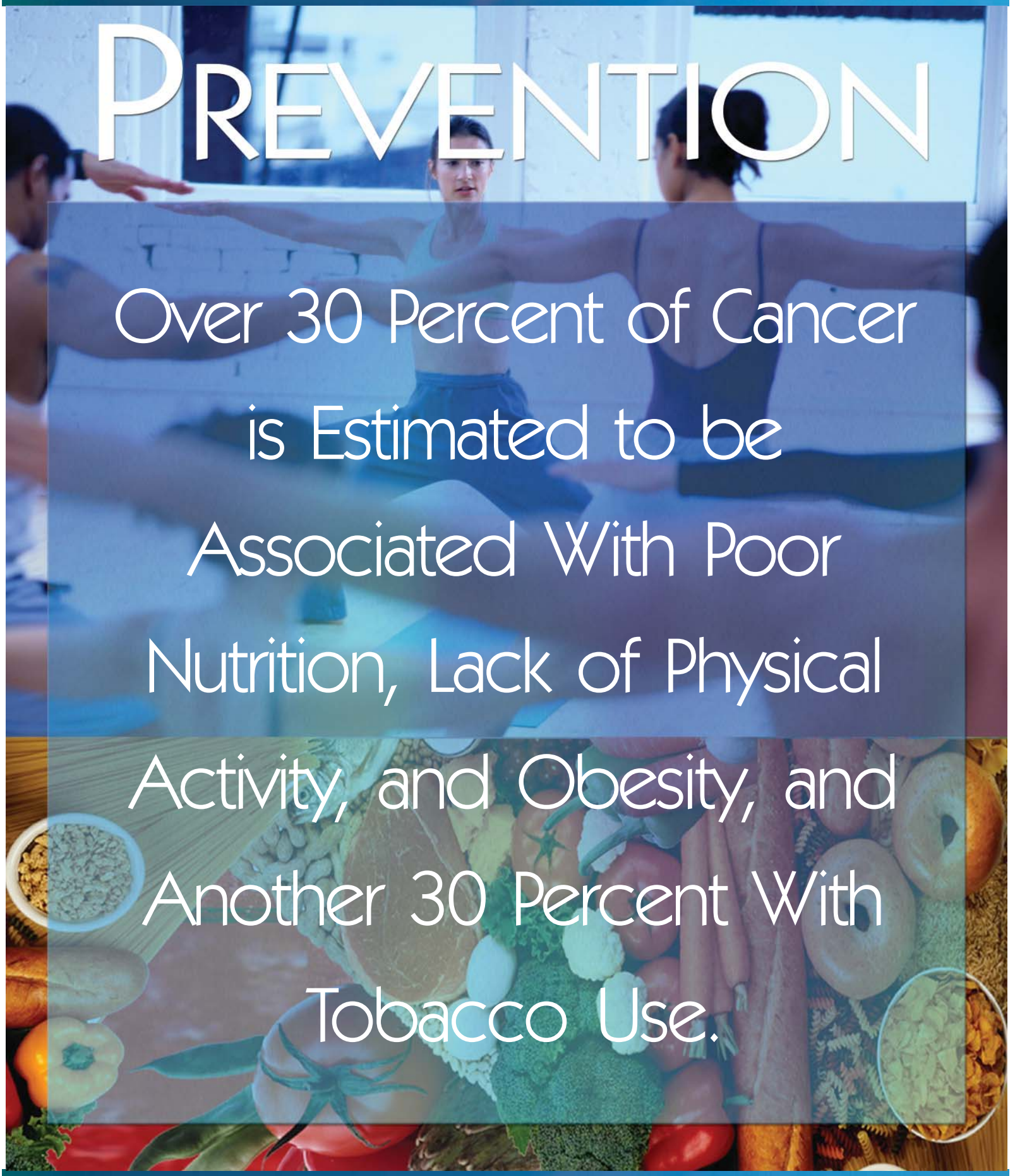
Table 6 shows the relative survival from cancer by stage at diagnosis. Women diagnosed with breast cancer at an early stage have a 97 percent probability of surviving five years, but this drops considerably for women diagnosed with more advanced disease. Similar results can be seen for other cancers.

In the U.S., many minority groups experience poorer cancer survival than whites. For California, statewide survival rates by race/ethnicity are not currently available but race-specific and socioeconomic status (SES)-specific life tables are being developed in order to better characterize survival among individuals of the four largest race-ethnic groups in California.

Although cancer remains a major cause of illness and death, incidence rates for most common cancers have declined among both men and women since statewide cancer reporting became mandatory in 1988. Much of this decline is the result of significant decreases in smoking-related cancers such as lung and bronchus, oral cavity, larynx, pancreas, stomach, cervix, uterus, and bladder. Yet smoking remains a significant problem among some groups and among young people of California.

Declining cancer incidence and mortality among non-Hispanic white men and women is not always apparent among the other race/ethnic groups in California. Continued research is needed to explore the unequal burden of cancer among Californians who are poor, lack health insurance, and lack access to adequate cancer care, factors which affect the cancer incidence, mortality, and survival.

Prevention



Over 30 Percent of Cancer is Estimated to be Associated With Poor Nutrition, Lack of Physical Activity, and Obesity, and Another 30 Percent With Tobacco Use.

Chapter III
Cross-Cutting Issues in Cancer Control

Cross-Cutting Issues in Cancer Control

Certain issues cut across the full spectrum of cancer control. Although many of them are also discussed within each cancer site-specific or risk factor-specific chapter that follows, several are given special emphasis here to highlight their importance in implementing this plan and achieving its goals. Disparities in cancer burden, one of the paramount cross-cutting issues in cancer control, is addressed in the next chapter, "The Unequal Burden of Cancer."

Access to Quality Care

Access to health care is a leading national health indicator, and strong predictors of access includes having health insurance, a higher income, and a regular source of ongoing health care. Equal access to quality cancer care should ensure that all people diagnosed with cancer have access to appropriate treatment and follow-up, resulting in minimized disparities in treatment outcome.

The barriers to accessible quality cancer care, however, are enormous. Individuals with inadequate health insurance, low-income populations, and the working poor are at higher risk for increased cancer incidence and mortality rates and poorer cancer survival. This is also true for MediCal and Medicare recipients who are unable to get the care they need from physician groups, hospitals, or health care plans because of low reimbursement rates or gaps in coverage.

Access to care does not mean just getting in the door. What happens to people after they get into primary care can defeat the best of health care provider intentions and desires of their patients. Cultural, linguistic, and gender differences may impede communication and understanding, resulting in additional barriers to quality care.

Prevention

According to the National Cancer Institute (NCI) and other cancer experts, prevention is a key strategy to reduce the nation's cancer burden. In the U.S., four cancers - lung, breast, prostate, and colorectal - account for 55.9 percent of all cancer cases and 52.7 percent of all cancer deaths. If California expects to reduce its cancer trends further, aggressive preventive strategies must be employed to reduce the cancer burden. For example, two of the most critical determinants affecting future cancer rates are the ability to reduce tobacco use and to increase healthier eating and physical activity in all populations. Over 30 percent of cancer is estimated to be associated with poor nutrition, lack of physical activity, and obesity, and another 30 percent with tobacco use.

The answers are clear where program priorities should lie. California must put limited resources where they will have the greatest impact for the largest number of people. This, however, is easier said than done. Academicians may prefer the investment be made supporting research in diagnostic and treatment advances, clinicians may prefer to focus on adequate compensation for clinical services rendered, and the public health constituency will likely look to primary prevention as the optimal strategy. A consensus of choices is needed as to where California makes its investments in cancer control in these lean fiscal times.

Survivorship, Palliative Care, and Quality of Life

The 2001 Annual Report to the Nation on the Status of Cancer states, "Although it is encouraging that overall cancer incidence and death rates continue to decline in the U.S., measures to sustain this progress must address the entire spectrum of prevention, early detection, and improved treatment and quality of life and must be aimed at reducing mortality among all populations."

"Quality of life" is really the optimum of what can be achieved to enhance the physical, psychological, social, and spiritual dimensions of cancer survivors' lives from the time of diagnosis through their balance of life. As the number of cancer survivors continues to grow and, in fact, survive to increasingly older ages, quality of life measures at each phase of the cancer continuum become a major concern.

Quality of life issues related to the needs of cancer patients, their families, friends, and caregivers include the following:

- Control and relief of pain, fatigue, nausea, and other side effects of treatment.
- Amelioration of cancer's impact on physical appearance and body image.
- A support network of family, friends, social and cancer survivor groups, and a culturally competent and caring health care team.
- Socioeconomic support to help patients deal with financial, employment, and insurance barriers, and access to quality treatment and follow-up care.
- Care or referral to services that can assist the patients' and their families' psychological, emotional, and spiritual needs.
- Health care givers knowledgeable about and sensitive to their patient's culture and language and able to provide quality care and referral to support services.
- The Institute of Medicine (IOM) and the National Research Council (NRC) in their report, "Improving Palliative Care for Cancer," tell us that, "Improvements in the development and delivery of symptom control and other aspects of palliative care needed in the late stages of cancer...have not kept pace with the medical advances that have allowed people to live longer."
- Palliative care may not currently be a higher priority within the health care system for several reasons, for example: lack of insurance reimbursement; inadequate skill of health care workers with poor, if any, training in symptom management; poor public sector investment in palliative care research and training; lack of standards of care and accountability in the care of dying and suffering patients; lack of public information resources for people dealing with end of life care; lack of reliable data on quality of life and care; and disparities in care for ethnic and low-income populations, even when that care is available.
- The IOM-NRC report cites several recommendations regarding palliative care that include: adequate reimbursement for palliative care by public and private insurers; culturally relevant adult and child patient oriented educational materials that give comprehensive, accurate information on palliative care ; standards of care dictated by best practices guidelines for physical and psychological symptoms and encouraged by accreditation bodies; and enhanced data systems through cancer control registries, core quality measures, and support for research or demonstration projects in cancer care.

Surveillance and Evaluation

Cancer surveillance data provide the background and make the case for priorities and programs in cancer control. NCI states that a truly comprehensive cancer surveillance system would embrace the entire life cycle from birth to death and would include cancer data regarding healthy people, the newly diagnosed, patients receiving treatment, and those living with and dying of the disease.

The goal of surveillance data is to identify and prioritize at-risk populations for prevention strategies, early-detection programs, and research. Data are also crucial to determine access to the best treatment and to improve quality of life throughout the continuum of cancer and at the end of life.

California's greatest resource for cancer data is the CCR. The data it collects, compiles, and publishes helps to paint a clear picture of where our program priorities must lie, where disparities exist, and what populations California must reach. CCR data are essential to monitor the progress of this plan and the CCR requires adequate funding to do it.

Evaluation answers the question, "What works?" Evaluation must determine a cancer control program's progress, impacts, and outcomes and demonstrate (or not demonstrate) linkage between a program and its observed impacts and outcomes. Evaluation is based on what a program is expected to achieve and requires measurable program objectives. Unexpected achievements are also important to capture, therefore, both quantitative (e.g. number of deaths) and qualitative (e.g., impact on quality of life) methodologies are required. Evaluation is not only integral to this plan but to the objectives and strategies it generates between now and 2010.

The Cost of Cancer

The National Institutes of Health (NIH) estimated overall U.S. costs for cancer in the year 2000 at $180.2 billion which included $60 billion for direct medical costs (all health expenditures); $15 billion for indirect morbidity costs (lost productivity due to illness); and $105.2 billion for indirect mortality costs (cost of lost productivity due to premature death). Allowing that California has at about 12 percent of the U.S. population and also the highest uninsured population (25 percent), it is easy to see that California's cancer costs are considerable.

Prostate Cancer: For prostate cancer alone, Max, et al., estimated that the total cost of prostate cancer in California in 1998 was $360 million - divided equally between direct (health care) and indirect (premature death and lost productivity). Prostate cancer costs are expected to rise in the future as populations age.

Gynecologic Cancers: Max, et al., looked at the 1998 economic burden of gynecologic cancers that included cervical, ovarian, and uterine cancer. Direct medical costs were derived from California patient discharge data and the 1997 Medical Expenditure Survey. Indirect mortality costs were derived from the numbers of deaths and expected value of female future earnings.

The three gynecologic cancers in California cost a total of $624 million. Direct costs, of which hospitalization was about half, were $200 million. Indirect costs were over twice that amount at $424 million. Ovarian cancer was the most costly at an estimated $292 million, then cervical cancer at $206 million, and uterine cancer at $126 million.

Obesity: The "Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity: Economic Consequences," calculated

the year 2000 cost of obesity in the U.S. at more than $117 billion. These costs do not bode well for California that has an overweight and obesity rate over 54 percent among adults and an overweight rate of 22 percent among teens 12-17 years of age (15, 16).

A Recent California Study Has Already Found That the Cost of Cancer-Related Health Care in California Attributable to Obesity Was $15 Million While the Cost Associated With Physical Inactivity Was $34 Million.

Lung Cancer and Tobacco: In California, the care and treatment for illness caused by smoking reached an estimated $8.7 billion in 1993 (19). Other cost details related to lung cancer and tobacco are discussed in the chapter specifically addressing lung cancer.

Public Policy and Legislation

Cancer control constituencies must continue to address policy and legislative issues in order for progress to be made in controlling cancer in California. In framing issues, California must declare how serious the cancer problem is, how serious we are to solve it, that there is something we can do about it, and that the resources to solve the problem are insufficient. For example, social and political will and a lot of hard work made two huge advances possible to reduce the cancer burden in California: the 1988 Tobacco Tax Initiative, or Proposition 99 as it is commonly called, and the California smoke free workplace law that also included bars - a first in the U.S.

This same social and political will is needed to enact policies and legislation that, for example:

- End disparities in cancer care and outcomes.
- Institutionalize quality of care, quality of life, and pain management standards.
- Protect Californians from environmental risks and determine the linkage of environmental factors with the development of cancer.
- Reduce or eliminate chemical, physical, and biological exposures.
- Ensure access for everyone to quality cancer prevention, early detection, and treatment programs as well as the entire cancer control continuum.
- Ensure adequate funding for cancer research that includes translational research and technology transfer.
- Fund population-based programs to curb obesity, overweight and physical inactivity among adults and youth and increase consumption of fruits and vegetables.
- Protect school children from access to junk food on school campuses.
- Defeat policies and legislation that maintain health disparities in California's multicultural population.

Research

In order to truly control cancer, sustained support for cancer research is paramount and must span across the entire research continuum, i.e., from basic/molecular/genetic research through epidemiologic and clinical research to translational research which focuses on the transfer of current technology from the academic cancer centers to the larger communities of both providers and consumers.

Increased funding for research is imperative and research results must be translated into cancer

control policies and practice. There are unacceptable lengthy lag times between scientific understanding of prevention and control measures and the widespread application of those measures in the community.

The result is tragic numbers of unnecessary deaths. For example, the Pap test was perfected in 1943, but not widely used until the early 1970s, mammography was available in the late 1950s, but not widely promoted until 1985. And the 1964 Surgeon General Report that warned about the link between smoking and cancer did not result in the application of comprehensive population-based tobacco control interventions until the late 1980s.

The first major National Academy of Science report on diet, physical activity and cancer was published in 1982. Today, however, several thousand more peer reviewed articles later, we are yet to see the systematic allocation of federal or state funds for diet and physical activity interventions as we have seen in tobacco control.

Over the years there has been a major emphasis on basic biomedical research at the federal level to the significant exclusion of support for more applied public health-oriented research. If California wants to accelerate its control of cancer in a timely manner, the type of research funded needs to be broadened. Primary prevention, early detection, innovative treatment, public issues and policies, health communications, and palliative and end of life care research all should be considered.

Future funding of research should include:

- nutritional, physical activity, epidemiologic, and behavioral research,
- diffusion, translational, and technology transfer research, and
- health-delivering cancer control services research that examines societal barriers.

The need for systemic and fundamental social changes that are invariably connected to effective cancer control interventions is now recognized. The unequal burden of cancer in the U.S. is the most dramatic example that we must address. California, with its mainstream multicultural population, is in an important position to take on the kind of practical research that could help to eliminate disparities in cancer control.

In the meantime, California has not only tapped national and various foundation sources, it has made a major investment in its own comprehensive state-based cancer control research programs such as:

- DHS' gender-based Cancer Research Program that provides the research and development base (100 million dollars) for many of the state's cancer control interventions;
- The University of California's (UC) Tobacco-Related Disease Research Program that has funded (approximately 225 million dollars) a variety of research including basic, community-based and policy, and the UC Breast Cancer Research Program which has funded (about 115 million dollars) similar research focusing on breast cancer.

The downside to California's cancer research picture is that many still think research has more than adequate funding. California research initiatives supported to date represent a miniscule investment toward a disease that

continues to cost the State over 10 billion dollars a year. Expansion of this prudent investment would benefit not only Californians, but also the nation as a whole.

The Environment and Cancer

The 2002 International Summit on Breast Cancer and the Environment defined the environment as including "...the totality of living and working conditions as well as the physical, biological, social and cultural responses to those conditions." The Summit was primarily concerned with environmental exposures "involving activities that subject people to agents that they, as individuals, cannot control such as pesticides, dioxins, passive tobacco smoke and other chemicals, and ionizing and non-ionizing radiation." Environmental carcinogens of this type may be in air, food, water, and soil, and exposure can occur in the home, school, workplace, health care facilities, and many other places. Exposures are often influenced by social, economic, and cultural factors and may be chronic or acute. Science has long known of the linkage of certain cancers with the environment such as exposure to second hand smoke, asbestos, excess sunlight, and certain chemicals.

One of the Earliest Cancers Linked With the Environment Was Scrotal Cancer Among Chimney Sweeps in 1775.

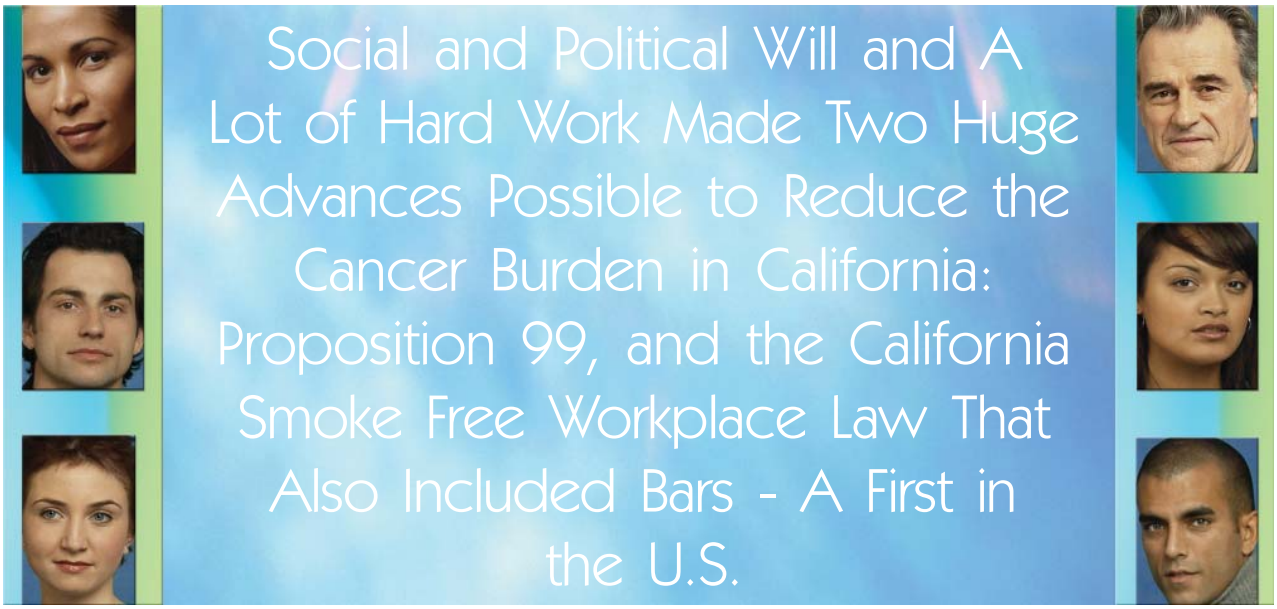
Currently there are more questions than answers as to how environmental factors influence the development of cancer, and finding areas of agreement among scientists is indeed a challenge. Studies suggest, for example, that there are dietary influences on cancer, and that specific foods and their components may reduce cancer risk.

The effects of "environmental" influences in poor communities such as tobacco promotions, excessive numbers of liquor stores, lack of affordable healthy food, unsafe streets and playgrounds require new study and broader approaches. Certain employees low in the corporate hierarchy may suffer increased exposure to certain occupational carcinogens, and migrant farm workers and their families are more vulnerable to high pesticide exposures and other potentially carcinogenic agents. Studies are also needed to explain to what extent country of residence vs. country of origin plays a role in the predisposition of cancer. The list of unanswered questions is long.

Major progress has been made in survival following diagnosis of cancer, yet the incidence of some cancers is on the rise, most notably the epidemic of breast cancer which cannot be totally explained by increasing screening rates. Current knowledge about the link between breast cancer and the environment is uncertain at best and more research is definitely needed. The link between long-term hormonal therapy with breast cancer only recently came to light and obesity is now an acknowledged breast cancer risk.

Although, the International Summit was largely concerned with the environment and breast cancer, some of its recommendations about research, community education, policy needs can apply more broadly to all cancers. The Summit participants recommended improved exposure assessment in population studies, identification of better biomarkers indicative of exposure, and that more cohort and collaborative studies should be funded.

Also identified as needed were studies of the interplay between timing of events and chronic exposure, linkage of cancer registries to occupational data, large multi-center epidemiological studies to look at breast cancer international differences and environmental exposures, how the estrogen receptor status of tumors is related to causes of breast cancer, and inclusion of all ages in future breast cancer research. Additional research is certainly warranted in this controversial and important area.



Chapter IV
The Unequal Burden of Cancer

The Unequal Burden of Cancer

GOAL

By 2010, all populations in California will have access to quality cancer care across the entire continuum of cancer with no disparity in outcomes.

OBJECTIVES

1. By 2010, eliminate disparities in cancer incidence, morbidity, mortality, survivorship, and quality of life.
2. Provide equal access to optimal cancer care along the entire cancer care continuum (including prevention, screening, early detection, treatment, and palliative care) for everyone by providing comprehensive, culturally competent, language appropriate health care regardless of race or ethnicity, gender, age, income, insurance status, geographical location, sexual orientation, housing status, occupation, physical or developmental or mental ability, or immigration status.
3. Eliminate institutional racism, classism, sexism, and other related barriers in the delivery of optimal cancer care where they exist.
4. Increase the diversity of the health care workforce.
5. Eliminate late-stage cancer presentation at diagnosis in ethnically diverse Californians.
6. Develop a set of consistent guidelines for cancer screening for health care providers.

Background and Barriers to Achieving Goals and Objectives

Disparities in California

"Disparities" is the common term used to describe a population-specific difference in the presence of disease (in this case cancer), health outcomes, and access to the continuum of cancer care (which includes prevention, screening, early detection, treatment, rehabilitation, and palliative care). In other words, a disparity usually refers to a difference in what happens to a racial, ethnic, low-income, underserved, rural, or disabled population in contrast to the comparison group, which is, in most reports, non-Hispanic whites.

Disparities in cancer prevention and control are usually found among those who encounter barriers, not necessarily of their choosing, to optimal cancer care (education, prevention, detection, treatment and rehabilitation).

The term underserved includes, but is not limited to: Individuals and their children who are indigent; working poor without adequate medical insurance; elderly; homeless; those who have limited education; those who have limited literacy or language ability; persons with physical and/or mental disabilities, and those whose cultural beliefs and practices are not supported by Western biomedicine.

Since over half of California's population is non-white, addressing health disparities is of monumental importance to reduce the incidence, morbidity, and mortality of cancer and to improve the quality of life in this state. California has no population majority and is unique as the most diverse state in the U.S.

The 2000 U.S. Census shows that of California's total 33.9 million people, 47 percent are non-Hispanic white, 32 percent Hispanic/Latino, 11 percent Asian, 7 percent African American, 1 percent American Indian, and 0.3 percent Native Hawaiian and other Pacific Islander.

California has the largest Asian population group in the U.S. and approximately 70 percent are first generation immigrants. In addition, California has large low-income, uninsured, and rural populations.

Disparities and Cancer

Cancer is the second leading cause of death across all populations (except Asian-American females, for whom cancer is the leading cause of death) and the four major cancers - lung, breast, colorectal, and prostate - make up over 50 percent of cancer incidence and mortality. The risk of developing cancer, however, varies by ethnicity. The underserved are often diagnosed at later stages and with a higher incidence of cancers with higher mortality, such as lung cancer.

The reasons for this variability are not fully understood. In California, for example, African-American men have the highest overall cancer rates, and though African-American women are less likely to have a cancer diagnosis than non-Hispanic white women, they are more likely to die from it. African-Americans have higher rates of stomach, liver, and multiple myeloma cancer than non-Hispanic whites, and are 50 to 80 percent more likely to have cancer of the prostate and larynx (48).

Asian, Native Hawaiian and other Pacific Islanders, and Hispanic/Latinos have higher rates of stomach and liver cancer than non-Hispanic whites. In fact, liver cancer mortality is second only to lung cancer for Cambodian, Hmong, Laotian, and Vietnamese males. Lung cancer is rising among recently immigrated Cambodian and Vietnamese men, who also have among the highest smoking rates of all ethnic groups. American-Indian males have high smoking rates as well, and suffer from high lung cancer rates.

Poverty, Disparities, and Access to Care

Disparities exist in knowledge, access, treatment, and survival among California's diverse, low-income, rural, and disabled populations. Strong predictors of access to care, for example, includes having a higher income, health insurance, and a regular source of on going health care. Since a significant number of Californians do not have health insurance, and this certainly includes ethnically diverse groups, their access to quality care or even care at all is

clearly limited. As a result the uninsured are at risk for high cancer incidence, mortality, poor cancer survival, and poor quality of life.

Early in the 1990s, Harold P. Freeman, MD, current Director of the Center to Reduce Cancer Health Disparities, National Cancer Institute, declared poverty as a carcinogen. Poverty not only acts as a barrier to prevention, screening, and treatment services, it can contribute to the development of cancer through social and physical environments in which the low-income live and often work. While SES is not a substitute for ethnicity, the reality is that many ethnic groups live in lower SES neighborhoods. The consequences to cancer care are many, including higher incidence, more advanced stage of cancer at presentation/diagnosis, inadequate treatment, and hence greater mortality rates.

Gaps

California must continue to work hard to overcome gaps in its cancer control programs with efforts specifically directed to the state's many diverse and low-income populations.

Gaps include:

- lack of health insurance for critical services that can prevent, detect, treat, rehabilitate and support quality of life for cancer survivors;
- lack of funding for the CCR to provide surveillance data and monitoring for smaller populations groups such as the many Asian, Native Hawaiian, and other Pacific Islander nationalities and American Indians;
- lack of health care providers who reflect the diversity of this state and who have cultural competency to communicate with their patients and diverse co-workers;
- lack of assistance for patients to navigate their health care and receive quality of life support;
- lack of access to social support services;
- lack of facilities with appropriate equipment to accommodate people with physical and/or sensory disabilities;
- costs of medications not covered by insurance;
- the need for scientists to involve the community in research, particularly translational research;
- lack of knowledge of available services by both patients and providers; and
- a lack of appropriate cultural and linguistic skills in education and delivery of cancer services.

Calls for Action

Disparities in the burden of cancer are discussed in each chapter of this plan and are imperative for California to solve in the face of the state's large multicultural and diverse population. Fifty-three percent of California's total of 33.9 million people equals an ethnically diverse population of almost 18 million , and this figure does not include all of the low-income and uninsured.

Three calls for action on this issue have gone out from the IOM, a fourth from the U.S. Department of Health and Human Services (DHHS), and a fifth from the U.S. Centers for Disease Control and Prevention (CDC).

Two reports from the IOM specifically cite the disparate care provided to ethnic minorities in the U.S. The 1999 IOM Report on Unequal Burden of Cancer for Racial and Ethnic Minorities, and the 2002 IOM Report,"Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," which reported minorities are more likely to receive lower quality health care

regardless of income and insurance coverage. The DHHS national health objectives for 2010 set as its second of two goals to eliminate health disparities among racial and ethnic populations within the U.S. CDC followed, stating "Differences in cancer death rates result from a combination of factors such as behaviors (e.g., smoking and poor nutrition); access to preventive, diagnostic, therapeutic, and screening services and aggressiveness of treatment. If these factors were modified, more than half of the cancer deaths could be prevented and most racial-ethnic disparities in cancer death rates could be eliminated."

Herein lies the challenge to California.

The Unequal Burden of Cancer — Strategies and Tactics

Strategies to Achieve Goals and Objectives:

Strategy 1

Increase Cancer Health Disparities Research. Within the Next Two Years:

- Enhance the funding for California-based special population networks toward increasing clinical trial participation and for cancer disparities research.
- Advocate for private and corporate donors to fund cancer disparities research
- Support community-based participatory research.
- Advocate and recruit community-based organizations and community-based providers for participation and/or collaboration in research and clinical trials.
- Provide funding for support services for participants in diverse and low-income communities to participate in clinical trials, e.g., transportation and childcare, and cost of added ancillary treatment required due to participation in clinical trials.
- Increase the awareness of community oncologists of the need for participation of diverse groups in clinical trials by encouraging those efforts in oncology associations.

Strategy 2

Increase the Capacity of Agencies, Institutions, and Community-Based Organizations to Work With Diverse Communities. Within the Next Two Years:

- Identify existing barriers to working with diverse populations in community-based organizations, agencies, and institutions.
- Increase the capacity for in-depth, comprehensive and substantive diversity training in state medical and educational institutions and the development of measurable behavioral outcomes. This should include information regarding language access requirements, an education campaign to inform the public regarding laws relating to meaningful access, identifying organizations that could provide this training, and identifying best practices and advance replicated models to the entire state.
- Participate in existing and future governmental and community-based network meetings and forums.

Strategy 3

Increase Surveillance Data, Especially for Population Subgroups. Within the Next Two Years:

- Increase awareness and lobby the Department of Finance for intercensus population estimates for smaller populations other than the major five groups specified by OMB Directive 15.
- Educate staff in hospitals who enter patient information to include more definitive patient data regarding diversity, including socioeconomic information.
- Gather data on immigrant status and add more identifiers such as "rural," first generation or second generation acculturation indicators, and disability status.
- Increase and sustain funding for the CCR.
- Improve population, racial/ethnic classification techniques.

Strategy 4

Provide Universal Health Care Coverage.

- Promote and support legislation to make this a reality.

Strategy 5

Enforce Existing Laws, Including, but not Limited to, Americans with Disabilities Act and Language Access Laws, Such as:

- Title VI Civil Rights Act of 1964
- Executive Order 13166, Year 2000, requires "meaningful access" to all federally funded programs, including medical institutions
- KOPP Act, California Health and Safety Code, Section 1259
- Dymally-Alatorre Bilingual Service Act

Chapter V

Colorectal Cancer

COLORECTAL CANCER

GOAL

By 2010, reduce the colorectal cancer mortality rate in California by 40 percent, from a baseline of 17.6 deaths per 100,000 persons.

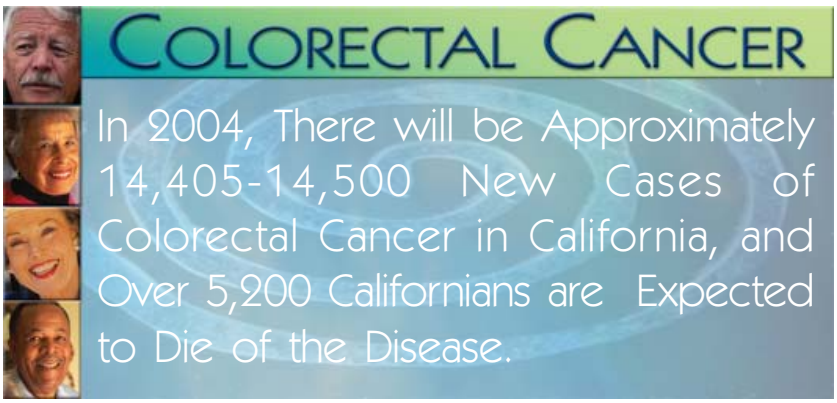
OBJECTIVES

1. By 2010, increase the percent of Californians over age 50 who have had a flexible sigmoidoscopy or a colonoscopy within the past five years from 40 percent to 58 percent, including women, Asian/Pacific Islanders, African Americans, Latinos, and those of low income.
2. By 2010, increase the percent of colorectal cancer diagnosed at an early stage from 42 percent to 65 percent.

Background and Barriers to Achieving Goals and Objectives

Burden of Colorectal Cancer in California

Colorectal cancer is the third most common cause of cancer in California for both men and women, and it is the second most common cause of cancer death (48). The importance of finding colorectal cancer at an early stage cannot be overstated. The survival rate is nearly 90 percent when the cancer is caught before it has spread beyond the intestinal wall (1). The overall five-year survival rate for colorectal cancer is 61 percent, much lower than the survival rate for either breast cancer (85 percent) or prostate cancer (94 percent). This low colorectal survival rate may be related in part to later stage of cancer detection. Screening can detect colorectal



cancer at an earlier stage or even prevent it altogether by detecting precancerous polyps that can be removed before they become cancers.

Risk Factors and Disparity in Burden

Men and women ages 50 and over, regardless of ethnicity, are at greatest risk for development of colorectal cancer, and that risk increases with age. Other risk factors include a history of inflammatory bowel disease, certain hereditary and genetically determined conditions, and having had a personal or family history of colorectal polyps or colorectal cancer. Lifestyle risk factors include a diet low in fruits, vegetables, fiber, and/or high in red meats, obesity and lack of physical exercise, alcohol consumption, and tobacco use (1, 35, 49).

Socioeconomic factors or barriers can also influence who will develop or die from colorectal cancer. Low SES can mean an environment that nurtures the onset of cancer by hindering healthy personal and family behaviors. Many low-income communities lack stores selling affordable healthy foods, and low SES is associated with lack of health insurance that may also result in lack of access to appropriate screening methods for early detection and prevention of colorectal cancer (36).

Age-adjusted colorectal cancer incidence and mortality rates are actually declining in California as they are in the rest of the nation. The biggest decline is among non-Hispanic whites, and the least is among African Americans. African Americans also have the highest mortality rate from colorectal cancer when compared with other ethnic or racial groups (1). The reason for the decline in colorectal cancer incidence and mortality is not fully understood but it may be due in some part to colonoscopy polyp detection and removal, and to dietary and lifestyle changes (1, 49).

Since California, like the rest of the nation, has an aging population, increases in the incidence of colorectal cancer can be expected as the population grows older (2). This expected increase in colorectal cancer incidence and mortality can be avoided largely by improving colorectal cancer screening rates. Ensuring that people of all races, ethnicities, and socioeconomic levels have equal access to screening services will help achieve California's goals.

Screening

The case for focusing state cancer control efforts on prevention, screening, and early detection of colorectal cancer in California couldn't be stronger (1). Average-risk persons without symptoms should undergo regular colorectal cancer screening beginning at age 50. Recommended screening procedures and intervals for the detection of polyps and colorectal cancer include colonoscopy (examining the entire colon) every 10 years, flexible sigmoidoscopy (an endoscopic examination of the lower colon) every 5 years, or fecal occult blood test (FOBT) yearly. A barium enema examination every 5 years has also been recommended for situations where access to the other screening methods is lacking. Diminished sensitivity to the detection of polyps and smaller cancers limits the effectiveness of the barium enema as a screening tool (1).

In 2001, only 42 percent of California adults ages 50 and over reported having had sigmoidoscopy or colonoscopy within the past five years. Persons living in poverty and Asian/Pacific Islanders had the lowest screening rates of Californians (under 28 percent), compared to over 50 percent for non-Hispanic white males earning over 200 percent of federal poverty level (1).

Randomized prospective studies have demonstrated that colorectal cancer screening significantly reduces mortality from colorectal cancer, most likely by removing precancerous

polyps and detecting asymptomatic cancer at an early stage. Increasing access to and affordability of colorectal cancer screening for all Californians, regardless or race, ethnicity or SES, is of primary importance.

A statewide educational program aimed at the public and health care providers, emphasizing early detection and prevention of colorectal cancer through screening and healthful living, would significantly reduce the incidence and mortality of colorectal cancer in California.

Californians, especially those over age 50, should be taught and constantly reminded of the importance of colorectal cancer screening as the primary means of prevention and early detection of this disease. Not only must the generally accepted (e.g., by the American Cancer Society (ACS) and the U.S. Preventive Services Task Force) colorectal cancer screening tests be widely available and accepted by the health care and insurance industries, they must be put into practice. Health care providers and consumer groups need to advocate for increased availability of colorectal cancer screening tests.

Sensitivity to cultural and ethnic diversity and social needs is required in every aspect of colorectal cancer prevention, screening, referral, treatment, and subsequent care. How a patient is guided through the process - clear and culturally sensitive instructions for test preparation, descriptions of the test procedures themselves, and explanations of the test results and follow-up - become the keys to public acceptance.

Evaluation and Treatment

Once cancer is detected, a number of tests are done before treatment to evaluate the stage of the cancer, to help plan treatment, and to rule out additional cancer foci. These tests may include a colonoscopy (if this has not already been done), blood tests (including for tumor markers such as carcinoembryonic antigen), chest x-rays, computed tomographic (CT) scans, and sometimes more sophisticated studies such as endorectal ultrasound examinations and Positron Emission Tomography (PET) scanning.

The primary treatment for colorectal cancer is surgery. For early-stage cancer, surgical resection alone is often curative. More advanced colon cancer may benefit from the addition of chemotherapy, and more advanced rectal cancer may be treated with radiation as well as chemotherapy. Rectal cancers are often treated with chemotherapy and radiation therapy before surgery. Only rarely today does surgical treatment of colorectal cancer result in a stoma (an opening on the patient's abdomen for fecal waste), and even then the stoma is occasionally only temporary. The treatment of colorectal cancer today is fairly well standardized. These standards have been developed through the systematic application of clinical trials that have demonstrated clear benefits of the use of certain methods and agents for the treatment of colorectal cancer. For this reason, it is essential that all patients with colorectal cancer be treated according to these generally accepted protocols to assure the highest possible survival rates. To help ensure continued progress in the treatment of colorectal cancer, patients of all ethnicities should be encouraged and recruited to participate in clinical trials.

Quality of Life

Quality of life for a cancer patient and his or her family refers to the physical, psychological, social, and spiritual well-being of their lives from diagnosis, through treatment, and for the balance of the patient's life. Not only should patients have access to appropriate quality treatment and follow-up, they and their families should receive help in navigating the health care

system to find resources and services that match their needs (4). All patients deserve accurate, complete, comprehensible, and culturally relevant information, and culturally sensitive and compassionate support goes hand-in-hand with treatment. This will minimize fear and result in patients and families who are partners in their own care.

Quality of life considerations include minimizing suffering through control of pain and anxiety. Patients with advanced, colorectal cancer should receive appropriate end-of-life care, including adequate pain management. There are generally accepted standards of pain control and these should be adhered to, again through quality assurance tracking with acceptable levels mandated by governmental and independent regulatory agencies (4).

Funding Colorectal Cancer Prevention, Screening, Early Detection, Treatment, and Follow-up Care

Elimination of cost as a barrier to quality care should be one of California's highest priorities. Some insurance companies will not pay for some or any of the screening tests, and this needs to change. Although a majority of Californians are covered by some form of health insurance, implementation of additional legislation mandating coverage for colorectal cancer screening and treatment by the state's health insurers is essential toward reducing California's colorectal cancer mortality.

Colonoscopy is now a covered benefit for Medicare patients. Other publicly funded colorectal cancer screening programs to cover the entire uninsured and underinsured population are needed. Universal health insurance coverage for all Californians may be the ultimate solution.

It is not enough for health care providers or insurers to offer colorectal cancer screening. Rates of screening should be subjected to quality assurance tracking, with minimum acceptable levels mandated by National Committee for Quality Assurance (NCQA) and other regulatory agencies as is currently done for breast and cervical cancer screening.

Colorectal Cancer - Strategies and Tactics

Top Strategies to Achieve Goals and Objectives:

1. By January 1, 2006, develop and support proactive colorectal cancer advocacy groups that will, in turn, support community, state, and national agendas for increasing awareness of colorectal cancer issues.
2. By January 1, 2006, develop and support evidence-based, culturally sensitive public awareness campaigns that focus on the importance of colorectal cancer screening, prevention, and early detection through media, community outreach, and through a collaboration among health care providers and community and voluntary organizations.
3. By January 1, 2006, work toward universal insurance coverage for colorectal cancer screening and treatment.

Additional Strategies:

- Increase colorectal cancer screening capacity among health care providers and facilities by promoting and encouraging expansion of the base of providers who can offer flexible sigmoidoscopy and colonoscopy to include

primary care physicians, nurses, and physician assistants.
- Achieve optimal outcomes in the prevention, detection, and treatment of colorectal cancer by promoting evidence-based best practices among health care providers, and by promoting and supporting research and education in colorectal cancer.
- Develop methods of evaluating the outcomes of prevention, detection, and treatment strategies in colorectal cancer and promote use of these methods.
- Establish stable funding that will enable state and local public health departments to implement culturally competent colorectal education and outreach at state, county and community levels.
- Assure that health professionals receive training in all aspects of colorectal cancer as a part of their initial and continuing medical education programs.
- Require health plans to meet approved colorectal cancer screening guidelines through the licensure process with the California Department of Managed Care.
- Establish and monitor evidence-based clinical guidelines for colorectal cancer care including quality of life measures, pain management, and palliative care.
- Provide information and navigation tools and services to colorectal cancer patients, families, and caregivers to help them receive the care and support they need when, and for however long, they need that care and support.
- Assure that colorectal screening is included in the Health Plan Employer Data and Information Set (HEDIS) guidelines and that promotion of adherence to guidelines are followed.

Tactics for Implementing the Top Strategies:

Strategy 1

By January 1, 2006, develop and support proactive colorectal cancer advocacy groups that will, in turn, support community, state, and national agendas for increasing awareness of colorectal cancer issues.

- Identify survivors motivated to build an advocacy coalition that also includes physicians, the ACS, other interested groups, and community leaders.
- Obtain funds from foundations to support advocacy activities from the U.S. Centers for Disease Control and Prevention, The ACS, corporations, and others, e.g. pharmaceutical companies.
- Create a combined patient support, legislative, and education focus.
- Develop a State of California Colorectal Roundtable modeled after the National Colorectal Roundtables to promote an on-going dialogue among experts and advocates in colorectal cancer.
- Explore beyond local level to national and international activities and tie groups together.
- Partner with a health plan or disease management program dealing with colorectal cancer.

Strategy 2

By January 1, 2006, develop and support evidence-based, culturally sensitive public awareness campaigns that focus on the importance of colorectal cancer screening, prevention, and early detection through media, community outreach, and through a collaboration among health care providers and community and voluntary organizations.

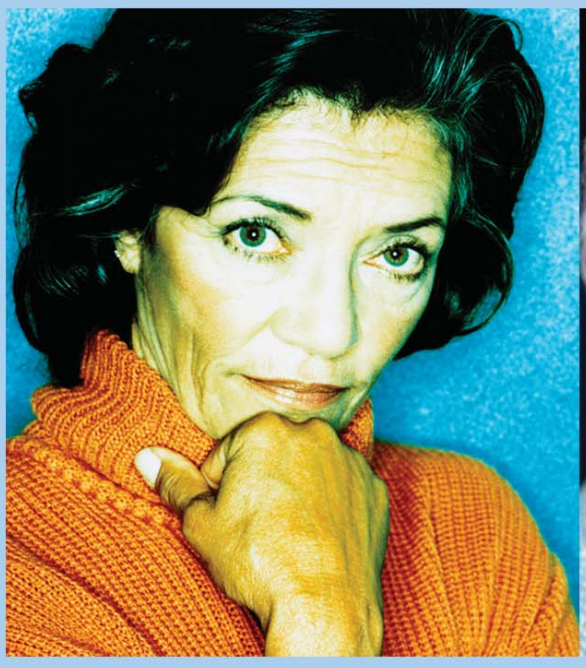
- Make early diagnosis of colorectal cancer a family issue and heighten awareness through special campaigns.
- Collaborate with diverse communities and leaders; identify what message(s) will reach different communities and cultures.
- Obtain funding to support outreach and awareness campaigns.
- Create and implement a media campaign.

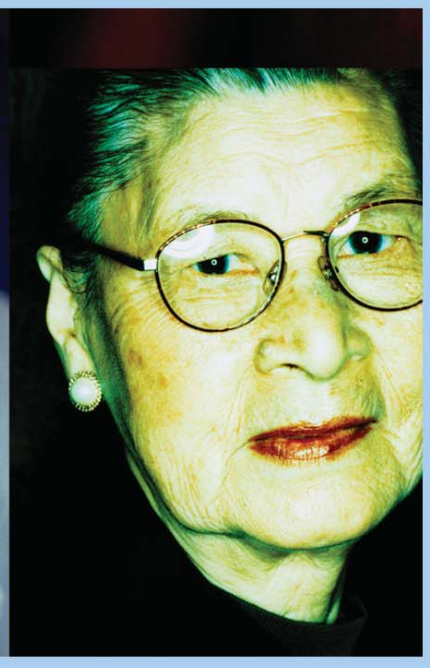
Strategy 3

By January 1, 2006, work toward universal insurance coverage for colorectal cancer screening and treatment.

- Obtain funding to support an Office of Colorectal Cancer at the DHS to provide outreach, screening, and treatment programs.
- Work to pass legislation that covers screening and treatment for colorectal cancer. At the federal level, work on supporting the passage of Comprehensive Cancer legislation.
- Develop advocacy groups to implement this strategy.

Every
24 Minutes
One California
Woman is
Diagnosed With
Breast Cancer.





Chapter VI

Breast Cancer

BREAST CANCER

GOALS

1. By 2010, reduce the mortality rate from female breast cancer in California by 36 percent, from a baseline of 130.9 deaths per 100,000 women, through early detection and treatment.
2. By 2010, advance scientific and public understanding of modifiable risk factors, how they affect the incidence of breast cancer, and how breast cancer may be prevented
3. By 2010, reduce the morbidity impact of breast cancer on short and long-term quality of life.

OBJECTIVES

1. By 2010, increase the percent of women in California age 40 and older, particularly those women over 50, who have an annual mammogram and clinical breast examination from 60 percent to 90 percent by increasing breast cancer education and access to services.
2. By 2010, increase the percent of breast cancers diagnosed at an early stage (in situ and localized) from 70 percent to 80 percent, including reducing disparities in stage of diagnosis for the insured and uninsured regardless of race and ethnicity.
3. By 2010 create new ways to continue the breast cancer mortality reduction beyond 2010 at the same rate of decline as outlined in Goal number one through research and improved detection methods.

Background and Barriers to Achieving Goals and Objectives

Breast Cancer Burden in California

Every 24 minutes one California woman is diagnosed with breast cancer (48). It is the most common cancer among women, and for California women it is the leading cause of cancer deaths in women younger than 65 year of age and the second leading cause of cancer deaths in women older than age 65 after lung cancer. Although women fear it the most, survival is excellent if this cancer is diagnosed early, that is, at the *in-situ* or localized stage.

New breast cancer cases expected in California women in 2004 will number approximately 22, 400, while expected deaths will be around 4,200. Fortunately, numbers of cases diagnosed at a late stage are declining as more cancers are detected early. About 68 percent of female breast cancers diagnosed in 1999 were discovered at an early, (*in situ* or localized) stage. The breast cancer mortality rate in 1999 (24.5 per 100,000 women) was 24 percent lower than in 1988 (32.4 per 100,000 women)(1, 48).

Disparity in Burden

African-American women are less likely to get breast cancer than non-Hispanic white women, but they are more likely to die from it. Invasive breast cancer incidence rates have increased about 20 percent for Asian/Pacific Islander women in California over the past decade (1). Clearly, the diagnosis of breast cancer at a late stage remains a particular challenge to overcome among the ethnically diverse and underinsured women in California.

Risk Factors

Women of all ages and population groups need enhanced knowledge of breast cancer risks. Although it is difficult to predict who will develop breast cancer based on exposure to various risk factors, the incidence of breast cancer increases with age and begins a steep rise after age 40. For this reason, California expects to see an increase of new breast cancer cases as "baby boomers" (individuals born between 1945-1961) grow older (1, 2).

Primary risk factors for breast cancer include:

- Age (nearly 80 percent of women first diagnosed with breast cancer are over age 50),
- A family history of breast cancer, and
- A past personal history of breast cancer.

Risk factors that we can control and that provide a basis for risk reduction strategies include:

- Obesity,
- Physical inactivity,
- Alcohol consumption (2-5 drinks per day), and
- Long-term use of hormone replacement therapy.

Other risk factors that may or may not be within our control include:

- Lack of breast feeding (every year of breast feeding reduces breast cancer risk),
- Early menarche,
- Delayed childbirth or having no children, and
- Late menopause.

Poor nutritional habits, that is, a diet low in fruits and vegetables and high in fat, and cigarette smoking are also considered possible risk factors. As with the development of other cancers that may be influenced by poor diet and physical inactivity, low SES may also play a significant role requiring a much broader societal approach (35, 36).

Other more general risks are poorly understood at this time. For example, for yet to be clarified reasons, being well educated and of higher SES appears associated with a higher risk for developing breast cancer (1). This may be due to a concomitant association with other more specific risk factors mentioned above.

We also do not know definitively whether or not a relationship between environmental exposures and the etiology of breast cancer clearly exists. A few epidemiological studies, including the Long Island Breast Cancer Study, have suggested the risk of breast cancer may increase to various extents in women after high exposure to some selected environmental carcinogens such as polycyclic aromatic hydrocarbons. Although disagreement about the role of the environment exists within the scientific and advocacy communities, this issue needs California's attention and additional research (13, 40).

Early Detection

Finding breast cancer at an early stage is key to survival. When found at the early *"in situ"* or localized stages, the five-year survival rate can be as high as 95 percent compared to 22 percent if the cancer has spread to other organs or tissues outside the breast (1).

Clinical breast examinations by a health care provider starting at age 40 (every three years for women ages 20-39 years) and annual mammograms after age 40 are recommended for early breast cancer detection (1). For women aged 40-49, the evidence that screening mammography reduces breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women.

Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit makes it difficult to determine the incremental benefit of beginning screening at age 40 versus 50. Mortality can be reduced by up to 30 percent in women age 50 and older if they are screened annually.

Screening Progress

As a result of screening, about 68 percent of female breast cancer cases diagnosed in 1999 were found at an early, localized stage (1). In 2000, 63 percent of women of screening age reported that they had a mammogram within the past year, compared to 39 percent in 1987. Examining screening rates by ethnicity has revealed that non-Hispanic white women, African American women, and Latina women, were likely to have been recently screened but that Asian/Pacific Islander women lagged considerably behind.

In 2000, reflecting a trend seen in recent years, women of poverty were almost as likely to have been screened as women from households with higher income (1). During 2000-2001, over 167,000 or 17 percent of the estimated eligible population of low-income women, largely of color, received free breast cancer screening through California's Cancer Detection Programs: Every Woman Counts (18). This marked progress is a result of the many efforts in California to reach all women for screening. (See Appendix D: California's breast cancer programs.)

Treatment, Recovery, and Quality of Life

Today there are a number of treatment options for women diagnosed with breast cancer. Options range from lumpectomy and radiation to mastectomy for local treatment, and chemotherapy and/or hormone therapy for

systemic treatment. Choice of treatment options depends on the stage of the cancer, family history, the patient's age, reconstruction consideration, available treatments close to where the woman lives, and many other factors (41).

How a woman deals with her diagnosis should be of great importance to her quality of life as is the process by which she chooses her treatment after all of the options have been explained to her. Support can be essential to help her through this stage as well as through her treatment, recovery, follow-up, rehabilitation, and the on-going care she may need for the balance of her life. Community support and education programs can also provide mechanisms that help the patient with improving or maintaining her quality of life. Breast cancer survivors, for example, can answer sensitive questions, listen to her fears and respond, discuss breast reconstruction, and help her find other needed resources.

A more global quality of life issue concerns breast cancer treatment for every woman in California. California must ensure that all women diagnosed with breast cancer have equal access to appropriate, quality, evidence-based treatment and follow-up, and that there are no disparities in treatment.

California must also ensure that breast cancer survivors receive all of the services and help they need in a culturally responsive manner. They need to be able to determine what services are available to them and then navigate the health care system for those services. This includes managing and relieving pain, easing treatment side effects, recovering with social, emotional, psychological, and spiritual assistance, and obtaining the socioeconomic support required to deal with finances, insurability, employment, transportation, and other major concerns of daily living (4).

Health care professionals and community advocates have a responsibility to see that breast cancer survivors are linked to the services they need when they need them, and if such supportive resources do not exist, to organize or create them.

Breast Cancer - Strategies and Tactics

Top Strategies to Achieve Goals and Objectives:

1. By January 1, 2006, begin to conduct statewide tracking of women's breast cancer health care.
2. By January 1, 2006, provide education for health professionals, policy makers, and consumers, including diverse populations, regarding breast cancer risk assessment and risk reduction through a variety of materials and mechanisms developed to increase cultural competency and communication skills.
3. By January 1, 2006, develop a coordinated system and resources to provide access for patients to breast cancer detection, diagnosis, and treatment services which ensures quality of life throughout the continuum of cancer care including recovery and palliative care.

Additional Strategies:

- Facilitate access to Medi-Cal and Medicare for those individuals who are uninsured and diagnosed with breast cancer.
- Work to achieve universal healthcare.
- Provide paid advertising to promote the public's awareness of the importance of breast cancer early detection.
- Increase reimbursement for all aspects of breast cancer screening, diagnosis, and treatment.
- Increase research to identify modifiable risk factors for breast cancer.

- Develop evaluation capacity to measure progress in meeting breast cancer plan goals and objectives.
- Obtain increased funding for breast cancer research in California.

Tactics for Implementing the Top Strategies:

Strategy 1

By January 1, 2006, begin to conduct statewide tracking of women's breast cancer health care.

- Map the stage of breast cancer diagnoses and number of cases to identify high need areas based upon stage at diagnosis, mortality, and ethnicity, etc. Map supporting resources and services related to the continuum of cancer care. Resources should include all providers and support services for all women.
- Develop and fund a statewide, comprehensive database with patient demographics, containing information on CBE, mammography, ultrasound, and biopsies in women age 40 years and older, and correlate this data base with the census. Provide statewide and local data identifying all screening and diagnostic services. Identify geographic areas with gaps in services and resources.

Strategy 2

By January 1, 2006, provide education for health professionals, policy makers, and consumers, including diverse populations, regarding breast cancer risk assessment and risk reduction through a variety of materials and mechanisms developed to increase cultural competency and communication skills.

- Promote participation of health educators in the DHS' Cancer Detection Section's Professional Education Module, "Healthcare Providers and Women: Partners in Communication." Provide professional education to improve sensitivity and communication skills and cultural competency through medical school curricula and as part of continuing education requirements for state licensure.
- Disseminate the course, "Clinical Breast Examination: Proficiency and Risk Management," developed by the Cancer Detection Section at the DHS, to all medical schools, nurse practitioner schools, and physician assistant schools in California for use in their respective educational programs.
- Educate medical professionals treating breast cancer to treat patients following evidence-based medicine and provide access to clinical trials to all patients, even if his or her facility does not offer the particular trial.
- Continue to fund the DHS to develop statewide educational and outreach materials. Disseminate this information through a variety of media and venues.
- Identify and/or develop age, literacy level, culturally, and linguistically appropriate breast cancer-related outreach and educational materials. Create a clearing house of these materials in order to compile California-produced resources and linkage to national resources.

Use a wide variety of distribution methods to disseminate.

- Provide a directory via an 800 number and on the web with the location of all resources and services available to all women statewide and locally.

The directory should include information gathered by the following:

1. Cancer Detection Programs: Every Woman Counts
   Regional Cancer Detection Partnerships,
2. The National Cancer Institute,
3. The American Cancer Society
4. Medi-Cal
5. Community health clinics
6. Women's health organizations
7. Other relevant organizations.

Information provided should include:

1. Comprehensive cancer centers serving California,
2. Resources and services by county, and
3. Community services and organizations.

- Fund and partner with the CCR to provide statewide and local data on stage at diagnosis and identify areas with high incidence of late stage at diagnosis.
- Develop a cancer orientation packet containing information for lawmakers, policy makers, and community providers that covers the statewide issues regarding breast cancer and also covers issues specific to represented areas.
- Identify guidelines and quality bench marks for early detection, diagnosis, and treatment.
- Educate providers and consumers on available clinical trials for treatment as well as risk reduction.
- Educate consumers and providers about pharmacological agents, such as tamoxifen, that have shown promise in reducing breast cancer risk, and include the considerations involved in deciding whether to use them.
- Provide health professionals and consumers with information regarding the location and availability of centers that can provide an enhanced complexity of care for cancer treatment.

Strategy 3

By January 1, 2006, develop a coordinated system and resources to provide access to breast cancer detection, diagnosis, and treatment services which ensures quality of life throughout the continuum of cancer care including recovery and palliative care.

Develop and provide resources for a high quality, coordinated system of networks that:

- Makes high quality entry-level screening services widely and easily accessible statewide in the communities where women live,
- Provides referral and ensure access to progressively more complex levels of high quality care when needed for subsequent diagnostic evaluation, treatment, and/or supportive care, and
- Deploys resources optimally to fill gaps in communities where there is insufficient entry level screening and referral capacity and to fill gaps or eliminate redundancies in regional capacity for more complex care.
- Encourages collaboration among DHS, voluntary and community organizations, community clinics, medical professionals, and medical schools in all counties to increase efficiency of services provided.

- Provides a structure and process to identify and ensure appropriate care or referral for early detection, diagnosis, and treatment to include symptom control, amelioration of pain, rehabilitation, and reduction in the side effects of treatment based upon an appropriate care plan using uniform standards of care.
- Establish a network for appropriate interventions, such as advocacy, referral and education to address financial, employability, and insurability issues, and access to treatment and follow-up care.
- Establish a network to provide appropriate care or referral to services and support groups, such as those provided by ACS, the wellness community, hospice services, and others for identified psychological, emotional, and spiritual problems or needs.
- Enhance the existing system of networks to include all Medi-Cal physicians. The system should work closely with community organizations to provide patient navigation systems and education.
- Identify areas of need for indigenous patient navigators and train them for culturally specific outreach and patient interaction.
- Lobby local, state, and federal governments and health insurance carriers to increase funding for early detection, diagnosis, and treatment of breast cancer.

Chapter VII
Prostate Cancer

PROSTATE CANCER

GOALS

1. By 2010, reduce the prostate cancer mortality rate of California men, including men in high-risk groups, by 23 percent, from a baseline of 27.6 deaths per 100,000 men.

2. By 2010, improve the quality of life of men with prostate cancer and their families while creating measures to monitor and evaluate quality of life improvement.

OBJECTIVES

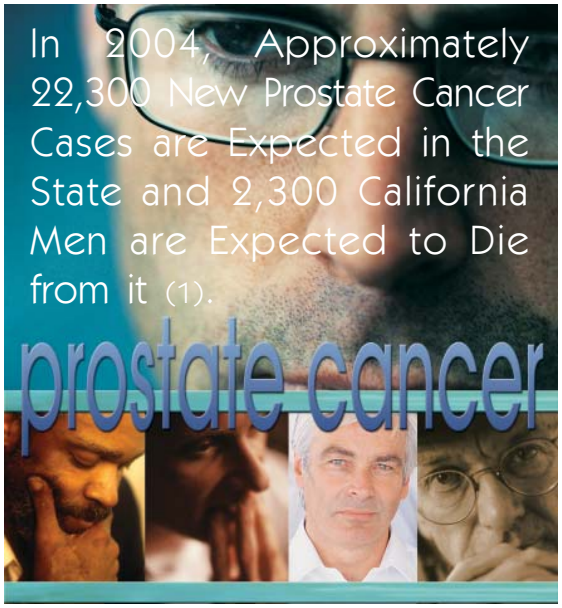
By 2010, provide all California men diagnosed with prostate cancer timely access to treatment programs and information that will help them make an informed choice among treatment options, including the risks, benefits, and the impact on their quality of life.

Background and Barriers to Achieving Goals and Objectives

Burden of Prostate Cancer

Prostate cancer is the most commonly diagnosed cancer in California excluding skin cancer. Among California men it is the second most common cause of cancer-related death.

Prostate cancer is common, but the five-year survival rate can be relatively high (at 98 percent) as reflected in data from the 2002 NCI Surveillance, Epidemiology, and End Results (SEER) program. The prostate cancer mortality rate has dropped 20 percent over the past five years, even among African American men who are hit the hardest by this disease. The reason for the 20 percent decline in prostate cancer deaths over the past five years is unclear, although it has



been suggested that the previous successful efforts at early detection of prostate cancer may be a contributing cause (1, 48).

Producing a 23 percent reduction in the prostate cancer mortality rate by the year 2010 is definitely a challenge. There are many factors that affect this mortality rate:

- Lack of prevention information,
- Lack of a comprehensive early detection program and consistent message,
- Treatment of late stage and disseminated cancers is frequently ineffective,
- Lack of universal access to treatment, and
- Because prostate cancer can be both slow growing and aggressive in nature, the results of treatment and research take years to assess.

Each of these factors needs to be addressed in order to lower the mortality rate of prostate cancer by 2010 and beyond.

Men at Risk and Disparity in Burden

About 75 percent of prostate cancers are diagnosed among men age 65 and older with a median age at diagnosis of 71 years. Only about 12 percent of the U.S. population is age 65 years and older, but as the population ages, this proportion will increase as will the number of prostate cancer diagnoses (1, 45).

African-American men experience by far the highest incidence of prostate cancer of any ethnic group, and are diagnosed at a younger age and later stage of the disease compared to other racial ethnic groups. Although they have seen a 20 percent decline in mortality, they are 65 percent more likely to develop this disease than non-Hispanic white males, twice as likely as Hispanic/Latino men, and three times more likely than Asian/Pacific Islanders (1) .

The precise underlying causes of prostate cancer are unknown, but may involve diet, lack of physical exercise, and other lifestyle factors when one looks at differences among cases and the general population worldwide (45).

Screening and Early Detection

In the 1990s, the incidence of prostate cancer increased significantly with the introduction of the prostate-specific antigen (PSA) test that led to an increase in diagnoses. As a direct result of this, incidence rates rose dramatically and peaked in 1992-1993 when the PSA test became more widely used. Rates have decreased since then and are now relatively stable. In all probability, the rise of incidence is attributable to increased screening versus increased risk of the disease (48). Thus the rise in incidence was, in effect, largely a screening artifact.

In 2001, 75 percent of men 50 years of age and older reported having had at least one PSA test. Most of these men were African American and non-Hispanic white men as opposed to Hispanic/Latino and Asian American men. Household income, however, played a discriminating role. Men of all ethnic groups, including non-Hispanic white men, from households above 200 percent of the federal poverty level were more likely to have had a PSA test than men from households below the poverty level (1).

The ACS suggests that men at high risk, such as those with a family history of prostate cancer (two or more affected first-degree relatives) and African American men, get a PSA test and digital rectal examination (DRE) every year beginning at age 45. Other lower risk men need to tailor their screening needs in consultation with their primary care physician.

The Prostate Screening Dilemma

The literature does not clearly establish (using randomized clinical trial data as the gold standard) whether a decrease in mortality from prostate cancer occurs with screening by DRE or the PSA test. Thus, the issue of screening remains controversial, particularly for asymptomatic men.

In 2002, the U.S. Preventive Services Task Force stated that the evidence is insufficient to recommend for or against routine screening for prostate cancer using the PSA test or DRE (46). The apparent value of the PSA test is in its simplicity, objectivity, reproducibility, lack of invasiveness, and relatively low cost.

Despite this prostate screening dilemma, a great deal of screening for prostate cancer is occurring and, therefore, the discrepancy between the state of the science and the state of the practice needs to be reconciled in some rational fashion. The state of the practice regarding prostate cancer screening by PSA unfortunately exceeds what perhaps can be justified by the state of the science.

Treatment

The ability to diagnose prostate cancer is a mixed blessing. Even though it can now be identified early in the course of the disease in some cases, the options for treatment may or may not result in an increase in a man's life span, and may significantly affect his quality of life.

The most common treatments for prostate cancer are surgery, radiation, and hormone therapy. There are also other treatments including cryosurgery and "expectant therapy" (watching and waiting). Treatment, however, depends on age, stage of the cancer at diagnosis, and other medical conditions of the patient as well as his quality of life concerns.

A major problem that accompanies a diagnosis of prostate cancer is the array of treatment options from which a man must choose. At diagnosis, men are often not given complete, unbiased and accurate information about the benefits and risks of their treatment options and the potential impact on their quality of life. This lack of benefit vs. risk translation may leave men confused and feeling a loss of control over their lives and their future (51).

Unfortunately, treatment options presented to a man often reflect the biases of the physician he happens to see first. Men newly diagnosed need a coordinated multidisciplinary approach with treatment options and their rationale presented openly, objectively, and in a forthcoming manner. Optimally his partner should be included in the discussion. Ultimately, the man should be the one who makes a truly informed decision.

Quality of Life

Although many men may be ill-informed about their treatment options, this can and should be changed. Serious quality of life issues that can emerge with some of the treatments include issues of diminished sexuality, impotence, incontinence, and other side effects. These must be addressed with sensitivity - both culturally and otherwise - and include the men's partners and families as well.

Men also need consistent help to navigate the health care system and to obtain the necessary resources for themselves and their families that can support a good quality of life from diagnosis through the balance of their lives (4). The Man to Man program of ACS and Us Too! are good examples of community support programs that offer men and their families the opportunity to speak openly with each other and with health professionals.

Finally, the burden of pain, its management, and its relief are other major quality of life components that must be an integral part of any cancer care from diagnosis thorough end of life care (4). This is a particularly salient concern for advanced prostate cancer, because bone is the most common metastatic site and presents major pain management issues. The ACS estimates that one-third of people living with cancer suffer needlessly from significant pain. This too can and must change.

Prostate Cancer - Strategies and Tactics

Top Strategies to Achieve Goals and Objectives:

1. By January 1, 2006, educate the public, health professionals, and policy makers regarding major issues relating to prostate cancer including its risks, treatment options and associated quality of life issues, fears, beliefs and perceptions about the cancer and its treatment, lack of trust in the health care system among diverse groups, the need for easier access to prostate cancer detection and care, and lack of accurate, unbiased information conveniently accessible to men within and outside the health care system.
2. By January 1, 2006, increase state funding for prostate cancer research that includes basic, translational, clinical, health services, quality of life, and outcomes research.
3. By January 1, 2006, ensure consistent funding of existing prostate cancer mandates and programs for the low income, uninsured, and underinsured, and ensure that programs are culturally and linguistically appropriate for ethnic communities.

Additional Strategies:

- By January 1, 2006, encourage and support collaborative prostate cancer research among California cancer centers.
- Encourage state provision/coordination of universal health care coverage for prostate cancer detection, diagnosis, treatment, recovery, and palliative care. This should be part of a larger effort to provide universal health care coverage for all Californians.
- The same prostate cancer treatment should be available to all California men regardless of their insurance coverage.
- Encourage multidisciplinary evaluation of prostate cancer patients.
- Provide supportive interventions that include partners as part of disease management.
- Bolster the CCR financially to obtain additional data about prostate cancer to aid decision-making and priority setting.
- Develop a more comprehensive system to help prostate cancer patients navigate through the health care system and obtain resources for their own care and needs.
- Encourage healthy diet and physical activity to help prevent prostate cancer.
- Coordinate collaboration among prostate cancer volunteer organizations.
- Create a statewide comprehensive prostate cancer resource guide.

Tactics for Implementing the Top Strategies:

Strategy 1

By January 1, 2006, educate the public, health professionals, and policy makers regarding prostate cancer including its risks, treatment options and quality of life, fears, beliefs and perceptions about the cancer and its treatment, lack of trust in the health care system among diverse groups, the need for easier access to prostate cancer detection and care, and lack of accurate, unbiased information conveniently accessible to men within and outside the health care system.

- Develop a unified and uniform message on prostate cancer to distribute to health professionals in California.
- Provide information and education to patients through NCI's Cancer Information Service and the ACS's National Cancer Information Center.
- Develop a unified and uniform message on prostate cancer to distribute to public policy makers in California
- Work with the American Board of Family Practice to educate primary care physicians about prostate cancer.
- Encourage the DHS to develop a media campaign, culturally sensitive to all, about prostate cancer education.
- Incorporate prostate cancer information in material provided to women about breast cancer.
- Encourage collaboration among those groups interested in the disease to disseminate information about the prostate cancer.
- Provide education about successful outcomes and treatment for localized prostate cancer.
- Involve prominent figures, especially those with prostate cancer, to reach the public, e.g., George Foreman - "Real Men Get It Checked" campaign.

Strategy 2

By January 1, 2006, increase state funding for prostate cancer control research that includes basic, translational, clinical, and health services, quality of life, and outcomes research.

- Restore funding for the California Department of Health Services Cancer Research Program. Seek funding for the infrastructure to implement the comprehensive cancer control plan.
- Highlight the deficiencies in our knowl edge of prostate cancer to policy makers.
- Identify and aggressively seek funding from private sources for prostate cancer research and education.
- Encourage organizations like the ACS to provide targeted research funding for prostate cancer.
- Create an entity dedicated to raising funds for prostate cancer like the Susan G. Komen Foundation for breast cancer.
- Seek state funding to bring California comprehensive and clinical cancer centers together and formulate a plan for collaboration.

Strategy 3

By January 1, 2006, ensure consistent funding of existing prostate cancer mandates and programs for the low income, uninsured, and underinsured.

- Restore adequate funding for the state's Prostate Cancer Treatment Program, IMPACT: Insuring Access, Counseling and treatment for Californians with Prostate Cancer.
- Adequately fund existing prostate cancer mandated programs for the low income, uninsured, and the underinsured.

Chapter VIII
Lung and Oral Cancer and Tobacco Control

LUNG AND ORAL CANCER AND TOBACCO CONTROL

GOALS

By 2010, accelerate significantly the rate of decline of lung and oral cancer mortality by preventing tobacco use, helping smokers and users of spit tobacco to quit, and diagnosing lung and oral cancer at an earlier, potentially more curative stage.

OBJECTIVES

1. By 2010, decrease the smoking prevalence rate in adults ages 18 and older from 16.6 percent in 2000 to 10 percent.
2. By 2010, decrease the smoking prevalence rate in youth ages 12 to 17 years from seven percent to four percent.
3. By 2010, decrease exposure to secondhand smoke to 10 percent or less of the California population.
4. By 2010, double the percentage of lung cancer diagnosed in California at Stage 1A.

Background and Barriers to Achieving Goals and Objectives

Lung Cancer Burden in California

Lung cancer is by far the leading cause of cancer deaths in California and is the most preventable. Smoking is responsible for approximately 85 percent of lung cancer deaths and 30 percent of all cancer-related deaths (1, 19, 48). Lung cancer alone kills about 14,000 Californians each year, more than prostate, breast, and colorectal cancers combined.

One-year survival rates for lung cancer increased from 34 percent in 1975 to 41 percent in 1996, largely due to improvements in surgical treatments. The five-year survival rate for all stages of the cancer combined, however, is only 15 percent. If the cancer is caught while still localized, the five-year survival rate is 48 percent, but few cases are discovered that early (1). This fact underscores the need to identify lung cancer at a much earlier stage.

Fortunately, fewer men are dying than in earlier years. From 1988 to 1999, lung cancer mortality dropped 30 percent for males in California (48). Though the mortality rate for women is also now beginning to decline, this delay is an unfortunate reflection of the historical gender difference in the uptake of smoking.

Women, for example, started smoking in the 1930s and 1940s, about 20 to 30 years later than men. Declines in lung cancer mortality among both men and women are expected to continue along with declines in smoking prevalence.

Overall, lung cancer incidence in California declined 22.3 percent from 1988 to 1999. This decline may likely be a good predictor of future potential reductions in lung cancer incidence and mortality elsewhere in the U.S. During that same time period, the U.S. lung cancer incidence rates declined by only 4.7 percent (1).

In 2002, 16.6 percent of California adults still smoked. However, 18 to 24 year olds are smoking at increasing rates and are now recognized as the growing age group using tobacco. Tobacco companies target them in earnest as the "Smokers of the Future (19)."

Efforts to decrease lung cancer mortality must also include protection of non-smokers from secondhand smoke (SHS). Cancers causally associated with exposure to SHS include lung and nasal-sinus cancer, and also breast cancer to a lesser extent (61).

Early Detection of Lung Cancer

Although there are no Food and Drug Administration (FDA) approved screening tests for lung cancer at this time, the spiral CT scan is under investigation by the NCI in a large clinical trial to determine its efficacy. The spiral CT scan involves a process by which a sensitive imaging device rotates around the body to detect small tumors that can be missed by chest x-rays.

Many questions exist about the spiral CT scan such as its cost-effectiveness, its use as a population-based screening tool, and its benefit in treatment outcomes, particularly when programs to prevent or stop smoking yield better results in lowering lung cancer mortality. The National Cancer Institute trial will hopefully answer important questions about this test.

Lung Cancer Treatment and Quality of Life

Symptoms of lung cancer include persistent cough, sputum streaked with blood, chest pain, and recurring pneumonia or bronchitis. Treatment is determined by the type and stage of the cancer and includes surgery, radiation therapy, and chemotherapy. Surgery is often the treatment of choice for many localized tumors. If the cancer has spread by time it is detected, then radiation therapy and chemotherapy are often used in combination with surgery. Each treatment may have adverse effects that can last a short time or be permanent. Before treatment, health care providers can help patients be aware of side effects so that steps can be taken to prevent or ease the effects and/or shorten their duration (7).

Quality of life issues associated with lung cancer treatment include not only a relief of side effects, but that all patients receive appropriate quality treatment and follow-up with no disparities in treatment outcomes. Patients and their families should receive help to navigate their health care system, to find the resources and services that match their needs, and to receive accurate, complete, and culturally competent information. Education and compassionate support must go hand-in-hand with treatment to reduce fear and enlist the patient as a partner in his or her own care (4).

Other factors affecting quality of life can positively affect how the patient copes with the cancer. These include the health of the patient's immune system, a history of good nutrition, strong family support, and spiritual faith. Counseling regarding nutrition, exercise and rest, psychosocial issues, estate planning, and any other patient and family concerns is also critical to the patient's quality of life, as are local support groups for emotional support, friendship, and understanding.

Finally, relief from pain and dyspnea must also be managed as much as possible in patients' treatment, follow-up, and palliative care so that they have greater physical comfort in dealing with the balance of their lives (4, 7).

Oral Cancer Burden in California

In 2004, oral or pharyngeal cancers will be diagnosed in an estimated 3,150 Californians and are expected to cause about 830 deaths. More than 90 percent of these cancers are squamous cell carcinomas - cancers of the epithelial cells. The most common oral sites are on the tongue, lips, and floor of the mouth. Oral cancer is the seventh most common cancer in California males and takes a disproportionate toll on minorities.

The life of each person with oral or pharyngeal cancer is shortened by an average of 16.5 years. The median age at diagnosis is 64, and the rate of occurrence increases with age. More than 95 percent of oral cancers occur in individuals aged 35 and older.

According to the CDC, only about half of people with oral or pharyngeal cancer survive more than five years. If oral cancer is detected early, the five-year survival rate is 81.3 percent; however, only 35 percent of persons with oral and pharyngeal cancers are diagnosed at an early stage. The five-year survival rate drops to 21.6 percent among people diagnosed with advance stage cancer. Compared to persons with other types of cancer, oral and pharyngeal cancer survivors have the highest rate of developing new cancers in the mouth or other parts of the body (55).

Early Detection of Oral Cancer

At present, the principal diagnostic test for oral and pharyngeal cancer is a comprehensive

clinical examination that includes a visual/tactile examination of the mouth, full protrusion of the tongue with the aid of a gauze wipe, and palpation of the tongue, floor of the mouth, and lymph nodes in the neck. The U.S. Preventive Services Task Force concluded that there was insufficient evidence to recommend for or against routine screening for oral cancers, but noted that clinicians should remain vigilant for signs and symptoms or oral cancer and premalignancy in people who use tobacco or regularly use alcohol.

The Canadian Task Force on Periodic Health Examination states that although there is insufficient evidence to include or exclude screening for oral cancers from the periodic health examination of the general public, those at high risk - smokers and heavy drinkers over 60 years of age, warrant an annual oral cancer examination by a physician or dentist (31).

A relatively new diagnostic procedure in dentistry is the use of the oral brush biopsy to identify oral lesions that may need further evaluation. The oral brush biopsy is minimally invasive, requires no anesthesia, and definitively distinguishes benign from pre-cancerous and cancerous lesions (31).

Oral and Pharyngeal Cancer and Tobacco Use

Smoking and the use of chew or spit tobacco are devastating to the mouth and throat and combined with alcohol are particularly deadly. Tobacco and alcohol, working in tandem, are thought to account for 75 to 90 percent of all oral and pharyngeal cancers in the U.S. This combination damages cells in the lining of the mouth and throat - cells that must now grow rapidly to repair the damage. Not only do the chemicals in tobacco damage DNA, but alcohol also helps this process by aiding chemical penetration (6).

Use of chew or spit tobacco puts one at high risk for lip, tongue, and other oral cavity cancers. In California in 2001, 10.5 percent of middle and high school students under the age of 18 were current users of chewing tobacco (19). Tobacco industry marketing practices and poor role modeling by sports figures have particularly had their impact on teen males. In California, however, the state's Tobacco Control Program appears to have had an effect on spit tobacco use among adolescent boys. In 1999, their spit tobacco use was at only one-third of the level seen in 1993.

Treatment of Oral Cancer and Quality of Life

Although a number of treatment and quality of life issues for oral cancer patients are comparable to those discussed for lung cancer patients, the effects of surgical treatment of oral cancer may have uniquely adverse impacts on quality of life in terms of facial disfigurement and interference with speech and mastication. At the same time, treatments have improved. Patients who once would have been left with difficulty speaking, eating, and swallowing now are candidates for reconstructive surgery that leaves them less visibly scarred and more able to function normally. Most mortality due to oral cancer today is due to either a second primary cancer or to a spread of the cancer (31).

Palliative care with relief from pain and suffering and comprehensive support to address the needs of oral cancer patients, their families, and their culture are essential to maintain a good quality of life. Patients dealing with disfigurement associated with radical surgical procedures also require support such as prosthetics and cosmetic enhancements as well as support groups.

California's Tobacco Control Program

Cigarette addiction is extremely powerful. In 1999, 61.5 percent of adult California smokers

reported that they had tried to quit in the previous 12 months (19). Over the years, tobacco companies have cleverly engineered the cigarette to achieve its highly addictive properties (61). Tobacco companies and their allies continue their work as agents of lung cancer through predatory marketing practices and relentless efforts to thwart California's highly acclaimed anti-tobacco program. These efforts include time-consuming lawsuits that question the ability of the Tobacco Control Program to implement the programs that have been the will of the people of California and are required by legislation.

Californians have worked hard to achieve the lowest cigarette smoking prevalence rate in the nation next to Utah, reaching a low of 16.6 percent of adults who smoked in 2002 (19).

A vast network of partnerships and programs across the state from local and state level public health, government, business, labor, managed care, media, and academic sectors are a potent force to counter tobacco industry efforts and to decrease tobacco use. California's tobacco control efforts have been immensely successful. Two crowning achievements have been smoke-free environments in all California indoor worksites, including bars, and the unacceptability or denormalization of tobacco use throughout the state (22, 23).

California's smoke-free environments, a model for the nation, have had a multi-pronged impact. They not only protect adults and children from a highly carcinogenic substance, but also protect workers, reduce cigarette consumption, and provide a supporting environment for smokers trying to quit. Adult per capita consumption alone has decreased over 50 percent since the passage of Proposition 99 to a low of about 48 packs per capita in Fiscal Year 2001-2002.

Many challenges still remain. Adult tobacco use rates still must come down sharply to curtail thousands of preventable tobacco-related deaths. Currently, there is great hope for youth as their smoking prevalence rates have fallen significantly, helped by the 50-cent tobacco tax increase in 1999. From 1991-1999, California's youth smoking rates have fallen faster than anywhere else in the nation (21).

However, there is another side to this coin. CDC estimates that in the U.S., the average 14-year-old has been exposed to more than $20 billion in imagery advertising and promotions since age six, creating a "friendly familiarity for tobacco products (62)." In addition, there are still priority populations, including youth and adults, that are still being targeted by the tobacco industry and whose smoking rates are still high.

This is what California is up against.

Costs of Smoking

Smoking costs Californians dearly. Besides shortening the average smoker's life by over 15 years or more, smoking costs the state $15.8 billion per year or $475 per man, woman, and child in California (42). Over half that amount - $8.6 billion - goes toward annual smoking-health care costs. Previous research suggests 43 percent of direct costs are borne by publicly funded health care programs. The remaining costs are attributed to lost productivity associated with illness and premature death. If these figures are compared to the $3.8 billion Californians spent on cigarettes in 1998-1999, the tobacco industry wins and California loses.

Disparity of Burden and Addiction to Tobacco

The state's diverse populations have not escaped Big Tobacco. Despite significant decreases in

smoking among Californians overall, new data show smoking prevalence remains high among California's ethnic and gay and lesbian communities. During much of the 1990s, the percentage of adult smokers was highest for African Americans, particularly men.

Many of the state's immigrant populations, especially males from Asian countries, have brought their tobacco addiction with them, adding to California's prevalence rates. Lung cancer is the most common cancer among Cambodian and Vietnamese males living in California (1). Considering the States' many ethnic groups and particularly the diversity among Asian/Pacific Islanders, a great deal more data are needed to track smoking prevalence successes and failures among these specific populations.

Until recently little data were available on American Indians. The continuing collection and analysis of data on an American Indians will help to build successful programs. We do know that lung cancer is the most common cancer among American Indian males who have high smoking rates.

Additionally, little data have historically been collected on smoking prevalence for gay, lesbian, bisexual, and transgender (GLBT) populations, as they are increasingly victimized by tobacco industry marketing. Low socio-economic status (SES) and education are also a concern as the uninsured and Medi-Cal recipients have smoking rates twice that of the privately insured (31).

According to the 2001 California Health Interview Survey (CHIS), conducted by the Center for Health Policy Research at the University of California, Los Angeles, gays and lesbians had a combined smoking prevalence of 30.8 percent, followed by American Indians (30.3 percent), African Americans (20.6 percent) and non-Hispanic whites (18.1 percent). Smoking prevalence was 21.4 percent among Asian males and 19.5 percent among Hispanic/Latino males. According to the survey, smoking prevalence was 14.6 percent for Asians, but there was a major difference between males and females. Smoking prevalence was 21.4 percent for Asian males compared to 7.8 percent for females. Among Pacific Islanders, smoking prevalence was 32.3 percent for males and 21.4 percent for females (31).

Culturally-specific tobacco use prevention services are critical to reduce smoking prevalence in these communities. A one-size-fits-all approach is not an effective means to create behavior change. Over 52 percent of California's residents are represented in our state's non-white communities, and are at risk for being negatively impacted by tobacco use. California needs to continue to conduct surveillance activities on major population groups and determine which interventions are the most effective at decreasing tobacco use in these groups.

Cigars

Cigars are definitely not a safe alternative to cigarettes. Cigar smokers have a four to ten times higher risk of dying from laryngeal, oral, and esophageal cancers than non-smokers. In addition, men who smoke five or more cigars a day are three times more likely to die of lung cancer than non-smokers. Deeper inhalation can increase that risk (20).

Cigars are not overlooked in California's Tobacco Control Program. Cigars pack a terrific nicotine wallop - one cigar can deliver up to 70 times more nicotine than a cigarette. Young white adult males aged 18 to 24 years are the most common users of cigars. Their cigar smoking prevalence rate in 1998 was as high as 17.2 percent. Consequently, California launched its

cigar campaign mainly targeting this group on college campuses, in cities, clubs, and events where young, more affluent men congregate. In 2002, current cigar use prevalence among adult men was 8.2 percent and among women was 1.3 percent. The overall prevalence rate of cigar smoking in 2002 was 4.7 percent of California adults (20).

Lung and Oral Cancer - Strategies and Tactics

Top Strategies to Achieve Goals and Objectives:

1. Prevent or control tobacco use by funding and implementing the Tobacco Education and Research Oversight Committee Master Plan to strengthen the California Tobacco Control Program structure (community-based and school-based programs and tobacco-related disease research).
2. Integrate evidence-based and efficacious smoking and smokeless tobacco cessation services into the state's school systems, community-based organizations, public health programs, and health care plans and institutions.
3. Improve current and develop new technologies for screening, early diagnosis, and treatment of lung, oral cancer, and other tobacco-related cancers (e.g. cervical, stomach, pancreatic), and improve the quality of life measures at all stages of the patient's health care and balance of life.

Additional Strategy:

- Prevent or stop the use of spit tobacco through a public education campaign that shows the dangerous link between use of tobacco with alcohol and an increase in public demand for oral cancer examinations.

Tactics for Implementing the Top Strategies:

Strategy 1

Prevent tobacco use by funding and implementing the Tobacco Education and Research Oversight Committee Master Plan to strengthen the California Tobacco Control Program structure.

- By January 1, 2006, augment the Tobacco Control Program's budget by $200 million.
- By January 1, 2006, recommend that the California Legislature increase the tobacco tax with an earmark for California's Tobacco Control Program to increase the cost of tobacco products and generate funds for tobacco-use prevention and control programs and tobacco-related cancer research. Educate the Legislature that even though consumption may be declining, more resources are needed to prevent and control tobacco use due to the tobacco industry's continuing marketing and promotion efforts.
- By January 1, 2006, strive to eliminate disparities in tobacco control by funding more programs, surveillance, and research for California's varied racial and ethnic groups and other priority populations (GLBT, low-SES, etc.)
- Increase surveillance capacity by increasing funding of the CCR from non-Proposition 99 sources to compile and track tobacco-related data on Asian/Pacific Islander and American Indian populations.
- Decrease exposure to SHS in all enclosed workplaces, outdoor working environments, entertainment venues, and homes by continuing to educate Californians about the dangers of SHS and by implementing progressive policies that protect all Californians where they live, work, and play.

- Initiate policy efforts to regulate the tobacco industry and the sellers of tobacco products and their influence. Polices should include:
  1. Requiring tobacco retailers to obtain a license to sell tobacco that can be suspended or revoked if they sell tobacco to children,
  2. Prohibiting tobacco industry sponsorship and advertising at community entertainment, and sporting events, and
  3. Asking elected officials not to accept tobacco industry campaign contributions and publicize those who do.
- Increase the enforcement of tobacco control laws (i.e., sales to minors, smoke-free workplaces) by specifically earmarking funding for local law enforcement agencies and providing training and technical assistance.
- Encourage more professional organizations to make tobacco control a priority.
- Hold state and county First Five Commissions accountable for their mission by allocating substantial resources to programs in conjunction at DHS Tobacco Control Section.

Strategy 2

Integrate evidence-based and efficacious smoking and smokeless tobacco cessation services into the state's school systems, community-based organizations, public health programs, and health care plans and institutions.

- By January 1, 2006, increase funding of diverse community-based organizations to address cessation in a culturally and linguistically appropriate manner.
- By January 1, 2006, increase the level and capacity of cessation services to assist tobacco users in diverse communities and in a variety of languages and methods.
- By January 1, 2006, encourage health care providers to assess patient tobacco use and exposure to second hand smoke status routinely and to provide assistance and referral to evidence-based and efficacious cessation services.
- By January 1, 2006, advocate for evidence-based and culturally linguistically appropriate cessation counseling coverage as a core benefit of health insurance plans.
- Fully implement "Tobacco as a Vital Sign" in all patient visits.
- Continue to publicize the services provided by the California Smokers' Helpline and encourage tobacco users to use its free services.
- Require the California Department of Managed Health Care to make evidence-based best practices for tobacco use services a required component of man aged health care plans.
- Increase funding for research on tobacco-use cessation strategies for priority populations that include racial and ethnic groups, GLBT, teens, hard-core smokers and other tobacco users, and those individuals with low SES, and Medi-Cal and Healthy Families enrollees.
- Support research to uncover the barrier to cessation counseling and services by health care providers. Support the provision of cessation facilitator trainings in health and social service organizations.
- Support programs that strive to engage health care providers in cessation counseling and referrals.
- Assure that tobacco use cessation is included in the Health Plan Employer Data and Information Set.

Strategy 3

Improve current and develop new technologies for screening, early diagnosis, and treatment of lung, oral cancer, and other tobacco-related cancers (e.g. cervical, stomach, pancreatic), and improve the quality of life measures at all stages of the patient's health care and balance of life.

- By January 1, 2006, improve access to quality lung and oral cancer treatment and palliative care for all patients.
- By January 1, 2006, increase research to improve and expand upon quality of life for lung and oral cancer patients.
- Identify and bring together national and California organizations and researchers who perform or other wise have an interest in spiral CT scans as an efficient community screening methodology in California. Determine screening and infrastructure guidelines based on results of the NCI spiral CT scan clinical trial when it is completed.
- Advocate for insurers to cover lung cancer screening methods that are recommended by the ACS.
- Encourage participation of diverse populations in clinical trials dealing with lung and oral cancer.
- Encourage additional studies within the National Institutes of Health that look at biomarkers as cancer detection tools.
- Encourage research and clinical trials to improve treatments for oral and lung cancers.
- Increase health care coverage of experimental treatments.
- Encourage increased sampling of the environment for radon and asbestos exposure, where appropriate.

Chapter IX
Nutrition, Obesity, Physical Activity, and Cancer

NUTRITION, OBESITY, PHYSICAL ACTIVITY, AND CANCER

GOALS

1. By 2010, change the environmental and societal norms in California to those of healthy eating and physical activity.
2. By 2010, arrest the upward obesity and overweight trends by increasing physical activity, consumption of fruits and vegetables and reducing caloric intake among Californians.
3. By 2010, reduce the 2001-2002 prevalence rate of obesity among California adults from 19.9 percent to 14 percent.
4. Reduce the 2001-2002 prevalence rate of overweight among California adults from 54.4 percent to 40 percent.
5. By 2010, reduce the prevalence rate of overweight and obese children from 34 percent in 1999 to 14 percent.
6. By 2010, reduce the prevalence rate of at-risk and overweight teens from 25 percent in 2000 to 17 percent.

OBJECTIVES

1. By 2010, increase the proportion of adults who consume at least 5 servings per day of fruits and vegetables from 32 percent in 2001 to 45 percent.
2. By 2010, increase the proportion of all teens, ages 12 to 17 years, who consume at least 5 servings of fruits and vegetables from 44 percent in 2000 to 58 percent.
3. By 2010, increase the proportion of children, ages 9 to 11 years, who consume at least 5 servings of fruits and vegetables from 20 percent in 1999 to 30 percent.
4. By 2010, decrease the consumption among children, teens, and adults of high calorie, low nutrient foods (soft drinks, fried snacks, and sweet desserts) by 30 percent, 15 percent, and 30 percent respectively.

Continued

OBJECTIVES

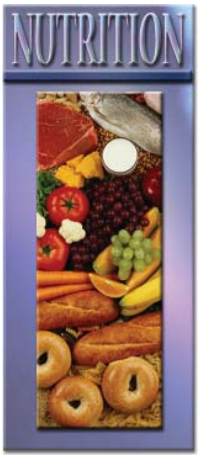
Continued

5. By 2010, increase the prevalence rate of adults who do physical activity for 30 minutes at least five days a week from 22 percent in 2001 to 35 percent.
6. By 2010, increase the prevalence rate of children and youth who do physical activity for 60 minutes daily from 61 percent in 1999 to 80 percent in children ages 9 to 11 years, and 40 percent in 2000 to 55 percent in teens ages 12 to 17 years.
7. By 2010, increase the proportion of students, grades 5, 7, and 9, meeting the healthy zone requirement (six areas of fitness gram test) from 24 percent to 35 percent.

Background and Barriers to Achieving Goals and Objectives

Nutrition in California

Poor nutrition, physical inactivity, and obesity together are estimated to account for approximately one-third of all cancer cases, equivalent to tobacco use. Like the risk of tobacco use, people can control these risk factors. The potential exposure to risk is enormous. Since everyone eats and moves, the entire California population may be exposed to dietary and physical inactivity contributors to cancer.



Studies from around the world indicate that healthier eating can reduce the risk of cancer over one's lifetime (35). The American Institute for Cancer Research (AICR) has reported a global projection of cancers that can be prevented by good diet, physical activity, and obesity prevention.

After controlling for non-dietary cancer risk factors such as smoking, AICR estimates that a healthy diet and physical activity may prevent obesity and reduce the risk of developing certain types of cancers (12), by as much as:

- Colon, rectum: 66 percent to 75 percent
- Breast: 33 percent to 50 percent
- Stomach: 66 percent to 75 percent
- Prostate, endometrium, cervix, bladder, thyroid: 10 percent to 20 percent

Considering their potential impact on cancer prevention, nutrition and physical activity promotion programs are not adequately funded in California. What is needed is steady, long-term funding for broad population-based policy, environmental, and educational interventions that can make it easier for people to eat healthily, exercise, and to reduce their risk of multiple chronic diseases, including heart disease and cancer (34).

In 1988, California launched the groundbreaking 5 a Day for Better Health! campaign that is now nationwide, a public-private partnership supported by the NCI, the U.S. Department of Agriculture (USDA), ACS, and the produce industry as notable leaders (47). These authorities recommend that individuals eat at least 5 to 9 servings of fruits and vegetables every day.

Simple enough, but the California Dietary Practices Survey that studied trends in healthy eating among California adults from 1989-2001 found that only one in three adults ate 5 or more daily servings of fruits and vegetables. One out of three ate two or fewer servings - a frequency that essentially doubles their risk of developing some of the common cancers listed above compared to eating at least 5 servings (3). Further, there is new evidence that nationwide consumption of fruits and vegetables is declining.

The proportion of adults eating 5 a Day rose when state nutrition campaigns were conducted but declined when they ended. The percentages of individuals eating 5 a Day are worse among males (30 percent), African Americans (22 percent), young adults (27 percent), people with less formal education (24 percent), and among those living in low income households less than $15,000 (24 percent).

Obesity

California, like the United States and the world, is in the midst of an obesity epidemic that has been characterized as the most serious uncontrolled public health problem facing us today. Obesity has been identified as a major risk factor for a host of other chronic diseases including cancers, such as cancer of the prostate, breast, colon, esophagus, ovary, liver, and pancreas (53).

A recent study on obesity published in the New England Journal of Medicine suggests that death rates from all cancers are significantly higher for obese men and women compared to men and women of normal weight. (NEJM, April 2003) The study also suggests current patterns of overweight and obesity in the United States could account for 14 and 20 percent of all deaths from cancer in men and women, respectively.

Obesity and physical inactivity were estimated to account for nearly $29.6 billion of California's health care costs and related lost productivity in 2000, which includes about seven percent of health care in the general population, and at least 10 percent of the Medicaid (Medi-Cal in California) budget (15). If California's diet-attributable health care costs for cancer were extrapolated from the USDA figure of $4.3 billion (U.S.), the costs would be approximately $516 million based on California's proportion (12 percent) of the U.S. population.

In 2001, 57 percent of adults in California were identified as overweight or obese compared to 38 percent in 1984 (15). The trend is similar nationwide and cuts across all ages, racial, and ethnic groups, and genders. (See Appendix C: Definitions of Obesity and Overweight.)

Physical Activity

Regular physical activity is crucial in maintaining healthy weight and body composition. Unfortunately, Californians, like many in the rest of the nation, are not achieving the recommended level of regular physical activity. Statewide surveillance data demonstrate that since 1996, only one out of five California adults engages in moderate-intensity physical activity for 30 minutes or more at least 5 days of the week.

This means that over two-thirds of Californians are not participating in sufficient physical activity to reap significant benefits.

Recent research suggests a strong link between physical activity and cancer risk. Regular physical activity at a level that meets the Surgeon General's recommendations is associated with a 40 to 50 percent decreased

risk for colon cancer, and 33 percent of colon cancer cases are attributed to physical inactivity (15).

There is a clear inverse dose-response relationship between physical activity level and colon cancer risk: the more physical activity, the lower the risk. Several studies also indicate that regular physical activity can reduce breast cancer risk by up to 30 percent (15). In addition, physical activity is an essential component of cancer treatment and rehabilitation, with positive impact upon functional ability, fatigue, body weight, mood, side effect severity, and quality of life (63).

Nutrition, Children, and Cancer Prevention

Lifelong eating behaviors develop early in childhood. Over 25 percent of California teens aged 12 to 17 are at-risk or already overweight. Rates are especially high among Latino and African American teens and older teen boys (16).

The California Children's Healthy Eating and Exercise Practices Survey (CalCHEEPS) conducted in 1999 among 9-to 11-year-olds yielded additional disturbing data. One-third of the children were found to be overweight or at-risk of overweight, and African American, Latino, and Asian/Pacific Islander or other children of color were more likely than non-Hispanic white children to meet this criterion. Overweight children ate fewer servings of fruits and vegetables, drank more soda, and ate more high-fat snacks and fast food (17).

ACS and other public health officials have viewed with extreme alarm the low fruit and vegetable consumption reported in this study. While this trend continues, schools are succumbing to the sales pitches of the fast food, snack, and soft drink industries to place these products in schools, sometimes in return for hefty monetary contributions from industry. This represents an unfortunate disregard of California's children, their health, and their future cancer risks for short-term monetary gain.

Adult behaviors and knowledge about healthy nutrition and physical activity practices lay the foundation for children in the home. Therefore, helping adults to improve the nutrition and physical activity practices of the next generation is important. This foundation also establishes the nutrition and physical activity behaviors that reduce site-specific cancers in adults.

Nutrition, Obesity, Physical Activity, and Cancer - Strategies and Tactics

Top Strategies to Achieve Goals and Objectives:

Based on the model provided by the successful tobacco prevention campaign in California, identify current funding streams and mobilize new resources to at least a comparable level of California's Tobacco Control Program. Create a similar statewide infrastructure to change state norms regarding healthy dietary and physical activity behaviors as follows:

1. Develop a statewide infrastructure that provides leadership, management, planning, information and intervention dissemination, resource development training, and coordination.

2. Institute environmental and policy change.

3. Implement mass communication strategies.

Additional Strategy:

- Increase research and surveillance to monitor and evaluate healthy behaviors, interventions, and new programs.

Tactics for Implementing the Top Strategies:

Strategy 1

Develop leadership, planning, management, and coordination.

- By January 2006, create statewide leadership through the development of a state-level education and research oversight committee to (1) develop and monitor a statewide plan, (2) coordinate and plan the development of a comprehensive nutrition and physical activity control program, (3) conduct state wide research and evaluation, and (4) secure and diversify funding sources for public agencies and CBO's.
- Create and manage a nutrition and physical activity regional infrastructure of constituencies, locally funded programs, networks, and advocacy groups.
- By January 2006, develop and maintain an action-oriented Intervention Clearing house that encourages collaboration for partners, provides resources to program planners and resources to the public regarding nutrition and physical activity and cancer risk reduction, and provides sample ordinances, organizational initiatives, and strategies.
- Annually conduct at least one statewide conference, local summits and trainings for the purpose of gathering agencies together to prioritize the issues of obesity, poor nutritional habits, and physical inactivity. Partners would include business, industries, and other new partners. Topics may include awareness of health impacts, costs of inaction, access for change, and education of health care providers, the public, and policy makers. Outcomes would include increased funds for programs from agencies, foundations, and health care providers.
- Increase and monitor collaborative projects among leadership agencies such as the American Heart Association, the ACS, and the American Diabetes Association.
- Fund and implement national and evidence-base state programs throughout California, particularly in schools, e.g., Healthier U.S., Garden in Every School, International Walk to School Day, School Health Index, 5 a Day—Power Play! Toolbox, and Shape Up America.
- Increase and monitor collaborative projects among agricultural organizations, the food/retail industry and fitness industry.
- Document the state's physical activity campaign intervention efforts and population, environmental and policy changes. Validate that large-scale population change and smaller-scale behavior and policy changes are associated with subsequent health outcomes.

Strategy 2

Institute environmental and policy change

- By January 2006, secure funding to implement environmental and policy interventions to reduce barriers and increase access to affordable low-cost fruits and vegetables in communities, retail and foodservice establishments, schools and work places.
- By January 2006, secure funding to implement environmental and policy interventions to reduce barriers and provide safe, affordable and accessible opportunities for physical activity for adults and children in communities, schools, and work places.

- By January 2006, develop a systematic framework for (1) assessing community needs and assets, (2) determining environmental and community-level measures, and (3) implementing and evaluating appropriate policy and environmental interventions.
- By January 2006, make the issues of obesity, nutrition, and physical activity an organizational priority by providing incentives for local organizations to adopt healthy lifestyle policies.
- Develop parallel mission and vision statements among major voluntary organizations.

Strategy 3
Implement mass communication strategies

Conduct a large multi-level, multi-component mass communication campaign to frame issues appropriately and move communities, policy makers and individuals toward healthy behavior norms.

By January 2006, key activities will include:

- State-level and regional media campaigns to increase awareness and likelihood of improving health behaviors.
- Media advocacy trainings for locally funded agencies and community-based organizations to use media effectively to advocate for environmental and policy change.
- Marketing kits and web-based resources to train and empower community-based agencies to conduct local media activities and coordinate health messages.
- Public relations to increase partner activities and increase media coverage.

Chapter X
Other Cancers: Melanoma and Non-Melanoma Skin, Liver, Cervical, Childhood-Adolescent, Ovarian, and Pancreatic Cancers

Other Cancers: Melanoma and Non-Melanoma Skin, Liver, Cervical, Childhood-Adolescent, Ovarian, and Pancreatic Cancers

GOALS

1. By 2010, decrease the mortality rate of melanoma cancer by 20 percent, from a baseline of 2.8 deaths per 100,000 persons.
2. By 2010, reduce hepatitis B infection by 99 percent and increase the survival rate of primary liver cancer by 20 percent. By 2010, all Asian/Pacific Islanders should be screened for hepatitis B to decrease the liver cancer mortality rate among Asian/Pacific Islanders.
3. By 2010, reduce the mortality rate from cancer of the cervix by 40 percent among all women in California, from a baseline of 2.8 deaths per 100,000 women.
4. By 2010, increase the survival rate of cancers of childhood and adolescence by 10 percent.
5. By 2010, increase the survival rate of ovarian and pancreatic cancers by at least 10 percent through referral of patients to cancer centers for aggressive treatment and clinical trials.

Cancers of the lung, breast, prostate, and colon-rectum account for the majority of cancer cases and deaths, but other cancers, particularly those that are readily preventable must be addressed to continue or accelerate California's overall progress against this disease.

Cancers addressed in this chapter include melanoma and non-melanoma skin cancers, liver, ovarian, pancreatic, and childhood and adolescent cancers, as well as cervical cancer because it is largely preventable through screening and early detection.

Melanoma and Non-Melanoma Skin Cancers

Burden

Non-melanoma skin cancer includes basal cell carcinoma (BCC) and squamous cell carcinoma (SCC), usually involving the upper layers of skin, and for the most part are easily treated if detected early. Malignant melanoma, on the other hand, involves pigment cells of the skin and requires more aggressive treatment.

Excessive sunlight exposure is associated with the majority of skin cancer. As little as one sunburn may significantly increase an individual's risk of developing skin cancer. Skin cancer can appear anywhere on the body, but is usually found on areas that receive the greatest exposure to the sun. Non-Hispanic whites are at the highest risk for all skin cancers. Treatment of skin cancer consists of surgery, cryosurgery, laser surgery, and other methods. Prevention, however, is key to avoiding these cancers (24).

In 2004, over 5,700 Californians are expected to be diagnosed with malignant melanoma and approximately 775 people are expected to die from it (1). In younger people less than 45 years of age, more women than men are expected to be diagnosed with invasive malignant melanoma, but over age 65 twice as many men will be diagnosed. In California, melanoma, both in-situ and invasive, has increased three to four percent each year over the past ten years, and data from the San Francisco Bay Area Cancer Registry show that cases of melanoma doubled from 1973 to 1992 (48). These cancers have risen dramatically due to a culture of "tan is beautiful," depletion of stratospheric ozone, an aging population, migration to sunnier regions, more outdoor leisure time, and less clothing coverage (24).

The incidence rate for invasive melanoma continues to rise significantly. Mortality, however, decreased significantly from 1988 to 2000 for women, but less so for men.

People at Risk

Californians at higher risk for skin cancer tend to have one or more of these characteristics:

- Fair skin
- Blue, green, or hazel eyes
- Light colored hair
- Freckles
- Tendency to burn rather than tan
- History of severe sunburn
- Have many moles which can also be precancers or markers
- Personal or family history of skin cancer
- Outdoor occupation

Identifying Skin Cancer

Melanoma is often distinguished by a mole or nearby lesion that is asymmetrical, has an irregular border, uneven color, and the diameter is larger than an ordinary pencil eraser (56). BCC and SCC are primarily identified by a pale, wax-like, pearly bump or a red, scaly sharply outlined patch that may crust, discharge, or bleed. A person's skin that is routinely exposed to the sun should be examined for any of these changes during an annual physical examination in order to detect skin cancer at its earliest stage.

Prevention and Treatment

It is vital that healthcare providers educate the public, especially parents, of sun safety prevention measures. Adults and children should reduce or avoid excessive sun exposure from 10 a.m. to 4 p.m. When outdoors during daylight hours, individuals should wear protective clothing, hats with wide brims

and/or side and neck flaps, and Ultraviolet (UV) protective sunglasses. Sunscreen with an Sun Protection Factor (SPF) minimum of 15 should be applied to the skin that remains exposed.

Child care centers, schools, outdoor recreation sites and camps, outdoor occupation venues, and all other entities that provide outdoor activities for children, youth, and adults should incorporate sun-safety measures including policies to reduce risk for skin cancer.

Objective

Increase the proportion of adults age 18 years and older to 60 percent who use at least one protective measure when outdoors.

Skin Cancer - Strategies and Tactics to Achieve Goals and Objectives

Strategy 1

Promote and disseminate existing skin cancer prevention education and policy resources to child care centers, schools (K-12), parks and recreation departments, sports venues, outdoor-based businesses, camps, planning commissions for construction requirements, and developers to support integration of sun protection strategies into their activities, policies, and structures.

Tactics:

- Obtain funding from the Centers for Disease Control and Prevention, private foundations, sun product manufacturers and retailers, and through legislation to increase the California Department of Health Services' Skin Cancer Prevention Program budget.
- Collaborate with national, state, and local professional organizations and other cancer prevention entities to implement this strategy.
- Promote distribution and use of existing sun-safety materials through promotional pieces placed in journals, newsletters, web sites, and other media that target populations at high-risk for skin cancer.

Strategy 2

Increase awareness among the general public regarding the dangers of unprotected exposure to UV rays and the corresponding recommended practices for decreasing skin cancer risk.

Tactics:

- Produce and disseminate culturally and linguistically appropriate, user-friendly sun-protection educational and policy resources.
- Produce and distribute media pieces designed for use in or at the classroom, beach, and sports venues.
- Conduct forums at state and national meetings occurring in California where public policy is crafted, e.g., Conference of State Legislatures, Society of Optical Engineers, and others.
- Identify celebrity spokespersons who will use their influence to encourage individuals and organizations to adopt pro sun-safety practices.

Liver Cancer

Burden

Primary liver cancer, a very deadly form of cancer, is on the rise in California. Since 1988, liver cancer incidence rates have increased by more than 45 percent. In 2004, approximately

1,770 new cases of liver cancer are expected and 1,420 deaths (48). Of these cases, 1,200 will be among men and 570 will be among women (1). Although liver cancer comprises about one percent of new cancer cases and two percent of cancer related deaths in the overall California population, a high proportion of cases occur in California's Asian/Pacific Islander populations, particularly those who have immigrated to the state from Asia, where liver cancer is common.

The San Francisco Bay Area has 33 percent of the state's Asian/Pacific Islander population and has the highest incidence of liver cancer in California and in the country. The average age at diagnosis is 65 years for men in California, and 69 years for women, with an earlier age at diagnosis for Asian/Pacific Islanders (28).

People at Risk

Men are three-four times more likely to develop liver cancer than women. Asian/Pacific Islanders have the highest incidence of liver cancer followed by Hispanics/Latinos and African Americans. The burden of liver cancer, however, is carried chiefly by California's Asian/Pacific Islanders where it ranks among the top five causes of death. Liver cancer ranks first in cancer prevalence and incidence among Laotians', and as a cause of death it is second for Vietnamese, fourth for Koreans and Chinese, and fifth for Filipinos. For Cambodian, Hmong, Laotian, and Vietnamese males, liver cancer mortality is second only to lung cancer (28).

The major risk factor for liver cancer is infection with the hepatitis virus B or C. In China, over 90 percent of liver cancer patients have detectable hepatitis B infection and antibodies, compared to 10-26 percent in the U.S. Asian/Pacific Islander immigrants arriving in California may bring this infection with them, only to have the infection predispose them to liver cancer over time (28).

Hepatitis B spreads mostly in Asian/Pacific Islanders via mothers who pass the virus on to their newborns. Hepatitis B and C are also spread through blood transfusions, contaminated needles, sharing personal items with infected blood on them (e.g., toothbrushes, razors), and by unprotected sexual intercourse (8).

Prevention and Treatment

Hepatitis B infection can be prevented by immunization. However, there is no vaccine for hepatitis C (8). Although the hepatitis B vaccine is free for school children under 18 years of age, an immunization gap exists for high school students. The same gap exists for people of childbearing age. In addition, health insurance frequently does not cover hepatitis B vaccination in adults. This vaccine should be widely accessible at no or low cost for high-risk populations who, in turn, need to be screened and treated for hepatitis B or C infection as early in life as possible. In addition, immigrant populations and health care providers should be provided with culturally appropriate knowledge of risk factors for liver cancer.

There is no effective systemic chemotherapy to treat primary liver cancer. Treatment for liver cancer is surgical resection, but that is possible only if the cancer is detected early. Currently only about 20 percent of liver cancer is resectable by the time the diagnosis is made. Early diagnosis of small tumors is the only effective way of improving the outcome of liver cancer treatment, and that is only possible through the screening of high-risk populations. If symptoms are already present, the patient's balance of life is short (32).

Objectives:

1. Assure hepatitis B immunization of all children, teenagers, and adults, especially those of childbearing age or who remain sexually active.
2. Screen all Asian/Pacific Islanders for hepatitis B infection, especially those who are foreign born, 18 years of age and under with hepatitis B vaccine and persons who are not already immune.

Liver Cancer - Strategies and Tactics to Achieve Goals and Objectives

Strategy 1

Implement a culturally appropriate campaign aimed at Asian/Pacific Islander communities and health care providers (physicians and others) to increase their awareness about hepatitis B, liver cancer, and preventive measures.

Tactics:

- Conduct a media campaign such as San Francisco's "Jade Ribbon" campaign that includes culturally and linguistically appropriate materials about what every Asian/Pacific Islander should know regarding liver cancer and hepatitis B, a web site in Asian languages, and a personally staffed toll-free number.
- Expand collaboration to all Asian/Pacific Islander groups, health insurers, the DHS, and policy-makers for funding, monitoring, and successful hepatitis B and liver cancer preventive outcomes.

Strategy 2

Screen all Asian/Pacific Islanders for hepatitis B and immunize those who are not protected.

Tactics:

- Work with insurance companies and state and federal legislators for hepatitis B immunization coverage for adults.
- Reach Asian/Pacific Islander populations for education, screening, and immunization at points of entry into the country, points of service, areas of worship, cultural organizations, and any other locations determined through collaboration with Asian/Pacific Islander communities and their leaders.
- Extend hepatitis B immunization requirement to junior and senior high schools and colleges.
- Provide early treatment of hepatitis B and C infections and screen those with chronic hepatitis for liver cancer.
- Make hepatitis B immunization a Health Plan Employer Data and Information Set (HEIDIS) indicator.
- Educate health care providers about the need for hepatitis B screening in all Asian/Pacific Islanders, and educate them about liver cancer, its risk factors, persons at-risk, and culturally appropriate ways to reach and communicate with their Asian/Pacific Islander patient populations.

Cervical Cancer

Burden

Cervical cancer used to be one of America's most common cancers, but since 1955, the number of cervical cancer deaths has decreased 74 percent in the U.S. It is now the ninth most common cancer in the U.S. and accounts for 1.7 percent of

deaths among females. The CCR estimates that in 2004 about 1,690 California women will be diagnosed with invasive cervical cancer and 470 will die from it (1). When cervical cancer is diagnosed and treated in its earliest, non-invasive stage, the five-year survival rate approaches 100 percent (25).

Cervical cancer is becoming less of a priority for the mainstream population, however, it is equally important to stress that many women still do not receive adequate screening.

In California, Latinas have the highest incidence of cervical cancer - more than twice that of non-Hispanic white women, while African-American women have the highest mortality rate. Latinas may forgo Pap tests even by a physician for various reasons including cultural values of modesty. Asian/Pacific Islander and African- American women have the second highest incidence of this cancer, and cervical cancer is the most common cancer among California's Laotian women (1). In fact, recent Asian/Pacific Islander immigrants still experience cervical cancer incidence equivalent to the rates found in their countries of origin.

Risk Factors

Exposure to certain subtypes of human papillomavirus (HPV) is heavily implicated in cervical cancer - an infection that is passed from one person to another through sexual intercourse. Having unprotected sex makes HPV infection more likely, especially among young, sexually active women. Women who have many sexual partners greatly increase their risk for HPV. This is also true if a woman has sex with a male who has had many partners (9).

Other factors that increase the risk of cervical cancer include a history of abnormal Pap tests, history of cervical cancer, treatment for cancer or precancerous lesions, immune compromised state, smoking, and early age of intercourse. Additional risk factors associated with cervical cancer include chlamydia infection, family history of cervical cancer, poor diets low in fruits and vegetables, and exposure to diethylstilbestrol (DES). Additional barriers to preventing cervical cancer include, lack of access to the Pap test, lack of or no insurance coverage, and cultural values or ethnic practices.

Early Detection and Prevention

Avoiding risk factors, particularly HPV infection, is the best way to prevent cervical cancer, as well as having routine Pap tests that can detect HPV and precancerous cervical lesions that are treatable before cancer develops. Most invasive cervical cancers are found in women who have not had regular Pap tests. Low-income women and women over 65 years of age are less likely than other groups to have had a Pap test within the past two years. (See Appendix E: American Cancer Society Guidelines for Early Detection of Cervical Cancer.)

In 2000, the percent of women age 18 and older who reported having a Pap test in the previous three years was 90 percent among African-Americans, 87 percent among non-Hispanic whites, 83 percent of Latinas, and 78 percent among Asian/Pacific Islanders. According to the 1997 California Women's Health Survey, 12 percent of low-income women in California have never had a Pap test, and this is fifty years after its introduction (25).

Diagnosis and Treatment

Treatment for cervical cancer depends on factors such as stage of the disease, patient's age, and overall health of the woman. Pre-invasive lesions detected by a Pap test and followed up by colposcopic-directed biopsies may be treated by Loop Electrosurgical Excision Procedure (LEEP) or conization. Invasive cervical cancer is

generally treated by surgery with radiation and with or without chemotherapy (18).

California's Programs

For several decades, organizations such as the ACS led the way in partnership with local health departments and other federally funded programs in promoting community Pap test clinics throughout California. Pap tests were subsequently integrated into routine primary care for women in health care institutions, and insurance coverage followed. During 2000-01, over 20,000 women received cervical cancer screening through the DHS programs, but this only represents about 1 percent of the population eligible for this program (See Appendix D: California's Breast and Cervical Cancer Programs.)

Objectives:

1. Increase the proportion of women 18 years of age and older who have had a Pap test within the past three years.
2. When available, promote the vaccine for HPV among high-risk women. Although this vaccine is still under development, studies suggest this vaccine will have substantial efficacy and public health benefit.

Cervical Cancer - Strategies and Tactics to Achieve Goals and Objectives

Strategy 1

Promote access to free or affordable and appropriate screening and treatment services.

Tactics:

- Expand the California Department of Health Services' Cancer Detection Programs: Every Woman Counts to all communities in California; obtain additional funding to support the program through legislation.
- Provide patient transportation where needed to screening and treatment locations.
- Involve leaders in the community to advocate for cervical cancer control programs.
- Involve state legislators to lobby Congress to fund California's Cancer Detection Programs: Every Woman Counts.
- Obtain legislation to expand the California Department of Health Services Cancer Detection Programs: Every Woman Counts funding to include cervical cancer screening.

Strategy 2

Provide culturally appropriate comprehensive cervical cancer education reaching all women including Latinas, Asian/Pacific Islanders, African Americans, older women, the uninsured, low-income, underserved, as well as tribal leaders, community leaders, and health care providers.

Tactics:

- Develop an awareness campaign among these groups.
- Build collaboration with groups that include representation from ethnic communities, health care, geographical areas, women's organizations, senior citizens organizations, faith-based communities, and other community agencies.
- Include information about cervical cancer and its prevention in all women's health informational packets.

Childhood and Adolescent Cancers

Burden

Cancer is the second leading cause of death of children age 1 to 14 years in California (29). Each year approximately 7,500 children under the age of 15 years are diagnosed with cancer in the U.S., and a total of 10,000 children and adolescents under the age of 21 years are diagnosed. This age group accounts for about one percent of all invasive primary cancers diagnosed annually, compared to 70 percent of cases which are diagnosed in adults over age 60. The incidence rate of childhood and adolescent cancer in California has remained fairly consistent since 1988, but varies by age, sex, race, and ethnicity. Sadly, the death of a single child from cancer may result in over 60 years of life lost compared to an average of 15 years lost by an adult dying from cancer.

Risk Factors

In contrast to adult cancers, few risk factors have been identified for childhood malignancies. The few that have been suggested include radiation, chemotherapeutic agents, and other medications. Inherited genetic disorders and prenatal exposures may increase the risk for certain tumors but these are relatively rare in the overall picture. Carcinogenic risk factors debated at this time include electromagnetic fields, pesticides, and some parental occupational exposures (29).

Treatment and Quality of Life

The ten leading causes of cancer mortality in California children and adolescents, ages 0 to 19 years, all races combined for the period 1988-1994, by site were: leukemia, brain and nervous system, lymphoma, endocrine, bone, soft tissue, ill-defined cause, kidney, liver, and genital system. In California, over one-half of these cancer deaths are due to leukemia or tumors of the brain or nervous system (26, 29).

The increase in childhood and adolescent cancer survival has been dramatic over the past thirty years due to advances in treatment. A majority of young cancer patients now attain five-year survival. However, children treated at approved pediatric cancer centers have greater survival rates than those treated at other treatment centers.

Diagnosis of cancer in children and adolescents is frequently difficult because early symptoms are relatively non-specific (29). Treatment now commonly involves coordinated aggressive, multi-modalities relying on combinations of surgery, chemotherapy, radiation, and supportive treatments. Recruitment of children with cancer into clinical trials would help advance the search for effective treatment modalities even further.

Treatment of children's cancers, even with a resultant cure, is extremely traumatic both for the children and their families, thus childhood cancer should really be treated as a family disease. Quality of life concerns that must be dealt with by health care providers and the families are paramount and include the significant emotional, physical, and financial costs that are related to the treatment process. Every effort needs to be made to bring support systems not only into the treatment regimen, but also into the child's recovery. For the cured patient, quality of life and long term supportive or palliative care are still needed. Long-term survivors of childhood malignancies are also at high risk for second malignancies (29, 38).

Objectives:

1. Increase the number of health care providers and healthcare organizations that provide quality of life support and palliative care to children with cancer and their families.
2. Promote the latest advances in treating childhood cancers through provider education.
3. Increase referral of childhood cancer patients to pediatric cancer centers and clinical trials.

Childhood and Adolescent Cancers - Strategies and Tactics to Achieve Goals and Objectives

Strategy 1

Emphasize the need for comprehensive care for children and adolescents with cancer and their families to maximize quality of life outcomes.

Tactics:

- Promote professional education (physicians, nurses, social workers, psychologists, and others), professional societies, insurance carriers, philanthropic groups, advocacy groups, and other professional associations to advance quality of life outcomes for children and adolescents with cancer.
- Establish a statewide information or educational system on how to create culturally sensitive programs for children and adolescents with cancer.

Strategy 2

Promote medical, psychosocial, and educational follow-up care for childhood cancer survivors.

Tactics:

- Tactics are the same as those for Strategy 1.

Ovarian Cancer

Burden

Ovarian cancer is a particularly virulent form of gynecologic cancer occurring in one or both of a woman's ovaries. It is the fifth most common cancer among California women and causes more death than any other gynecologic cancer (50).

In California, about 2, 655 new cases of ovarian cancer are expected to be diagnosed in 2004 and 1,515 women are expected to die from it (1). Over the past decade, the incidence rate for ovarian cancer has decline by 16 percent and the mortality rate has fallen as well. In the U.S. overall, women diagnosed with ovarian cancer have a survival rate of only 50 percent no matter what the cancer stage at diagnosis.

Non-Hispanic white women are at the greatest risk for this cancer and Asian/Pacific Islander women have the lowest risk. Fifty percent of ovarian cancer occurs in women 60 years of age and older with a median age of diagnosis of 62 years. The incidence peaks at age 75 years (51).

Risk Factors

There is no screening test for ovarian cancer. Understanding the risk factors and methods by which to reduce risk is critical.

The following factors may increase the risk (51):

- Family history of ovarian, breast or colon cancer,
- Increasing age,
- Fertility drug use, and
- Not bearing children.

Early Detection

A chance for early detection may improve with an annual vaginal/rectal pelvic examination, trans-vaginal ultrasound, and a blood test measuring CA 125 antigen as a tumor marker. Warning signs for ovarian cancer are very subtle, but may include swelling of the stomach, gas, bloating, indigestion or long-term stomach pain, unusual vaginal bleeding, a sense of pressure in the pelvic area, pain during intercourse, unusual tiredness, shortness of breath, and unexpected weight gain or loss. Women should be educated to see a health care professional if any of these symptoms are present and persistent (51).

Treatment

Treatment for ovarian cancer depends on the disease stage, type of disease, and the patient's age and overall health. Treatment usually involves a combination of surgery and chemotherapy. In some cases radiation therapy may also be used to kill cells and shrink tumors (51).

Support of the patient, including the spouse, partner or family during treatment and recovery are essential to the patient's quality of life and the difficulties she faces. Community cancer support groups and cancer survivor volunteers can also help the woman during this difficult time, and if needed, pain management and other palliative care measures should be a highly prioritized part of her care (4).

Objective:

Increase the survival rate of ovarian cancer by promoting aggressive treatment modalities and alerting women to the risks, symptoms, and detection measures.

Ovarian Cancer - Strategies to Achieve Goals and Objectives

Strategy 1

Promote the referral of ovarian cancer patients to clinical trials.

Strategy 2

Promote the education of women about detection and treatment of ovarian cancer, especially those at higher-risk, in California communities, organizations, and venues where older women are likely to be reached.

Strategy 3

Provide state funding for ovarian cancer research focusing on prevention and early detection.

Pancreatic Cancer

Burden

Pancreatic cancer is one of the deadliest of all cancers. It is the fourth leading cause of cancer mortality in men and women. In 2004, 2,965 new cases of pancreatic cancer are expected among Californians - the number is almost equally divided between men and women. Approximately 3,075 Californians are expected to die of this disease in 2004 (1). About two out of 10 patients will live for at least one year after diagnosis, but very few will survive for five years (10).

Risk Factors

Although scientists at this time do not know exactly what causes pancreatic cancer, several risk factors are associated with the disease. Like many risk factors, people can control some, and others, e.g., age, sex, and race, they cannot (10).

The major risk factors are:

- Age: Most pancreatic cancers are found in people over 60 years of age.
- Sex: Men have pancreatic cancer some what more often than women.
- Race: African Americans are at higher risk than other populations.
- Smoking: About three out of 10 pancreatic cancer cases are linked to smoking.
- Diet: A diet high in meats and fat increases the risk whereas eating fruits and vegetables seems to offer some protection.
- Diabetes: Pancreatic cancer is more common in people with this disease.

Detection

The pancreas is located behind the stomach, and is responsible for breaking down fats and protein for the body to use and to help control the amount of sugar in the blood. Cancer is more commonly found in the portion of the pancreas that breaks down fats and proteins. Because the pancreas is found so deep in the body, early stage tumors are seldom found. They cannot usually be seen or felt by health care providers during routine examinations, and there are no blood tests or screening tests that can accurately detect early cancers (10).

Cancers are more often found when the tumors have become large enough to have spread and exhibit symptoms. Symptoms of pancreatic cancer can include: jaundice, abdominal pain, weight loss, digestive problems, gallbladder enlargement, blood clots in veins or fatty tissue abnormalities, and problems with sugar metabolism (10).

Treatment and Quality of Life

Pancreatic cancer is very difficult to cure once it is diagnosed. In 2001, the European Study Group for Pancreatic Cancer reported on its investigation of treatment of patients by comparing surgery plus chemotherapy to surgery plus chemoradiotherapy. The study found that chemoradiotherapy had little effect on survival but that chemotherapy alone following surgery did provide some benefit.

Objective:

Increase research to find effective diagnostic tests and treatment(s) for pancreatic cancer in order to improve five-year survival rates to at least 15 percent over the current rate of near zero. Obtain state funds for research on prevention of pancreatic cancer.

Pancreatic Cancer - Strategies to Achieve Goals and Objectives

Strategy 1

Promote the referral of pancreatic cancer patients to clinical trials.

Strategy 2

Promote the education of the public regarding pancreatic cancer. This is particularly important considering the large increase in diabetes cases expected as a result of the current obesity epidemic.

Strategy 3

Solicit the legislature to provide state funds for pancreatic cancer research.

Global Strategies for "Other Cancers"

Strategy 1

For all cancer patients, provide access to state-of-the-art screening, early detection, prevention, immunization, and treatment, with access to a third party payment with no disparities in clinical outcomes.

Tactics:

- Advocate for universal health insurance coverage.
- Define a minimum cancer coverage benefits package.
- Provide multi-lingual web sites with links to other web sites.
- Provide a clearinghouse of sites including culturally appropriate material and sites in other languages.
- Teach advocacy to all cancer-related constituent groups.

Strategy 2

Provide culturally appropriate information and education about cancer prevention in rural and metropolitan areas assuring equitable access to quality care.

Tactics:

- Provide education on tobacco use, control, and cessation.
- Other tactics are the same as for Strategy 1.

Strategy 3

Conduct a public awareness campaign regarding the cause, impact, prevention, and treatment of indicated cancers.

Tactics:

- Develop and integrate cancer risk-reduction educational resources and policies into organizations that serve high-risk populations for the indicated cancers.

Chapter XI
APPENDICIES

APPENDICIES

Appendix A: Steering Committee Members

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Jennie Cook
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Appendix C: Definitions of Obesity and Overweight.

CDC defines a healthy body mass index (BMI) as between 18.5 and 24.9. BMI = (weight in pounds divided by height in inches divided by height in inches) x 703. For example, a person weighing 210 pounds and 6 feet tall would have a BMI = 210 pounds divided by 72 inches divided by 72 inches multiplied by 703 = 28.5. Individuals with a BMI of 25 to 29.9 are considered overweight, while persons with a BMI of 30 or more are considered obese.

The National Institutes for Health Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in adults aged 18 years and older indicates those who have a BMI of 25 or more are considered at risk for premature death and disability. These risks increase as the severity of an individual's obesity increases.

Appendix D: California's Breast Cancer Programs.

California has a remarkable history and determination to reach low-income and ethnic women with breast cancer screening, follow-up, and treatment services. Programs of ACS and the DHS, plus support for breast cancer research, legislation, and policies, have made a huge difference in accelerating California's progress against breast cancer for all women.

In 1991, DHS received $4 million a year from the CDC for a Breast and Cervical Cancer Control Program (BCCCP). The program, which operated in several locations, provided income eligible women, age 40 and older, with free breast and cervical cancer screening tests and free mammograms for women over 50 years of age.

With help from the ACS, this program was followed in 1992 by a state income tax check-off for a breast cancer research program that amounted to $300,000 a year. In 1993, the State Legislature passed a special tobacco tax that included a two-cent tax per pack of cigarettes to fund a DHS Breast Cancer Early Detection Program - a significant expansion to the federally funded BCCCP - and the Breast Cancer Research Program, each for $16 million a year. The two-cent tax made it possible to give access to all women throughout the entire state through over 2,000 providers. In 2002, this program and BCCCP were unified under a common billing and data collection system with the name: "Cancer Detection Program: Every Woman Counts." These events, again with assistance from the ACS and many others, helped to put California's Breast Cancer Program on a more secure footing.

However, what the breast cancer screening program revealed was an urgent need for breast cancer treatment for low-income women. When uninsured, low-income women were diagnosed with breast cancer, they felt they had nowhere to turn and would forego potentially life-saving treatment due to financial hardship it would create.

In 1994, therefore, the program received a one-time award of $12.4 million from private foundations to establish the California Breast Cancer Treatment Fund for a DHS Breast Cancer Diagnostic and Treatment Program that served all 58 California counties. The foundations extended the funding by $8 million in 1998 and another $8 million was received with tobacco tax dollars. This kept the program alive until the State Legislature allocated a one-time $5 million in 1999 and in 2000, $20 million annually. The Federal Breast and Cervical Cancer Treatment Act for Medicaid expansion enacted in 2000 made it possible to expand treatment for breast and cervical cancers including precancerous conditions.

Since inception, the Breast Cancer Treatment Program has served over 5,000 patients through 1000 participating providers. With new funding by the State of California in 1999-2000, patients are now eligible for treatment over an 18-month period as opposed to a 12-month period earlier. In addition, California law now requires all physicians who perform breast biopsies or treatment for breast cancer, to provide women with their options, including the risks, advantages, and disadvantages of each procedure. During 200-2001, over 167,000 women received breast cancer screening and 20,000 received cervical cancer screening. This is a magnitude of service rarely matched, particularly in a state as diverse as California.

Appendix E: American Cancer Society Guidelines for Early Detection of Cervical Cancer.

For early detection of cervical cancer, the ACS recommends:

- All women begin Pap tests about 3 years after they start having vaginal intercourse, but no later than 21 years of age.
- Starting at age 30, women who have had 3 normal tests in a row may get screened every 2 to 3 years. Women with certain risk factors should continue annual screening, e.g. diethylstilbestrol (DES) exposure, HIV infection, a weakened immune system due to organ transplant, chemotherapy, or chronic steroid use.
- Women 70 years of age or older who have had 3 or more normal pap tests in a row and no abnormal Pap tests in the last 10 years may choose to stop screening. And women with a history of cervical cancer, DES exposure before birth, HIV infection or weakened immune system should continue to be screened as long as they are in good health.
- Women who have had a total hysterectomy (removal of the uterus and cervix) may choose to stop screening unless the surgery was done as treatment for cervical cancer or precancer.
- Women who have had a hysterectomy without removal of the cervix should follow the guidelines above.

Chapter XII

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Goals and Objectives Tables

COLORECTAL CANCER

GOAL

By 2010, Reduce the Colorectal Cancer Mortality Rate in California by 40 Percent.

OBJECTIVES

1) **Increase screening for flexible sigmiodoscopy or colonscopy for Californians over age 50.**
2) **Increase diagnosis of colorectal cancer at an early stage.**

STRATEGIES	TACTICS FOR IMPLEMENTATION
1) Develop and support proactive advocacy groups.	1.1) Identify survivors, physicians, community leaders and interested groups motivated to build an advocacy coalition. 1.2) Obtain funds from foundations to support advocacy activities. 1.3) Create a combined patient support, legislative and educational focus. 1.4) Develop a State of California Colorectal Roundtable to promote on-going dialogue among experts and advocates. 1.5) Build relationships between local level efforts and national / international groups. 1.6) Partner with a health plan or disease management program dealing with colorectal cancer.
2) Develop and support evidence-based, culturally sensitive public awareness campaigns.	2.1) Make early diagnosis of colorectal cancer a family issue and heighten awareness through special campaigns. 2.2) Collaborate with diverse communities and leaders to identify messages to reach different communities and cultures. 2.3) Obtain funding to support outreach and awareness campaigns. 2.4) Create and implement a media campaign.
3) Work toward universal insurance coverage for colorectal cancer screening and treatment.	3.1) Obtain funding to support an Office of Colorectal Cancer at the California Department of Health Services to provide outreach, screening and treatment programs. 3.2) Work to pass legislation that covers screening and treatment for colorectal cancer at the state and federal level. 3.3) Develop advocacy groups.

BREAST CANCER

GOALS

1) By 2010, reduce the mortality rate from female breast cancer in California by 36 percent through early detection and treatment.
2) By 2010, advance scientific and public understanding of modifiable risk factors, how they affect the incidence of breast cancer, and how breast cancer may be prevented.
3) By 2010, reduce the morbidity impact of breast cancer on short and long-term quality of life.

OBJECTIVES

1) **By 2010, increase the percent of women in California (age 40 and older) who have had an annual mammogram and clinical breast examination from 60 percent to 90 percent.**
2) **By 2010, increase the percent of breast cancers diagnosed at an early stage from 70 percent to 80 percent, including reducing disparities in stage of diagnosis for the insured and uninsured regardless of race and ethnicity.**
3) **By 2010 create new ways to continue the breast cancer mortality reduction beyond 2010 at the same rate of decline as outlined in Goal number 1 through research and improved detection methods.**

STRATEGIES	TACTICS FOR IMPLEMENTATION
1) By 2006, begin to conduct a statewide tracking of women's breast cancer health care.	1.1) Map the stage of breast cancer diagnoses and number of cases to identify high need areas. Map supporting resources and services related to the continuum of cancer care. 1.2) Develop and fund a statewide, comprehensive database with patient information and correlate this database with census information. Provide statewide and local data identifying all screening and diagnostic services. Identify geographic areas with gaps in services and resources.
2) By 2006, provide education on breast cancer risk assessment and risk reduction.	2.1) Promote participation of health educators and provide professional education to improve sensitivity, communication skills and cultural competency. 2.2) "Disseminate the course," Clinical Breast Examination: Proficiency and Risk Management to all medical schools, nurse practitioner schools, and physician assistant schools in California. 2.3) Educate medical professionals treating breast cancer to treat patients following evidence-based medicine and provide access to clinical trials to all patients. 2.4) Continue to fund the California Department of Health Services to develop statewide educational and outreach materials and disseminate this information through a variety of media. 2.5) Identify and/or develop age, literacy level, culturally, and linguistically appropriate breast cancer-related outreach and educational materials.

BREAST CANCER

(CONTINUED)

STRATEGIES	TACTICS FOR IMPLEMENTATION
2) By 2006, provide education on breast cancer risk assessment and risk reduction.	2.6) Provide a directory via an 800 number and on the web with the location of all resources and services available to all women statewide and locally. 2.7) Fund and partner with the California Cancer Registry to provide statewide and local data on stage at of diagnosis and identify areas with high incidence of late stage diagnosis. 2.8) Develop a cancer orientation packet containing information for lawmakers, policy makers, and community providers that covers the statewide and local issues regarding breast cancer. 2.9) Identify guidelines and quality benchmarks for early detection, diagnosis, and treatment. 2.10) Educate providers and consumers on available clinical trials for treatment as well as risk reduction. 2.11) Educate consumers and providers about pharmacological agents, such as tamoxifen, that have shown promise in reducing breast cancer risk. 2.12) Provide health professionals and consumers with information regarding the location and availability of centers that can provide an enhanced complexity of care for cancer treatment.
3) By 2006, develop a coordinated system and resources to provide access to breast cancer detection, diagnosis, and treatment services including recovery and palliative care.	3.1) Develop and provide resources for a high quality, coordinated system of networks that a) makes high quality entry-level screening services widely and easily accessible statewide in the communities where women live b) provides referral and ensure access to progressively more complex levels of high quality care c) deploys resources optimally to fill gaps in communities where there is insufficient entry-level screening and referral capacity and fill gaps or eliminate redundancies in regional capacity for more complex care. 3.2) Encourage collaboration among the California Department of Health Services, voluntary and community organizations, community clinics, medical professionals, and medical schools in all counties to increase efficiency of services provided.

BREAST CANCER

(CONTINUED)

STRATEGIES	TACTICS FOR IMPLEMENTATION
3) By 2006, develop a coordinated system and resources to provide access to breast cancer detection, diagnosis, and treatment services including recovery and palliative care.	3.3) Provide a structure and process to identify and ensure appropriate care or referral for early detection, diagnosis, and treatment to include symptom control, amelioration of pain, rehabilitation, and reduction in the side effects of treatment based upon an appropriate care plan using uniform standards of care. 3.4) Establish a network for appropriate interventions, such as advocacy, referral and education to address financial, employability, and insurability issues, and access to treatment and follow-up care. 3.5) Establish a network to provide appropriate care or referral to services and support groups, such as those provided by the American Cancer Society, the wellness community, hospice services, and others for identified psychological, emotional, and spiritual problems or needs. 3.6) Enhance the existing system of networks to include all Medi-Cal physicians. 3.7) Identify areas of need for indigenous patient navigators and train them for culturally specific outreach and patient interaction. 3.8) Lobby local, state, and federal governments and health insurance carriers to increase funding for early detection, diagnosis, and treatment of breast cancer.

PROSTATE CANCER

GOALS

1) By 2010, reduce the prostate cancer mortality rate of California men, including men in high-risk groups, by 23 percent.

2) By 2010, improve the quality of life of men with prostate cancer and their families while creating measures to monitor and evaluate quality of life improvements.

OBJECTIVES

1) By 2010, provide all California men diagnosed with prostate cancer timely access to treatment programs and information that will help them make an informed choice among treatment options, including the risks, benefits, and the impact on their quality of life.

STRATEGIES	TACTICS FOR IMPLEMENTATION
1) By January 1, 2006, educate the public, health professionals, and policy makers regarding prostate cancer including its risks, treatment options and quality of life, fears, beliefs and perceptions about the cancer and its treatment, lack of trust in the health care system among diverse groups, the need for easier access to prostate cancer detection and care, and lack of accurate, unbiased information.	1.1) Develop a unified and uniform message on prostate cancer to distribute to health professionals in California. 1.2) Provide information and education to patients through NCI's Cancer Information Service and the American Cancer Society's National Cancer Information Center. 1.3) Develop a unified and uniform message on prostate cancer to distribute to public policy makers in California. 1.4) Work with the American Board of Family Practice to educate primary care physicians about prostate cancer. 1.5) Encourage the California Department of Health Services to develop a media campaign, culturally sensitive to all, about prostate cancer education. 1.6) Incorporate prostate cancer information in material provided to women about breast cancer. 1.7) Encourage collaboration among those groups interested in prostate cancer to disseminate information about the disease. 1.8) Provide education about successful outcomes and treatment for localized prostate cancer. 1.9) Involve prominent figures to reach the public, e.g., George Foreman – "Real Men Get It Checked campaign."

PROSTATE CANCER

(CONTINUED)

STRATEGIES	TACTICS FOR IMPLEMENTATION
2) By 2006, increase state funding for prostate cancer control research that includes basic, translational, clinical, and health services, quality of life, and outcomes research.	2.1) Restore funding for the California Department of Health Services Cancer Research Program. Seek funding for the infrastructure to implement the comprehensive cancer control plan. 2.2) Highlight the deficiencies in our knowledge of prostate cancer to policy makers. 2.3) Identify and aggressively seek funding from private sources for prostate cancer research and education. 2.4) Encourage organizations like the American Cancer Society to provide targeted research funding for prostate cancer. 2.5) Create an entity dedicated to raising funds for prostate cancer like the Susan G. Komen Foundation for breast cancer. 2.6) Seek state funding to bring California comprehensive and clinical cancer centers together and formulate a plan for collaboration.
3) By 2006, ensure consistent funding of existing prostate cancer mandates and programs for the low income, uninsured, and underinsured.	3.1) Restore adequate funding for the state's Prostate Cancer Treatment Program, IMPACT 3.2) Adequately fund existing prostate cancer mandated programs for the low income, uninsured, and the underinsured.

LUNG AND ORAL CANCER

GOAL

By 2010, accelerate significantly the rate of decline of lung and oral cancer mortality by preventing tobacco use, helping smokers and users of spit tobacco to quit, and diagnosing lung and oral cancer at an earlier, potentially more curative stage.

OBJECTIVES

1) **By 2010, decrease the smoking prevalence rate in adults ages 18 and older from 16.6 percent in 2000 to 10 percent.**
2) **By 2010, decrease the smoking prevalence rate in youth ages 12 to 17 years from 7 percent to 4 percent.**
3) **By 2010, decrease exposure to secondhand smoke to 10 percent or less of the California population.**
4) **By 2010, double the percentage of lung cancer diagnosed in California at Stage 1A.**

STRATEGIES	TACTICS FOR IMPLEMENTATION
1) Prevent or control tobacco use by funding and implementing the Tobacco Education and Research Oversight Committee Master Plan to strengthen the California Tobacco Control Program structure.	1.1) By 2006, augment the Tobacco Control Program's budget by $200 million. 1.2) By 2006, recommend that the California Legislature increase the tobacco tax with an earmark for California's Tobacco Control Program. Educate the Legislature that even though consumption may be declining, more resources are needed to prevent and control tobacco use. 1.3) By 2006, strive to eliminate disparities in tobacco control by funding more programs, surveillance, and research for California's varied racial and ethnic groups and other priority populations (GLBT, low-SES, etc.) 1.4) Increase surveillance capacity by increasing funding of the California Cancer Registry from non-Proposition 99 sources to compile and track tobacco-related data on Asian-Pacific Islander and American Indian populations. 1.5) Decrease exposure to secondhand smoke (SHS) in all enclosed workplaces, outdoor working environments, entertainment venues, and homes by continuing to educate Californians about the dangers of SHS and by implementing progressive policies that protect all Californians. 1.6) Initiate policy efforts to regulate the tobacco industry and the sellers of tobacco products and their influence. Polices should include a) requiring tobacco retailers to obtain a license to sell tobacco that can be suspended or revoked if they sell tobacco to children b) prohibiting tobacco industry sponsorship and advertising at community entertainment, and sporting events, and c) asking elected officials not to accept tobacco industry campaign contributions and publicize those who do.

LUNG AND ORAL CANCER

(CONTINUED)

STRATEGIES	TACTICS FOR IMPLEMENTATION
1) Prevent or control tobacco use by funding and implementing the Tobacco Education and Research Oversight Committee Master Plan to strengthen the California Tobacco Control Program structure.	1.7) Increase the enforcement of tobacco control laws (i.e., sales to minors, smoke-free workplaces) by specifically earmarking funding for local law enforcement agencies and providing training and technical assistance. 1.8) Encourage more professional organizations to make tobacco control a priority. 1.9) Hold state and county First Five Commissions accountable for their mission by allocating substantial resources to programs in conjunction at DHS' TCS.
2) Integrate evidence-based and efficacious smoking and smokeless tobacco cessation services into the state's school systems, community-based organizations, public health programs, and health care plans and institutions.	2.1) By 2006, increase funding of diverse community-based organizations to address cessation in a culturally and linguistically appropriate manner. 2.2) By 2006, increase the level and capacity of cessation services to assist tobacco users in diverse communities and in a variety of languages and methods. 2.3) By 2006, encourage health care providers to assess patient tobacco use and exposure to SHS status routinely and to provide assistance and referral to evidence-based and efficacious cessation services. 2.4) By 2006, advocate for evidence-based and culturally linguistically appropriate cessation counseling coverage as a core benefit of health insurance plans. 2.5) Fully implement "Tobacco as a Vital Sign" in all patient visits. 2.6) Continue to publicize the services provided by the California Smokers' Helpline and encourage tobacco users to use its free services. 2.7) Require the California Department of Managed Health Care to make evidence-based best practices for tobacco use services a required component of managed health care plans. 2.8) Increase funding for research on tobacco-use cessation strategies for priority populations that include racial and ethnic groups, LGBT, teens, hard-core smokers and other tobacco users, and those individuals with low SES, and Medi-Cal and Healthy Families enrollees. 2.9) Support research to uncover the barrier to cessation counseling and services by health care providers. Support the provision of cessation facilitator trainings in health and social service organizations.

LUNG AND ORAL CANCER

(CONTINUED)

STRATEGIES	TACTICS FOR IMPLEMENTATION
2) Integrate evidence-based and efficacious smoking and smokeless tobacco cessation services into the state's school systems, community-based organizations, public health programs, and health care plans and institutions.	2.10) Support programs that strive to engage health care providers in cessation counseling and referrals. 2.11) Assure that tobacco use cessation is included in the Health Plan Employer Data and Information Set (HEDIS).
3) Improve current and develop new technologies for screening, early diagnosis, and treatment of lung, oral cancer, and other tobacco-related cancers (e.g. cervical, stomach, pancreatic), and improve the quality of life measures at all stages of the patient's health care and balance of life.	3.1) By 2006, improve access to quality lung and oral cancer treatment and palliative care for all patients. 3.2) By 2006, increase research to improve and expand upon quality of life for lung and oral cancer patients. 3.3) Identify and bring together national and California organizations and researchers who perform or otherwise have an interest in spiral CT scans as an efficient community screening methodology in California. Determine screening and infrastructure guidelines based on results of the NCI spiral CT scan clinical trial when it is completed. 3.4) Advocate for insurers to cover lung cancer screening methods that are recommended by the American Cancer Society. 3.5) Encourage participation of diverse populations in clinical trials dealing with lung and oral cancer. 3.6) Encourage additional studies within the National Institutes of Health that look at biomarkers as cancer detection tools. 3.7) Encourage research and clinical trials to improve treatments for oral and lung cancers. 3.8) Increase health care coverage of experimental treatments. 3.9) Encourage increased sampling of the environment for radon and asbestos exposure, where appropriate.

NUTRITION, OBESITY, PHYSICAL ACTIVITY AND CANCER

GOALS

1) By 2010, change the environmental and California societal norms to those of healthy eating and physical activity.

2) By 2010, arrest the upward obesity and overweight trends by increasing physical activity, consumption, consumption of fruits and vegetables and reducing caloric intake among Californians.

3) By 2010, reduce the 2001-2002 prevalence rate of obesity among California adults from 19.9 percent to 14 percent.

4) Reduce the 2001-2002 prevalence rate of overweight among California adults from 54.4 percent to 40 percent.

5) By 2010, reduce the prevalence rate of overweight and obese children from 34 percent in 1999 to 14 percent.

6) By 2010, reduce the prevalence rate of at-risk and overweight teens from 25 percent in 2000 to 17 percent.

OBJECTIVES

1) **By 2010, increase the proportion of adults who consume at least 5 servings per day of fruits and vegetables from 32 percent in 2001 to 45 percent.**
2) **By 2010, increase the proportion of all teens, ages 12 to 17 years, who consume at least 5 servings of fruits and vegetables from 44 percent in 2000 to 58 percent.**
3) **By 2010, increase the proportion of children, ages 9 to 11 years, who consume at least 5 servings of fruits and vegetables from 20 percent in 1999 to 30 percent.**
4) **By 2010, decrease the consumption among children, teens, and adults of high calorie, low nutrient foods (soft drinks, fried snacks, and sweet desserts) by 30 percent, 15 percent, and 30 percent respectively.**
5) **By 2010, increase the prevalence rate of adults who do physical activity for 30 minutes at least five days a week from 22 percent in 2001 to 35 percent.**
6) **By 2010, increase the prevalence rate of children and youth who do physical activity for 60 minutes daily from 61 percent in 1999 to 80 percent in children ages 9 to 11 years, and 40 percent in 2000 to 55 percent in teens ages 12 to 17 years.**
7) **By 2010, increase the proportion of students, grades 5, 7, and 9, meeting the healthy zone requirement (six areas of fitness gram test) from 24 percent to 35 percent.**

STRATEGIES	TACTICS FOR IMPLEMENTATION
1) Develop leadership, planning, management, and coordination.	1.1) By 2006, create statewide leadership through the development of a state-level education and research oversight committee to a) develop and monitor a statewide plan b) coordinate and plan the development of a comprehensive nutrition and physical activity control program c) conduct statewide research and evaluation and d) secure and diversify funding sources for public agencies and CBO's . 1.2) Create and manage a nutrition and physical activity regional infrastructure of constituencies, locally funded programs, networks, and advocacy groups.

NUTRITION, OBESITY, PHYSICAL ACTIVITY AND CANCER

(CONTINUED)

STRATEGIES	TACTICS FOR IMPLEMENTATION
1) Develop leadership, planning, management, and coordination.	1.3) By 2006, develop and maintain an action-oriented Intervention Clearinghouse that encourages collaboration for partners, provides resources to program planners and resources to the public. 1.4) Annually conduct at least one statewide conference, local summits and trainings for the purpose of gathering agencies together to prioritize the issues of obesity, poor nutritional habits, and physical inactivity. Outcomes would include increased funds for programs from agencies, foundations, and health care providers. 1.5) Increase and monitor collaborative projects among leadership agencies such as the American Heart Association, the American Cancer Society, and the American Diabetes Association. 1.6) Fund and implement national and evidence-based State programs throughout California, particularly in schools, e.g., Healthier U.S., Garden in Every School, International Walk to School Day, School Health Index, 5 a Day- -ToolboxPower Play! Toolbox, and Shape Up America, etc. 1.7) Increase and monitor collaborative projects among agricultural organizations, the food/retail industry and fitness industry. 1.8) Document the state's physical activity campaign intervention efforts and population, environmental and policy changes. Validate that large-scale population change and smaller-scale behavior and policy changes are associated with subsequent health outcomes.
2) Institute environmental and policy change.	2.1) By 2006, secure funding to implement environmental and policy interventions to reduce barriers and increase access to affordable low-cost fruits and vegetables in communities, retail and foodservice establishments, schools and work places. 2.2) By 2006, secure funding to implement environmental and policy interventions to reduce barriers and provide safe, affordable and accessible opportunities for physical activity for adults and children in communities, work, and school. 2.3) By 2006, develop a systematic framework for a) assessing community needs and assets b) determining environmental and community-level measures, and c) implementing and evaluating appropriate environmental and policy and environmental interventions.

NUTRITION, OBESITY, PHYSICAL ACTIVITY AND CANCER

(CONTINUED)

STRATEGIES	TACTICS FOR IMPLEMENTATION
2) Institute environmental and policy change.	2.4) By 2006, make the issues of obesity, nutrition, and physical activity an organizational priority by providing incentives for local organizations to adopt healthy lifestyle policies . 2.5) Develop parallel mission and vision statements among major voluntary organizations.
3) Implement mass communication strategies	3.1) Conduct a large multi-level, multi-component mass communication campaign to frame issues appropriately and move communities, policy makers and individuals toward healthy behavior norms. By 2006, key activities will include: a) State-level and regional media campaigns to increase awareness and likelihood of improving health behaviors. b) Media advocacy trainings for locally funded agencies and community-based organizations. c) Marketing kits and web-based resources to train and empower community-based agencies to conduct local media activities and coordinate health messages.d) Public relations to increase partner activities and increase media coverage.

SKIN, LIVER, CERVICAL, CHILD-ADOLESCENT, OVARIAN AND PANCREATIC CANCERS

GOALS

1) By 2010, decrease the mortality rate of melanoma cancer by 20 percent, from a baseline of 2.8 deaths per 100,000 persons.

2) By 2010, reduce hepatitis B infection by 99 percent and increase the survival rate of primary liver cancer by 20%. By 2010, all Asian-Pacific Islanders should be screened for hepatitis B to decrease the liver cancer mortality rate among Asian-Pacific Islanders.

3) By 2010, reduce the mortality rate from cancer of the cervix by 40 percent among all women in California, from a baseline of 2.8 deaths per 100,000 women.

4) By 2010, increase the survival rate of cancers of childhood and adolescence by 10 percent.

5) By 2010, increase the survival rate of ovarian and pancreatic cancers by at least 10 percent through referral of patients to cancer centers for aggressive treatment and clinical trials.

OBJECTIVES - MELANOMA AND NON-MELANOMA SKIN CANCER

1) Increase the proportion of adults age 18 years and older to 60 percent who use at least one sun protective measure when outdoors.

STRATEGIES	TACTICS FOR IMPLEMENTATION
1) Promote and disseminate existing skin cancer prevention education and policy resources and support integration of sun protection strategies into activities, policies, and structures.	1.1) Obtain funding from the Centers for Disease Control and Prevention, private foundations, sun product manufacturers and retailers, and through legislation to increase the California Department of Health Services' Skin Cancer Prevention Program budget. 1.2) Collaborate with national, state, and local professional organizations and other cancer prevention entities to implement this strategy. 1.3) Promote distribution and use of existing sun-safety materials through promotional pieces placed in journals, newsletters, web sites, and other media that target populations at high-risk for skin cancer.
2) Increase awareness among the general public regarding the dangers of unprotected exposure to UV rays and the corresponding recommended practices for decreasing skin cancer risk.	2.1) Produce and disseminate culturally and linguistically appropriate, user-friendly sun-protection educational and policy resources. 2.2) Produce and distribute media pieces designed for use in or at the classroom, beach, and sports venues. Conduct forums at state and national meetings occurring in California where public policy is crafted. 2.3) Identify celebrity spokespersons who will use their influence to encourage individuals and organizations to adopt pro sun-safety practices.

SKIN, LIVER, CERVICAL, CHILD-ADOLESCENT, OVARIAN AND PANCREATIC CANCERS

(CONTINUED)

OBJECTIVES - LIVER CANCER

1) **Assure hepatitis B immunization of all children, teenagers, and adults, especially those of childbearing age or who remain sexually active.**

2) **Screen all Asian-Pacific Islanders for hepatitis B infection, especially those who are foreign born, 18 years of age and under with hepatitis B vaccine and persons who are not already immune.**

STRATEGIES	TACTICS FOR IMPLEMENTATION
1) Implement a culturally appropriate campaign aimed at Asian-Pacific Islander communities and health care providers (physicians and others) to increase their awareness about hepatitis B, liver cancer, and preventive measures.	1.1) Conduct a media campaign that includes culturally and linguistically appropriate materials about what every Asian-Pacific Islander should know regarding liver cancer and hepatitis B, a Website in Asian languages, and a personally staffed toll-free number. 1.2) Expand collaboration to all Asian-Pacific Islander groups, health insurers, the California Department of Health Services, and policy-makers for funding, monitoring, and successful hepatitis B and liver cancer preventive outcomes.
2) Screen all Asian-Pacific Islanders for hepatitis B and immunize those who are not protected.	2.1) Work with insurance companies and state and federal legislators for hepatitis B immunization coverage for adults. 2.2) Reach Asian-Pacific Islander populations for education, screening, and immunization at points of entry into the country, points of service, areas of worship, cultural organizations, and other locations. 2.3) Extend hepatitis B immunization requirement to junior and senior high schools and colleges. 2.4) Provide early treatment of hepatitis B and C infections and screen those with chronic hepatitis for liver cancer. 2.5) Make hepatitis B immunization a Health Plan Employer Data and Information Set (HEIDIS) indicator. 2.6) Educate health care providers about the need for hepatitis B screening in all Asian-Pacific Islanders, and educate them about liver cancer, its risk factors, persons at risk, and culturally appropriate ways to reach and communicate with their Asian-Pacific Islander patient populations.

SKIN, LIVER, CERVICAL, CHILD-ADOLESCENT, OVARIAN AND PANCREATIC CANCERS

(CONTINUED)

OBJECTIVES - CERVICAL CANCER

1) **Increase the proportion of women 18 years of age and older who have had a Pap test within the past three years.**

2) **When available, promote the vaccine for HPV among high-risk women. Although this vaccine is still under development, studies suggest this vaccine will have substantial efficacy and public health benefit.**

STRATEGIES	TACTICS FOR IMPLEMENTATION
1) Promote access to free or affordable and appropriate screening and treatment services.	1.1) Expand the California Department of Health Services' Cancer Detection Section's (CDS): Every Woman Counts to all communities in California; obtain additional funding to support the program through legislation. 1.2) Provide transportation for patient where needed to screening and treatment. 1.3) Involve leaders in the community to advocate for cervical cancer control programs. 1.4) Involve state legislators to lobby Congress to fund California's CDS's: Every Woman Counts. 1.5) Obtain legislation to expand the California Department of Health Services CDS's: Every Woman Counts funding to include cervical cancer screening.
2) Provide culturally appropriate comprehensive cervical cancer education reaching all women including Latinas, Asian-Pacific Islanders, African Americans, older women, the uninsured, low-income, underserved, as well as tribal leaders, community leaders, and health care providers.	2.1) Develop an awareness campaign among these groups. 2.2) Build collaboration with groups that include representation from ethnic communities, health care, geographical areas, women's organizations, senior citizens organizations, faith-based communities, and other community agencies. 2.3) Include information about cervical cancer and its prevention in all women's health informational packets.

OBJECTIVES - CHILDHOOD AND ADOLESCENT CANCERS

1) **Increase the number of health care providers and health care organizations that provide quality of life support and palliative care to children with cancer and their families.**

2) **Promote the latest advances in treating childhood cancers through provider education.**

3) **Increase referral of childhood cancer patients to pediatric cancer centers and clinical trials.**

SKIN, LIVER, CERVICAL, CHILD-ADOLESCENT, OVARIAN AND PANCREATIC CANCERS

(CONTINUED)

STRATEGIES	TACTICS FOR IMPLEMENTATION
1) Emphasize the need for comprehensive care for children and adolescents with cancer and their families to maximize quality of life outcomes.	1.1) Promote professional education, professional societies, insurance carriers, philanthropic groups, advocacy groups, and other professional associations to advance quality of life outcomes for children and adolescents with cancer. 1.2) Establish a statewide information or educational system on how to create culturally sensitive programs for children and adolescents with cancer.
2) Promote medical, psychosocial, and educational follow-up care for childhood cancer survivors.	2.1) Tactics are the same as those for Strategy 1.

OBJECTIVE - OVARIAN CANCER

1) Increase the survival rate of ovarian cancer by promoting aggressive treatment modalities and alerting women to the risks, symptoms, and detection measures.

STRATEGIES

1) Promote the referral of ovarian cancer patients to clinical trials.

2) Promote the education of women about detection and treatment of ovarian cancer, especially those at higher-risk, in California communities, organizations, and venues where older women are likely to be reached.

3) Provide state funding for ovarian cancer research focusing on prevention and early detection.

OBJECTIVE - PANCREATIC CANCER

1) Increase research to find effective diagnostic tests and treatment(s) for pancreatic cancer in order to improve five-year survival rates to at least 15 percent over the current rate of near zero. Obtain state funds for research on prevention of pancreatic cancer.

STRATEGIES

1) Promote the referral of pancreatic cancer patients to clinical trials.

2) Promote the education of the public regarding pancreatic cancer. This is particularly important considering the large increase in diabetes cases expected as a result of the current obesity epidemic.

3) Solicit the legislature to provide state funds for pancreatic cancer research.

SKIN, LIVER, CERVICAL, CHILD-ADOLESCENT, OVARIAN AND PANCREATIC CANCERS

(CONTINUED)

GLOBAL STRATEGIES FOR OTHER CANCERS	GLOBAL TACTICS FOR IMPLEMENTATION
1) For all cancer patients, provide access to state-of-the-art screening, early detection, prevention, immunization, and treatment, with access to a third party payment with no disparities in clinical outcomes.	1.1) Advocate for universal health insurance coverage. 1.2) Define a minimum cancer coverage benefits package. 1.3) Provide multi-lingual Web sites with links to other web sites. 1.4) Provide a clearinghouse of Web sites including culturally appropriate material and sites in other languages. 1.5) Teach advocacy to all cancer-related constituent groups.
2) Provide culturally appropriate information and education about cancer prevention in rural and metropolitan areas assuring equitable access to quality care.	2.1) Provide education on tobacco use, control, and cessation. 2.2) Other tactics are the same as for Strategy 1.
3) Conduct a public awareness campaign regarding the cause, impact, prevention, and treatment of indicated cancers.	3.1) Develop and integrate cancer risk-reduction educational resources and policies into organizations that serve high-risk populations for the indicated cancers.

INSIDE BACK COVER

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Comprehensive Cancer Control in California, 2004