

RHODE ISLAND DEPARTMENT OF HEALTH

Rhode Island

Cancer Control Plan




Donald L. Carcieri, Governor
Patricia A. Nolan, MD, MPH, Director
January, 2004



State of Rhode Island
Department of Health
www.health.ri.gov

Rhode Island *Cancer Control Plan*

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<u>Update History</u>	<u>Completion Date</u>	<u>Work Schedule</u>	<u>Proposed Deadline</u>
1. Original Cancer Control Plan (Plan)	Sept 1998	1. Introduction for Monitoring Cancer Burden	March 2004
2. Updated burden statistics in original Plan	Feb 2003	2. Introduction for Monitoring Cancer Disparities	March 2004
3. Removed burden stats from original Plan to create companion document (Cancer in RI)	June 2003	3. RI Screening Recommendations	Ongoing
- First draft of Cancer in RI	Sept 2003	4. RI Prevention Recommendations	Ongoing
- Critiqued	Oct 2003	5. RI specific goals for cancer surveillance	April 2004
- Revised	Dec 2003	6. RI specific goals for cancer prevention (except: Tobacco Control, Obesity Control)	Ongoing
- Discussed with Epi team at HEALTH	Jan 2004	7. RI specific goals for cancer screening	June 2004
- Edited for dissemination	Feb 2004	8. RI specific goals for cancer treatment	June 2004
- Provisional 2002 statistics added	Feb 2004		
4. Linkage of Cancer Control Plan to other plans	Feb 2004		
		Note: Items under development are indicated throughout the Plan with the following symbol:	

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<i>To be developed: Interventions Literature</i> <i>To be developed: Evaluation Principles</i>

LIST OF ACRONYMS

HEALTH	Rhode Island Department of Health
RICAN	Rhode Island Cancer Council
ACS	American Cancer Society
HARI	Hospital Association of Rhode Island
ACOS	American College of Surgeons
RICR	Rhode Island Cancer Registry
BRFSS	Behavioral Risk Factor Surveillance System
HIS	Health Interview Survey
HDD	Hospital Discharge Dataset
GIS	HEALTHgis - Rhode Island Department of Health Geographic Information System
RIGIS	Rhode Island Geographic Information System
HCPs	Health Care Providers

INTRODUCTION

Preface

Cancer is a serious health threat in Rhode Island. However, cancer can be controlled as shown by progress made since writing the State's first cancer control plan in 1990. Science has learned more about how to prevent cancer, how to detect it early (when treatments work best), and how to treat cancer more effectively.

Origins of the Plan

In response to gains in science, the Director of Health convened a Cancer Control Planning Task Force in 1996, composed of cancer control experts from the Rhode Island community and staff from the Rhode Island Department of Health ("HEALTH"), to revise Rhode Island's Cancer Control Plan. The plan was used by HEALTH and others in the State to guide public health programs that control cancer.

The membership of the Cancer Control Planning Task Force started with a small group of cancer control professionals to serve as advisers on the planning process itself. Then, following their guidance, membership was expanded to develop three Expert Panels, each of which took responsibility for studying one of the three traditional approaches to cancer control, including primary prevention, screening, and treatment, and making recommendations relevant to that approach. A fourth Expert Panel on Palliative Care was created at the recommendation of the Expert Panel on Cancer Treatment, to emphasize the need for better palliative care in the treatment of terminally ill cancer patients.

Many of the ideas proposed by the Task Force were published in *Medicine and Health / Rhode Island*, Rhode Island's journal of medicine and public health practice. Articles were written on prevention, screening, treatment, and palliation, inviting comments from readers. These comments were analyzed by the Task Force and resulted in changes to the ideas as they were used to write the Cancer Control Plan.

The findings of the Task Force were pulled together to draft a revised Cancer Control Strategic Plan for Rhode Island, which was read by cancer control experts throughout the State. Comments from these experts were used to refine the plan prior to its formal adoption by HEALTH in September 1998.

Revising the Strategic Plan

Current revisions to the plan have been developed from the 1998 Cancer Control Plan, the Comprehensive Cancer Control grant proposal developed by the Core Team, and the Healthy People 2010 goals for the nation. HEALTH intends this to be a "working plan," easily revised in response to Rhode Island's changing cancer profile and to new scientific findings about the prevention, detection, and treatment of cancer. As old sections are revised and new sections written, they will be circulated for public review, and revised on the basis of comments received. Separate Annual Action Plans will be written for the Cancer Control Program at large and for each specific intervention, to guide activity in detail.

THE BURDEN OF CANCER IN RHODE ISLAND

Cancer is a major cause of morbidity and the second leading cause of death in Rhode Island, as it is in the United States as a whole. About four out of every 10 people in Rhode Island will develop cancer sometime in the course of their lives (5,800 new cases annually), and half of them will die of the disease (2,400 deaths annually). (ACS Facts 2003) At any one time, it is estimated that over 33,000 Rhode Islanders are living with cancer or are cancer survivors.

According to data from 1995-1999, Rhode Island ranks 13th in highest overall cancer mortality rates among the 50 states and Washington D.C. (ACS Facts 2003) Rhode Island cancer mortality, among the highest in the nation, displays an "urban profile." When the differential between RI and US rates is decomposed, it is found to be caused by cancers of a limited number of anatomical sites, including cancers in which diet is implicated and cancers related to tobacco use. Mortality rates from these cancers are elevated in urban areas throughout the developed world.

Working from American Cancer Society estimates for the nation as a whole, and prorating them on the basis of total population, cancer costs RI about \$545 million per year, about \$196 million in direct medical costs, and about \$349 million in lost productivity from illness and death. (ACS Facts 2002)

Rhode Island Specific Objectives for Overall Cancer

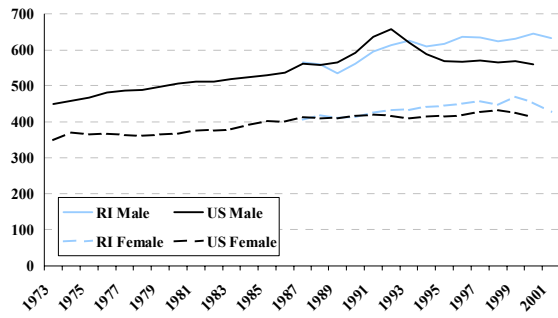
By 2005:	RI Baseline (1990-94)	2005 Target	RI Current (1996-00)
• Reduce the age-adjusted mortality rate for all cancers combined among men (deaths per 100,000; age-adjusted to the year 2000 standard population).	290.0	278.6	270.7
• Reduce the age-adjusted mortality rate for all cancers combined among women (deaths per 100,000; age-adjusted to the year 2000 standard population).	183.9	177.0	179.0

Cancer Trends

Over the past decade, the incidence of all cancers combined increased among Rhode Island men. Among Rhode Island women, cancer incidence increased for most of the early 1990's but has decreased in recent years. The increase in cancer incidence rates can be partly attributed to the development and use of cancer screening techniques which are effective in finding cancerous lesions at early stages.

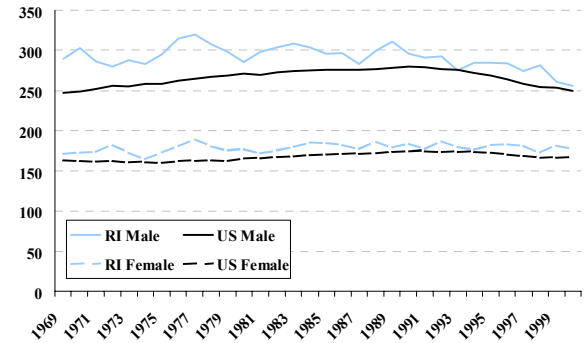
RI has experienced higher rates of cancer mortality than the nation over a period of at least five decades. Although this continued into the 1990s, the difference between RI and US cancer mortality rates, among both males and females, has gotten smaller over time.

Figure 5-1. Cancer incidence for all cancers combined by year and sex
Annual invasive* cancer incidence rates** by sex for all cancers combined, RI and US, 1973-2001.



* Invasive includes the following stages of disease at diagnosis: local, regional, distant, and unknown.
** Rates are age-adjusted to the year 2000 US population, expressed as cases per 100,000 population.
Source: RICR, HEALTH; SEER Public-Use 1973-2000 Data; calculated with SEER*Stat.

Figure 5-2. Cancer mortality by year and sex for all cancers combined
Annual cancer mortality rates* by sex for all cancers combined, RI and US, 1969-2000.

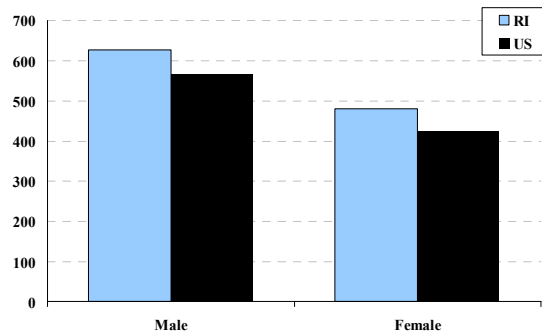


* Rates are age-adjusted to the 2000 US standard population, expressed as deaths per 100,000 population.
Source: Office of Vital Records, HEALTH; SEER US Mortality 1969-2000 Data; calculated with SEER*Stat.

Cancer Disparities

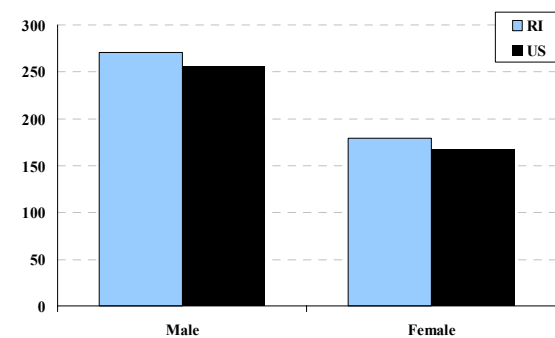
Differentials in cancer rates by sex are expected. They can be related to internal factors that differ between males and females, such as reproductive systems, or to external factors, such as historical lifestyle differences (i.e., occupational exposures to carcinogens, historical trends in smoking). In both Rhode Island and the national as a whole, the burden of cancer is higher among men than women. This disparity is largely attributable to cancers of the colon-rectum, lung-bronchus, and urinary bladder.

Figure 5-3. Cancer incidence by sex for all cancers combined
Cancer incidence rates* by sex for all cancers combined, RI and US, 1996-2000.



* Rates are age-adjusted to the 2000 US standard population, expressed as cases per 100,000 population.
Source: RICR, HEALTH; SEER Public-Use 1973-2000 Data; calculated with SEER*Stat.

Figure 5-4. Cancer mortality by sex for all cancers combined
Cancer mortality rates* by sex for all cancers combined, RI and US, 1996-2000.

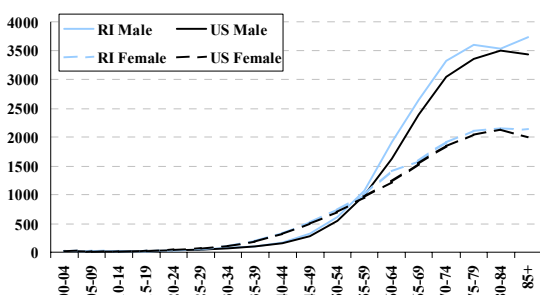


* Rates are age-adjusted to the 2000 US standard population, expressed as deaths per 100,000 population.
Source: Office of Vital Records, HEALTH; SEER US Mortality 1969-2000 Data; calculated with SEER*Stat.

Cancer differentials by age are also expected. Due to both internal factors, such as normal aging processes, and external factors, such as exposure to carcinogens, cancer is largely a disease of age. With a population that is both growing and aging, even if cancer rates remain stable, the number of people diagnosed with cancer is expected to increase. (Age)

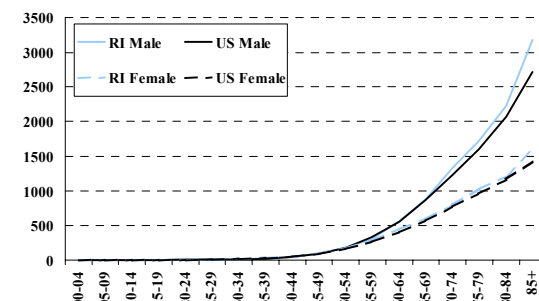
Careful consideration must be taken when comparing populations with different age distributions. Age-adjustment of rates eliminates the effect of different age distributions in different populations.

Figure 5-5. Cancer incidence by age and sex for all cancers combined
Invasive* cancer incidence rates** by age and sex for all cancers combined, RI and US, 1996-2000.



* Invasive includes the following stages of disease at diagnosis: local, regional, distant, and unknown.
** Rates are age-specific, expressed as cases per 100,000 population.
Source: RICR, HEALTH; SEER Public-Use 1973-2000 Data; calculated with SEER*Stat.

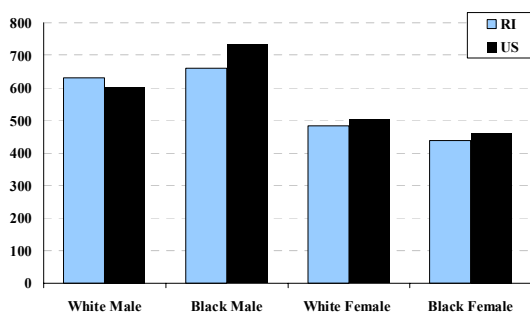
Figure 5-6. Cancer mortality by age and sex for all cancers combined
Cancer mortality rates* by age and sex for all cancers combined, RI and US, 1996-2000.



* Rates are age-specific, expressed as deaths per 100,000 population.
Source: SEER Incidence and US Mortality Statistics, NCHS

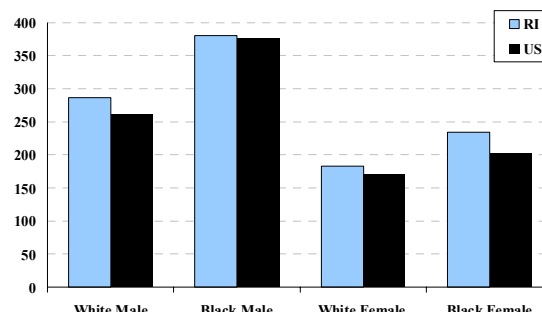
Even though incidence rates from all cancers combined are higher among white females than black females, mortality rates from all cancers combined are higher among blacks than whites in RI. With few unproven exceptions, there is no expected internal or genetic reason for this racial differential. Cancer prevention and control efforts may not have effectively reached minority populations. Several factors may be involved, such as late stage of disease at diagnosis, health care access, disease history, genetic differences, survivorship, risk factors, and health behaviors. (Race)

Figure 5-7. Cancer incidence by race and sex for all cancers combined
Average annual cancer incidence rates* by race and sex for all cancers combined, RI and US, 1987-2000.



* Rates are age-adjusted to the year 2000 US standard population, expressed as cases per 100,000 population.
Source: RICR, HEALTH; SEER Public-Use 1973-2000 Data; calculated with SEER*Stat.

Figure 5-8. Cancer mortality by race and sex for all cancers combined
Average annual cancer mortality rates* by race and sex for all cancers combined, RI and US, 1987-2000.



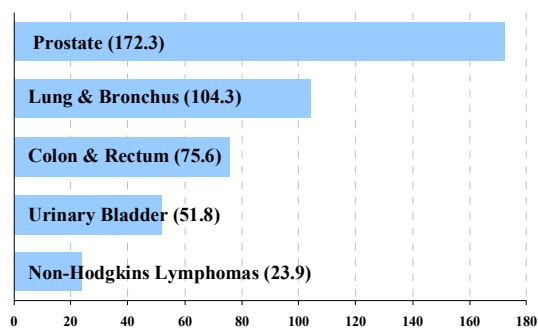
* Rates are age adjusted to the year 2000 US standard population, expressed as deaths per 100,000 population.
Source: Office of Vital Records, HEALTH; SEER US Mortality 1969-2000 Data; calculated with SEER*Stat.

Common Cancers

In 2003, an estimated 5,800 cancer cases will be diagnosed in RI. The four leading cancer diagnoses are cancers of the prostate (estimated 900 new cases), lung and bronchus (800 new cases), female breast (800 new cases), and colon and rectum (700 new cases). (ACS Facts 2003) Leading cancer sites differ for males and females.

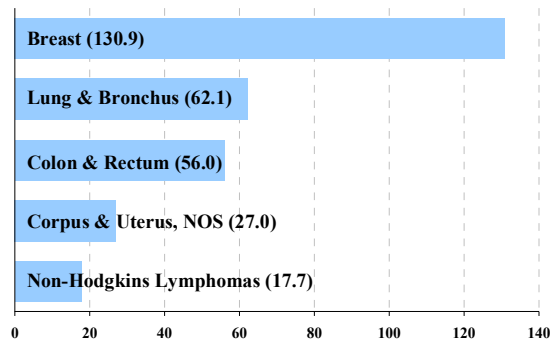
In 2003, an estimated 2,400 Rhode Islanders will die of cancer. The four most deadly cancers in RI are cancers of the lung and bronchus (700 estimated new deaths), colon and rectum (300 estimated new deaths), female breast (200 estimated new deaths), and prostate (100 estimated new deaths). (ACS Facts 2003) Leading causes of cancer death differ for males and females.

Figure 5-9. Leading male cancer sites
Cancer incidence rates among males, RI, 1996-2000.*



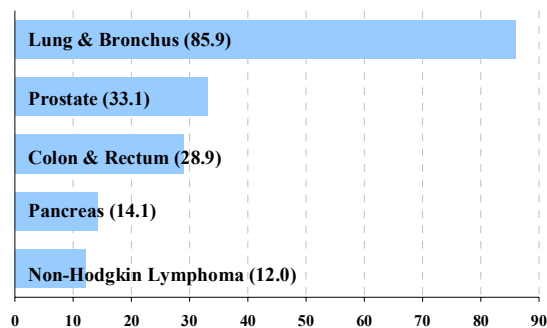
* Rates are age-adjusted to the year 2000 US standard population, expressed as cases per 100,000 population. Source: RICR, HEALTH; calculated with SEER*Stat.

Figure 5-10. Leading female cancer sites
Cancer incidence rates among females, RI, 1996-2000.*



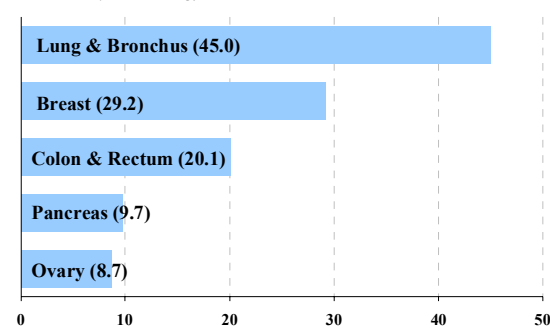
* Rates are age-adjusted to the year 2000 US standard population, expressed as cases per 100,000 population. Source: RICR, HEALTH; calculated with SEER*Stat.

Figure 5-11. Leading male cancer deaths
Cancer mortality rates among males, RI, 1996-2000.*



* Rates are age-adjusted to the year 2000 US standard population, expressed as deaths per 100,000 population. Source: Office of Vital Records, HEALTH; calculated with SEER*Stat.

Figure 5-12. Leading female cancer deaths
Cancer mortality rates among females, RI, 1996-2000.*



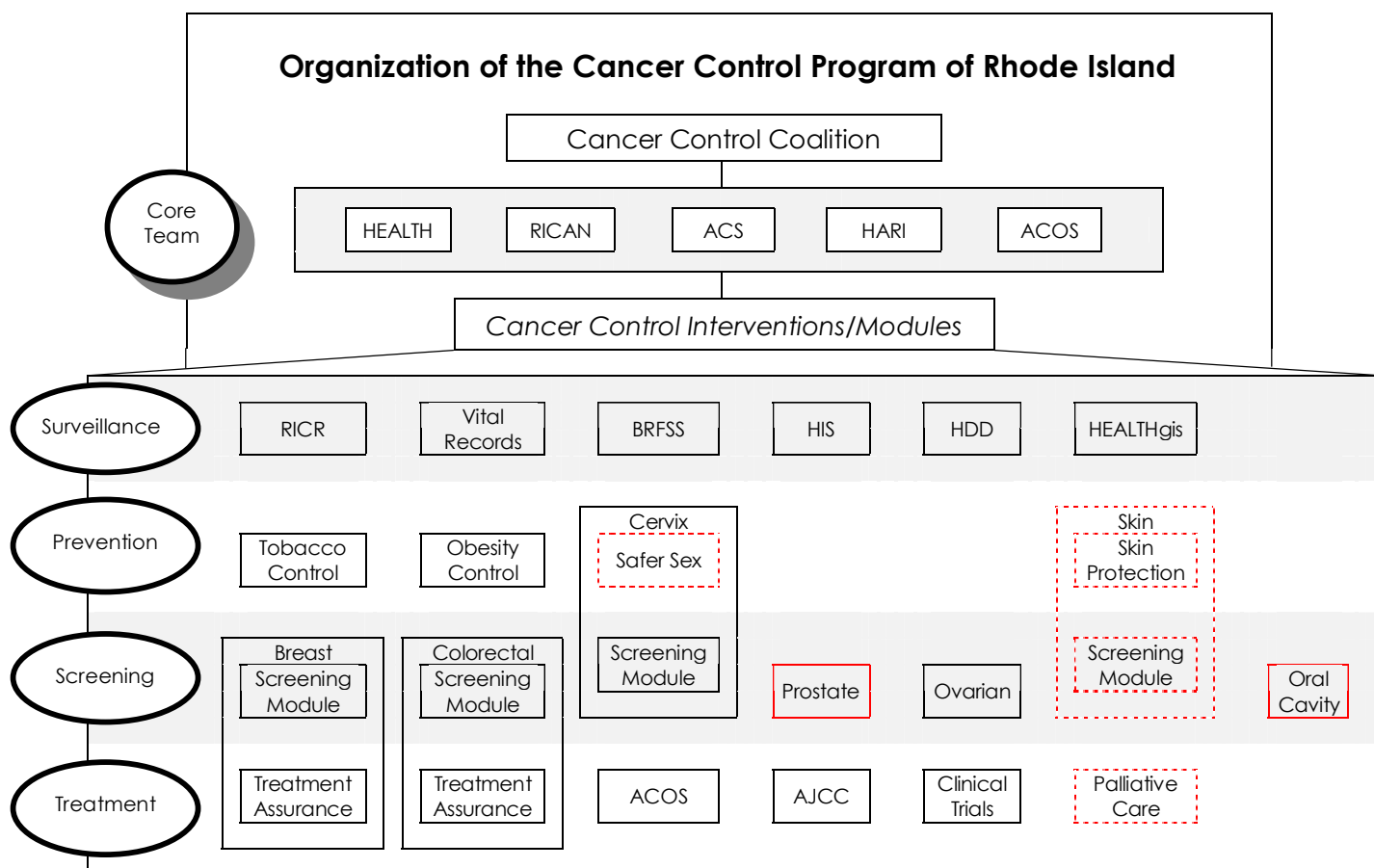
* Rates are age-adjusted to the year 2000 US standard population, expressed as deaths per 100,000 population. Source: Office of Vital Records, HEALTH; calculated with SEER*Stat.

ORGANIZATION OF THE CANCER CONTROL PROGRAM

The Rhode Island Cancer Control Program was created by the General Assembly in 1985 as a responsibility of the Department of Health (HEALTH). In response to this critical mandate, HEALTH:

- Tracks cancer trends through the RI Cancer Registry
- Develops plans to fight cancer in RI
- Helps people prevent cancer with healthy lifestyles
- Promotes cancer screening, to find cancer when it can be cured
- Provides free mammograms and Pap tests for women of low income
- Promotes high-quality hospital cancer programs and clinical trials
- Promotes hospice care for cancer patients who are very ill

The Cancer Control Program is comprised of a cancer control coalition, a Core Team of the coalition, and cancer control interventions and modules. In the model below, cancer control interventions/modules are grouped into four interventions: surveillance, prevention, screening, and treatment. Intervention boxes with red borders indicate intervention/modules that have been proposed but have not yet been actuated. There are several other collaborations and partnerships within the RI community that are not displayed in the diagram of the Cancer Control Program, but are listed at the end of this section.



Note: Black borders indicate existing interventions/modules
 Red borders indicate interventions/modules that have existing infrastructure but are still under development
 Red-checked borders indicate proposed interventions/modules

Cancer Control Coalition

RI has a cancer control network that has been used to pull together small groups for advocacy (legislation, cancer control plans). The goal of the Cancer Control Program is to develop this network into a cancer control coalition. The Coalition would: provide executive function for the coalition; monitor and support planning; develop new interventions; and coordinate activities and information. To provide these functions, the coalition would need a defined mission, annual gatherings (meeting, conferences, mini-summits) to provide planning opportunities, a central information mode to disseminate information quickly and simultaneously (newsletter), and advocacy.

Core Team of the Coalition

The leadership of five organizations (HEALTH, RICAN, ACS, HARI, and ACOS) composes the Core Team of the Coalition. HEALTH, RICAN, ACS, HARI, and ACOS are all central to the cancer control program. Although each has a specific primary role, the five organizations work collaboratively to advise and support all aspects of the program as a team, meeting monthly to assess program progress, barriers to progress, and ways to overcome the barriers. Members of the Core Team help recruit new members to the Coalition, and serve as ambassadors to other organizations in the RI community.

HEALTH: The Department of Health houses the RI Cancer Control Program, created by the General Assembly in 1986 and funded by the State of RI and the CDC. The Cancer Control Program at HEALTH runs the RICR (collaboratively with HARI) and other cancer surveillance programs, engages in cancer control advocacy at the state and municipal levels, and has developed statewide WCSP and TCP.

RICAN: The RI Cancer Council is a state-supported community program established in 1999 by a grant from the RI General Assembly. RICAN was established to encourage cooperative, comprehensive, and complementary planning among the public, private, and volunteer sectors of the State by maintaining an integrated information network of resources for all to use. Through this network, RICAN helps the public find resources to learn about and deal with cancer, and helps the medical community build consensus about cancer screening and treatment.

ACS: The American Cancer Society is a nationwide community-based voluntary health organization founded in 1913. The mission of the ACS is to eliminate cancer as a major health problem by "preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service."

HARI: The Hospital Association of RI, established in XXXX, represents and advocates for the interests of the hospitals in RI in order to "positively influence public opinion, legislative outcomes, and regulatory policy." HARI (collaboratively with HEALTH) maintains the RICR, and HARI staff conducts the day-to-day operations of the Registry.

ACOS: The American College of Surgeons "is a scientific and educational association of surgeons that was founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice." The ACOS has approved and supports 10 hospital-based cancer programs in the State, and participates in cancer control advocacy at the state level.

Cancer Control Interventions/Modules

Cancer surveillance

RICR: The RI Cancer Registry, established in 1986, is a statewide surveillance database that contains demographic and clinical information on all cancer diagnoses in RI, and produces official cancer statistics for the Cancer Control Program and the State. The Registry is run jointly by HEALTH and HARI, while HARI staff conducts the day-to-day operations, assuring data accuracy and completeness.

Office of Vital Records: The Office of Vital Records is the State agency responsible for the registration, filing, and maintenance of vital records (legal documents of birth, death, and marriage) in RI, and the periodic publication of data derived from them.

BRFSS: The Behavioral Risk Factor Surveillance System is an annual telephone survey that monitors behavioral risk factors among adults 18 years and older in the United States. The BRFSS produces sample survey data on preventive behaviors and screening activities relevant to cancer control. Fifty states and four territories perform the BRFSS each year with funding and methodological standards provided by the CDC. Rhode Island participation in the BRFSS began in 1984 and is overseen by the Office of Health Statistics at HEALTH.

HIS: The RI Health Interview Survey, a periodic telephone survey of approximately 2,600 households including 6,500 individuals per iteration, "collects and analyzes data for all members of contacted households on a variety of health topics including: health status, health care utilization, health care coverage, health behaviors, preventive services, environment, and some health conditions. The RI-HIS, overseen by the Office of Health Statistics at HEALTH, was administered in 1985, 1990, 1996, and most recently in 2001. The next RI-HIS will be administered in 2003."

HDD: Hospital Discharge Database is a statewide data set including raw hospital discharge data with patient identifiers. Data for public use removes all patient identification information. Reporting of hospital discharge information has been mandatory since 1989 (prior voluntary reporting since mid-1970's) and is maintained by HEALTH in conjunction with HARI.

HEALTHgis: The RI Geographic Information System (RIGIS) program uses a collective database of comprehensive geographically related information to assimilate, analyze, and depict spatially related information. In 2002, HEALTHgis was created in the Office of Health Statistics at HEALTH to utilize geographic information for public health purposes.

Cancer prevention

Tobacco Control: The RI Tobacco Control Program (TCP) based at HEALTH (under the jurisdiction of the Cancer Control Program?) is the "governmental organization responsible for addressing smoking as a major health problem." The goals of this Program include tobacco prevention among youth, smoking cessation, elimination of ETS, and elimination of tobacco use disparities. The Program, established in 1975, was expanded extensively in 1991 when RI was funded by the National Cancer Institute as one of the first ASSIST states.

Obesity Control: The obesity control program, established in 2001, is a three-year program based at HEALTH that aims to reduce obesity and related chronic diseases among Rhode Islanders. This goal will be reached through the development of a "statewide system to implement and evaluate nutrition and physical activity programs within priority communities."

Cervical Cancer Prevention: The focus of cervical cancer prevention is the promotion of safe sex. Although there is no intervention directly related to cervical cancer prevention, the Office of Communicable Diseases at HEALTH promotes abstaining from sexual intercourse, limiting sexual relationships to those between mutually monogamous partners, and using latex condoms during all sexual activity.

Skin Cancer Prevention: The focus of skin cancer prevention is to reduce exposure to ultraviolet light. A proposed skin cancer program, under development by the Core Team (ACS lead), would cover skin cancer prevention and skin cancer screening as an integrated intervention. The prevention goal of this program would be to reduce excessive exposure to ultraviolet light by promoting healthy skincare behaviors through professional education and public education.

Cancer screening

Breast Cancer Screening: Breast cancer screening (and cervical cancer screening) is covered by the RI Women's Cancer Screening Program (WCSP), funded by the CDC and managed by HEALTH. The WCSP "provides free breast and cervical cancer screening services, including mammograms, for Rhode Island women who are 50 or older, uninsured or underinsured, and with incomes at or less than 250% of the poverty level." This Program was established in 1986 by the Director of HEALTH to increase the proportion of women who were screened for breast cancer according to NCI screening guidelines, and was later expanded to include cervical cancer screening.

Cervical Cancer Screening: Cervical cancer screening (and breast cancer screening) is covered by the RI Women's Cancer Screening Program (WCSP). See *Breast Cancer Screening* for detailed information about this intervention.

Colorectal Cancer Screening: Colorectal cancer screening (and colorectal cancer treatment) would be covered by a proposed colorectal cancer program under development by the Core Team (RICAN lead). The screening goal of this program would be to assure that all eligible people get screened for colorectal cancer by promoting colorectal cancer screening through professional education and public education.

Prostate Cancer Screening: The existing infrastructure for a prostate cancer screening program includes a mini-plan developed by HEALTH and ACS, and community liaison built through ACS. However, the foundation of this program is under development by the Core Team (ACS lead). The goal of this program would be to assure that all eligible men are informed about the risks and benefits of prostate cancer screening, and that screening is available to all men who request to be screened. This goal would be reached by promoting prostate cancer screening through professional education and public education.

Ovarian Cancer Screening: RICAN has addressed ovarian cancer education in previous years. However, the development of an ovarian cancer program is being undertaken by the Core Team. The goal of this program would be to increase awareness of and screening for ovarian cancer through professional education and public education.

Skin Cancer Screening: A proposed skin cancer program, under development by the Core Team (ACS lead), would cover skin cancer prevention and skin cancer screening as an integrated intervention. The screening goal of this program would be to assure that health care providers and patients perform visual inspections and remain alert for skin lesions by promoting skin cancer screening through professional education and public education.

Oral Cancer Screening: Oral cavity cancer screening is addressed by the Oral Health Program at HEALTH. Although the infrastructure for this program exists, further development is under way to focus more specifically on oral cancer. The purpose of an oral cancer program would be to assure that health care providers and patients perform visual inspections and remain alert for lesions in the oral cavity.

Cancer treatment

Breast Cancer Treatment Assurance: There are two parts to breast cancer treatment in RI. The first is the assurance of breast cancer treatment through the WCSP at HEALTH to assure treatment to any women diagnosed in the program. The second part is ongoing projects to promote breast health through the RI Breast Care Task Force at RICAN, such as the Breast Care Algorithm disseminated in September, 2002.

Cervical Cancer Treatment Assurance: Cervical cancer treatment is assured through the WCSP at HEALTH to assure treatment to any women diagnosed with CIN I/, CIN II/CIS, or cervical cancer in the program.

Colorectal Cancer Treatment: The proposed colorectal cancer program would promote appropriate and effective treatment of colorectal cancer through a Colorectal Care Task Force (RICAN lead).

ACOS: The American College of Surgeons, also part of the Core Team, is an association of surgeons that strives to improve quality of care by setting treatment standards. For cancer treatment, the ACOS participates in cancer control advocacy and promotes the approval of cancer treatment programs. ACOS has approved and currently supports 10 approved hospital based cancer programs in RI.

Clinical Trials: The enrollment of patients in clinical trials is crucial for the development of new therapeutic drugs and techniques. The promotion of patients in clinical trials is a collaborative effort of many organizations, including the five organizations of the Core Team.

Palliative Care: Palliative care is care to terminally ill patients who are in the final stage of their lives and often to patients in the progressive stages of a life-threatening illness. Hospice care represents a proven, systematic approach to the provision of palliative care, aiming to control symptoms and maximize the quality of life, not to cure the disease. The purpose of a proposed palliative care program would be to inform the public about hospice care and to increase accessibility to services.

Other collaborative partnerships and community involvement

- Brown University
- Lifespan (hospital consortium)
- RI Breast Cancer Coalition
- RI General Assembly
- RI Oncology Nurses' Society
- RI Prevention Coalition
- RI Tobacco Control Coalition
- RI Worksite Wellness Council
- University of RI

CANCER CONTROL STRATEGIES

The overall goal of *Healthy People 2010* for the control of cancer is to “Reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer.” The Cancer Control Coalition has modified the Healthy People 2010 goal for RI by recognizing its own focus on cancer:

“Promote health through better prevention, detection, and treatment of cancer, and through better education of cancer patients, their families, and the health care providers who serve them.”

Strategies proven to be helpful in reaching this goal are: monitoring the burden of cancer (**surveillance**); avoiding known external (non-genetic) causes of cancer (**prevention**); identifying tumors at early stages of development, when treatment is more likely to effect a long-term, disease-free state (**screening**); using state-of-the-art cancer therapies (**treatment**) to control or cure the disease; and assuring effective pain control and other supportive measures (**palliative care**) for those patients who will eventually die of their disease, including supportive services for family care givers. Because different types of cancer vary in the extent to which they may be controlled by prevention, screening, and treatment, comprehensive cancer control embraces all approaches.

After reviewing the burden of cancer to Rhode Islanders, the national 2010 objectives, and several known strategies for cancer control, the Core Team selected objectives in the following four key areas to address the RI problem:

1. Cancer Surveillance
2. Cancer Prevention
3. Cancer Screening
4. Cancer Treatment

Objectives from the original 1998 plan were developed as “SMART” objectives. As the plan is updated on the basis of ongoing and future planning efforts, the objectives will be updated in this format. Each will be tested to meet the following criteria:

Specific:	It identifies a specific event or action that will take place.
Measurable:	It quantifies the amount of change to be achieved.
Achievable and Ambitious:	It is realistic given available resources and plans for implementation, yet challenging enough to accelerate program objectives.
Relevant:	It is logical and relates to the program's goals.
Time-bound:	It specifies a time by which the objective will be achieved.

Source: MacDonald G, Starr G, Schooley M, Yee SL, Klimowski K, Turner K. Introduction to Program Evaluation for Comprehensive Tobacco Control Programs. Atlanta (GA): Centers for Disease Control and Prevention; 2001.

LOGIC MODEL FOR CANCER CONTROL IN RHODE ISLAND

This logic model outlines the layout of a strategic plan for cancer control in Rhode Island. Further detail will be explored in subsequent sections.

Reduce the burden of cancer among RI residents.

Monitor cancer burden.

Prevent cancer development.

Detect cancer at earlier stages of development.

Treat cancer to maximize survival, functionality, and quality of life.

Eliminate disparities in cancer mortality among RI residents.

Identify socially meaningful disparities in cancer burden.

Identify modifiable determinants of disparities, like cancer risks and healthcare access.

Plan and field targeted interventions to minimize the causes of disparities.

Reduce the burden of cancer among Rhode Island residents.

Monitor cancer burden.

- Measure, describe, and interpret the absolute cancer burden borne by 24 segments of the Rhode Island population:

Age	FAMILY INCOME > 200 % POVERTY		FAMILY INCOME < 200 % POVERTY	
	Males	Females	Males	Females
00-17	[abs. burden]	[abs. burden]	[abs. burden]	[abs. burden]
18-39	[abs. burden]	[abs. burden]	[abs. burden]	[abs. burden]
40-49	[abs. burden]	[abs. burden]	[abs. burden]	[abs. burden]
50-64	[abs. burden]	[abs. burden]	[abs. burden]	[abs. burden]
65-74	[abs. burden]	[abs. burden]	[abs. burden]	[abs. burden]
75+	[abs. burden]	[abs. burden]	[abs. burden]	[abs. burden]

...where absolute burden is defined as:

Absolute Burden	Examples
Risk of Cancer	<ul style="list-style-type: none">✓ The number of people with a family history of specific cancers✓ The number of people with characteristics such as overweight✓ The number of people with behaviors such as smoking✓ The number of people with exposures to environmental carcinogens such as tobacco smoke
Risk of Poor Care	<ul style="list-style-type: none">✓ The number of people who do not have health insurance✓ The number of people who have Medicaid as their health insurance✓ The number of people with no regular source of primary care
Incidence	<ul style="list-style-type: none">✓ The number of people diagnosed with cancer per year✓ The number of people diagnosed with late stage cancer per year
Prevalence	<ul style="list-style-type: none">✓ The number of people alive on a selected date who have ever been diagnosed with a specific cancer
Mortality	<ul style="list-style-type: none">✓ The number of people dying of cancer per year
Health care costs	<ul style="list-style-type: none">✓ Dollars spent per year on screening, diagnosing, and treating cancers
Opportunity costs	<ul style="list-style-type: none">✓ The number of years of potential life lost to cancer mortality✓ The number of people limited in usual activity (work, school, leisure) because of cancer

...where trends in absolute burden are measured, described, and interpreted,

...and where robust statistics are presented by county and municipality.

- Give oversight of cancer surveillance to a committee of experts from the following "core" cancer control organizations in Rhode Island (hereafter referred to hereafter as the "Core Team"):

<u>Organization</u>	<u>Abbreviation</u>
✓ Rhode Island Department of Health	(HEALTH)
✓ Rhode Island Cancer Council	(RICAN)
✓ American Cancer Society	(ACS)
✓ American College of Surgeons	(ACOS)
✓ Hospital Association of Rhode Island	(HARI)

- Invite the Core Team to serve as the Cancer Surveillance Committee (CSC).
- Work cancer surveillance into the Core Team's regular meeting agenda.
- Develop an annual calendar of activities for the CSC.

Plan:	• Rhode Island Cancer Registry Workplan
Lead:	• HEALTH
Partners:	• Core Team

- Develop a Cancer Surveillance Plan for Rhode Island.
 - Draft a provisional Cancer Surveillance Plan from goals and objectives developed in the Rhode Island Cancer Control Plan of 1998, the Workplan of the Rhode Island Cancer Registry, the Workplan of the Rhode Island Cancer Control Program, and surveillance plans of other chronic disease programs at HEALTH.
 - Present the provisional Cancer Surveillance Plan to the CSC for initial discussion. Develop issues for further discussions, to be worked into the agenda of regular CSC (Core Team) meetings.

Plan:	• Rhode Island Cancer Control Plan
Lead:	• HEALTH
Partners:	• Core Team

- Build a cadre of well-trained cancer control epidemiologists.
 - Recruit and train epidemiologists for the Rhode Island Comprehensive Control Program and the Rhode Island Cancer Registry. Develop a team approach to the development of cancer control data and reports (EPI Team). Integrate the work of the epidemiologists into the fabric of the Rhode Island Comprehensive Control Program and its several planning and implementation projects.

Plan:	• Rhode Island Cancer Surveillance Plan
Lead:	• HEALTH
Partners:	• Core Team

- Maintain a strong central cancer registry.
 - Maintain funding and well-trained staff for the Rhode Island Cancer Registry.
 - Compete for special project funding from the National Program of Cancer Registries (NPCR), to enlarge the Rhode Island Cancer Registry staff and to create new incentives for timely, complete, and accurate cancer registry data.
 - Promote active participation of Rhode Island Cancer Registry staff in meetings and activities of the NPCR and of the North American Association of Central Cancer Registries (NAACCR).

Plan:	• Rhode Island Cancer Surveillance Plan
Lead:	• HEALTH
Partners:	• Core Team

- Maintain a strong vital records system.
 - Schedule regular meetings with HEALTH's Office of Vital Records staff to keep them abreast of cancer surveillance needs, to identify unmet needs, and to support them in meeting those needs.

- Advocate within HEALTH for timely, complete, and accurate vital records data, and support the Office of Vital Records in achieving these ends.

Plan:	• Rhode Island Cancer Surveillance Plan
Lead:	• HEALTH
Partners:	• Core Team

- Assure scheduled use of cancer control questions in essential surveys of the Rhode Island population, including:

- ✓ **Behavioral Risk Factor Surveillance System Survey**
- ✓ **Youth Risk Behavior Survey**
- ✓ **Health Interview Survey**
- ✓ **Youth Tobacco Survey**

- Schedule regular meetings with HEALTH's Office of Health Statistics staff to keep them abreast of cancer surveillance needs, to identify unmet needs, and to support them in meeting those needs.
- Advocate within HEALTH for timely, complete, and accurate population survey data, and support the Office of Health Statistics in achieving these ends.

Plan:	• Rhode Island Cancer Surveillance Plan
Lead:	• HEALTH
Partners:	• Core Team

- **Publish and disseminate statistics on the absolute cancer burden borne by 24 segments of the Rhode Island population, focusing on several audiences with a variety of data needs:**

Audience	Potential Data Needs
The General Public	✓ To understand cancer risks, cancer control strategies, and ways in which they may further the latter
State Lawmakers	✓ To understand the full extent of the cancer burden borne by their constituents, cancer control strategies, and ways in which they may assist cancer control efforts through policy-making and funding
Cancer Care Providers	✓ To receive feedback on the effectiveness of screening and treatment interventions
Primary Care Providers	✓ To receive feedback on the effectiveness of patient education and screening interventions
Cancer Control Planners	✓ To deploy cancer control resources where they are most likely to make the greatest impact on cancer burden in the state as a whole
Local Cancer Control Task Forces	✓ To deploy cancer control resources where they are most likely to make the greatest impact on cancer burden in local areas such as counties and municipalities

- Research the most appropriate media for conveying cancer burden statistics and other cancer control information to selected audiences, working with HEALTH's Office of Health Statistics staff and Office of Communication's staff to identify issues and develop ideas.

Plan:	• Rhode Island Cancer Surveillance Plan
Lead:	• HEALTH
Partners:	• Core Team

- Maintain an up-to-date website to serve as publication clearinghouse.

- Assign web redesign and maintenance responsibilities to the EPI Team.
- Develop a regular schedule for web updates.

Plan:	• Rhode Island Cancer Surveillance Plan
Lead:	• HEALTH
Partners:	• Core Team

- Update a comprehensive cancer burden document annually.

- Assign document maintenance and modification responsibilities to the EPI Team.
- Develop a regular schedule for updating the cancer burden document.

Plan:	• Rhode Island Cancer Surveillance Plan
Lead:	• HEALTH
Partners:	• Core Team

- Extract, customize, and repackage sections of the burden document for specific audiences (above).

- Research audience needs through the auspices of the CSC and its members.
- Develop a year-round publishing program with CSC guidance.

Plan:	• Rhode Island Cancer Surveillance Plan
Lead:	• HEALTH
Partners:	• Core Team

Prevent cancer development.

- **Reduce the incidence of cancers related to tobacco use (esp. cancers of the trachea, bronchus, lung, oral cavity, pharynx, larynx, esophagus, kidney, bladder, and pancreas).**

- Reduce tobacco use through decreased initiation and increased cessation.

- Raise the cost of retail tobacco products by maintaining high prices through state taxation and by enforcing the prohibition of tobacco sales to minors.
- Minimize the effect of tobacco advertising on the behaviors of teens and young adults by enhancing health education programs and by counter-marketing tobacco use in the mass media with “media advocacy” and with anti-tobacco ads.
- Promote “quitting” by encouraging physicians, dentists, and pharmacists to provide smokers with strong and consistent “quit” messages, and by increasing the accessibility of “quitting” resources such as counseling and nicotine replacement therapy.

Plan:	• Rhode Island Tobacco Control Plan
Lead:	• Rhode Island Tobacco Control Program (of the Rhode Island Department of Health)
Partners:	• Numerous community based organizations

- Reduce exposure to second-hand smoke.

- Enforce existing prohibitions of smoking in indoor areas.
- Promote the total prohibition of smoking in restaurants.

- Promote the elimination of indoor smoking in homes.

Plan:	• Rhode Island Tobacco Control Plan
Lead:	• Rhode Island Tobacco Control Program (of the Rhode Island Department of Health)
Partners:	• Numerous community based organizations

- **Reduce the incidence of cancers related to overweight (esp. cancers of the colon, endometrium, and breast).**

- Increase the proportion of people at healthy weight.
- Promote increased physical activity.
- Promote balanced diet.

Plan:	• Rhode Island Obesity Control Plan
Lead:	• Rhode Island Obesity Control Program (of the Rhode Island Department of Health)
Partners:	• Numerous community based organizations

- **Reduce the incidence of colorectal cancer.**

- Increase the proportion people ages 50 and over (and younger people at increased risk of developing colorectal cancer) who are screened with colonoscopy every 5-10 years for pre-cancerous polyps of the colon.
- Evaluate and enhance hospital-centric colorectal screening systems encompassing the geographic areas and medical practices (primary and specialty care) served by the hospitals.

Plan:	• Collaboration Plan of the Rhode Island Cancer Control Program
Lead:	• Rhode Island Cancer Control Program – "CCC" - (of the Rhode Island Department of Health)
Partners:	• Comprehensive Cancer Control Program Core Team * • Acute care hospitals (12) • Hospital Association of Rhode Island • Rhode Island Cancer Council • American Cancer Society • American College of Surgeons

* <u>The Core Team includes:</u>	<u>Abbreviations:</u>
• American Cancer Society	⇒ (ACS)
• American College of Surgeons	⇒ (ACOS)
• Hospital Association of Rhode Island	⇒ (HARI)
• Rhode Island Cancer Council	⇒ (RICAN)
• Rhode Island Department of Health	⇒ (HEALTH)

- Promote demand for colonoscopy among all people ages 50 and over and all people under age 50 who are at elevated risk of colorectal cancer.

Plan:	• <i>Under Development:</i> Plan for developing and supporting municipal cancer control task forces
Lead:	• CCC (HEALTH)
Partners:	• Core Team • Municipal Cancer Control Task Forces

- Identify segments of the population of all people 50 and over who are less likely to seek screening, and develop segment-specific social marketing campaigns to increase the likelihood that these people will seek screening.

Plan:	<ul style="list-style-type: none"> • <i>Under Development</i>: Plan for developing and supporting municipal cancer control task forces
Lead:	<ul style="list-style-type: none"> • CCC (HEALTH)
Partners:	<ul style="list-style-type: none"> • Core Team • Municipal Cancer Control Task Forces

• **Reduce the incidence of cervical cancer.**

- Increase use of barrier protection during sexual intercourse.
 - Promote the use of barrier protection during sexual intercourse.
 - Promote gynecological care for all sexually active women.
 - Promote the distribution of condoms by family planning programs.

Plan:	<ul style="list-style-type: none"> • <i>Develop work plan.</i>
Lead:	<ul style="list-style-type: none"> • Rhode Island Sexually Transmitted Diseases Prevention Program (HEALTH)
Partners:	<ul style="list-style-type: none"> • Division of Family Health (HEALTH) • Office of Primary Care (HEALTH) • Community Health Centers

- Increase the proportion of women (from age of first sexual activity) who are screened every 1-3 years with the Pap test for pre-cancerous lesions of the cervix.
 - Enhance the outreach capability of the RI Women's Cancer Screening Program.
 - Expand the capacity of community health centers to provide gynecological care.

Plan:	<ul style="list-style-type: none"> • Rhode Island Women's Cancer Screening Program Plan
Lead:	<ul style="list-style-type: none"> • Rhode Island Women's Cancer Screening Program (HEALTH)
Partners:	<ul style="list-style-type: none"> • Office of Primary Care (HEALTH) • Community Health Centers

• **Reduce the incidence of skin cancers, including melanomas of skin.**

- Prevent sunburn and decrease cumulative skin exposure to sunlight.
 - Promote avoidance of mid-day sun exposure.
 - Promote sun-safe outdoor clothing and use of sunscreen.

Plan:	<ul style="list-style-type: none"> • <i>Develop work plan.</i>
Lead:	<ul style="list-style-type: none"> • ACS
Partners:	<ul style="list-style-type: none"> • Core Team • [Dermatologists]

- Avoid artificial sources of UV light.
 - Educate the public about the risks of tanning salon use.

Plan:	<ul style="list-style-type: none"> • <i>Develop work plan.</i>
Lead:	<ul style="list-style-type: none"> • ACS
Partners:	<ul style="list-style-type: none"> • Core Team • [Dermatologists]

- **Reduce the incidence of oral, pharyngeal, and esophageal cancers.**

- Reduce tobacco use through decreased initiation and increased cessation.
 - (See above; "Reduce the incidence of cancers related to tobacco use.")
- Reduce excessive alcohol use.
 - Support alcohol-abuse-prevention programs on college campuses.
 - Educate the public about chronic alcohol use as a risk factor for cancer.
 - Encourage physicians and dentists to provide strong and consistent messages about chronic alcohol use and alcohol abuse.

Plan:	• <i>Develop work plan.</i>
Lead:	• <i>To Be Determined</i>
Partners:	• <i>Core Team</i>

Detect cancer at earlier stages of development.

- **Reduce the incidence of late stage breast cancer.**

- Increase the proportion of women ages 40 and over who are screened every 1-2 years with mammography.
 - Enhance the outreach capability of the Rhode Island Women's Cancer Screening Program to enroll more low-income women with no health insurance.
 - Expand the capacity of community health centers to provide gynecological care to more low-income women, insured and uninsured.
 - Identify segments of the population of women ages 40 and over who are less likely to seek screening, and develop segment-specific social marketing campaigns to increase the likelihood that these women will seek screening.

Plan:	• Rhode Island Women's Cancer Screening Program Plan
Lead:	• Rhode Island Women's Cancer Screening Program (HEALTH)
Partners:	• Office of Primary Care (HEALTH) • Community Health Centers

- **Reduce the incidence of invasive cervical cancer.**

- Increase the proportion of women (from age of first sexual activity) who are screened every 1-3 years with the Pap test.
 - (See above; "Reduce the incidence of cervical cancer.")

- **Reduce the incidence of late stage colorectal cancer.**

- Increase the proportion people ages 50 and over (and younger people at increased risk of developing colorectal cancer) who are screened with colonoscopy every 5-10 years.
 - (See above; "Reduce the incidence of colorectal cancer.")

- **Reduce the incidence of late stage prostate cancer.**

- Increase the proportion of men ages 40 and over who are informed about their statistical risk of developing prostate cancer (based on family history and personal factors), the course of the disease in its various forms, the pros and cons of prostatic specific antigen (PSA) to screen for prostate cancer, and the pros and cons of various forms of prostate cancer treatment.
- Educate the public about factors that increase the risk of prostate cancer and the importance of regular primary care for those at increased risk.

Plan:	• <i>Develop work plan.</i>
Lead:	• ACS
Partners:	• Core Team

- **Reduce the incidence of late stage ovarian cancer.**

- Increase the proportion of women at increased risk of developing ovarian cancer who are examined regularly by a gynecologist.
- Educate the public about factors that increase the risk of ovarian cancer and the importance of regular gynecological care for those at increased risk.

Plan:	• <i>Develop work plan.</i>
Lead:	• RICAN
Partners:	• Core Team

- **Reduce the incidence of late stage oral cancer.**

- Increase the proportion of people at increased risk of developing oral cancer who are examined regularly by a dentist.
- Educate the public about factors that increase the risk of oral cancer and the importance of regular dental care for those at increased risk.

Plan:	• <i>Under Development: Rhode Island Dental Health Plan</i>
Lead:	• Rhode Island Dental Health Program (HEALTH)
Partners:	• Core Team • Rhode Island Dental Society

- **Reduce the incidence of late stage skin cancer.**

- Increase the proportion of people at increased risk of developing skin cancer who are examined regularly by a dermatologist.
- Educate the public about factors that increase the risk of skin cancer and the importance of regular dermatological care for those at increased risk.

Plan:	• <i>Develop work plan.</i>
Lead:	• ACS
Partners:	• Core Team • [Dermatologists]

Treat cancer to maximize survival, functionality, and quality of life.

- **Use state-of-the-art protocols for the treatment of all cancers.**

- Increase enrollment in clinical trials.

- Evaluate and enhance the enrollment of cancer patients in clinical trials.
- Educate the public about the benefits of enrollment in clinical trials.

Plan:	<ul style="list-style-type: none">• <i>Develop work plan.</i>
Lead:	<ul style="list-style-type: none">• CCC (HEALTH)
Partners:	<ul style="list-style-type: none">• Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals• Core Team

- Promote the use of the Rhode Island consensus treatment protocol for breast cancer.

- Evaluate and enhance the use of the Rhode Island consensus treatment protocol for breast cancer patients who are not enrolled in clinical trials.

Plan:	<ul style="list-style-type: none">• <i>Develop work plan.</i>
Lead:	<ul style="list-style-type: none">• RICAN
Partners:	<ul style="list-style-type: none">• Core Team• Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals

- Develop a Rhode Island consensus treatment protocol for colorectal cancer.

- Engage representative community stakeholders in a planning process to draft, vet, and adopt a Rhode Island consensus treatment protocol for colorectal cancer.

Plan:	<ul style="list-style-type: none">• <i>(Will follow procedures used in developing a consensus treatment protocol for breast cancer.)</i>
Lead:	<ul style="list-style-type: none">• RICAN
Partners:	<ul style="list-style-type: none">• Core Team• [Gastroenterologists]

- Assure that all cancer patients in Rhode Island are treated under the auspices of an ACOS-approved hospital cancer program.

- Support and enhance the work of ACOS-approved cancer programs in eleven of Rhode Island's twelve acute care hospitals.

Plan:	<ul style="list-style-type: none">• <i>Develop work plan.</i>
Lead:	<ul style="list-style-type: none">• HARI
Partners:	<ul style="list-style-type: none">• Core Team• Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals

- Develop an ACOS-approved cancer program in the twelfth of Rhode Island's twelve acute care hospitals.

Plan:	• <i>Develop work plan.</i>
Lead:	• HARI
Partners:	• Core Team • Hospital No. 12

- Improve the proportion of cancer cases staged according to AJCC guidelines.
- Identify cancer cases recently treated without AJCC staging, investigate reasons for non-use; support necessary enhancements.

Plan:	• <i>Develop work plan.</i>
Lead:	• HARI
Partners:	• Core Team • Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals

- Increase the frequency and duration of hospice use for advanced illness.
- Educate the public about the benefits of hospice care for advanced illness.
- Identify barriers to the use of hospice care for advanced illness.
- Partner with ACOS-approved cancer programs to develop, promote, and monitor the use of local hospice-use guidelines, and to remove local barriers to the use of hospice care for advanced illness.

Plan:	• <i>Develop work plan.</i>
Lead:	• CCC
Partners:	• Core Team • Hospice programs licensed in Rhode Island • Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals

Eliminate disparities in cancer mortality among Rhode Island residents.

Identify socially meaningful disparities in cancer burden.

- **Produce annual cancer incidence and mortality statistics with detail by age, sex, socio-economic status, and race/ethnicity.**
 - Define a level of specificity for cancer statistics that facilitates the identification of socially meaningful disparities in cancer burden, the planning of targeted interventions, and the deployment of customized resources.
 - Inventory the level of specificity with which health statistics are used by three groups: 1/ Rhode Island stakeholders engaged generally in the elimination of health disparities; 2/ national organizations working to eliminate disparities in cancer burden (National Cancer Institute; Centers for Disease Control and P); /3 researchers publishing the results of social marketing interventions relevant to cancer control.
 - Assess the costs of surveying the various sub-populations thus defined at different levels of specificity.
 - Assess the effectiveness of social marketing campaigns designed to reach the various sub-populations thus defined at different levels of specificity.

Plan:	<ul style="list-style-type: none">• <i>Develop work plan.</i>
Lead:	<ul style="list-style-type: none">• Chronic Disease Surveillance Unit, Division of Disease Prevention and Control (HEALTH)
Partners:	<ul style="list-style-type: none">• Core Team• Office of Minority Health (HEALTH)• Rhode Island Tobacco Control Program (HEALTH)• Rhode Island Women's Cancer Screening Program (HEALTH)• Rhode Island Oral Health Program (HEALTH)• Rhode Island Cancer Registry (HEALTH)• Office of Health Statistics (HEALTH)

- Assure the timeliness, completeness, and accuracy of Rhode Island Cancer Registry data on age, sex, socio-economic status, and race/ethnicity.
- Improve the completeness and accuracy of demographic data in cancer case reports from twelve essential hospital tumor registries.

Plan:	<ul style="list-style-type: none">• Rhode Island Cancer Registry – RICR – Work Plan (HEALTH / HARI)
Lead:	<ul style="list-style-type: none">• RICR (HARI staff)
Partners:	<ul style="list-style-type: none">• Core Team (Doubles as Surveillance Committee of the RICR)• Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals

- In the immediate future, avoid undercounts of Hispanic case reports by attributing Hispanic ethnicity on the basis of surname.
 - Stay abreast of national-level research on ethnic attribution.
 - Make use of proven algorithms for ethnic attribution.

Plan:	• RICR Work Plan (HEALTH / HARI)
Lead:	• RICR (HEALTH staff)
Partners:	• Core Team (Doubles as Surveillance Committee of the RICR) • Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals

- Publish incidence and mortality statistics in formats that highlight socially meaningful disparities in cancer burden.

Plan:	• CCC Surveillance Plan (HEALTH / HARI)
Lead:	• RICR (HEALTH staff)
Partners:	• Core Team (Doubles as Surveillance Committee of the RICR) • Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals

Identify modifiable determinants of disparities, like cancer risks and healthcare access.

- **Produce annual cancer risk and healthcare utilization statistics with detail by age, sex, socio-economic status, and race/ethnicity.**
 - Define a level of specificity for cancer statistics that facilitates the identification of socially meaningful disparities in cancer burden, the planning of targeted interventions, and the deployment of customized resources.
 - (See above; "Identify socially meaningful disparities in cancer burden.")
 - Improve surveillance surveys by over-sampling two groups of Rhode Island residents: 1/ those who describe their ethnicity as "Hispanic," and 2/ those who describe their race as "Black."
 - Identify and convene a coalition of stakeholders within the Hispanic and African American communities of Rhode Island to advocate and plan for over-sampling.
 - Develop a practical, affordable plan to build over-sampling into regular public health surveys for key public health indicators.
 - Develop monetary resources to support implementation of the plan.

Plan:	• <i>Develop work plan.</i>
Lead:	• Office of Minority Health (HEALTH)
Partners:	• Office of Health Statistics (HEALTH) • Division of Disease Prevention and Control (HEALTH)

Plan and field targeted interventions to minimize the causes of disparities.

- **Build infrastructure for targeted planning.**
 - Produce statistical reports to inform comparisons between sub-populations (as defined, above), focusing on cancer burden, cancer risks, and healthcare access.

- Partner with public health program managers to design a standard report format.

Plan:	• <i>Develop work plan.</i>
Lead:	• Chronic Disease Surveillance Unit, Division of Disease Prevention and Control (HEALTH)
Partners:	<ul style="list-style-type: none"> • Office of Minority Health (HEALTH) • Rhode Island Tobacco Control Program (HEALTH) • Rhode Island Women's Cancer Screening Program (HEALTH) • Rhode Island Oral Health Program (HEALTH) • Rhode Island Cancer Registry (HEALTH) • Office of Health Statistics (HEALTH)

- Obtain marketing profiles of sub-populations (as defined, above) from local sources to assist in the design of effective, targeted interventions.
- Identify and contact community-based organizations with missions embracing the elimination of health disparities.
- Identify and contact community-based professionals with expertise in marketing to sub-populations of Rhode Island residents.

Plan:	• <i>Develop work plan.</i>
Lead:	• Communications Unit, Division of Disease Prevention and Control (HEALTH)
Partners:	<ul style="list-style-type: none"> • Core Team • Office of Minority Health (HEALTH) • Rhode Island Tobacco Control Program (HEALTH) • Rhode Island Women's Cancer Screening Program (HEALTH) • Rhode Island Oral Health Program (HEALTH) • Rhode Island Cancer Registry (HEALTH) • Office of Health Statistics (HEALTH)

- **Build tight, specific coalitions to “own,” plan, and field targeted interventions.**

- Develop coalitions around tightly focused missions and objectives.
- Develop specific missions.
- Develop quantified, time-limited objectives for interventions.

Plan:	• <i>Develop work plan.</i>
Lead:	• <i>To be determined.</i>
Partners:	<ul style="list-style-type: none"> • Core Team • Office of Minority Health (HEALTH)

- Enlist organizations with a strong stake in achieving missions and objectives.
- Research potential members' organizational missions, histories of advocacy and service to the relevant sub-populations, and ability to contribute meaningful resources to the elimination of specific disparities in cancer burden.
- Invite specific organizations to participate at the behest of the Director of Health.

Plan:	• <i>Develop work plan.</i>
Lead:	• <i>To be determined.</i>
Partners:	<ul style="list-style-type: none"> • Core Team • Office of Minority Health (HEALTH)

- Nurture coalitions with logistical support, regular feedback, and statistical information tailored to the management of missions.
 - Assign trained support staff and a resource budget to each coalition.
 - Design, publish, and disseminate a brief, coalition-specific newsletter, containing statistics, plans, progress to date, and challenges ahead.

Plan:	• <i>Develop work plan.</i>
Lead:	• <i>To be determined.</i>
Partners:	• Core Team • Office of Minority Health (HEALTH) • Communications Unit, Division of Disease Prevention and Control (HEALTH)

• **Develop targeted intervention “action plans.”**

- Frame.
 - Convene coalitions.
 - Present missions, including broad timetables for planning and action.
 - Present a standard written format for an action plan.
 - Present planning organization, method and schedule.
 - Define and assign first tasks.

Plan:	• <i>Develop work plans.</i>
Lead:	• <i>To be determined.</i>
Partners:	• Core Team • Other supportive organizations and professionals, as fit the planning challenges.

- Plan.
 - Meet in work groups with specific tasks and written products.
 - Foster communication among work groups with brief newsletters (above).
 - Fit written products into formatted action plans.
 - Reconvene coalition to review and discuss action plans as they come together.

Plan:	• <i>Develop work plans.</i>
Lead:	• <i>To be determined.</i>
Partners:	• Core Team • Other supportive organizations and professionals, as fit the planning challenges.

- Implement.
 - Define the specific contributions of each coalition member to implementation, using core funding to leverage community resources through coalition members.
 - Define an organizational “lead” for the implementation of each action plan.
 - Monitor implementation closely, using brief, regularly published newsletters (above) to communicate progress made and challenges encountered.
 - Convene coalitions regularly to discuss progress and amend action plans, as necessary, to overcome challenges.

- Publicize the work of the coalitions, celebrate successes, thank coalition members for their contributions.

Plan:	<ul style="list-style-type: none"> • <i>Develop work plans.</i>
Lead:	<ul style="list-style-type: none"> • <i>To be determined.</i>
Partners:	<ul style="list-style-type: none"> • Core Team • Other supportive organizations and professionals, as fit the planning challenges.

I. CANCER SURVEILLANCE

Cancer surveillance, the systematic collection, analysis, and interpretation of cancer data, provides the foundation for cancer control. It is an indispensable tool that enables public health professionals to better understand and tackle the cancer burden while advancing clinical, epidemiologic, and health services research. (HP) Surveillance data are "essential for planning and evaluating cancer control programs, allocating preventive and treatment resources, targeting and conducting research, and responding to concerns from citizens about the occurrence of cancer in their communities." (HP)

Please refer to the Rhode Island Cancer Surveillance Plan for complete detail on cancer surveillance.

Two foci of cancer surveillance interventions in Rhode Island are:

- Monitoring Cancer Burden
- Monitoring Cancer Disparities

National Healthy People 2010 Objectives

By 2010:	US Baseline	Target	RI Current
<ul style="list-style-type: none">• Increase the number of States that have a statewide population-based cancer registry that captures case information on at least 95 percent of the expected number of reportable cancers (number of states).	21 (1999)	45	*

* The Rhode Island Cancer Registry (RICR) was established by the RI General Assembly in 1985. The RICR database is about 95% complete. Because of their completeness (and accuracy), RICR data for calendar years from 1988 through 2001 have been included in NAACCR's calculation of combined national and international incidence rates (published annually in Cancer in North America from 1994 through 2003, and to be published in 2004). An independent outside audit of 1996 RICR data was undertaken by the CDC and NAACCR in 1998. The audit focused on data for cancers of the breast, prostate, lung, and colon-rectum. The audit report estimated the completeness of reporting for the four cancers to be 94.9%. Finally, the RICR submitted 1997-2001 data for evaluation by NAACCR in 2003. NAACCR staff evaluated the completeness of these data to exceed 95%.

DNC = Data not collected

MONITORING CANCER BURDEN



This section is to be redeveloped on the basis of results from researching current literature on cancer burden.

Monitoring Cancer Burden: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Please refer to the logic model on page 5-1 for the surveillance logic model.

National Healthy People 2010 Objectives

- None to date

Rhode Island Specific Goals

- None to date



UNDER
REVISION

DNC = Data not collected

MONITORING CANCER DISPARITIES



This section is to be redeveloped on the basis of results from researching current literature on cancer burden.

Monitoring Cancer Disparities: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Please refer to the logic model on page 5-1 for the surveillance logic model.

National Healthy People 2010 Objectives

- None to date

Rhode Island Specific Goals

1998 Cancer Control Plan

- Topic is discussed but there are no specific goals.

UNDER
REVISION

DNC = Data not collected

II. CANCER PREVENTION

Many cancer deaths could be prevented through lifestyle changes. Some common cancers, such as cancers of the lung, colon-rectum, oral cavity, skin, and cervix are largely preventable by avoiding certain risk factors, such as tobacco use, fatty diet, sedentary lifestyle, chronic alcohol use, exposure to ultraviolet radiation (sunlight), and certain sexually transmitted diseases. More than 180,000 tobacco-related cancer deaths (estimated in 2003) and another estimated 180,000 cancer deaths related to nutrition, physical inactivity, obesity and other lifestyle factors could be prevented through behavioral changes. (ACS Facts 2003)

Common risk behaviors and associated cancer types partially controllable by prevention		
Risk behaviors	Preventive Behaviors	Associated Cancer Type
Tobacco smoke	<ul style="list-style-type: none">Do not use tobacco.Avoid second hand tobacco smoke.	Lung-bronchus
Unbalanced diet	<ul style="list-style-type: none">Eat more fruits and vegetables.	Colon-rectum
Sedentary lifestyle	<ul style="list-style-type: none">Get regular moderate physical activity	
Unsafe sex	<ul style="list-style-type: none">Practice safer sex to reduce exposure to sexually transmitted diseases	Cervix
Ultraviolet radiation	<ul style="list-style-type: none">Avoid excessive sun exposure.Do not use artificial tanning devices.	Skin
Chronic alcohol use	<ul style="list-style-type: none">Limit consumption of alcohol	Oral cavity

Five foci of cancer prevention interventions in Rhode Island are:

- Tobacco Control
- Obesity Control
- Cervical Cancer Prevention
- Skin Cancer Prevention
- Oral Cancer Prevention Chronic Alcohol Use

TOBACCO CONTROL

Over the past forty years, more than 20 Surgeon General's reports (NIH) and countless studies have confirmed that both cigarette smoking and environmental tobacco smoke cause lung cancer. Lung cancer is a preventable cause of death, and with no effective screening procedures or treatments, the reduction of tobacco use is crucial. (HP) As such, a primary control strategy for lung cancer in RI is to reduce the proportion of current smokers and to reduce exposure to second-hand smoke. This presents a challenge because heavy advertisement from economically powerful companies continues to attract new consumers, and the drug's highly addictive nature makes smoking cessation difficult.

Based at HEALTH, the Rhode Island Tobacco Control Program aims to prevent tobacco use among youth, promote smoking cessation, eliminate environmental tobacco smoke, and eliminate tobacco use disparities. Increasing cigarette tax and restricting youth access to tobacco are notable achievements. However, more needs to be done to reduce exposure to environmental tobacco smoke and to increase tobacco program funding.

Rhode Island Lung Cancer Facts

- Lung cancer is the second most commonly diagnosed cancer and the leading cause of cancer death. Approximately 1,500 Rhode Islanders alive today were diagnosed with lung cancer at some point in the past 25 years.
- Lung cancer mortality decreased among men and increased among women in the 1990's. These changes reflect smoking trends of past decades.
- In the 1990's, the burden of lung cancer in Rhode Island surpassed that of the nation as a whole.
- Black men were more likely to be diagnosed with lung cancer than white men in the 1990's. At the national level, this racial disparity was considerably larger.
- Among persons diagnosed with lung cancer in Rhode Island, black persons were more likely to die from the disease than white persons in the 1990's.
- Kent, Providence, and Washington counties bear a greater burden of lung cancer than the nation as a whole.

Rhode Island Prevention Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Tobacco Control: Goals And Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of cancers related to tobacco use (esp. cancers of the trachea, bronchus, lung, oral cavity, pharynx, larynx, esophagus, kidney, bladder, pancreas).
 - Reduce tobacco use through decreased initiation and increased cessation.
 - Raise the cost of retail tobacco products by maintaining high prices through state taxation and by enforcing the prohibition of tobacco sales to minors.
 - Minimize the effect of tobacco advertising on the behaviors of teens and young adults by enhancing health education programs and by counter-marketing tobacco use in the mass media with "media advocacy" and with anti-tobacco ads.
 - Promote "quitting" by encouraging physicians, dentists, and pharmacists to provide smokers with strong and consistent "quit" messages, and by increasing the accessibility of "quitting" resources such as counseling and nicotine replacement therapy.
- Plan: • Rhode Island Tobacco Control Plan
 Lead: • Rhode Island Tobacco Control Program (of the Rhode Island Department of Health)
 Partners: • Numerous community based organizations
- Reduce exposure to second-hand smoke.
 - Enforce existing prohibitions of smoking in indoor areas.
 - Promote the total prohibition of smoking in restaurants.
 - Promote the elimination of indoor smoking in homes.
- Plan: • Rhode Island Tobacco Control Plan
 Lead: • Rhode Island Tobacco Control Program (of the Rhode Island Department of Health)
 Partners: • Numerous community based organizations

National Healthy People 2010 Objectives

By 2010:	US 1998 Baseline	2010 Target	RI Current
• Increase the proportion of Internists who counsel their at-risk patients about smoking cessation.	50%	85%	DNC
• Increase the proportion of Family physicians who counsel their at-risk patients about smoking cessation.	43%	85%	DNC
• Increase the proportion of Dentists who counsel their at-risk patients about smoking cessation.	59% (1997)	85%	DNC
• Reduce tobacco use by adults.			
Cigarette smoking	24%	12%	22.4% (2002) BRFSS
Spit tobacco	2.6%	0.4%	DNC
Cigars	2.5%	1.2%	DNC
Other products	Developmental		DNC
• Reduce tobacco use by adolescents			
Tobacco products (past month)	40%	21%	23.4% (2003) YRBS

Cigarettes (past month)	35%	16%	19.3% (2003) YRBS
Spit tobacco (past month)	8%	1%	4.6% (2003) YRBS
Cigars (past month)	18%	8%	10.5% (2003) YRBS
<ul style="list-style-type: none"> Increase smoking cessation attempts by adult smokers [adults who stopped smoking for one day or longer because they were trying to quit]. 	41%	75%	61.8% (2002) BRFSS
<ul style="list-style-type: none"> Increase smoking cessation attempts by adolescent smokers [ever-daily smokers in grades 9 through 12 who tried to quit smoking]. 	76%	84%	50.3% (2003) YRBS
<ul style="list-style-type: none"> Increase insurance coverage of evidence-based treatment for nicotine dependency. 			
Managed care organizations	75% (1997-98)	100%	33% (2004)
Medicaid program in States and the District of Columbia (number of programs)	24	51	None in RI
All insurance	Developmental		DNC
<ul style="list-style-type: none"> Reduce the lung cancer death rate (deaths per 100,000; age-adjusted to the year 2000 US standard population). 	57.6	44.9	61.8 (1996-00)

Rhode Island Specific Goals

From the Rhode Island Tobacco Control Program

Please refer to the Tobacco Control Program's Annual Action Plan for further detail on RI specific goals for tobacco control. A copy of the plan can be obtained by contacting Betty Harvey from the RI Tobacco Control Program at bettyh@doh.state.ri.us. Major goals of the Program include:

- Goal 1:** Eliminate exposure to environmental tobacco smoke.
- Goal 2:** Prevent tobacco initiation of tobacco use among youth.
- Goal 3:** Promote cessation for adults and youth.
- Goal 4:** Identify and eliminate tobacco-related disparities in specific population groups.

1998 Cancer Control Plan

By 2005:	RI Baseline	Target	RI Current
<ul style="list-style-type: none"> Reduce the proportion of people ages 18 and over who smoke cigarettes. 	24.7% (1995)	15%	22.4% (2002) BRFSS
<ul style="list-style-type: none"> Reduce the age-adjusted incidence rate for cancer of the lung-bronchus among men (cases per 100,000; age-adjusted to the year 2000 standard population). 	106.3 (1990-94)	94.0	102.3 (1997-01)
<ul style="list-style-type: none"> Limit the age-adjusted incidence rate for cancer of the lung-bronchus among women (cases per 100,000; age-adjusted to the year 2000 standard population). [Note: Like the post-WWII increases in lung cancer incidence and mortality observed among men, it is feared that lung cancer may reach epidemic proportions among women before eventually plateauing and decreasing.] 	52.4 (1990-94)	69.6	61.3 (1997-01)
<ul style="list-style-type: none"> Reduce the age-adjusted mortality rate for cancer of the lung-bronchus among men (deaths per 100,000; age-adjusted to the year 2000 standard population). 	91.9 (1990-94)	79.2	85.9 (1996-00)

<ul style="list-style-type: none"> Limit the age-adjusted mortality rate for cancer of the lung-bronchus among women (deaths per 100,000; age-adjusted to the year 2000 standard population). [Note: Like the post-WWII increases in lung cancer incidence and mortality observed among men, it is feared that lung cancer may reach epidemic proportions among women before eventually plateauing and decreasing.] 	39.2 (1990-94)	59.8	45.0 (1996-00)
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Healthy Rhode Islanders 2010

By 2010:	RI Baseline	Target	RI Current
<ul style="list-style-type: none"> Reduce cigarette smoking by adults. 	23% (1998-00) BRFSS	10%	22.4% (2002) BRFSS
<ul style="list-style-type: none"> Reduce cigarette smoking by adolescents. 	35% (1997) YRBS	14%	19.3% (2003) YRBS

DNC = Data not collected

OBESITY CONTROL

Overweight and obesity are associated with an increased risk of cancer and unfortunately, obesity rates in the US are increasing in epidemic proportions. Some studies estimate that overweight and obesity may account for 20% of cancer deaths among US women and 14% among US men. (ACS2) Causes of obesity include poor diet and sedentary lifestyles, which may also be risk factors for cancer. Hence, obesity control involves interventions in two areas: diet and nutrition, and physical activity.

Diet and nutrition: Diets high in fat have been associated with an increased risk of various cancers, particularly breast, colon, and prostate. (CRR) Current research suggests that diets high fiber, fruits, vegetables, and grain products are associated with a reduced risk of cancer. (CRR) From 1993 through 2000, the proportion of Rhode Islanders who reported consuming five or more servings of fruits and vegetables a day increased from 19 to 23 percent among males, and varied from 27 to 35 percent among females. The median proportion of persons in the US as a whole who reported consuming enough fruits and vegetables from 1994 to 2000 remained at around 19 percent for males and around 27 percent for females.

Physical activity: Physical activity reduces the chance of being overweight, and may also independently reduce the risk of cancer. The proportion of Rhode Islanders who reported no leisure time physical activity hovered around 26 percent from 1990 until the proportion jumped to 30 percent in 1998. Since that time, the proportion has dropped to 25 percent in 2001. The median proportion of persons in the US as a whole who reported no leisure time physical activity hovered around 28 percent from 1990 until 2001, when it hit a decade low of 26 percent.

Rhode Island Obesity-Related Cancer Facts

- The Obesity Control Program is currently drafting a burden document. Its availability is anticipated in early March.

Rhode Island Prevention Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Obesity Control: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of cancers related to overweight (esp. cancers of the colon, endometrium, and breast).
 - Increase the proportion of people at healthy weight.
 - Promote increased physical activity.
 - Promote balanced diet.

Plan: • Rhode Island Obesity Control Plan
 Lead: • Rhode Island Obesity Control Program (of the Rhode Island Department of Health))
 Partners: • Numerous community based organizations

National Healthy People 2010 Objectives

By 2010:	US Baseline	Target	RI Current
• Increase the proportion of adults who are a healthy weight.	42% (1988-94)	60%	43.9% (2002) BRFSS
• Reduce the proportion of adults who are obese.	23% (1988-94)	15%	18.5% (2002) BRFSS
• Reduce the proportion of children aged 6 to 11 years who are overweight or obese.	11% (1988-94)	5%	50.1%* (2001) RI HIS
• Reduce the proportion of adolescents aged 12 to 19 years who are overweight or obese.	11% (1988-94)	5%	26.6%** (2001) RI HIS
• Reduce the proportion of children and adolescents aged 6 to 19 years who are overweight or obese.	11% (1988-94)	5%	25% (2001) RI HIS
• Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit.	28% (1994-96)	75%	27%*** (1998-00) BRFSS
• Increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one third being dark green or orange vegetables.	3% (1994-96)	50%	27%*** (1998-00) BRFSS
• Increase the proportion of persons aged 2 years and older who consume less than 10 percent of calories from saturated fat.	36% (1994-96)	75%	DNC
• Increase the proportion of persons aged 2 years and older who consume no more than 30 percent of calories from total fat.	33% (1994-96)	75%	DNC
• Reduce the proportion of adults who engage in no leisure-time physical activity.	40% (1997)	20%	24.6% (2002) BRFSS
• Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.	15% (1997)	30%	22% (1998-00) BRFSS
• Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous days.	27% (1999)	35%	21.8% (2003) YRBS

<ul style="list-style-type: none"> • Increase the proportion of primary care providers who counsel their at-risk patients about physical activity. 	22% (1995)	85%	DNC
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* 50.1% of children ages 6 to 10 years were overweight or obese in 2001
 ** 26.6% of children ages 11 to 17 years were overweight or obese in 2001
 *** The proportion of adults ages 18 years and older who consume at least five daily servings of fruits and vegetables (regardless of color).

Rhode Island Specific Goals

Obesity Control Program

Please refer to the Obesity Control Program's Annual Action Plan for further detail on RI specific goals for obesity control. A copy of the plan can be obtained by contacting Ann Thacher at AnnT@doh.state.ri.us. Goals of the program include:

Goal: Reduce cancers related to obesity through community, health care, schools, and worksite outreach.

- Objective 1:** Conduct community-wide campaigns to increase awareness and knowledge about physical activity, healthy eating, and the health impacts of obesity
- Objective 2:** Increase awareness among HCPs about the health impacts of obesity and the validity of obesity-related guidelines.
- Objective 3:** Assure access to effective preventive and therapeutic programs for obesity through the health care system.
- Objective 4:** Implement plans and policies for environmental improvements in schools that support physical activity and healthy eating practices.
- Objective 5:** Provide students with age-appropriate and culturally sensitive instruction that supports the development of a physically active lifestyle and healthy eating habits.
- Objective 6:** Establish worksite wellness programs in RI to increase the daily physical activity and healthy eating of employees and their families.

1998 Cancer Control Plan

By 2005:

	RI Baseline	Target	RI Current
<ul style="list-style-type: none"> • Increase the proportion of people ages 18 and over who eat at least five servings of fruits and vegetables every day. 	24.1 (1996)	at least 35%	28.6% (2002) BRFSS
<ul style="list-style-type: none"> • Increase the proportion of adults who engage in moderate physical activity for at least 30 minutes per day, five days per week. 			
Proportion of adults getting some leisure time physical activity	45.8%* (1994)	at least 50%	75.4%** (2002) BRFSS
Proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day	*	*	22% (1998-00) BRFSS

* For this objective, baseline data for the 1998 Cancer Control Plan was based on leisure time physical activity in 1994. However, recent data more closely reflects the actual objective and is included here for comparison (but was not included in the 1998 Cancer Control Plan).

** Proportion of respondents who report any leisure-time physical activity in the past month.

Healthy Rhode Islanders 2010

By 2010:

	RI Baseline	Target	RI Current
<ul style="list-style-type: none"> Reduce the proportion of adults who are obese. 	17% (1998-00) BRFSS	14%	18.5% (2002) BRFSS
<ul style="list-style-type: none"> Reduce the proportion of children and adolescents who are overweight or obese. 	25% (2001) RI HIS	10%	25% (2001) RI HIS
<ul style="list-style-type: none"> Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day. 	22% (1998-00) BRFSS	30%	22% (1998-00) BRFSS
<ul style="list-style-type: none"> Increase the proportion of persons aged 2 years and older who consume at least five daily servings of fruits and vegetables. 	27% (1998-00) BRFSS	50%	27%* (1998-00) BRFSS

* The proportion of adults ages 18 years and older who consume at least five daily servings of fruits and vegetables (regardless of color).

DNC = Data not collected

CERVICAL CANCER PREVENTION

According to current research, infection with human papilloma virus (HPV) is the major cause of cervical cancer. (NCI Cancer Facts, NIH Consensus) All sexually active females are at risk for developing cervical cancer. Additional factors associated with increased risk include low socioeconomic status, history of multiple sexual partners, early onset of sexual intercourse, cigarette smoking, and infection with human immunodeficiency virus (HIV). (Clinical) Modification of sexual behaviors in young people and development of an effective vaccine for HPV may prevent cervical cancer. However, screening with the Pap test, is currently the most clinically significant strategy for the prevention of cervical cancer. (NIH Consensus)

Exposure to sexually transmitted diseases has not been measured in sample surveys of the Rhode Island population as a whole. For information on cervical cancer screening, refer to "Cervical Cancer Screening on page 7-4.

Rhode Island Cervical Cancer Facts

- Cervical cancers are preventable. The annual averages of 54 newly diagnosed cervical cancer cases and 17 cervical cancer deaths are largely the result of failures to screen.
- Cervical cancer mortality was slightly lower in RI than the US throughout the 1990s, but this differential decreased over the decade.
- Cervical cancer rates are higher among black women than white women.

Rhode Island Prevention Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Cervical Cancer Prevention: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of cervical cancer.
 - Increase use of barrier protection during sexual intercourse.
 - Promote the use of barrier protection during sexual intercourse.
 - Promote gynecological care for all sexually active women.
 - Promote the distribution of condoms by family planning programs.
- | | |
|-----------|--|
| Plan: | • <i>Develop work plan.</i> |
| Lead: | • Rhode Island Sexually Transmitted Diseases Prevention Program (HEALTH) |
| Partners: | • Division of Family Health (HEALTH) |
| | • Office of Primary Care (HEALTH) |
| | • Community Health Centers |
- Increase the proportion of women (from age of first sexual activity) who are screened every 1-3 years with the Pap test for pre-cancerous lesions of the cervix.
 - Enhance the outreach capability of the RI Women's Cancer Screening Program.
 - Expand the capacity of community health centers to provide gynecological care.
- | | |
|-----------|--|
| Plan: | • Rhode Island Women's Cancer Screening Program Plan |
| Lead: | • Rhode Island Women's Cancer Screening Program (HEALTH) |
| Partners: | • Office of Primary Care (HEALTH) |
| | • Community Health Centers |

National Healthy People 2010 Objectives

By 2010:	US Baseline	Target	RI Current
<ul style="list-style-type: none"> • Reduce the death rate from cancer of the uterine cervix (deaths per 100,000 females; adjusted to the year 2000 standard population). 	3.0 (1998)	2.0	2.8 (1996-00)

Rhode Island Specific Goals

Women's Cancer Screening Program Plan

- For detailed goals related to cervical cancer prevention, please refer to the Women's Cancer Screening Program Plan which can be obtained by contacting Brenda DiPaolo at 401-222-1161.

1998 Cancer Control Plan

By 2005:	RI Baseline	Target	RI Current
<ul style="list-style-type: none"> • Reduce the age-adjusted incidence rate for cancer of the cervix among women (cases per 100,000; age-adjusted to the year 2000 standard population). 	11.1 (1990-94)	5.5	8.8 (1997-01)
<ul style="list-style-type: none"> • Reduce the age-adjusted mortality rate for cancer of the cervix among women (deaths per 100,000; age-adjusted to the year 2000 standard population). 	3.0 (1990-94)	1.5	2.8 (1996-00)

DNC = Data not collected

UNDER
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SKIN CANCER PREVENTION

Exposure to the sun is important for healthy living. However, too much exposure to the sun's ultraviolet rays can cause premature aging, wrinkles, and skin cancer. Factors that influence the intensity of the sun's rays include time of day, season, altitude, global location, and length of time spent in the sun. (CancerCare) Exposure to ultraviolet light also occurs from artificial sources such as tanning booths and sun lamps. Limiting sun exposure by wearing protective clothing and using sunscreen, preventing sunburn, and performing regular skin exams (fair-skinned adults should get regular skin examinations from a dermatologist) may help protect against melanoma.

Clinicians should advise patients to protect their skin from exposure to sunlight. (Clinical)

Rhode Island Skin Cancer Facts

- The annual averages of 197 newly diagnosed melanoma of skin cases and 31 in Rhode Island are theoretically preventable by practicing sun safety behaviors and getting screened appropriately.
- The incidence of melanoma of skin increased approximately 50% over the period 1987-2001.
- In the 1990's, incidence of melanoma of skin was lower in Rhode Island than in the nation as a whole, despite upward trends in both areas. Mortality rates were similar.
- Melanoma incidence and mortality are higher among males than females.
- White persons are more likely to be diagnosed with melanoma of skin than black persons, largely because those with fair skin are at a higher risk than those with dark skin. However, mortality from melanoma of skin is only slightly higher among whites than blacks, a differential worthy of further investigation.

Rhode Island Prevention Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Skin Cancer Prevention: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of skin cancers, including melanomas of skin.
 - Prevent sunburn and decrease cumulative skin exposure to sunlight.
 - Promote avoidance of mid-day sun exposure.
 - Promote sun-safe outdoor clothing and use of sunscreen.
- Plan: • *Develop work plan.*
 Lead: • ACS
 Partners: • Core Team
 • [Dermatologists]
- Avoid artificial sources of UV light.
 - Educate the public about the risks of tanning salon use.
- Plan: • *Develop work plan.*
 Lead: • ACS
 Partners: • Core Team
 • [Dermatologists]

National Healthy People 2010 Objectives

By 2010:	US Baseline	Target	RI Current
<ul style="list-style-type: none"> Increase the proportion of adolescents in grades 9 through 12 who use at least one of the following protective measures that may reduce the risk of skin cancer: avoid the sun between 10 a.m. and 4 p.m., wear sun-protective clothing when exposed to sunlight, use sunscreen with a sun-protective factor (SPF) of 15 or higher, and avoid artificial sources of ultraviolet light. 	Developmental		
Proportion of adolescents ages 12 to 17 years who used sunscreen in past 12 months	--	--	75.5%
Proportion of adolescents ages 12 to 17 years who wore hats or protective clothing in past 12 months	--	--	43.9%
<ul style="list-style-type: none"> Increase the proportion of adults aged 18 years and older who use at least one of the following protective measures that may reduce the risk of skin cancer: avoid the sun between 10 a.m. and 4 p.m., wear sun-protective clothing when exposed to sunlight, use sunscreen with a sun-protective factor (SPF) of 15 or higher, and avoid artificial sources of ultraviolet light. 	47% (1998)	75%	
Proportion of adults ages 18 years and older who used sunscreen in past 12 months	--	--	59.7%
Proportion of adults ages 18 years and older who wore hats or protective clothing in past 12 months	--	--	49.3%
<ul style="list-style-type: none"> Reduce the rate of melanoma cancer deaths (deaths per 100,000; age-adjusted to the year 2000 US standard population). 	2.8 (1998)	2.5	2.8 (1996-00)

Rhode Island Specific Goals

1998 Cancer Control Plan

UNDER
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By 2005:

	RI Baseline	Target	RI Current
<ul style="list-style-type: none">• Increase the proportion of people of all ages who limit sun exposure, use sunscreens and protective clothing when exposed to sunlight, and avoid artificial sources of ultraviolet light (e.g., sun lamps, tanning booths).	Unavailable	at least 75%	DNC
<ul style="list-style-type: none">• Reduce the age-adjusted mortality rate for malignant melanoma among men (deaths per 100,000; age-adjusted to the year 1970 standard population).	3.6 (1990-94)	2.5	3.3 (1996-00)
<ul style="list-style-type: none">• Reduce the age-adjusted mortality rate for malignant melanoma among women (deaths per 100,000; age-adjusted to the year 1970 standard population).	1.7 (1990-94)	1.3	2.5 (1996-00)

DNC = Data not collected

ORAL CANCER PREVENTION

Major risk factors for oropharyngeal cancer are tobacco use in all forms and alcohol abuse, accounting for approximately 90% of oral cancer in the US. (Clinical) Alcohol abuse includes chronic “high-risk” drinking (14 or more alcoholic drinks per week for males and seven or more alcoholic drinks per week for women). Oral cancers are therefore theoretically preventable by abstaining from tobacco and limiting alcohol consumption. (NIH) Clinicians should advise patients to discontinue use of all forms of tobacco and to limit consumption of alcohol. (Clinical)

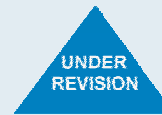
In the 1990's, the proportion of chronic drinkers was higher in Rhode Island than in the nation as a whole. Given Rhode Island's high rates of chronic drinking, especially among men, it is questionable whether the decline in male oropharyngeal cancer mortality will be sustained.

Rhode Island Oropharyngeal Cancer Facts

- The annual averages of 114 newly diagnosed oropharyngeal cancer cases and 29 deaths are theoretically preventable by avoiding tobacco use and limiting alcohol consumption. Regular oral cancer examinations can detect oral cancers at an earlier, more treatable stage.
- Among RI men, mortality from oropharyngeal cancer was halved in the 1990's. The RI rate was higher than the national rate in the early 1990's and was lower than the national rate in the late 1990's.
- Incidence and mortality from oropharyngeal cancer were higher among men than women in the 1990's. However, the substantial decrease in mortality that occurred among RI men narrowed the gender gap in the late 1990's.
- Both incidence and mortality were higher among black men than white men in the 1990's. At the national level, the racial disparity in mortality was more pronounced.

Rhode Island Prevention Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Oral Cancer Prevention: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of oral, pharyngeal, and esophageal cancers.
 - Reduce tobacco use through decreased initiation and increased cessation.
 - (See above; "Reduce the incidence of cancers related to tobacco use.")
 - Reduce excessive alcohol use.
 - Support alcohol-abuse-prevention programs on college campuses.
 - Educate the public about chronic alcohol use as a risk factor for cancer.
 - Encourage physicians and dentists to provide strong and consistent messages about chronic alcohol use and alcohol abuse.
- Plan: • *Develop work plan.*
 Lead: • *To Be Determined*
 Partners: • *Core Team*

National Healthy People 2010 Objectives

By 2010:	US Baseline	Target	RI Current
• (See "National Healthy People 2010 Objectives Related to Tobacco Use" on p. 7-3)			
• Reduce the proportion of male adults who exceed guidelines for low-risk drinking.	74% (1992)	50%	39.2%* (2002) BRFSS
• Reduce the proportion of female adults who exceed guidelines for low-risk drinking.	72% (1992)	50%	48.1%** (2002) BRFSS
• Reduce the oropharyngeal cancer death rate (deaths per 100,000; age-adjusted to the year 2000 US standard population).	3.0 (1998)	2.7	2.5 (1996-00)
*Percent of male current drinkers who drank an average of 3 drinks or more on days when they drank in the past month. **Percent of female current drinkers who drank an average of 2 drinks or more on days when they drank in the past month.			

Rhode Island Specific Goals

- None to date

UNDER
REVISION

DNC = Data not collected

III. CANCER SCREENING

Screening involves checking for cancer or cancerous conditions in asymptomatic persons. This is important because screening for some cancers is effective in detecting precancerous cells or finding cancer at an early stage when treatment is more effective. Screening procedures vary for different cancers, and may involve a physical exam, a laboratory test, or procedures such as mammography or colonoscopy that look at an internal organ. (Vermont)

Cancers of certain anatomical sites, accounting for about half of all new cases, may be detected with screening tests. (ACS Facts 2003) Many malignancies of the colon-rectum, female breast, and cervix may be detected and treated early enough to effect a long-term disease-free state, and screening tests for cancers of the prostate, skin, and oral cavity are used inconsistently as their effectiveness is still under debate. The effectiveness of mass screenings for cancers of other sites has not been fully evaluated.

In general, screening works if the disease has a relatively long period of development during which it is susceptible to treatment, if the screening test has high sensitivity and specificity (the ability of the test to identify a high proportion of true positives and true negatives, while avoiding false positives and false negatives), and if the available treatment is effective. If any one of these three elements is missing, screening may not help control the disease.

Cancers partially controllable by screening		
Cancer Type	Common Screening Tests	Screening Goals
Female breast	<ul style="list-style-type: none">• Mammography• Clinical breast examination	<ul style="list-style-type: none">• Identify in situ and localized tumors
Cervix	<ul style="list-style-type: none">• Pap test	<ul style="list-style-type: none">• Identify pre-cancerous lesions and localized tumors
Colon-rectum	<ul style="list-style-type: none">• Digital rectal examination (DRE)• Flexible sigmoidoscopy or colonoscopy	<ul style="list-style-type: none">• Identify pre-cancerous lesions and localized tumors
Oral cavity	<ul style="list-style-type: none">• Visual examination	<ul style="list-style-type: none">• Identify pre-cancerous lesions and in situ tumors
Ovarian	<ul style="list-style-type: none">• Risk education and evaluation	<ul style="list-style-type: none">• Risk awareness among high-risk groups
Prostate	<ul style="list-style-type: none">• Prostate specific antigen (PSA)• Digital rectal examination	<ul style="list-style-type: none">• Identify in situ and localized tumors
Skin	<ul style="list-style-type: none">• Visual examination	<ul style="list-style-type: none">• Identify pre-cancerous lesions and in situ tumors

Six cancers are the foci of cancer screening interventions in Rhode Island:

- Female Breast Cancer Screening
- Cervical Cancer Screening
- Prostate Cancer Screening
- Ovarian Cancer Screening
- Oral Cavity Cancer Screening
- Skin Cancer Screening

FEMALE BREAST CANCER SCREENING

Among several common screening tests for breast cancer (mammography, clinical breast exam, breast self-exam), mammography is the most effective method for detecting tumors at an early stage (in situ and localized) when they are more likely to be controlled and “cured” than later stage (regional and distant) tumors. A number of clinical trials and clinical-trial-like studies have demonstrated the effectiveness of mammography screening for the reduction of breast cancer mortality, suggesting that screening women according to guidelines “can reduce breast cancer deaths by 20 to 39% in women aged 50 to 74 years and about 17% in women aged 40 to 49.” (HP)

In response to aggressive promotion from the RI health care community, the percentage of women age 40 and older who report that they have been screened with mammography within the previous two years increased from 71% in 1990 to 85% in 2001. Rhode Island is ahead of the nation in breast cancer screening, and by 2001, Rhode Island had already exceeded the Healthy People 2010 goal of 70% (HP). Nonetheless, despite a decade and a half of steady progress, 15% of Rhode Island women age 40 and over are not being screened according to guidelines, a cause for concern. Identifying who these women are, and why they have not benefited from the State's substantial breast cancer screening infrastructure may help us plan special interventions to accelerate the upward trend in eligible women screened according to guidelines.

The Women's Cancer Screening Program (WCSP), based at HEALTH, has helped increase the percentage of Rhode Island women who are screened for breast cancer (and cervical cancer). Based at HEALTH, the WCSP provides free breast cancer screening services for Rhode Island women. Since 1995, the WCSP has paid for 11,635 mammograms and an equal number of clinical breast examinations for women who are age 40 or older, uninsured or underinsured, and with incomes at or less than 250% of the poverty level.

Screening with mammography may have contributed to the decrease in breast cancer incidence in Rhode Island. The effectiveness of screening with mammography is reflected in trends of stage-specific breast cancer incidence rates, analyzed in previous reports (Review).

Rhode Island Breast Cancer Facts

- Among RI women, breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer death. Approximately 8,900 women alive today were diagnosed with breast cancer at some point in the past 25 years.
- In RI over the period 1987-2000, mortality from breast cancer decreased 19%. The mortality rate in RI exceeded the US rate by about 13% in 1990. By the year 2000, the percent elevation had dropped to 5%.
- Female breast cancer incidence is lower in Rhode Island than in the United States as a whole, probably due to different screening dynamics.
- In RI, black women are less likely to survive breast cancer than white women.
- Kent county bears a greater burden of female breast cancer compared with the nation as a whole.

Rhode Island Screening Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Breast Cancer Screening: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of late stage breast cancer.
 - Increase the proportion of women ages 40 and over who are screened every 1-2 years with mammography.
 - Enhance the outreach capability of the RI Women's Cancer Screening Program.
 - Expand the capacity of community health centers to provide gynecological care.
 - Identify segments of the population of women ages 40 and over who are less likely to seek screening, and develop segment-specific social marketing campaigns to increase the likelihood that these women will seek screening.

Plan: • Rhode Island Women's Cancer Screening Program Plan
 Lead: • Rhode Island Women's Cancer Screening Program (HEALTH)
 Partners: • Office of Primary Care (HEALTH)
 • Community Health Centers

National Healthy People 2010 Objectives

By 2010:	US Baseline	Target	RI Current
• Increase the proportion of Primary care providers who counsel their at-risk patients about mammograms.	37% (1998)	85%	DNC
• Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years.	67% (1998)	70%	85.4%* (2002) RI-BRFSS
• Reduce the breast cancer death rate (deaths per 100,000 females; age-adjusted to the year 2000 US standard population).	27.9 (1998)	23.0	29.2 (1996-00)

* 85.4% of women ages 40 years and older had received a mammogram within the preceding 2 years in 2002

Rhode Island-Specific Goals

UNDER
REVISION

Women's Cancer Screening Program Plan

- For detailed goals related to breast cancer screening, please refer to the Women's Cancer Screening Program Plan which can be obtained by contacting Brenda DiPaolo at 401-222-1161.

1998 Cancer Control Plan

By 2005:

	RI Baseline	Target	RI Current
<ul style="list-style-type: none"> Increase the proportion of women ages 40-49 who receive clinical breast examinations and mammograms according to current recommendations. 	74.6% (1995)*	at least 85%	79.8%*** (2002) RI-BRFSS
<ul style="list-style-type: none"> Increase the proportion of women ages 50 and over who receive clinical breast examinations and mammograms according to current recommendations. 	49.7% (1995)**	at least 85%	87.7%**** (2002) RI-BRFSS
<ul style="list-style-type: none"> Reduce the age-adjusted mortality rate for cancer of the breast among women (deaths per 100,000; age-adjusted to the year 1970 standard population). 	36.2 (1990-94)	32.6	29.2 (1996-00)

* women ages 40-49 who had received a mammogram within the preceding 2 years in 1995

** women ages 50 and over who had received a mammogram within the preceding 2 years in 1995

*** women ages 40-49 years who had received a mammogram within the preceding 2 years in 2002

**** weighted average of women ages 50-64 and 65+ who had received a mammogram within the preceding 2 years in 2002

DNC = Data not collected

CERVICAL CANCER SCREENING

Among RI women, cervical cancer is not one of the most prevalent cancers in the state. However, it is a very important cancer to monitor, because the potential for much higher cervical cancer rates is great, absent aggressive screening for precancerous lesions with the Pap test. Several risk factors for cancer of the uterine cervix have been identified. (CRR) However, the most clinically significant strategy for the reduction of cervical cancer is use of the Pap test (Pap smear), a noninvasive, inexpensive, simple screening procedure that allows physicians to find and treat precancerous dysplasias and localized tumors. The effectiveness of screening with the Pap test for the reduction of cervical cancer mortality has been demonstrated by several studies. (HP) Although reports of high false-negative and false-positive rates have caused the accuracy of the Pap test to be questioned, the rescanning of smears and the development of computer-based automated technology have reduced the proportion of false results. (Cvx1) Aggressive use of the Pap test remains a key control strategy.

In the 1990's, cervical cancer screening rates increased from 80 percent to 88 percent in RI. The effectiveness of screening with the Pap test is reflected in trends of stage-specific cervical cancer incidence rates, analyzed in previous reports (Review). The low rates of cervical cancer in RI reflect very effective use of an extensive screening system.

The WCSP has helped increase the percentage of Rhode Island women who are screened for cervical cancer. The Women's Cancer Screening Program (WCSP) aims to increase the percentage of women who receive Pap tests (and mammograms). Based at HEALTH, the WCSP provides free cervical cancer screening services for RI women who are age 50 or older (note the difference with the breast cancer screening age criterion), uninsured or underinsured, and with incomes at or less than 250% of the poverty level.

Rhode Island Cervical Cancer Facts

- Cervical cancers are preventable. The annual averages of 54 newly diagnosed cervical cancer cases and 17 cervical cancer deaths are largely the result of failures to screen.
- Cervical cancer mortality was slightly lower in RI than the US throughout the 1990s, but this differential decreased over the decade.
- Cervical cancer rates are higher among black women than white women.

Rhode Island Screening Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Cervical Cancer Screening: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of invasive cervical cancer.
 - Increase the proportion of women (from age of first sexual activity) who are screened every 1-3 years with the Pap test.
 - Enhance the outreach capability of the RI Women's Cancer Screening Program.
 - Expand the capacity of community health centers to provide gynecological care.
- Plan: • Rhode Island Women's Cancer Screening Program Plan
 Lead: • Rhode Island Women's Cancer Screening Program (HEALTH)
 Partners: • Office of Primary Care (HEALTH)
 • Community Health Centers

National Healthy People 2010 Objectives

By 2010:	US Baseline	Target	RI Current
• Increase the proportion of primary care providers who counsel their at-risk patients about Pap tests.	55% (1998)	85%	DNC
• Increase the proportion of women aged 18 years and older who have ever received a Pap test.	92% (1998)	97%	94.2% (2002) RI-BRFSS
• Increase the proportion of women aged 18 years and older who received a Pap test within the preceding 3 years.	79% (1998)	90%	89.8% (2002) RI-BRFSS
• Reduce the death rate from cancer of the uterine cervix (deaths per 100,000 females; age-adjusted to the year 2000 US standard population).	3.0 (1998)	2.0	2.8 (1996-00)

Rhode Island Specific Goals

Women's Cancer Screening Program Plan

- For detailed goals related to cervical cancer screening, please refer to the Women's Cancer Screening Program Plan which can be obtained by contacting Brenda DiPaolo at 401-222-1161.

1998 Cancer Control Plan

By 2005:

	RI Baseline	Target	RI Current
<ul style="list-style-type: none"> Increase the proportion of women ages 18-44 who receive Pap tests according to current recommendations. 	83.0%* (1995)	at least 95%	92.6%*** (2002) RI-BRFSS
<ul style="list-style-type: none"> Increase the proportion of women ages 45 and over who receive Pap tests according to current recommendations. 	68.1%** (1995)	at least 80%	83.8%**** (2002) RI-BRFSS
<ul style="list-style-type: none"> Reduce the age-adjusted incidence rate for cancer of the cervix among women (cases per 100,000; age-adjusted to the year 1970 standard population). 	11.1 (1990-94)	5.5	8.8 (1997-01)
<ul style="list-style-type: none"> Reduce the age-adjusted mortality rate for cancer of the cervix among women (deaths per 100,000; age-adjusted to the year 1970 standard population). 	3.0 (1990-94)	1.5	2.8 (1996-00)

* 83.0% of women ages 18-44 were screened within the preceding 2 years in 1995.

** 68.1% of women ages 45 and over were screened within the preceding 2 years in 1995.

*** 92.6% of women ages 19-49 had received a Pap test within the previous three years in 2002.

**** 83.8% of women ages 50 and over had received a Pap test within the previous three years in 2002.

DNC = Data not collected

COLORECTAL CANCER SCREENING

A preferred strategy for the control of colorectal cancer is early detection and removal of precancerous polyps. A number of clinical trials have demonstrated the effectiveness of screening for the reduction of colorectal cancer mortality. (HP) Endoscopic colorectal cancer screening tests, much like screening tests for cervical cancer, find precancerous lesions that can be removed before they progress into cancer, and thus are effective preventives. "FOBT and sigmoidoscopy are widely used to screen for CRC, and barium enema and colonoscopy are used as diagnostic tests." (HP) Screening with sigmoidoscopy or colonoscopy has the added advantage that precancerous polyps may be removed during the procedure. Screening recommendations include:

In Rhode Island, the proportion of persons screened for colorectal cancer increased in the 1990's, but is still low. From 1995 to 1999, Rhode Island edged ahead of the United States in the proportions of people ages 40 and over ever screened for colorectal cancer. Despite this progress, considerable work is needed to reach the 63% of RI men and women who have never been screened for colorectal cancer.

In Rhode Island, increased use of endoscopy for colorectal cancer screening is likely responsible for the recent decrease in colorectal cancer incidence. The effectiveness of colorectal cancer screening is reflected in trends of stage-specific colorectal cancer incidence rates, analyzed in previous reports (Review). Over the course of the 1990's in RI, the incidence of in situ colorectal tumors increased, while the incidence of local and regional colorectal tumors decreased, signs of effective screening.

Rhode Island Colorectal Cancer Facts

- Colorectal cancer is the fourth most commonly diagnosed cancer and the second leading cause of cancer death. Approximately 4,700 Rhode Islanders alive today were diagnosed with colorectal cancer at some point in the past 25 years.
- The incidence of colorectal cancer declined in the 1990's, probably because of aggressive screening.
- Rhode Islanders have higher colorectal cancer rates than Americans as a whole. This gap began to narrow in the late 1990's.
- The burden of colorectal cancer is greater among men than women. This differential began to decrease in the late 1990's.
- In 1987-2000, white men were more likely to be diagnosed with and to die from colorectal cancer than black men. This contrasts with the US experience where the opposite was true.
- The burden of colorectal cancer is greater in Kent and Providence counties than in the nation as a whole.

Rhode Island Screening Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Colorectal Cancer Screening: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of late stage (regional, distant) colorectal cancer.
 - Increase the proportion people ages 50 and over (and younger people at increased risk of developing colorectal cancer) who are screened with colonoscopy every 5-10 years.
 - Evaluate and enhance hospital-centric colorectal screening systems encompassing the geographic areas and medical practices (primary and specialty care) served by the hospitals.

Plan: • Collaboration Plan of the Rhode Island Cancer Control Program

Lead: • Rhode Island Cancer Control Program – “CCC” - (of the Rhode Island Department of Health)

Partners: • Comprehensive Cancer Control Program Core Team *

- Acute care hospitals (12)
 - Hospital Association of Rhode Island
 - Rhode Island Cancer Council
 - American Cancer Society
 - American College of Surgeons

<ul style="list-style-type: none"> • <u>The Core Team includes:</u> • American Cancer Society • American College of Surgeons • Hospital Association of Rhode Island • Rhode Island Cancer Council • Rhode Island Department of Health 	<p><u>Abbreviations:</u></p> <p>⇒ (ACS)</p> <p>⇒ (ACOS)</p> <p>⇒ (HARI)</p> <p>⇒ (RICAN)</p> <p>⇒ (HEALTH)</p>
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National Healthy People 2010 Objectives

By 2010:	US Baseline	Target	RI Current
• Increase the proportion of primary care physicians who counsel their at-risk patients about blood stool tests.	56% (1998)	85%	DNC
• Increase the proportion of primary care physicians who counsel their at-risk patients about proctoscopic exams.	23% (1998)	85%	DNC
• Increase the proportion of adults aged 50 years and older who have ever received a sigmoidoscopy.	37% (1998)	50%	54.6%* (2002) RI-BRFSS
• Increase the proportion of adults aged 50 years and older who have received a fecal occult blood test (FOBT) within the preceding two years.	35% (1998)	50%	48.8%** (2002) RI-BRFSS
• Reduce the colorectal cancer death rate (deaths per 100,000; age-adjusted to the year 2000 US standard population).	21.2 (1998)	13.9	23.4 (1996-00)

* 54.6 percent of adults ages 50 years or older had ever received a sigmoidoscopy or colonoscopy exam in 2002.

** 48.8 percent of adults ages 50 and over had ever used a home blood stool test kit to determine whether their stool contained blood in 2002.

Rhode Island Specific Goals

1998 Cancer Control Plan

By 2005:	RI Baseline	Target	RI Current
• Increase the proportion of eligible adults who receive digital rectal exams according to current recommendations.	52.8 % (1995)*.	at least 75%	DNC
• Increase the proportion of eligible adults who receive fecal occult blood tests and sigmoidoscopy (or colonoscopy) according to current recommendations.	33.3 % (1995)**	at least 75%	***
• Reduce the age-adjusted incidence rate for cancer of the colon-rectum among men (cases per 100,000; age-adjusted to the year 1970 standard population).	84.5(199 0-94)	70.3	76.4 (1997-01)
• Reduce the age-adjusted incidence rate for cancer of the colon-rectum among women (cases per 100,000; age-adjusted to the year 1970 standard population).	58.1 (1990-94)	49.7	55.4 (1997-01)
• Reduce the age-adjusted mortality rate for cancer of the colon-rectum among men (deaths per 100,000; age-adjusted to the year 1970 standard population).	35.3 (1990-94)	30.5	28.9 (1996-00)
• Reduce the age-adjusted mortality rate for cancer of the colon-rectum among women (deaths per 100,000; age-adjusted to the year 1970 standard population).	21.7 (1990-94)	20.1	20.1 (1996-00)

* 52.8% of eligible adults received a digital rectal exam according to current recommendations in 1995.

** 33.3% of adults ages 50 and over had ever received sigmoidoscopy in 1995.

*** Among adults ages 50 years or older, 54.6% had ever received a sigmoidoscopy or colonoscopy exam in 2002, and 48.8% had ever used a home blood stool test kit to determine whether their stool contained blood in 2002.

DNC = Data not collected

UNDER
REVISION

PROSTATE CANCER SCREENING

Although prostate cancer has been linked to several risk factors, effective preventives are unknown. Speculations about the role of diet, environmental factors, and hormones as risk factors for prostate cancer are inconclusive. (Pst1) Two common methods for detecting prostate cancer are the digital rectal examination (DRE) and the prostate-specific antigen (PSA). Although the PSA (AND DRE?) screening test is non-invasive, relatively inexpensive, and effective in the early detection of prostate tumors, its use is controversial. Clinical trials in progress have not yet proven that early detection and treatment are effective in reducing prostate cancer mortality, mass screening efforts are costly, and treatment is associated with high morbidity (e.g. urinary incontinence and sexual dysfunction). However, aggressive use of screening tests remains a key control strategy. [Unproven, but suggested by limited clinical studies:] It is possible that the burden of prostate cancer may be reduced in high-risk populations by screening with the PSA test. Known high-risk populations include black men ages 40 and over and other men with a strong family history of prostate cancer. Ways to obtain information on the use of prostate cancer screening tests among high-risk men are currently being explored.

Although other factors, such as an increase in operations for benign disease of the prostate (CRR), may have contributed to the increase in diagnosed prostate cancer observed in the 1990s, the introduction of the PSA screening test in the late 1980s is likely responsible for the observed upward trend in prostate cancer incidence. This trend was affected by the timing and proportions of men who were offered the new test and who elected to use it, and probably does not reflect a change in the underlying rate at which new prostate tumors develop. The trend in US prostate cancer incidence is suggestive of a classic "screening effect" such as this. Rhode Island may have lagged behind the nation in using the PSA test, which would explain the disparity in incidence rates which occurred in the early 1990s.

Rhode Island Prostate Cancer Facts

- Among RI men, prostate cancer is the most commonly diagnosed cancer, and the second leading cause of cancer death. Approximately 5,918 males alive today were diagnosed with prostate cancer at some point in the past 25 years.
- The incidence of prostate cancer increased in the 1990's, probably due to an increase in screening.
- Low prostate cancer mortality in the late 1990's may suggest the beginning of a decline.
- In the early 1990's prostate cancer incidence was lower in RI than in the nation as a whole. This differential had disappeared with the late 1990's. Recent trends in prostate cancer incidence in RI and the US suggest the influence of a screening innovation. A comparison of RI and US rates suggests that the screening innovation (the PSA test) was introduced earlier and more aggressively in other parts of the nation than in RI.
- Black men are more than two times as likely than white men to die from prostate cancer.

Rhode Island Screening Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Prostate Cancer Screening: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of late stage prostate cancer.
 - Increase the proportion of men ages 40 and over who are informed about their statistical risk of developing prostate cancer (based on family history and personal factors), the course of the disease in its various forms, the pros and cons of prostatic specific antigen (PSA) to screen for prostate cancer, and the pros and cons of various forms of prostate cancer treatment.
 - Educate the public about factors that increase the risk of prostate cancer and the importance of regular primary care for those at increased risk.

Plan: • *Develop work plan.*
Lead: • ACS
Partners: • Core Team

National Healthy People 2010 Objectives

By 2010:	US Baseline	Target	RI Current
• Reduce the prostate cancer death rate (deaths per 100,000; age-adjusted to the year 2000 US standard population).	32.0 (1998)	28.8	33.1 (1996-00)

Rhode Island Specific Goals

- None to date

UNDER
REVISION

DNC = Data not collected

OVARIAN CANCER SCREENING

The burden of ovarian cancer may be reduced by increasing women's awareness of risk factors for ovarian cancer, by increasing the proportion of women who have evaluated their risk, by assuring state-of-the-art gynecological care for high-risk women, and by assuring state-of-the-art treatment for all ovarian cancer patients.

At the present time, the proportion of adult women in Rhode Island who have evaluated their risk is unknown because this issue has not been a focus of statewide surveys from which we normally derive such data.

Rhode Island Ovarian Cancer Facts

- Although the annual number of new ovarian tumors diagnosed in Rhode Island is relatively small, the burden is significant because the case-fatality of ovarian cancer, except when diagnosed at the earliest stage of disease, is high.
- The incidence of ovarian cancer in Rhode Island may have started to decline in the late 1990's. The reason for this decline is unknown.
- Both incidence and mortality were slightly lower in Rhode Island than in the United States as a whole in the 1990's, although both followed a similar trend.
- In Rhode Island, white women are about twice as likely as black women to be diagnosed with ovarian cancer. A similar (but slightly smaller) differential is seen at the national level.

Rhode Island Screening Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Ovarian Cancer Screening: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of late stage (regional, distant) ovarian cancer.
 - Increase the proportion of women at increased risk of developing ovarian cancer who are examined regularly by a gynecologist.
 - Educate the public about factors that increase the risk of ovarian cancer, and the importance of regular gynecological care for those at increased risk.
- Plan: • *Develop work plan.*
Lead: • RICAN
Partners: • Core Team

National Healthy People 2010 Objectives

- None to date

Rhode Island Specific Goals

- None to date

UNDER
REVISION

DNC = Data not collected

ORAL CAVITY CANCER SCREENING

The effectiveness of screening for early oropharyngeal tumors is equivocal, (Clinical) although survival is clearly related to stage of disease at diagnosis. (Ries) The US Preventive Services Task Force last issued a recommendation on screening for oral cancer in 1996, at which time it stated: "There is insufficient evidence to recommend for or against routine screening of asymptomatic persons for oral cancer by primary care clinicians. Clinicians should remain alert to signs and symptoms of oral cancer and premalignancy in persons who use tobacco or regularly use alcohol." (Clinical)

The burden of oropharyngeal cancer may be lessened by promoting regular oral cancer examinations. Oral exams are highly recommended for persons who regularly use tobacco or alcohol.

Rhode Island Oropharyngeal Cancer Facts

- The annual averages of 114 newly diagnosed oropharyngeal cancer cases and 29 deaths are theoretically preventable by avoiding tobacco use and limiting alcohol consumption. Regular oral cancer examinations can detect oral cancers at an earlier, more treatable stage.
- Among RI men, mortality from oropharyngeal cancer was halved in the 1990's. The RI rate was higher than the national rate in the early 1990's and was lower than the national rate in the late 1990's.
- Incidence and mortality from oropharyngeal cancer were higher among men than women in the 1990's. However, the substantial decrease in mortality that occurred among RI men narrowed the gender gap in the late 1990's.
- Both incidence and mortality were higher among black men than white men in the 1990's. At the national level, the racial disparity in mortality was more pronounced.

Rhode Island Screening Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Oral Cavity Cancer Screening: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of late stage (regional, distant) oral cancer.
 - Increase the proportion of people at increased risk of developing oral cancer who are examined regularly by a dentist.
 - Educate the public about factors that increase the risk of oral cancer, and the importance of regular dental care for those at increased risk.

Plan: • *Under Development:* Rhode Island Dental Health Plan
 Lead: • Rhode Island Dental Health Program (HEALTH)
 Partners: • Core Team
 • Rhode Island Dental Society

National Healthy People 2010 Objectives

By 2010:	US Baseline	Target	RI Current
• Increase the proportion of oral and pharyngeal cancer detected at the earliest stage.	35% (1990-95)	50%	36% (2001-02)
• Increase the proportion of adults [aged 40 years and older], who, in the past 12 months, report having had an examination to detect oral and pharyngeal cancers.	13% (1998)	20%	33.4% (1996) HIS

* Estimated oral cancer screening rates from weighted average of adults ages 25-59 and 60+.

Rhode Island Specific Goals

- None to date

UNDER
REVISION

DNC = Data not collected

SKIN CANCER SCREENING

The burden of melanoma of skin may be reduced, among persons at high risk (persons with fair skin, significant history of excessive sun exposure, or family history of melanoma), by visiting annually with a dermatologist. Information on skin cancer screening rates is unavailable at this time.

In addition to skin cancer screening, prevention is an important component for the reduction of skin cancer in RI. For information on skin cancer prevention, please refer to "Skin Cancer Prevention" on page 7-10.

Rhode Island Skin Cancer Facts

- The annual averages of 197 newly diagnosed melanoma of skin cases and 31 in Rhode Island are theoretically preventable by practicing sun safety behaviors and getting screened appropriately.
- The incidence of melanoma of skin increased approximately 50% over the period 1987-2001.
- In the 1990's, incidence of melanoma of skin was lower in Rhode Island than in the nation as a whole, despite upward trends in both areas. Mortality rates were similar.
- Melanoma incidence and mortality were higher among men than women in the 1990's.
- White persons are more likely to be diagnosed with melanoma of skin than black persons, largely because those with fair skin are at a higher risk than those with dark skin.

Rhode Island Screening Recommendations

- To be updated.
(At present, please refer to Appendix: Cancer Prevention and Screening Recommendations for state and national recommendations from various organizations.)



Skin Cancer Screening: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Reduce the incidence of late stage (regional, distant) skin cancer.
 - Increase the proportion of people at increased risk of developing skin cancer who are examined regularly by a dermatologist.
 - Educate the public about factors that increase the risk of skin cancer and the importance of regular dermatological care for those at increased risk.
- Plan: • *Develop work plan.*
 Lead: • ACS
 Partners: • Core Team
 • [Dermatologists]

National Healthy People 2010 Objectives

By 2010:	US Baseline	Target	RI Current
<ul style="list-style-type: none"> Reduce the rate of melanoma cancer deaths (deaths per 100,000 population; adjusted to the year 2000 standard population) 	2.8 (1998)	2.5	2.8 (1996-00)

Rhode Island Specific Goals for Skin Cancer Screening

From the Rhode Island 1998 Cancer Control Plan

By 2010:	RI Baseline	Target	RI Current
<ul style="list-style-type: none"> Reduce the age-adjusted mortality rate for malignant melanoma among men (deaths per 100,000; age-adjusted to the year 1970 standard population). 	3.6 (1990-94)	2.5	3.3 (1996-00)
<ul style="list-style-type: none"> Reduce the age-adjusted mortality rate for malignant melanoma among women (deaths per 100,000; age-adjusted to the year 1970 standard population). 	1.7 (1990-94)	1.3	2.5 (1996-00)

UNDER
REVISION

DNC = Data not collected

IV. CANCER TREATMENT

The use of different methods of treatment for cancer, such as surgery, hormone therapy, radiation, chemotherapy, and biologic therapy, is based on a number of factors, including the type of cancer, the stage of the cancer, and the patient's age and general health. (ACS Guide) The effectiveness of treatment for many types of cancer has advanced significantly over the past two decades. Nonetheless, many cancer patients do not receive state-of-the-art treatment. Were they to do so, it is estimated that the mortality rate from all cancers combined would be reduced about one-fourth.

Six foci for improving access to state-of-the-art treatment in Rhode Island are:

- Clinical Trials
- Breast Cancer Treatment Protocol
- Colorectal Cancer Treatment Protocol
- American College of Surgeons (ACOS) approved hospital cancer programs
- American Joint Committee on Cancer (AJCC) staging methodology
- Palliative Care

CLINICAL TRIALS

The enrollment of patients in clinical trials improves access to state-of-the-art treatment, because clinical trials are specifically designed to test promising new treatments *against* state-of-the-art.

Enrolled patients are randomly assigned either to an experimental group (new treatment) or a control group (state-of-the-art treatment). Both groups are watched very carefully to assess the relative survival advantage of each study arm. When either of the two treatment approaches demonstrates a clear advantage over the other, the patients receiving the less advantageous treatment may be switched to the more advantageous treatment. About 80 percent of children with cancer are enrolled in clinical trials nationwide. However, only about three percent of adults with cancer (about one-seventh of those who are eligible) are enrolled in clinical trials. In Rhode Island, most health insurers cover cancer treatment given as part of phase II and III clinical trials.

A number of hypotheses have been offered to explain why few adult cancer patients who are eligible for clinical trials enroll in them. First, the health care system is not organized to get adult cancer patients enrolled in clinical trials by strict deadlines. Too much time passes during the initial phases of diagnosis and treatment to meet eligibility requirements. Second, few cancer patients understand the purpose and benefits of clinical trials, and therefore do not demand to explore enrollment in clinical trials in the initial phases of diagnosis and treatment, when they may be eligible for enrollment. Third, certain minority communities harbor significant distrust of clinical experimentation, especially if sponsored by the majority community, and have no knowledge of what is meant by clinical trials.

Clinical Trials: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Use state-of-the-art protocols for the treatment of all cancers.
 - Increase enrollment in clinical trials.
 - Evaluate and enhance the enrollment of cancer patients in clinical trials.
 - Educate the public about the benefits of enrollment in clinical trials.
-
- | | |
|-----------|---|
| Plan: | • <i>Develop work plan.</i> |
| Lead: | • CCC (HEALTH) |
| Partners: | • Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals |
| | • Core Team |

National Healthy People 2010 Objectives

- None to date

Rhode Island Specific Goals

From the Rhode Island 1998 Cancer Control Plan

By 2005:

- Increase the proportion of adult cancer patients enrolled in approved clinical trials.

RI
Baseline
3%
(1998)*

Target
at least
25%

UNDER
REVISION

RI
Current
DNC

* An estimated 3% of adult cancer patients were enrolled in approved clinical trials in 1998.

DNC = Data not collected

BREAST CANCER TREATMENT PROTOCOL

The use of different methods of treatment for cancer, such as surgery, hormone therapy, radiation, chemotherapy, and biologic therapy, is based on a number of factors, including the type of cancer, the stage of the cancer, and the patient's age and general health. (ACS Guide). Part of breast cancer treatment in RI includes ongoing projects to promote breast health through the RI Breast Care Task Force at RICAN, such as the Breast Care Algorithm disseminated in September, 2002. Please refer to RI Algorithm developed for the State by RICAN.

Breast Cancer Treatment Protocol: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Use state-of-the-art protocols for the treatment of all cancers.
 - Promote the use of the Rhode Island consensus treatment protocol for breast cancer.
 - Evaluate and enhance the use of the Rhode Island consensus treatment protocol for breast cancer patients who are not enrolled in clinical trials.
- | | | |
|-----------|---|---|
| Plan: | • | <i>Develop work plan.</i> |
| Lead: | • | RICAN |
| Partners: | • | Core Team |
| | • | Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals |

National Healthy People 2010 Objectives

- None to date

Rhode Island Specific Goals

- None to date

UNDER
REVISION

DNC = Data not collected

COLORECTAL CANCER TREATMENT PROTOCOL

The use of different methods of treatment for cancer, such as surgery, hormone therapy, radiation, chemotherapy, and biologic therapy, is based on a number of factors, including the type of cancer, the stage of the cancer, and the patient's age and general health. (ACS Guide). RICAN has convened a group to work on colorectal cancer treatment protocol for the state of RI, following a planning protocol similar to the one used to develop a breast cancer treatment protocol for the state.

Colorectal Cancer Treatment Protocol: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Use state-of-the-art protocols for the treatment of all cancers.
 - Develop a Rhode Island consensus treatment protocol for colorectal cancer.
 - Engage representative community stakeholders in a planning process to draft, vet, and adopt a Rhode Island consensus treatment protocol for colorectal cancer.

Plan:	• (Will follow procedures used in developing a consensus treatment protocol for breast cancer.)
Lead:	• RICAN
Partners:	• Core Team
	• [Gastroenterologists]

National Healthy People 2010 Objectives

- None to date

Rhode Island Specific Goals

- None to date

UNDER
REVISION

DNC = Data not collected

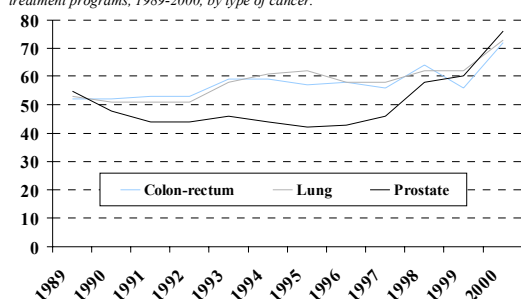
ACOS APPROVED HOSPITAL PROGRAMS

ACOS approved hospital cancer programs improve access to state-of-the-art treatment. Their purpose is to assure "that the atmosphere and organization exist within the institution to offer optimal care to the patient with cancer." The essence of ACOS approved programs is active quality assurance, based on four program components, a multi disciplinary cancer committee, multi disciplinary cancer conferences, patient care studies, and a cancer registry. Each of these components has a unique role to play in assuring the quality of cancer therapy in an institution. The multi disciplinary cancer committee provides leadership to the overall program. They maintain the vision of "optimal care to the patient with cancer," advocating for improved cancer care through quality assurance (including assessment, intervention, and evaluation). At present, 10 of the 12 major acute care hospitals in Rhode Island have ACOS approved cancer programs.

From 1989 through 1996, about half of cancer cases, for most cancer sites, newly diagnosed in Rhode Island were treated under the auspices of six ACOS-approved hospital cancer programs. Another program was approved in 1997, and two more in 2000, bringing the total to nine. With these additions, the proportion of newly diagnosed cancer cases treated under ACOS-approved programs had increased substantially by 2000.

Figure X. Percent of Male Cases in RI ACOS Treatment Programs

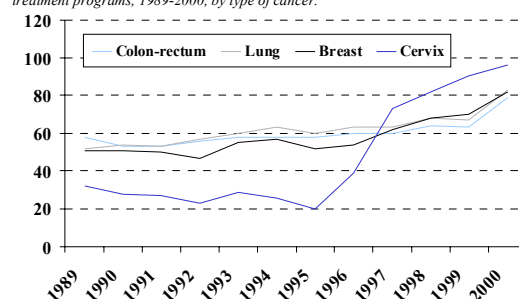
Percent of male cases in RI that were or are treated in ACOS approved cancer treatment programs, 1989-2000, by type of cancer.



Source: RICR, HEALTH

Figure X. Percent of Female Cases in RI ACOS Treatment Programs

Percent of female cases in RI that were or are treated in ACOS approved cancer treatment programs, 1989-2000, by type of cancer.



Source: RICR, HEALTH

ACOS Approved Programs: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Use state-of-the-art protocols for the treatment of all cancers.
 - Assure that all cancer patients in Rhode Island are treated under the auspices of an ACOS-approved hospital cancer program.
 - Support and enhance the work of ACOS-approved cancer programs in eleven of Rhode Island's twelve acute care hospitals.

Plan:	•	Develop work plan.
Lead:	•	HARI
Partners:	•	Core Team
	•	Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals
 - Develop an ACOS-approved cancer program in the twelfth of Rhode Island's twelve acute care hospitals.

Plan:	•	Develop work plan.
Lead:	•	HARI
Partners:	•	Core Team
	•	Hospital No. 12

National Healthy People 2010 Objectives

- None to date

Rhode Island Specific Goals

- None to date

UNDER
REVISION

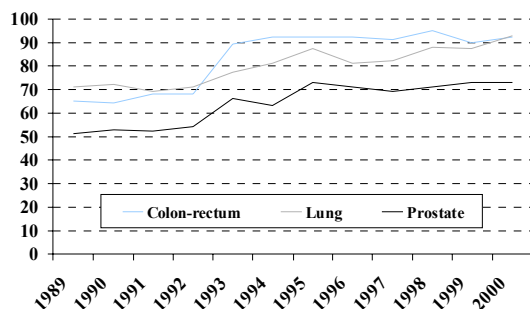
DNC = Data not collected

AJCC STAGING METHODOLOGY

American Joint Committee on Cancer (AJCC) staging methodology is an important basis for choosing appropriate treatments. A change in the Rules and Regulations of the Rhode Island Cancer Registry in 1992 was followed by a dramatic increase, for most cancer sites, in the proportion of cases with AJCC staging.

Figure X. Percent of Male Cases with AJCC Staging

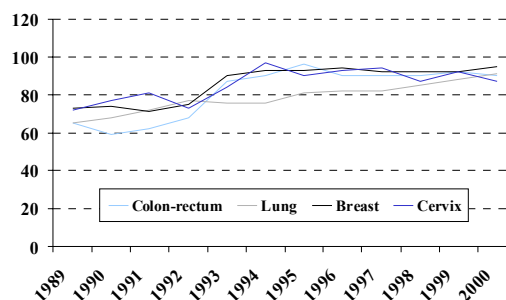
Percent of male cases in RI that were staged with AJCC staging, 1989-2000, by type of cancer.



Source: RICR, HEALTH

Figure X. Percent of Female Cases with AJCC Staging

Percent of female cases in RI that were staged with AJCC staging, 1989-2000, by type of cancer.



Source: RICR, HEALTH

AJCC Staging: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Use state-of-the-art protocols for the treatment of all cancers.
 - Improve the proportion of cancer cases staged according to AJCC guidelines.
 - Identify cancer cases recently treated without AJCC staging, investigate reasons for non-use; support necessary enhancements.
- Plan: • *Develop work plan.*
Lead: • HARI
Partners: • Core Team
• Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals

National Healthy People 2010 Objectives

- None to date

Rhode Island Specific Goals

- None to date

UNDER
REVISION

DNC = Data not collected

PALLIATIVE CARE

The goal of palliative care is to relieve suffering and improve quality of life for patients with advanced illness. (Center) Hospice, a proven systematic approach to the provision of palliative care, provides a compassionate, team-oriented approach to expert medical care, pain management, and emotional and spiritual support tailored to the needs and wishes of the patient. (Palliative) Although palliative care may be given outside the context of hospice, the latter has been successful in overcoming many existing barriers to effective palliation, especially with regard to the control of cancer pain.

In 1998, 31 years after the founding of the first hospice by Dr. Cicely Saunders in Great Britain, and 24 years after the founding of the first hospice in the U.S. (The Connecticut Hospice), many terminally ill cancer patients in this country still do not receive adequate palliative care. Only about 40% of terminally ill cancer patients receive hospice care, and many receive it only in the last few weeks of life, after enduring the side effects of misdirected curative treatment and uncontrolled pain. As a result, many experience very poor quality of life at the end of life. Many live and die in pain. This failure to meet the needs of the dying has fueled the movement toward physician assisted suicide.

As it is currently organized throughout the US, including Rhode Island, hospice care is less accessible to patients of low socioeconomic status than other patients, because it is usually provided in the home, requiring that family care givers be available to tend to the needs of terminally ill patients 24 hours a day. Although hospice services may be provided in other settings, hospitals and nursing homes have not been quick to develop the infrastructure which is necessary to support effective hospice care.

Palliative Care: Goals and Objectives

Rhode Island Cancer Control Logic Model

- Use state-of-the-art protocols for the treatment of all cancers.
 - Increase the frequency and duration of hospice use for advanced illness.
 - Educate the public about the benefits of hospice care for advanced illness.
 - Identify barriers to the use of hospice care for advanced illness.
 - Partner with ACOS-approved cancer programs to develop, promote, and monitor the use of local hospice-use guidelines, and to remove local barriers to the use of hospice care for advanced illness.

Plan:	• <i>Develop work plan.</i>
Lead:	• CCC
Partners:	• Core Team
	• Hospice programs licensed in Rhode Island
	• Cancer Committees of ACOS-approved cancer programs in eleven acute care hospitals

National Healthy People 2010 Objectives

- None to date

Rhode Island Specific Goals

From the Rhode Island 1998 Cancer Control Plan

By 2005:

- Increase the proportion of terminally ill cancer patients who receive hospice services beginning at least three months prior to death.
- Increase the proportion of terminally ill cancer patients who receive hospice services beginning at least two weeks prior to death.

RI Baseline	Target	RI Current
40% (1997)*	at least 50%	DNC
40% (1997)*	at least 75%	DNC

* An estimated 40% of terminally ill cancer patients who died in 1997 received any hospice services prior to death

DNC = Data not collected

UNDER
REVISION

EVALUATION OF CANCER CONTROL INTERVENTIONS

Evaluations of cancer control interventions in RI will be designed using the following basic principles:

- Ongoing
- Of practical value to program management and ongoing planning
- Carefully planned but flexible
- Stakeholder controlled
- Protective of human subjects and sensitive to community values
- Based on specific objectives and sound methodology
- Integrative of information from varied sources
- Productive

Evaluation management

Central evaluation team

HEALTH will have overall responsibility for evaluation of cancer control interventions. A multi-disciplinary Central Evaluation Team will oversee evaluation of cancer control interventions and will be an integral part of intervention management. The primary purpose of evaluation in a context of scarce resources must be sound management.

At least one member of the Central Evaluation Team will be trained in evaluation, epidemiology, or methods of sociological research, to assure the soundness of evaluation design and methodology. The team will be based at HEALTH, which operates a comprehensive cancer surveillance program and houses staff trained in surveillance and evaluation research.

The HEALTH Surveillance and Statistics Group will support the Central Evaluation Team. To facilitate support, members of the Team will regularly attend the weekly meetings of the Group. The Group includes epidemiologists, evaluators, and data managers with a wide range of public health service who are positioned throughout the seven Divisions of HEALTH.

Intervention-specific evaluation teams

Each specific intervention will identify an Evaluation Team composed of a lead advisor, intervention staff, and at least one staff member assigned from the Central Evaluation Team. The management / evaluation team will meet monthly to discuss management issues, including the design, execution, and use of evaluations to guide the development and management of the intervention.

Evaluation oversight committee

Members of the Core Team will serve as an Evaluation Oversight Committee to guide the work of the Central Evaluation Team and intervention-specific Evaluation Teams; some committee members will be selected for their expertise in surveillance, epidemiology, and management. The Oversight Committee will meet quarterly with the Central Evaluation Team and all intervention-specific teams to discuss approaches to evaluation, evaluation techniques, and specific evaluation products, emphasizing stakeholder needs at all levels of evaluation work.

We propose that the Oversight Committee will make an annual report to the Coalition at the Annual Summit.

Evaluation data sources

The Central Evaluation Team will use a variety of data in the evaluation of the Cancer Control Program and of its specific interventions:

Current data sources:

- RI Cancer Registry data
- Vital records
- RI Behavioral Risk Factor Surveillance System - survey data on preventive and early detection behaviors for cancer
- RI Health Interview Survey - survey data on preventive and early detection behaviors for cancer
- Hospital Discharge Data
- Geographic Information Systems
- Analysis of existing surveillance reports

We would like to expand upon the above data sources to increase the value for management of interventions. The following are proposed evaluation data sources:

- Intervention-specific survey instruments
- Key informant interviews
- Focus groups
- Stakeholder input at conferences and meetings

We will work with managers of specific interventions to design evaluations of those interventions.

Data analysis

The Central Evaluation Team will perform all complex data analyses. Initially, evaluation results will be summarized and interpreted in technical reports to be vetted by presentation to HEALTH's Surveillance and Statistics Group and the Evaluation Oversight Committee for criticism and modification.

Evaluation reports

Evaluation results will be disseminated to stakeholders in the RI cancer control community. The main audiences for presentation of evaluation results include:

- Coalition and its Core Team
- Program / intervention management
- Cancer control professionals at large (in RI or elsewhere)
- Persons and families affected by cancer
- The General Public (and mass media channels to them)

Evaluation staff will write evaluation reports in a variety of formats. The reports will be disseminated in a variety of ways, depending on the format. For example:

Table X. Evaluation report formats and dissemination venues	
Evaluation Report Formats	Examples of Dissemination Venues
Web pages	<ul style="list-style-type: none"> • HEALTH's website; • ACS's website
Press releases	<ul style="list-style-type: none"> • Faxes to media outlets
Briefs (1-2 page written evaluation summaries)	<ul style="list-style-type: none"> • Faxes (mainly to professionals), • mailings, • distribution at meetings
Brief articles	<ul style="list-style-type: none"> • <i>Medicine and Health / Rhode Island</i> (a journal of medicine and public health) • mailings, • distribution at meetings
Full-length articles	<ul style="list-style-type: none"> • National public health journals, • mailings, • distribution at meetings
Comprehensive collections of written evaluation reports	<ul style="list-style-type: none"> • Mailings, • distribution at meetings
Slide presentations	<ul style="list-style-type: none"> • Public talks

ORIGINAL STATE PLANNING PARTICIPANTS FOR 1998 PLAN

The membership of the Cancer Control Planning Task Force started with a small group of cancer control professionals to serve as advisors on the planning process itself. Then, following their guidance, membership was expanded to develop three Expert Panels, each of which took responsibility for studying one of three traditional approaches to cancer control, including primary prevention, screening, and treatment, and making recommendations relevant to that approach. A fourth Expert Panel on Palliative Care was created at the recommendation of the Expert Panel on Cancer Treatment, to emphasize the need for better palliative care in the treatment of terminally ill cancer patients.

Advisers on the Cancer Control Planning Process

Adviser	Affiliation
Charles McDonald, MD	Roger Williams General Hospital
Vince Mor, PhD	Brown University School of Medicine
Barbara Schepps, MD	Rhode Island Hospital
Barry Stein, MD	Rhode Island Hospital
Frank Cummings, MD	American Cancer Society
John Duhaime, DDS	RI Dental Society
Steve Falkenberry, MD	Women and Infants Hospital
Arvin Glicksman, MD	American Cancer Society
Laura Hilderly, RN, MS	American Cancer Society

Expert Panel on Cancer Prevention

Panel Member	Specialty	Representing
Ann Louise Assaf, PhD	Health Promotion	Memorial Hospital and Brown Univ
Nancy Beauchene, MS	Nutrition	Rhode Island Nutrition Forum
Judy DePue, EdD	Tobacco Control	Miriam Hospital and Brown Univ
Ellen Frankel, MD	Dermatology	Private Practice
Elizabeth Harvey, MA	Tobacco Use Prevention and Cessation	Rhode Island Project ASSIST
Mark Robbins, PhD	Clinical and Health Psychology	University of Rhode Island
Marie Stoekel, MS	Occupational Health	Rhode Island Department of Health
Ann Thacher, MS	Health Promotion	The Prevention Coalition
Robert Vanderslice, PhD	Environmental Health	Rhode Island Department of Health

Expert Panel on Cancer Screening

Panel Member	Specialty	Representing
Leslie Cashel, MD	Gastroenterology	Harvard Health
John Duhaime, DDS	Dental Surgery	Private Practice
Roger Griffith, MD	Pathology	Miriam Hospital
Janice Kizirian, MD	Internal Medicine	Rhode Island Hospital
Joann Lindenmayer, DVM, MPH	Chronic Disease Epidemiology	Brown University School of Medicine
Barbara Schepps, MD	Radiology	Rhode Island Hospital
Barry Stein, MD	Urology	Rhode Island Hospital
Sonia Uchman, MD	Gastroenterology	Rhode Island Hospital
Wendy Verhoek-Ofstedahl, PhD	Chronic Disease Epidemiology	Brown University School of Medicine
Marguerite Vigliani, MD	Obstetrics / Gynecology	Women & Infants Hospital

Expert Panel on Cancer Treatment and Care

Panel Member	Specialty	Representing
Peter Baute, MD	Surgery	Kent County Memorial Hospital
Frank Cummings, MD	Oncology	Roger Williams Medical Center
Steven Falkenberry, MD	Surgery	Women & Infants Hospital
Arvin Glicksman, MD	Radiotherapy	American Cancer Society
Edward Martin, MD	Internal Medicine	Hospice of RI
Gabriella Masko, MD	Radiotherapy	Private Practice
Marilyn Miller, MD	Oncology	Memorial Hospital, Pawtucket
Patricia Mitchell, RN	Oncology Nursing	Kent County Memorial Hospital

Expert Panel on Palliative Care

Panel Member	Specialty	Representing
Edward Martin, MD	Palliative Medicine	Philip Hulitar Center
Vincent Mor, PhD	Hospice Care	Brown University School of Medicine
Joan Teno, MD	Advance Directives	Brown University School of Medicine
The Rev. Lyle Mook	Hospice Care	RI State Hospice Association

Staff Assisting the Panels

Staff Member	Specialty	Representing
Francis Donahue, MA	Cancer Screening Interventions	Rhode Island Department of Health
John Fulton, PhD	Cancer Surveillance	Rhode Island Department of Health
Donald Perry, MPA	Evaluation of Cancer Control Interventions	Rhode Island Department of Health

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APPENDIX: *HEALTHY PEOPLE 2010* OUTCOME OBJECTIVES

The overall mission of *Healthy People 2010* for the control of cancer is to promote health through better prevention, screening, treatment, education, and surveillance efforts.

The following national 2010 objectives have informed the selection of strategies for RI:

HEALTHY PEOPLE 2010 CANCER OBJECTIVES

OBJECTIVE		1998 U.S. Baseline (unless noted)	2010 Target
By 2010:			
		-Rate per 100,000-	
3-1.	Reduce the overall cancer death rate.	202.4	159.9
3-2.	Reduce the lung cancer death rate.	57.6	44.9
3-3.	Reduce the breast cancer death rate.	27.9	22.3
3-4.	Reduce the death rate from cancer of the uterine cervix.	3.0	2.0
3-5.	Reduce the colorectal cancer death rate.	21.2	13.9
3-6.	Reduce the oropharyngeal cancer death rate.	3.0	2.7
3-7.	Reduce the prostate cancer death rate.	32.0	28.8
3-8.	Reduce the rate of melanoma cancer deaths.	2.8	2.5
		-Percent-	
3-9.	Increase the proportion of persons who use at least one of the following protective measures that may reduce the risk of skin cancer: avoid the sun between 10 a.m. and 4 p.m., wear sun-protective clothing when exposed to sunlight, use sunscreen with a sun-protective factor (SPF) of 15 or higher, and avoid artificial sources of ultraviolet light.		
3-9a.	Increase the proportion of adolescents in grades 9 through 12 who follow protective measures that may reduce the risk of skin cancer	Developmental	
3-9b.	Increase the proportion of adults aged 18 years and older who follow protective measures that may reduce the risk of skin cancer	47	75
3-10.	Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening.		
3-10a.	Internists who counsel about smoking cessation	50	85
3-10b.	Family physicians who counsel about smoking cessation	43	85
3-10c.	Dentists who counsel about smoking cessation	59 (1997)	85
3-10d.	Primary care providers who counsel about blood stool tests	56	85
3-10e.	Primary care providers who counsel about proctoscopic examinations	23	85
3-10f.	Primary care providers who counsel about mammograms	37	85
3-10g.	Primary care providers who counsel about Pap tests	55	85
3-10h.	Primary care providers who counsel about physical activity	22 (1995)	85
3-11.	Increase the proportion of women who receive a Pap test.		
3-11a.	Women aged 18 years and older who have ever received a Pap test	92	97
3-11b.	Women aged 18 years and older who received a Pap test within the preceding 3 years	79	90
3-12.	Increase the proportion of adults who receive a colorectal cancer screening examination.		

3-12a.	Adults aged 50 years and older who have received a fecal occult blood test (FOBT) within the preceding 2 years	35	50
3-12b.	Adults aged 50 years and older who have ever received a sigmoidoscopy	37	50
3-13.	Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years.	67	70
-Number-			
3-14.	Increase the number of States that have a statewide population-based cancer registry that captures case information on at least 95 percent of the expected number of reportable cancers.	21	45
-Percent-			
3-15.	Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis.	59 (1989-95)	70

HEALTHY PEOPLE 2010 CANCER-RELATED OBJECTIVES FROM OTHER FOCUS AREAS

OBJECTIVE		1998 U.S. Baseline (unless noted)	2010 Target
By 2010:		-Percent-	
19-1.	Increase the proportion of adults who are a healthy weight.	42 (1988-94)	60
19-2.	Reduce the proportion of adults who are obese.	23 (1988-94)	15
19-3b.	Reduce the proportion of children and adolescents who are overweight or obese.		
19-3a.	Children aged 6 to 11 years	11 (1988-94)	5
19-3b.	Adolescents aged 12 to 19 years	11 (1988-94)	5
19-3c.	Children and adolescents aged 6 to 19 years	11 (1988-94)	5
19-5.	Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit.	28 (1994-96)	75
19-6.	Increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third being dark-green or orange vegetables.	3 (1994-96)	50
19-8.	Increase the proportion of persons aged 2 years and older who consume less than 10 percent of calories from saturated fat.	36 (1994-96)	75
19-9.	Increase the proportion of persons aged 2 years and older who consume no more than 30 percent of calories from total fat.	33 (1994-96)	75
21-6.	Increase the proportion of oral and pharyngeal cancer detected at the earliest stage.	35 (1990-95)	50
21-7.	Increase the proportion of adults [aged 40 years and older], who, in the past 12 months, report having had an examination to detect oral and pharyngeal cancers.	13	20
22-1.	Reduce the proportion of adults who engage in no leisure-time physical activity.	40 (1997)	20
22-2.	Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.	15 (1997)	30
22-6.	Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous days.	27 (1999)	35

26-13.	Reduce the proportion of adults who exceed guidelines for low-risk drinking.		
26-13a.	Females	72 (1992)	50
26-13b.	Males	74 (1992)	50
27-1.	Reduce tobacco use by adults.		
27-1a.	Cigarette smoking	24	12
27-1b.	Spit tobacco	2.6	0.4
27-1c.	Cigars	2.5	1.2
27-1d.	Other products	Developmental	
27-2.	Reduce tobacco use by adolescents.		
27-2a.	Tobacco products (past month)	40	21
27-2b.	Cigarettes (past month)	35	16
27-2c.	Spit tobacco (past month)	8	1
27-2d.	Cigars (past month)	18	8
27-5.	Increase smoking cessation attempts by adult smokers [adults who stopped smoking for one day or longer because they were trying to quit].	41	75
27-7.	Increase tobacco use cessation attempts by adolescent smokers [ever-daily smokers in grades 9 through 12 who tried to quit smoking].	76	84
27-8.	Increase insurance coverage of evidence-based treatment for nicotine dependency.		
27-8a.	Managed care organizations	75 (1997-98)	100
27-8b.	Medicaid programs in States and the District of Columbia	24	51
27-8c.	All insurance	Developmental	

APPENDIX: RHODE ISLAND 2005 OBJECTIVES (FROM 1998 CANCER CONTROL PLAN)

The following Rhode Island-specific 2005 objectives for cancer control are from the 1998 Cancer Control Plan for Rhode Island.

Reduction of Risk Factors

Reduce to at most 15 percent the proportion of people ages 18 and over who smoke cigarettes.
(RI baseline: 24.7 percent in 1995)

Increase to at least 35 percent the proportion of people ages 18 and over who eat at least five servings of fruits and vegetables every day.
(RI baseline: 24.1 percent in 1996)

Increase to at least 50 percent the proportion of adults who engage in moderate physical activity for at least 30 minutes per day, five days per week.
(RI baseline: 45.8 percent of adults were getting some leisure time physical activity in 1994)

Increase to at least 75 percent the proportion of people of all ages who limit sun exposure, use sunscreens and protective clothing when exposed to sunlight, and avoid artificial sources of ultraviolet light (e.g., sun lamps, tanning booths).
(R.I. baseline: Data on the proportion of people of all ages who limit sun exposure and avoid exposure to artificial sources of ultraviolet light are unavailable.)

Reduction of Cancer Incidence

Reduce to 79.5 cases per 100,000 the age-adjusted incidence rate for cancer of the lung-bronchus among men.
(R.I. baseline: 89.9 cases per 100,000 in 1990-1994)

Limit to 60.0 cases per 100,000 the age-adjusted incidence rate for cancer of the lung-bronchus among women.
(R.I. baseline: 45.2 cases per 100,000 in 1990-1994)

[Note: Like the post-WWII increases in lung cancer incidence and mortality observed among men, it is feared that lung cancer may reach epidemic proportions among women before eventually plateauing and decreasing.]

Reduce to 55.8 cases per 100,000 the age-adjusted incidence rate for cancer of the colon-rectum among men.
(R.I. baseline: 67.1 cases per 100,000 in 1990-1994)

Reduce to 38.9 cases per 100,000 the age-adjusted incidence rate for cancer of the colon-rectum among women.
(R.I. baseline: 45.5 cases per 100,000 in 1990-1994)

Reduce to 4.6 cases per 100,000 the age-adjusted incidence rate for cancer of the cervix among women.
(R.I. baseline: 9.3 cases per 100,000 in 1990-1994)

Adherence to Cancer Screening Recommendations

Increase to at least 95 percent the proportion of women ages 18-44 who receive Pap tests according to current recommendations.
(R.I. baseline: 83.0 percent of women ages 18-44 were screened within the preceding 2 years in 1995.)

Increase to at least 80 percent the proportion of women ages 45 and over who receive Pap tests according to current recommendations.
(R.I. baseline: 68.1 percent of women ages 45 and over were screened within the preceding 2 years in 1995.)

Increase to at least 85 percent the proportion of women ages 40-49 who receive clinical breast examinations and mammograms according to current recommendations.
(R.I. baseline: 74.6 percent of women ages 40-49 received a mammogram within the preceding 2 years in 1995.)

Increase to at least 85 percent the proportion of women ages 50 and over who receive clinical breast examinations and mammograms according to current recommendations.
(R.I. baseline: 49.7 percent of women ages 50 and over received a mammogram within the preceding 2 years in 1995.)

Increase to at least 75 percent the proportion of eligible adults who receive digital rectal exams according to current recommendations.
(R.I. baseline: 52.8 percent of eligible adults received a digital rectal exam according to current recommendations in 1995.)

Increase to at least 75 percent the proportion of eligible adults who receive fecal occult blood tests and sigmoidoscopy (or colonoscopy) according to current recommendations.
(R.I. baseline: 33.3 percent of adults ages 50 and over had ever received sigmoidoscopy in 1995.)

Adherence to State-of-the-Art Treatment

Increase to at least 25 percent the proportion of adult cancer patients enrolled in approved clinical trials.
(R.I. baseline: An estimated 3 percent of adult cancer patients were enrolled in approved clinical trials in 1998.)

Reduction of Cancer Mortality

Reduce to 217.9 deaths per 100,000 the age-adjusted mortality rate for all cancers combined among men.
(R.I. baseline: 226.8 deaths per 100,000 in 1990-1994)

Reduce to 141.7 deaths per 100,000 the age-adjusted mortality rate for all cancers combined among women.
(R.I. baseline: 147.2 deaths per 100,000 in 1990-1994)

Reduce to 65.0 deaths per 100,000 the age-adjusted mortality rate for cancer of the lung-bronchus among men.
(R.I. baseline: 75.4 deaths per 100,000 in 1990-1994)

Limit to 50.0 deaths per 100,000 the age-adjusted mortality rate for cancer of the lung-bronchus among women.
(R.I. baseline: 32.8 deaths per 100,000 in 1990-1994)

[Note: Like the post-WWII increases in lung cancer incidence and mortality observed among men, it is feared that lung cancer may reach epidemic proportions among women before eventually plateauing and decreasing.]

Reduce to 22.4 deaths per 100,000 the age-adjusted mortality rate for cancer of the colon-rectum among men.
(R.I. baseline: 25.9 deaths per 100,000 in 1990-1994)

Reduce to 15.1 deaths per 100,000 the age-adjusted mortality rate for cancer of the colon-rectum among women.
(R.I. baseline: 16.3 deaths per 100,000 in 1990-1994)

Reduce to 1.3 deaths per 100,000 the age-adjusted mortality rate for cancer of the cervix among women.
(R.I. baseline: 2.6 deaths per 100,000 in 1990-1994)

Reduce to 26.4 deaths per 100,000 the age-adjusted mortality rate for cancer of the breast among women.
(R.I. baseline: 29.3 deaths per 100,000 in 1990-1994)

Reduce to 2.0 deaths per 100,000 the age-adjusted mortality rate for malignant melanoma among men.
(R.I. baseline: 2.9 deaths per 100,000 in 1990-1994)

Reduce to 1.0 deaths per 100,000 the age-adjusted mortality rate for malignant melanoma among women.
(R.I. baseline: 1.3 deaths per 100,000 in 1990-1994)

Provision of Palliative Care to Terminally Ill Cancer Patients

Increase to at least 50 percent the proportion of terminally ill cancer patients who receive hospice services beginning at least three months prior to death.
(R.I. baseline: An estimated 40 percent of terminally ill cancer patients who died in 1997 received any hospice services prior to death.)

Increase to at least 75 percent the proportion of terminally ill cancer patients who receive hospice services beginning at least two weeks prior to death.
(R.I. baseline: An estimated 40 percent of terminally ill cancer patients who died in 1997 received any hospice services prior to death.)

APPENDIX: CANCER PREVENTION AND SCREENING RECOMMENDATIONS

Female Breast Cancer Screening

1998 Cancer Control Plan Recommendations

- For women without a family history of pre-menopausal breast cancer, CBE should be performed at the periodic health examination after the age of 30.
- Annual CBE and mammography after age 40.
- For women with a first degree relative diagnosed with pre-menopausal breast cancer, annual mammography should commence 5-10 years prior to the age at which the relative was diagnosed.
- Women with BRCA1 and BRCA2 mutations should commence monthly BSE by 20 years of age, and should receive annual or semiannual CBE, and annual mammography, beginning at age 25 to 35 years.

2002 USPSTF Recommendations

- Recommends screening mammography every 1-2 years, with or without clinical breast examination, among women aged 40 and older.
- Recommends women should be informed of potential benefits, limitations, and possible harms of mammography in making decisions about when to begin screening.
- Concludes that there is insufficient evidence to recommend for or against routine clinical breast examination alone to screen for breast cancer.
- Concludes that there is insufficient evidence to recommend for or against teaching or performing routine breast self-examination.

American Cancer Society Recommendations

- Women age 40 and older should have a screening mammogram every year, and should continue to do so for as long as they are in good health.
- Women in their 20s and 30s should have a clinical breast examination (CBE) as part of a periodic (regular) health exam by a health professional preferably every 3 years. After age 40, women should have a breast exam by a health professional every year.
- BSE is an option for women starting in their 20s. Women should be told about the benefits and limitations of BSE. Women should report any breast changes to their health professional right away.
- Women at increased risk should talk with their doctor about the benefits and limitations of starting mammograms when they are younger, having additional tests, or having more frequent exams. Women should discuss with their doctor what approaches are best for them. Although the evidence currently available does not justify recommending ultrasound or MRI for screening, women at increased risk might benefit from the results.

National Cancer Institute Recommendations (Mammography)

- Women in their 40s should be screened every one to two years with mammography.
- Women aged 50 and older should be screened every one to two years.
- Women who are at higher than average risk of breast cancer should seek expert medical advice about whether they should begin screening before age 40 and the frequency of screening.

Cervical Cancer Screening

1998 Cancer Control Plan Recommendations

- For women in high-risk groups -- women with multiple sex partners, sexually promiscuous partners, early age at first intercourse, and/or a history of a sexually transmitted disease (including human papilloma virus) -- Pap smears should be performed annually.
- For women who are HIV positive, Pap smears should be performed at least annually.
- For asymptomatic women with a cervix and no risk factors, regular Pap smears should be performed if a woman is or has been sexually active. There is no upper age limit for the performance of regular Pap smears.
- If a history of past and/or present sexual activity cannot be accurately determined and a woman is 18 years of age or over, routine Pap screening should be initiated.
- Women who have had a hysterectomy cannot be presumed to be without cervical tissue and the decision to screen them with Pap smears should be determined on a case-by-case basis.

2003 USPSTF Recommendations

- Strongly recommends screening women for cervical cancer if they are sexually active and have a cervix.
- Recommends against routinely screening women older than age 65 if they have had adequate recent screening with normal Pap smears and are not otherwise at increased risk for cervical cancer.
- Recommends against routine Pap screening for women who have had a total hysterectomy for benign disease.
- Concludes that the evidence is insufficient to recommend for or against new technologies (such as ThinPrep®) in place of conventional Pap tests.
- Concludes that the evidence is insufficient to recommend for or against human papillomavirus (HPV) testing as a primary screening test for cervical cancer.

American Cancer Society Recommendations

- All women should begin cervical cancer screening about 3 years after they begin having vaginal intercourse, but no later than when they are 21 years old. Screening should be done every year with the regular Pap test or every 2 years using the newer liquid-based Pap test.
- Beginning at age 30, women who have had 3 normal Pap test results in a row may get screened every 2 to 3 years with either the conventional (regular) or liquid-based Pap test. Women who have certain risk factors such as diethylstilbestrol (DES) exposure before birth, HIV infection, or a weakened immune system due to organ transplant, chemotherapy, or chronic steroid use should continue to be screened annually.
- Another reasonable option for women over 30 is to get screened every 3 years (but not more frequently) with either the conventional or liquid-based Pap test, *plus* the HPV DNA test.
- Women 70 years of age or older who have had 3 or more normal Pap tests in a row and no abnormal Pap test results in the last 10 years may choose to stop having cervical cancer screening. Women with a history of cervical cancer, DES exposure before birth, HIV infection or a weakened immune system should continue to have screening as long as they are in good health.
- Women who have had a total hysterectomy (removal of the uterus and cervix) may also choose to stop having cervical cancer screening, unless the surgery was done as a treatment for cervical cancer or precancer. Women who have had a hysterectomy

without removal of the cervix should continue to follow the guidelines above.

National Cancer Institute Recommendations

- Cervical cancer screening should begin approximately three years after a woman begins having sexual intercourse, but no later than at 21 years old.
- Experts recommend waiting approximately three years following initiation of sexual activity because transient HPV infections and cervical cell changes that are not significant are common and it takes years for a significant abnormality or cancer to develop. Cervical cancer is extremely rare in women under the age of 25.
- Women should have a Pap test at least once every three years.
- Women 65 to 70 years of age who have had at least three normal Pap tests and no abnormal Pap tests in the last 10 years may decide, upon consultation with their healthcare provider, to stop cervical cancer screening.
- Women who have had a total hysterectomy (removal of the uterus and cervix) do not need to undergo cervical cancer screening, unless the surgery was done as a treatment for cervical precancer or cancer.
- Women should seek expert medical advice about when they should begin screening, how often they should be screened, and when they can discontinue cervical screenings, especially if they are at higher than average risk of cervical cancer due to factors such as HIV infection.

Colorectal Cancer Screening

1998 Cancer Control Plan Recommendations

- All persons should receive an annual digital rectal examination beginning at age 40.
- All persons 50 years of age and over should receive fecal occult blood testing annually and flexible sigmoidoscopy every 5 years. Persons positive by either screening test should be referred for colonoscopy.
- Persons at elevated risk for the development of colorectal cancer should be referred for diagnosis and management if there is:
 - a family history of hereditary syndromes associated with a high incidence of colon cancer (polyposis syndromes),
 - at least one first degree relative with colorectal cancer
 - a personal history of colon adenomas or colon cancer, inflammatory bowel disease involving the colon.

2002 USPSTF Recommendations

- The USPSTF strongly recommends that clinicians screen men and women aged 50 and older who are at average risk for colorectal cancer. For those at higher risk, such as those with a first-degree relative diagnosed with colorectal cancer before age 60, it is reasonable to begin screening at a younger age. Screening options for colorectal cancer include home fecal occult blood test (FOBT), flexible sigmoidoscopy, the combination of home FOBT and flexible sigmoidoscopy, colonoscopy, and double-contrast barium enema.

American Cancer Society Recommendations

- Beginning at age 50, both men and women should follow **one** of the five screening options below:
 - A fecal occult blood test (FOBT)* every year,
 - Flexible sigmoidoscopy every 5 years,
 - A fecal occult blood test every year plus flexible sigmoidoscopy every 5 years,
 - (Of these first 3 options, the combination of FOBT every year and flexible sigmoidoscopy every 5 years is preferable.)
 - Double-contrast barium enema every 5 years, or
 - Colonoscopy every 10 years.

* For FOBT, the take-home multiple sample method should be used.

National Cancer Institute Recommendations

- None

Lung Cancer Prevention (Tobacco use)

1998 Cancer Control Plan Recommendations

- Avoid tobacco use.
- Avoid environmental tobacco smoke.

1996 USPSTF Recommendations

- Tobacco cessation counseling on a regular basis is recommended for all persons who use tobacco products.
- The prescription of nicotine patches or gum is recommended as an adjunct for selected patients.
- In addition:
 - Pregnant women and parents with children living at home should be counseled on the potentially harmful effects of smoking on fetal and child health.
 - Anti-tobacco messages are recommended for inclusion in health promotion counseling of children, adolescents, and young adults.

American Cancer Society Recommendations*

- The best way to prevent lung cancer is to not smoke and to avoid people who do. If you already smoke, you should quit. You should also avoid breathing in other people's smoke.

* Recommendations pulled from text (not explicitly stated in document).

National Cancer Institute Recommendations

- Quitting smoking is beneficial at all ages, and the earlier in life one quits, the greater the benefits.
- Nicotine dependence exposes smokers in a dose-dependent fashion to carcinogenic and genotoxic elements that cause lung cancer. Overcoming nicotine dependence is often extremely difficult. The Agency for Health Care Policy and Research released in 1996 a set of clinical smoking-cessation guidelines for helping nicotine-dependent patients and healthcare providers. The 6 major elements of these guidelines include:
 - Clinicians must document the tobacco-use status of every patient.
 - Every patient using tobacco should be offered one or more of the effective smoking cessation treatments that are available.
 - Every patient using tobacco should be provided with at least one of the effective brief cessation interventions that are available.
 - In general, more intense interventions are more effective than less intense interventions in producing long-term tobacco abstinence, reflecting the dose-response relationship between the intervention and its outcome.
 - One or more of the 3 treatment elements identified as being particularly effective should be included in smoking-cessation treatment:
 - Nicotine-replacement, e.g., nicotine patches, gum.
 - Social support from clinician in the form of encouragement, assistance.
 - Skills training/problem solving (cessation/abstinence techniques).
 - To be effective, health care systems must make institutional changes resulting in systematic identification of tobacco users and intervention with these patients at every visit.

Lung Cancer Screening

1998 Cancer Control Plan Recommendations

- None

1996 USPSTF Recommendations

- Routine screening for lung cancer with chest radiography or sputum cytology in asymptomatic persons is not recommended. All patients should be counseled against tobacco use (see Chapter 54).

American Cancer Society Recommendations

- None

National Cancer Institute Recommendations

- None

Skin Cancer Prevention

1998 Cancer Control Plan Recommendations

- Avoid excessive sun exposure.
- Use protective clothing whenever excessive exposure to sunlight is anticipated.
- Children, individuals who cannot avoid excessive sun exposure, and individuals who are at substantially increased risk for skin cancer should use sunscreen (at least SPF 15).
- Do not use artificial tanning devices such as commercial tanning booths and sun lamps used in the home.

1996 USPSTF Recommendations

- Counseling patients at increased risk of skin cancer to avoid excess sun exposure is recommended, based on the proven efficacy of risk reduction, although the effectiveness of counseling has not been well established. There is insufficient evidence to recommend for or against sunscreen use for the primary prevention of skin cancer.

American Cancer Society Recommendations

- The most important ways to lower your risk of melanoma are to avoid being outdoors in intense sunlight too long and to practice sun safety when you are outdoors even on cloudy or cool days. You can maintain your level of outdoor physical activity and protect your skin at the same time. Practicing sun safety includes:
 - Seeking shade – avoid being outdoors in sunlight too long
 - Protecting your skin with clothing
 - Using sunscreen – SPF of 15 or more
 - Wearing sunglasses – wrap-around sunglasses with 99% to 100% UV absorption
 - Avoiding other sources of UV light – avoid tanning beds and sun lamps
 - Protecting children from the sun
 - Identifying abnormal moles and having them removed
 - Learning more about skin cancer prevention
 - Getting genetic counseling – If several members of one side of your family have had melanoma, if you have had multiple melanomas, or if you have had melanoma at young age or have dysplastic nevi, you may have a gene mutation causing melanoma and should talk to your doctor about genetic counseling.

National Cancer Institute Recommendations

- None

Skin Cancer Screening

1998 Cancer Control Plan Recommendations

- Do not recommend for or against routine screening for skin cancer by primary care providers.
- Clinicians should remain alert for skin lesions with malignant features (i.e., asymmetry, border irregularity, color variability, diameter > 6mm, or rapidly changing lesions) when examining patients for other reasons, particularly patients with established risk factors, including clinical evidence of melanocytic precursor or marker lesions, large numbers of common moles, immunosuppression, a family or personal history of skin cancer, substantial cumulative lifetime sun exposure, intermittent intense sun exposure or severe sunburns in childhood, freckles, poor tanning ability, light skin, hair, and eye color.
- Recommend to consider referring patients at substantially increased risk of malignant melanoma to dermatologists specializing in skin cancer for evaluation and surveillance. Persons at substantially increased risk for malignant melanoma include those with melanocytic precursor or marker lesions, e.g., atypical moles [also called dysplastic nevi], certain congenital nevi, familial atypical mole, and melanoma syndrome.

2001 USPSTF Recommendations

- The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routine screening for skin cancer using a total-body skin examination for the early detection of cutaneous melanoma, basal cell cancer, or squamous cell skin cancer

American Cancer Society Recommendations

- A monthly skin self-exam
- That your routine health exam include a skin examination for cancer

National Cancer Institute Recommendations

- None

Oral Cavity Cancer Screening

1998 Cancer Control Plan Recommendations

- Primary care providers should remain alert to the signs of early oral cancer, particularly leukoplakia and erythroplakia, and should refer patients with these lesions to a surgical specialist for further evaluation and treatment.

1996 USPSTF Recommendations

- There is insufficient evidence to recommend for or against routine screening of asymptomatic persons for oral cancer by primary care clinicians. All patients should be counseled to discontinue the use of all forms of tobacco (see Chapter 54) and to limit consumption of alcohol (see Chapter 52). Clinicians should remain alert to signs and symptoms of oral cancer and premalignancy in persons who use tobacco or regularly use alcohol.

American Cancer Society Recommendations

- None

National Cancer Institute Recommendations

- None

Ovarian Cancer Screening

1998 Cancer Control Plan Recommendations

- None

1996 USPSTF Recommendations

- Routine screening for ovarian cancer by ultrasound, the measurement of serum tumor markers, or pelvic examination is not recommended. There is insufficient evidence to recommend for or against the screening of asymptomatic women at increased risk of developing ovarian cancer.

American Cancer Society Recommendations

- None

National Cancer Institute Recommendations

- None

Prostate Cancer Screening

1998 Cancer Control Plan Recommendations

- Primary care providers should inform men ages 45 and over about the known risks and potential benefits of prostate cancer screening with the PSA and DRE, and make available annual screening with PSA and DRE to men ages 50 and over with at least a 10-year life expectancy and to men ages 45 and over with a high risk of developing prostate cancer (i.e., men with a family history of prostate cancer and African-American men) who, after considering information about the known risks and potential benefits of prostate cancer screening, request to be screened.

2002 USPSTF Recommendations

- The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for prostate cancer using prostate specific antigen (PSA) testing or digital rectal examination (DRE). Although the Task Force found evidence that screening can find prostate cancer early and that some cancers benefit from treatment, the Task Force is uncertain whether the potential benefits of prostate cancer screening justify the potential harms.

American Cancer Society Recommendations

- None

National Cancer Institute Recommendations

- None

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