The Ohio Comprehensive Cancer Control Plan 2011-2014

Ohio Partners for Cancer Control

May 2012

www.ohiocancercontrol.org

May 2012

Dear Ohioans:
During 2012 about 59,000 new cases of cancer will be diagnosed among Ohio residents. About 25,000 Ohioans will die this year with cancer as the underlying cause of death. In the U.S., and in Ohio, men and women have about a 1 in 3 lifetime risk of developing some type of invasive cancer.

You undoubtedly know someone who has been affected by cancer – a family member, friend, co-worker, or perhaps you yourself. The second leading cause of death in Ohio, cancer leaves virtually no family untouched.

In 2011 the Ohio Partners for Cancer Control, Ohio's statewide comprehensive cancer control partnership, recognized the need to reduce the cancer burden and created *The Ohio Comprehensive Cancer Control Plan 2011-2014*. Created with the collaboration of more than 20 organizations the Plan serves as a blueprint for cancer surveillance, prevention, screening and early detection, clinical trials, palliative care, and survivorship. The Plan includes objectives that were initiated in 2011, even as the plan was being developed. New organizations are continually encouraged to join and work toward completing the objectives and/or add new objectives to this dynamic plan.

The pathway to improved cancer surveillance, prevention, and control will not be easy. Cancer is rarely caused by just one factor and has a long latency period making identification of causes difficult. But we do know that healthy diets, plenty of exercise, and tobacco use prevention and cessation will greatly reduce the burden of cancer. Following age and gender appropriate screening guidelines will help us all find cancer at its earliest and most treatable stages. We must all work together to improve the quality of life for cancer survivors and their loved ones.

Thank you for using and sharing the *The Ohio Comprehensive Cancer Control Plan 2011-2014*. The Ohio Partners for Cancer Control invites you to learn more about our efforts and to join us as we work toward "a cancer-free future for all Ohioans".

Sincerely,

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DEDICATION

The Ohio Comprehensive Cancer Control Plan 2011-2014 is dedicated to all Ohioans whose lives have been affected by cancer.

Ohio Partners for Cancer Control

"A Cancer Free Future for All Ohioans"

Contents:

Appendices

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The *Ohio Comprehensive Cancer Control Plan 2011-2014* could not have been written without the dedication, expertise, and hard work of many professionals who gave of their time and talent to set priorities for cancer surveillance, prevention and control. Four committees were created to discuss and write this plan: "Data and Surveillance," "Primary Prevention and Screening and Early Detection," "Treatment/Survivorship/Palliative Care," and "Advocacy/Communication."

The Committee Chairs and Co-Chairs and those OPCC members who actively worked on the Plan are presented below. Many thanks and appreciation are due to these members:

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THE OHIO COMPREHENSIVE CANCER CONTROL PLAN 2011-2014:

14 Goals for "A Cancer-Free Future for All Ohioans"

Data and Surveillance

GOAL 1: Enhance the Quality and Reporting of Cancer Incidence Data and Increase the Dissemination and Use of Data for Cancer Prevention and Control

Primary Prevention

GOAL 2: Reduce Tobacco Use among Ohioans

GOAL 3: Reduce Exposure to Environmental Carcinogens

GOAL 4: Increase the Proportion of Adults and Children who Engage in Recommended Physical Activity Levels

GOAL 5: Increase the Proportion of Adults and Children Who Engage in Healthy Eating Behaviors

GOAL 6: Increase the Vaccination Rate for Vaccines Shown to Reduce the Risk of Cancer

GOAL 7: Reduce Exposure to Ultraviolet Radiation from the Sun and Sun Lamps

Screening and Early Detection

GOAL 8: Improve Screening and Early Detection and Follow-up for Breast, Colorectal, and Cervical Cancers

GOAL 9: Promote the Use of Cancer Genetic Services

Treatment/Survivorship/Palliative Care

GOAL 10: Promote Clinical Trials

GOAL 11: Optimize the Quality of Life for Cancer Survivors and Significant Others through Community - Based Wellness Programs and Clinical Linkages

GOAL 12: Provide Essential Survivorship Management Tools and Services to Cancer Survivors

GOAL 13: Impact the Quality of Life of Cancer Patients by Providing American Cancer Society Information and Referral to National, Local and Community Resources, Programs, and Services

Advocacy/Communication

GOAL 14: Increase Interest in Cancer Surveillance, Prevention, and Control Activities among State of Ohio Legislators and Organizational Policy Makers to Influence Policy and Systems Changes

INTRODUCTION

Comprehensive Cancer Control

The Centers for Disease Control and Prevention (CDC) defines Comprehensive Cancer Control as

> *"a collaborative process through which a community pools resources to reduce the burden of cancer that results in risk reduction, early detection, better treatment, and enhanced survivorship."*[1]

CDC created the National Comprehensive Cancer Control Program (NCCCP) to help states, tribes, and territories form coalitions to conduct comprehensive cancer control. Ohio received funding from CDC in 2002 to establish Ohio's Comprehensive Cancer Control Program. The CDC has identified seven NCCCP priorities for state Comprehensive Cancer Control Programs:[1]

1. An emphasis on primary prevention, e.g. improved nutrition, increased physical activity, smoking prevention and cessation;
2. Coordination of early detection and treatment interventions;
3. Addressing the public health needs of cancer survivors;
4. Implementation of policies to sustain cancer control;
5. Elimination of cancer disparities and achievement of health equity;
6. Use of evidence-based approaches, and
7. Measuring impact through evaluation.

Comprehensive Cancer Control relies on active involvement by concerned citizens and key stakeholders and uses data in a systematic process to:

- Determine the burden of cancer;
- Identify the needs of communities and/or population-based groups;
- Prioritize these needs;
- Develop interventions and infrastructure to address the needs;
- Mobilize resources to implement interventions; and
- Evaluate the impact of these interventions on the health of the community/population.

Ohio Partners for Cancer Control

The Ohio Partners for Cancer Control (OPCC) is a statewide coalition dedicated to reducing the burden of cancer in Ohio. The coalition includes representatives of organizations who have cancer prevention and control as a focus of their mission. Organizations represented include hospitals, universities, cancer centers, health care professional associates, nonprofit organizations, government agencies, minority health coalitions, and community organizations.

The OPCC vision is "A Cancer-Free Future for All Ohioans". The OPCC stresses a unified fight against cancer through collaboration and use of a comprehensive approach. The OPCC seeks to be inclusive not exclusive. New members and fresh ideas are always welcome. The OPCC will achieve far greater success than could be accomplished by individual organizations working alone. The OPCC Membership Enrollment Form (Appendix B) and the OPCC website at http://www.ohiocancercontrol.org describe how you can get involved.

The Ohio Comprehensive Cancer Control Plan 2011-2014

Ohio's Comprehensive Cancer Control Plan 2011-2014 (the Plan) is a strategic plan to reduce the cancer burden in our state. It is designed to provide guidance to individuals and organizations spanning a wide range of health and social disciplines that can play a role in controlling cancer. All aspects of the cancer surveillance prevention and control continuum are addressed. These aspects include data and surveillance, primary prevention, screening and early detection, treatment, quality of life and end-of-life care, and advocacy.

The Plan has three guiding principles that cut across all 14 goals and related objectives:

- Data driven decisions;
- Evidence based interventions, and
- Identification of disparities and progress toward equity.

The Plan's strategies are intended to direct collective efforts toward specific and measurable objectives that will reduce the cancer burden. Also, many of the outcomes will have benefits extending beyond cancer to other leading chronic diseases.

Finally, please note that this Plan is meant to be a dynamic document. As opportunities arise, funding sources appear, and breakthroughs in prevention, screening, etc., are found, new objectives can and will be added.

Plan Implementation

With support from the CDC, states, tribes, and territories throughout the nation are working to combat cancer through an integrated and coordinated approach to establish cancer control infrastructures, develop and implement comprehensive cancer control plans, mobilize coalitions, build partnerships, collect and analyze cancer data, and evaluate cancer control activities.

The Ohio Comprehensive Cancer Control Program (OCCCP) is charged with formulating and upholding a consolidated vision for reducing our state's cancer burden through policy, systems, and environmental change initiatives. The OCCCP will lead the development and distribution of this Plan, promote the efforts of stakeholders and the OPCC, foster statewide communication and collaboration on cancer control issues, and publish evaluation results in order to refine cancer control strategies.

While the OPCC provides the forum for coordination of Ohio's call to action, the individual partners are ultimately the driving force behind the achievement of the Plan's goals and objectives. The implementation of the Plan is the responsibility of all cancer surveillance, prevention and control stakeholders. Each objective in the Plan has responsible parties that have committed to completing specific objectives with committee members and OPCC support. Persons from other organizations are encouraged to join this team at any time. New partners are encouraged and needed. Again the OPCC seeks to be inclusive of all persons in the execution of this Plan. Only through collective action will Ohio succeed in reducing cancer incidence and mortality and improve the quality of life for cancer survivors.

To assist with plan implementation, the CDC recommends modeling comprehensive cancer control activities after evidence-based public health programs:[2]

> *"Evidence-based interventions are programs that have been evaluated as effective in addressing a health-specific condition in the context of a particular ethnicity or culture. These programs identify the target populations that benefited from the program, the conditions under which the program works, and sometimes the change mechanisms that account for their effects. They use various tested strategies that target a disease or behavior. A defining characteristic of evidence-based intervention is their use of health theory both in developing the content of the interventions and evaluations."*

To achieve the goals and objectives presented in the Plan, we need to implement strategies, practices, interventions, and/or programs that are grounded in evidence. Below are some resources that provide examples and further information about using evidence-based programs:

- Best Practices for Comprehensive Tobacco Control http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm
- Cancer Control P.L.A.N.E.T http://cancercontrolplanet.cancer.gov
- Cochrone Review www.cochrane.org/index.htm
- The Community Guide www.thecommunityguide.org
- Prevention Research Centers www.cdc.gov/prc
- Research-Tested Intervention Programs (RTIP) http://rtips.cancer.gov/rtips/index.do
- U.S. Preventive Services Task Force www.uspreventiveservicestaskforce.org/index.html

Evaluation

Program evaluation is the systematic collection of information about a programs processes, short-term impacts, and long-term outcomes in order to identify problems, determine if goals and objectives are met, guide program improvements, and build on successes. Both quantitative and qualitative methods must be used.

The OCCCP is responsible for developing and implementing an evaluation plan that will assess the 2011-2014 Plan and provide data driven revisions of statewide cancer goals and objectives. The ultimate long-term measure of the Plan's success will be the reduction of cancer mortality rates in Ohio. However, since long-term outcomes take years to achieve, short-term impacts will be assessed through progress on measurable objectives in the Plan.

Quantitative data obtained from the Ohio Cancer Incidence Surveillance System at the Ohio Department of Health (ODH) will measure improvements in cancer incidence and stage of diagnosis. Data from the Vital Statistics Program at ODH will be used to measure progress in reducing cancer mortality. For progress on objectives related to risk factors and screening, the Ohio Behavioral Risk Factor Surveillance System (BRFSS) and other quantitative data sources will be used. In addition, a statewide survey of OPCC stakeholders will be conducted each year by the OCCCP to collect quantitative and qualitative data on cancer control activities. All of the measurable objectives in the Plan will be followed in progress reports using the most reliable and recent data to assess cancer control progress, impacts, and outcomes in Ohio. To see a list of all data sources used and/or referred to in the Plan, please see Appendix A.

While the Ohio Comprehensive Cancer Control Program is responsible for evaluating the Plan, it is critical that other partners throughout Ohio also participate in monitoring progress and use data from available sources to guide their cancer control activities. Challenges are expected during the implementation and evaluation of the Plan as a result of shifts in science, healthcare, the economy, the environment, funding opportunities, and the political climates. Again, it is acknowledged that the Plan is a dynamic document that will evolve with time, new information, varying resources, and changing needs.

THE CANCER BURDEN IN OHIO

Cancer is not just one disease but at least 200 different diseases with an underlying pathology of runaway growth of abnormal cells.[1] If this runaway growth is not controlled it can result in death.

While anyone can develop cancer, the risk increases with age. About 78% of all cancers are diagnosed among persons age 55 years and older.[1] In the United States, males and females have about a 1 in 3 lifetime risk of developing some type of invasive cancer.[3]

Cancer incidence data from the Ohio Cancer Incidence Surveillance System (OCISS) and cancer mortality data from the Ohio Vital Statistics (VS) Program at ODH for the years 2004-2008 indicate about 30,237 new invasive cancer cases and about 12,895 cancer deaths each year among Ohio males.[4] Cancer of the prostate is the leading site/type for incidence (27% of new cases) while cancer of the lung and bronchus is the leading site/type for death from cancer (33% of cancer deaths). These data are presented in **Tables 1** and **2**.

The OCISS and VS data for 2004-2008 also indicate about 29,085 new invasive cancer cases and about 12,027 cancer deaths each year among Ohio females.[5] Breast cancer is the leading site/type for the incidence cases (28%) while cancer of the lung and bronchus is the leading site/type for cancer deaths (27%). These data are also presented in **Tables 1** and **2**.

Regular cancer screening by health care professionals, can result in the detection of cancers of the breast, cervix, colon and rectum, skin, oral cavity and pharynx, prostate, and testis at early stages, when treatment is more likely to be successful.[6] The five-year relative survival probability for all screenable cancers combined is about 86%, and even higher for selected sites/types.[6]

Courtesy of Indiana University

However, OCISS data for the years 2004-2008 indicate that about 29% of all female breast cancer cases and about 49% of all cervical cancer cases are diagnosed late (Regional or Distant) stage, when survival is poorest.[5] About 47% of colon and rectum cancers, 69% of lung and bronchus cancers, and 62% of oral cavity and pharynx cancers are diagnosed Regional or Distant stage. On a more positive note, about 86% of melanoma of the skin cases and about 83% of prostate cancer cases are diagnosed *in-situ* or localized stage. These data indicate that Ohio needs to continue to increase awareness of the advantages of screening and early detection to reduce mortality from these cancers. These data are presented in **Table 3**.

Significant disparities exist in cancer incidence rates by race/ethnicity. As shown in **Table 4**, the 2004-2008 average annual age-adjusted incidence rate for African Americans in Ohio (496.2 per 100,000) is 7% higher than the rate for whites (465.2 per 100,000) and is more than double the rate for Asian/Pacific Islanders (241.4 per 100,000). The incidence rate for prostate cancer is 63% higher among African American males (216.5 per 100,000) compared to white males (132.5 per 100,000), and the incidence rate of multiple myeloma is more than twice as high among African Americans (10.6 per 100,000) compared to both whites and Asian Pacific Islanders. Whites have a disproportionate burden of melanoma of the skin, with a 2004-2008 incidence rate (19.9 per 100,000) that is 17 times higher compared to African Americans (1.2 per 100,000). Asian/Pacific Islanders in Ohio had lower incidence rates than other races for most cancer sites/types, with the exception of liver and intrahepatic bile duct cancer and stomach cancer.

Table 5 presents the average annual number of cancer deaths and age-adjusted mortality rates for selected sites/types of cancer by race in Ohio for the years 2004-2008.[7] These data indicate that African-American Ohioans have higher death rates for most cancer sites/types when compared to white and Asian/Pacific Islander Ohioans. The average annual mortality rate per 100,000 for all sites/types of cancer combined for African-Americans is 245.9 per 100,000 which is 27% higher than the rate of 194.0 per 100,000 for whites. The disparity for prostate cancer mortality is very striking – the African-American male mortality rate is 52.4 per 100,000 which is 121% higher than rate of 23.7 for white Ohio males. The reasons for these disparities are not clear but are likely multifactorial including access to screening and care, prevalence of risk factors, and the biology of the tumors. These data clearly indicate that Ohio needs to continue to work to address these issues and eliminate these disparities.

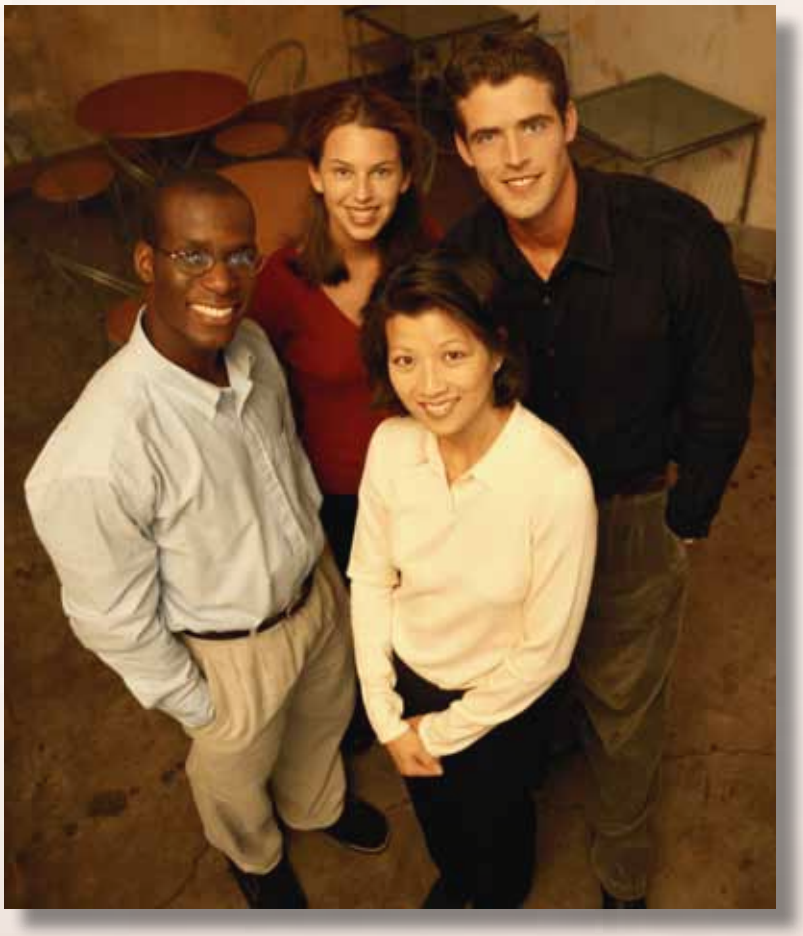


Table 1. Average Annual Number and Percentage of New Invasive Cancer Cases and Age-Adjusted Incidence Rates per 100,000, by Cancer Site/Type and Gender in Ohio, 2004-2008[1,2]

Primary Cancer Site/Type	Males			Females			Total		
	Cases	Percent	Rate	Cases	Percent	Rate	Cases	Percent	Rate
All Cancer Sites/Types	30,237	100.0%	552.7	29,085	100.0%	423.1	59,321	100.0%	474.6
Brain and Other CNS**	451	1.5%	8.1	395	1.4%	6.1	845	1.4%	7.0
Breast	70	0.2%	1.3	8,169	28.1%	120.3	8,239	13.9%	65.9
Cervix	*	*	*	483	1.7%	7.9	*	*	*
Colon and Rectum	3,147	10.4%	58.5	3,162	10.9%	43.8	6,309	10.6%	50.1
Esophagus	560	1.9%	10.2	149	0.5%	2.1	709	1.2%	5.6
Hodgkin's Lymphoma	185	0.6%	3.3	162	0.6%	2.7	348	0.6%	3.0
Kidney and Renal Pelvis	1,153	3.8%	20.5	810	2.8%	11.8	1,963	3.3%	15.7
Larynx	435	1.4%	7.6	128	0.4%	1.9	562	0.9%	4.4
Leukemia	771	2.5%	14.4	622	2.1%	9.0	1,393	2.3%	11.3
Liver and Intrahepatic Bile Duct	422	1.4%	7.4	182	0.6%	2.5	604	1.0%	4.7
Lung and Bronchus	5,164	17.1%	95.5	4,229	14.5%	60.3	9,393	15.8%	75.0
Melanoma of the Skin	1,251	4.1%	22.7	1,078	3.7%	17.0	2,329	3.9%	19.1
Multiple Myeloma	359	1.2%	6.6	309	1.1%	4.3	668	1.1%	5.3
Non-Hodgkin's Lymphoma	1,270	4.2%	23.3	1,135	3.9%	16.3	2,405	4.1%	19.3
Oral Cavity and Pharynx	875	2.9%	15.1	407	1.4%	5.9	1,282	2.2%	10.1
Ovary	*	*	*	831	2.9%	12.1	*	*	*
Pancreas	737	2.4%	13.5	737	2.5%	10.1	1,474	2.5%	11.7
Prostate	8,159	27.0%	146.7	*	*	*	*	*	*
Stomach	472	1.6%	8.8	297	1.0%	4.1	769	1.3%	6.1
Testis	309	1.0%	5.7	*	*	*	*	*	*
Thyroid	274	0.9%	4.8	908	3.1%	14.9	1,182	2.0%	10.0
Urinary Bladder	2,049	6.8%	39	700	2.4%	9.6	2,749	4.6%	21.9
Uterine Corpus and Uterine NOS***	*	*	*	1,889	6.5%	27.4	*	*	*
Other Sites/Types	2,124	7.0%	*	2,303	7.9%	*	4427	7.5%	*

[1] Source: Ohio Cancer Incidence Surveillance System, Ohio Department of Health, 2011
[2] Average annual rates are age-adjusted to the 2000 U.S. Standard Population
**Not Applicable*
***Central Nervous System*
****Not Otherwise Specified*

Table 2. Average Annual Number and Percentage of Cancer Deaths and Age-Adjusted Mortality Rates per 100,000, by Cancer Site/Type and Gender in Ohio, 2004-2008[1,2]

Primary Cancer Site/Type	Males			Females			Total		
	Cases	Percent	Rate	Cases	Percent	Rate	Cases	Percent	Rate
All Cancer Sites/Types	12,895	100.0%	245.6	12,027	100.0%	165.9	24,922	100.0%	197.5
Brain and Other CNS**	301	2.3%	5.4	250	2.1%	3.7	551	2.2%	4.5
Breast	12	0.1%	0.2	1,859	15.5%	26.0	1871	7.5%	14.8
Cervix	*	*	*	163	1.4%	2.5	*	*	*
Colon and Rectum	1,199	9.3%	23.1	1209	10.1%	16.0	2,408	9.7%	19.0
Esophagus	524	4.1%	9.6	137	1.1%	1.9	662	2.7%	5.2
Hodgkin's Lymphoma	32	0.2%	0.6	25	0.2%	0.4	57	0.2%	0.5
Kidney and Renal Pelvis	349	2.7%	6.6	227	1.9%	3.1	577	2.3%	4.6
Larynx	141	1.1%	2.5	38	0.3%	0.6	180	0.7%	1.4
Leukemia	514	4.0%	10.0	425	3.5%	5.8	939	3.8%	7.5
Liver and Intrahepatic Bile Duct	380	2.9%	6.8	206	1.7%	2.8	586	2.3%	4.6
Lung and Bronchus	4,195	32.5%	78.7	3209	26.7%	45.1	7,404	29.7%	59.1
Melanoma of the Skin	213	1.7%	4.0	120	1.0%	1.7	333	1.3%	2.7
Multiple Myeloma	242	1.9%	4.6	233	1.9%	3.1	476	1.9%	3.8
Non-Hodgkin's Lymphoma	487	3.8%	9.4	421	3.5%	5.6	908	3.6%	7.2
Oral Cavity and Pharynx	228	1.8%	4.1	111	0.9%	1.5	340	1.4%	2.7
Ovary	*	*	*	589	4.9%	8.3	*	*	*
Pancreas	705	5.5%	13.1	719	6.0%	9.7	1,424	5.7%	11.2
Prostate	1,233	9.6%	25.8	*	*	*	*	*	*
Stomach	249	1.9%	4.8	173	1.4%	2.3	422	1.7%	3.4
Testis	12	0.1%	0.2	*	*	*	*	*	*
Thyroid	30	0.2%	0.6	34	0.3%	0.5	65	0.3%	0.5
Urinary Bladder	447	3.5%	9.0	189	1.6%	2.4	636	2.6%	5.0
Uterine Corpus and Uterine NOS***	*	*	*	338	2.8%	4.6	*	*	*
Other Sites/Types	1,399	10.9%	*	1,349	11.2%	*	2,749	11.0%	*

[1] Source: Ohio Vital Statistics Program, Ohio Department of Health, 2011
[2] Average annual rates are age-adjusted to the 2000 U.S. Standard Population
**Not Applicable*
***Central Nervous System*
****Not Otherwise Specified*

Table 3. Average Annual Number and Percentage of New Cancer Cases by Stage at Diagnosis for Selected Sites/Types in Ohio, 2004-2008[1]

Primary Cancer Site/Type	in situ		Localized		Regional		Distant		Unstaged/ Unknown		Total
	Cases	Percent	Cases	Percent	Cases	Percent	Cases	Percent	Cases	Percent	Cases
Breast (Female)	1,871	19%	4,900	49%	2,501	25%	444	4%	324	3%	10,040
Cervix	*	*	215	45%	182	38%	53	11%	33	7%	483
Colon and Rectum	436	6%	2,507	37%	2,035	30%	1,116	17%	651	10%	6,745
Lung and Bronchus	9	<1%	1,587	17%	2,250	24%	4,277	45%	1,279	14%	9,402
Melanoma of the Skin	1,323	36%	1,819	50%	219	6%	91	2%	200	5%	3,652
Oral Cavity and Pharynx	24	2%	371	28%	578	44%	235	18%	98	8%	1,306
Prostate	3	<1%	6,770	83%	622	8%	275	3%	492	6%	8,161
Testis	1	<1%	202	65%	63	20%	35	11%	9	3%	310

[1] *Source: Ohio Cancer Incidence Surveillance System, Ohio Department of Health, 2011*
**Not Applicable. In situ cervical cancers are not required to be reported in Ohio*

Table 4. Average Annual Number and Percentage of New Invasive Cancer Cases and Age-Adjusted Incidence Rates per 100,000, by Cancer Site/Type and Race in Ohio, 2004-2008[1,2]

Primary Cancer Site/Type	White			African American			Asian/Pacific Islander		
	Cases	Percent	Rate	Cases	Percent	Rate	Cases	Percent	Rate
All Cancer Sites/Types	51,982	100.0%	465.2	5,785	100.0%	496.2	292	100.0%	241.4
Brain and Other CNS**	782	1.5%	7.4	51	0.9%	4.0	6	2.0%	5.4
Breast (Female)	7,169	28.0%	119.1	830	29.6%	121.4	47	16.1%	37.5
Cervix	411	1.6%	7.8	60	2.1%	8.6	4	1.4%	3.6
Colon and Rectum	5,538	10.7%	48.9	630	10.9%	55.1	35	12.1%	35.6
Esophagus	638	1.2%	5.6	62	1.1%	5.5	2	0.8%	2.9
Hodgkin's Lymphoma	300	0.6%	3.0	37	0.6%	2.8	2	0.6%	1.6
Kidney and Renal Pelvis	1,733	3.3%	15.5	208	3.6%	17.4	7	2.3%	7.0
Larynx	490	0.9%	4.3	66	1.1%	5.6	<1	0.3%	****
Leukemia	1,251	2.4%	11.5	117	2.0%	9.7	10	3.3%	8.8
Liver and Intrahepatic Bile Duct	477	0.9%	4.2	109	1.9%	8.9	12	4.2%	14.0
Lung and Bronchus	8,325	16.0%	74.0	983	17.0%	86.7	35	11.8%	39.4
Melanoma of the Skin	2,154	4.1%	19.9	14	0.2%	1.2	2	0.8%	3.4
Multiple Myeloma	537	1.0%	4.7	122	2.1%	10.6	4	1.2%	4.8
Non-Hodgkin's Lymphoma	2,184	4.2%	19.6	158	2.7%	13.0	12	4.1%	12.5
Oral Cavity and Pharynx	1,141	2.2%	10.1	118	2.0%	9.7	7	2.3%	7.2
Ovary	757	3.0%	12.5	60	2.1%	8.8	5	1.7%	5.1
Pancreas	1,282	2.5%	11.3	176	3.0%	15.5	7	2.5%	9.2
Prostate	6,673	25.3%	132.5	1,037	34.8%	216.5	27	9.3%	27.9
Stomach	629	1.2%	5.6	117	2.0%	10.4	11	3.7%	11.8
Testis	289	1.1%	6.2	10	0.3%	1.6	2	0.7%	1.6
Thyroid	1,047	2.0%	10.1	88	1.5%	7.0	12	4.2%	8.8
Urinary Bladder	2,517	4.8%	22.2	137	2.4%	12.4	10	3.6%	12.6
Uterine Corpus and Uterine NOS***	1,710	6.7%	28.0	139	4.9%	20.6	10	3.4%	8.4
Other Sites/Types	3,892	7.5%	*	448	7.8%	*	23	7.7%	*

[1] Source: Ohio Cancer Incidence Surveillance System, Ohio Department of Health, 2011
[2] Average annual rates are age-adjusted to the 2000 U.S. Standard Population
**Not Applicable*
***Central Nervous System*
****Not Otherwise Specified*
*****Rate not calculated when the 2004-2008 count is less than five (i.e., the average annual count is less than one).*
Note: Rates are gender-specific for breast, cervix, ovary, prostate, testis and uterine corpus/uterine NOS cancer.

Table 5. Average Annual Number and Percentage of Cancer Deaths and Age-Adjusted Mortality Rates per 100,000, by Cancer Site/Type and Race in Ohio, 2004-2008[1,2]

Primary Cancer Site/Type	White			African American			Asian/Pacific Islander		
	Cases	Percent	Rate	Cases	Percent	Rate	Cases	Percent	Rate
All Cancer Sites/Types	22,062	100.0%	194.0	2,756	100.0%	245.9	91	100.0%	85.5
Brain and Other CNS**	518	2.3%	4.7	30	1.1%	2.5	3	3.1%	1.7
Breast (Female)	1,624	7.4%	14.2	238	8.7%	20.5	4	8.8%	12.1
Cervix	138	0.6%	2.4	23	0.8%	3.4	1	1.3%	1.4
Colon and Rectum	2,122	9.6%	18.5	277	10.1%	25.2	8	8.4%	6.7
Esophagus	603	2.7%	5.3	57	2.1%	5.0	2	2.2%	1.7
Hodgkin's Lymphoma	52	0.2%	0.5	5	0.2%	0.4	0	0.0%	****
Kidney and Renal Pelvis	517	2.3%	4.5	57	2.1%	5.1	2	2.2%	1.8
Larynx	152	0.7%	1.3	27	1.0%	2.4	0	0.0%	****
Leukemia	854	3.9%	7.6	82	3.0%	7.3	3	3.7%	2.5
Liver and Intrahepatic Bile Duct	486	2.2%	4.2	93	3.4%	7.8	7	7.9%	6.8
Lung and Bronchus	6,586	29.9%	58.3	794	28.8%	70.9	18	20.3%	18.4
Melanoma of the Skin	328	1.5%	2.9	4	0.2%	0.4	<1	0.2%	****
Multiple Myeloma	394	1.8%	3.4	80	2.9%	7.3	1	1.1%	0.8
Non-Hodgkin's Lymphoma	850	3.9%	7.5	54	2.0%	4.7	4	4.2%	4.3
Oral Cavity and Pharynx	294	1.3%	2.6	43	1.6%	3.7	2	2.6%	2.0
Ovary	541	2.5%	8.5	46	1.7%	6.9	1	2.2%	3.5
Pancreas	1,247	5.7%	10.9	170	6.2%	15.2	6	7.0%	6.5
Prostate	1,029	4.7%	23.7	202	7.3%	52.4	2	2.2%	5.9
Stomach	334	1.5%	2.9	82	3.0%	7.5	7	7.3%	6.3
Testis	11	0.1%	0.2	1	0.0%	0.2	0	0.0%	****
Thyroid	57	0.3%	0.5	7	0.2%	0.6	<1	0.4%	****
Urinary Bladder	587	2.7%	5.1	47	1.7%	4.4	2	2.0%	2.2
Uterine Corpus and Uterine NOS***	286	1.3%	4.4	50	1.8%	7.6	2	1.8%	3.1
Other Sites/Types	2,453	11.1%	*	286	10.4%	*	10	10.6%	*

[1] Source: Ohio Vital Statistics Program, Ohio Department of Health, 2011
[2] Average annual rates are age-adjusted to the 2000 U.S. Standard Population
**Not Applicable*
***Central Nervous System*
****Not Otherwise Specified*
Note: Rates are gender-specific for breast, cervix, ovary, prostate, testis and uterine corpus/uterine NOS cancer.

CANCER DATA AND SURVEILLANCE

Background:

Cancer surveillance is the systematic collection and analysis of data that is used to guide the development, implementation, and evaluation of cancer prevention and control initiatives in Ohio.

By collecting and analyzing data on cancer incidence and mortality, cancer surveillance provides stakeholders with a better understanding of cancer and appropriate strategies and policies for cancer prevention, treatment, and control. The availability of statewide cancer data enables health researchers and policy makers to analyze demographic and geographic factors that impact cancer risk, early detection, and effective treatment of cancer patients. Combined with behavioral, attitudinal, environmental, and structural data, cancer surveillance informs the development, implementation, and evaluation of early detection, educational, and other cancer-related programs.

GOAL 1: Enhance the Quality and [illegible] Cancer Incidence Data and Increase the Dissemination and Us[illegible] Cancer Prevention and Control.

Objective 1.1: By December 31, 2014, identify and provide data and information relevant to the 10 objectives/activities in the *Ohio Comprehensive Cancer Prevention and Control Plan 2011-2014* for planning, monitoring and evaluation.

Measure: Baseline = 0, December 31, 2014 Target = 10

Data Source(s):

- Ohio Cancer Incidence Surveillance System (OCISS)
- Ohio Vital Statistics (VS)
- Ohio and U.S. Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavior Survey (YRBS)
- Adult Tobacco Survey (ATS)
- Youth Tobacco Survey (YTS)
- Surveillance, Epidemiology and End Results (SEER) Program of the National Cancer Institute
- National Center for Health Statistics

Time Frame: No later than December 31, 2014

Responsible Parties/Partners:

- Ohio Department of Health (ODH) Chronic Disease and Behavioral Epidemiology (CDBE) Section
- OCISS
- ODH Center for Public Health Statistics and Informatics (CPHSI)
- Ohio VS Program
- The Ohio State University
- ODH Comprehensive Cancer Control Program (OCCCP).

Strategy 1.1.1: Participate in meetings with other OPCC committees to identify data sources for planning, monitoring and evaluating OPCC objectives and activities

Strategy 1.1.2: Collect and/or analyze relevant data and provide to OPCC committee members

Strategy 1.1.3: Assist with the development of status/evaluation reports to track progress on meeting objectives and activities

Objective 1.2: Achieve at least 90 percent completeness of case reporting to the OCISS at 12 months based on the National Program of Cancer Registries (NPCR) evaluation method no later than December 14, 2014.

Measure: Baseline = 75.4% (2009 12-month data for 2010 submission), 2014 Target = at least 90.0%

Data Source:
- OCISS

Resources:
- OCISS Gateway
- CRS Plus
- OCISS staff
- Epidemiology staff
- OCISS reporting facilities
- State funding
- Federal funding

Time Frame: No later than December 31, 2014

Responsible Parties/Partners:
- OCISS staff
- Reporting facilities
- OCISS Data Quality Improvement Committee
- OPCC Data and Surveillance Committee
- OPCC Communications Committee
- ODH CDBE Section
- The Ohio State University

Strategy 1.2.1: Conduct an assessment of non-reporting facilities (e.g. dermatology, urology, free-standing surgery) to identify reasons for non-compliance and target interventions accordingly.

Strategy 1.2.2: Identify and contact new and/or prospective reporting sources to assure compliance with reporting laws

Strategy 1.2.3: Develop and distribute educational materials on the importance of and how to properly collect and report required data elements

Strategy 1.2.4: Establish list-serves of reporting sources for dissemination of OCISS reports to educate on the reporting sources on how the OCISS data are being used

Strategy 1.2.5: Conduct an assessment of factors associated with lower case completeness, overall and by site/type (e.g., impact of Ohio cancer mortality rates, differences in completeness estimation methods, impact of using SEER versus U.S. Cancer Statistics for national comparisons)

Objective 1.3: Create and disseminate three comprehensive cancer reports, e.g. "stage at diagnosis", "cancer facts and figures", "community cancer profiles" no later than December 31, 2014 for cancer prevention and control education, program planning and policy development.

Measure: Baseline = 0, December 31, 2014 Target = 3

Data Source(s):

- OCISS
- VS
- BRFSS
- SEER

Resources:

- OCISS data
- VS mortality data
- BRFSS data
- SAS and SEER*Stat analytic software
- ODH CDBE Section
- The Ohio State University
- OCCCP
- American Cancer Society East Central Division.

Time Frame: No later than December 31, 2014

Responsible Parties/Partners:

- ODH CDBE Section
- The Ohio State University
- OCCCP
- American Cancer Society East Central Division
- OPCC Data and Surveillance Committee.

Strategy 1.3.1: Participate in quarterly meetings/conference calls with responsible parties/partners

Strategy 1.3.2: Develop a timeline for data analysis, generation of tables/figures, drafting text, document review, completion, printing and distribution

Strategy 1.3.3: Develop a plan for distribution to target audience(s)

Strategy 1.3.4: Analyze data by relevant demographic (e.g., age, race/ethnicity, sex) and geographic (e.g., Appalachia, county, urban/rural) breakdowns to identify populations to target for cancer prevention, early detection and control initiatives

Strategy 1.3.5: Analyze trends in cancer incidence, mortality and stage at diagnosis to monitor progress in cancer prevention, early detection and survival

Objective 1.4: Disseminate three cancer-related datasets through the new Ohio Public Health Information Warehouse for use by health professionals and the general public no later than December 31, 2014.

Measure: 2011 Baseline=0, December 31, 2014 Target=3

Data Sources:
- OCISS
- VS
- BRFSS

Resources:
- OCISS data
- VS mortality data
- BRFSS data
- ODH Office of Management Information Systems (OMIS)
- Ohio Public Health Information Warehouse (the Warehouse) Committee
- Server and network capacity
- State funding
- Federal funding

Timeline: No later than December 31, 2014

Responsible Parties/Partners:
- ODH CDBE Section
- OCISS
- ODH CPHSI
- ODH OMIS
- City and county health departments

Strategy 1.4.1: Participate in scheduled meetings to determine cancer-related data and variables to be included in the Warehouse, with an emphasis on identifying disparate populations

Strategy 1.4.2: Assist with development of tabular, graphical, and mapping functionality for presentation of cancer-related data

Strategy 1.4.3: Conduct user acceptance testing prior to release of cancer-related data in the Warehouse

Strategy 1.4.4: Develop descriptive text, frequently asked questions, and technical notes regarding collection, analysis, and presentation of cancer-related data

Strategy 1.4.5: Develop a communication plan to optimize use of the Warehouse by health professionals and the public (e.g. encourage use of RSS feeds, promote the Warehouse to city and county health departments and cancer prevention and control programs)

Objective 1.5: By December 31, 2014 Increase the Number of City and County Health Departments Who are Able to Use Data for Cancer Prevention and Control, and Community Assessments from 4 to 20.

Measure: 2011 Baseline = 4 (Cuyahoga County, Summit County, Columbus City, Hamilton County), December 31, 2014 Target = 20

Data Sources:
- OCISS
- VS
- BRFSS

Resources:
- OCISS data
- VS mortality data
- BRFSS data
- The Warehouse
- CDBE Section
- The Ohio State University
- Venue(s) for training funding
- Funding

Time Frame: No later than December 31, 2014

Responsible Parties/Partners:
- CDBE Section
- OCISS
- ODH CPHSI
- The Ohio State University
- City and county health departments

Strategy 1.5.1: Revise the "Ohio Community Cancer Concerns Response Protocol" (the Response Protocol)

Strategy 1.5.2: Update PowerPoint slides/materials on how to conduct community cancer assessments

Strategy 1.5.3: Create media (e.g. toolkit, website, webinar) that includes links to data and information relevant to cancer prevention, control and community assessments (e.g. links to census and comparison data, copies of previous assessments, reports, statistical programs, and spreadsheets for calculating relevant statistics)

Strategy 1.5.4: Promote new OCISS data release policies to city and county health department

Strategy 1.5.5: Conduct a train-the-trainer session with city and county health departments on how to conduct a community cancer assessment (e.g. analysis and use of data for cancer prevention and control, use of the Response Protocol, responding to citizens, media, and stakeholders)

PRIMARY PREVENTION

Primary prevention of cancer consists of actions taken by individuals, communities, institutions, and governments to protect against the occurrence of cancer. This includes promotion of measures that reduce the risk of developing cancer by encouraging healthy lifestyles and environments and empowering Ohioans to make informed decisions.

Adopting specific lifestyle behaviors can reduce cancer risk. The healthy lifestyle behaviors most effective on prevention cancer include **avoiding tobacco products and exposure to secondhand smoke, minimizing alcohol intake, following a balanced diet, exercising regularly, and protecting against ultraviolet exposure.** Other behaviors linked to cancer prevention include **breastfeeding, practicing healthy sexual behaviors,** and **obtaining appropriate vaccinations.** Raising awareness regarding the impact Ohioans can have on their own health through adopting healthy lifestyles is an important step toward cancer prevention.

This chapter of the Plan will focus on prevention strategies pertaining to tobacco use, exercise and improved nutrition, and ultraviolet (UV) light exposure, radon, and the human papillomavirus.

GOAL 2: Reduce Tobacco Use a

Background:

Tobacco smoking causes about 30 percent of all U.S. deaths from cancer. Avoiding tobacco use is the most important step Ohioans can take to reduce the cancer burden in our state. Cigarette smoking is the leading preventable cause of death in the United States and Ohio. Tobacco smoking causes cancer of the lung, larynx, mouth, esophagus, pharynx, pancreas, kidney, cervix, and stomach, as well as acute myelogenous leukemia. According to the 2010 BRFSS, 22.5 percent of adults in Ohio are current cigarette smokers.

Due to funding reductions, the Ohio Tobacco Quit Line now only provides free cessation telephonic counseling services to uninsured, Medicaid recipients, pregnant women and members of the Ohio Tobacco Collaborative. The Ohio Tobacco Collaborative is a unique public-private partnership which provides insurance carriers, employers and third party administrators with access to Ohio Tobacco Quit Line services at a state-negotiated (reduced) rate. Funds for the quit line come from the Centers for Disease Control and Prevention and are available through March 28, 2012.

In 2009, the ODH Tobacco Use Prevention and Cessation Program () established a strategic plan for sustaining the quit line. This plan included the establishment of the Ohio Tobacco Cessation Benefits Team (OH CBT) to engage public and private health insurers and employers to provide cessation benefits for the treatment of tobacco use dependence and to identify opportunities to increase sustainability for existing cessation services, including the Ohio Tobacco Quit Line. The partnership includes the Bureau of Healthy Ohio, The Ohio Departments of Job and Family Services, Health Action Council Ohio, Medical Mutual Insurance Company of Ohio, the Ohio Association of Health Plans, Cleveland Clinic, National Jewish Health, Center for Community Solutions, Kent State University, American Cancer Society, American Heart Association, American Lung Association and the Tobacco Free Ohio Alliance.

Objective 2.1: By December 31, 2014, 2.3 million Ohioans will have access to the Ohio Tobacco Quit Line because their employer or health plan joined the Tobacco Collaborative.

Measure:
August, 2011 Baseline = 2.1 million Ohioans
December 31, 2014 Target = 2.3 million Ohioans

Data Source: National Jewish Health tracks the "covered lives" of employers and health plans that sign partnership agreements with the Ohio Tobacco Collaborative

Time Frame: No later than December 31, 2014

Responsible Parties/Partners:

- Tobacco Use Prevention and Cessation Program National Jewish Health
- Local health departments
- Tobacco Control advocates

Strategy 1.1.1: Ensure Ohioans have access to quit line services

Strategy 1.1.2: Promote tangible solutions to provide cessation benefits that are cost effective, evidence-based and use the combined leverage of public and private sectors

Strategy 1.1.3: Promote the Tobacco Collaborative and the Ohio Cessation Benefits Team

Objective 2.2: By June 30, 2014, Ensure all Medicaid clients have access to cessation services.

Measure: August 2011 Baseline=120,000; June 30, 2014 Target = all Medicaid clients

Data Source: TUPCP, Ohio Department of Job and Family Services (ODJFS), Medicaid

Time Frame: No Later than June 30, 2014

Strategy 2.2.1: ODH will work with the Ohio Department of Job and Family Services Medicaid to discuss changes to Ohio Administrative Code to allow the Ohio Medicaid Benefit Plan to pay for quit line calls and tobacco use cessation counseling for all clients

Strategy 2.2.2: ODH will work with partners to ensure all Medicaid clients have access to cessation services

Key Partners:

- Ohio Department of Job and Family Services -Ohio Medicaid
- ODH Tobacco Use Prevention and Cessation Program
- Centers for Disease Control and Prevention

GOAL 3: Reduce Exposure to Env cinogens

Background:

Naturally occurring as well as man-made exposures to environmental contaminants have been proven to increase the risk of cancer. Secondhand smoke (also known as environmental tobacco smoke) and indoor radon (formed by the breakdown of radium in soil and rock) continue to be leading environmental hazards.

It has been repeatedly demonstrated that comprehensive tobacco free school policies, combined with other efforts are effective in reducing the prevalence of tobacco use among youths.

The majority of Ohio homeowners are not aware of their risk of having elevated levels of radon in their homes or the cancer risk associated with exposure to radon. While current data indicates that Ohio homeowners are at considerable risk for elevated levels of indoor radon, only about 6% of all Ohio homes have been tested and even fewer homes have had radon mitigation systems installed. It is clear that increased efforts to educate homeowners about home testing of radon and the cancer risk associated with exposure to radon are necessary.

Objective 3.1: By March 28, 2014, increase the number of Ohio school districts with 100% tobacco-free policies at all facilities, at all events on school property and at all school sponsored events at all times from 173 to 261.

Measure: August 2011 Baseline of 173 school districts; March 28, 2014 Target of at least 261 school districts

Data Source: TUPCP maintains a database of school districts across Ohio and the corresponding tobacco policies

Time Frame: No later than March 28, 2014

Responsible Parties/Partners

- Tobacco Free Ohio Alliance
- Educated Service Centers
- Ohio Tobacco Use Prevention and Cessation Program
- Local Health Departments
- Ohio Department of Education
- American Heart Association

Strategy 3.1.1: Provide funding to local health departments and non-profit agencies to promote tobacco free school policies

Strategy 3.1.2: Work with the Ohio Educational Service Center Association to promote a tobacco free school policy

Strategy 3.1.3: Work to secure approval and support from the State Board of Education

Objective 3.2: By December 31, 2014, increase the number of Ohio multi-unit housing complexes with 100% tobacco-free policies from 0 to 5.

Measure:

- August 2011 Baseline of 0; March 28, 2014 Target of at least 5 multi-unit housing complexes

Data Source: TUPCP will create a database to track units as they change

Time Frame: No later than March 28, 2014.

Responsible Parties/Partners

- Tobacco Free Ohio Alliance
- Ohio Tobacco Use Prevention and Cessation Program
- Local Health Departments
- Ohio Healthy Homes

Strategy 3.2.1: Provide funding to local health departments and non-profit agencies to promote tobacco free multi-unit housing strategies

Strategy 3.2.2: Provide resources and information to landlords and tenants about smoke free multi-unit housing

Objective 3.3: By December 31, 2014, Increase the Percentage of Ohio Homes that Have Been Tested to Determine Indoor Radon Level From 6% to 7%.

Measure:

- September 2011 Baseline of 6% of Homes; December 31, 2014 Target of at least 7% homes

Data Source: University of Toledo, Ohio Radon Information System US Census

Resources: U.S. EPA
ODH Bureau of Radiation Protection
ODH Indoor Radon Program
Local Health Departments

Time Frame: No later than December 31, 2014.

Responsible Parties/Partners:

- ODH Indoor Radon Program
- Ohio Association of Radon Professionals
- ODH Healthy Homes/Lead Prevention Program
- ODH Comprehensive Cancer Control Program
- Ohio Realtors Association
- Community Development Program of the State of Ohio
- U.S. Department of Agriculture Rural Development Program

Strategy 3.3.1: Develop and implement continuing education courses and presentations specifically for realtors, builders, and the medical community

Strategy 3.3.2: Increase awareness of indoor radon and the health risk associated with exposure to indoor radon by increasing the number of outreach and education activities by 10 each year. [2010 baseline=130 activities]

Strategy 3.3.3: Continue to collect data regarding indoor radon levels in Ohio

GOAL 4: Increase the Proportion [illegible] Children who Engage in Recommend[illegible]tivity Levels.

Background:

Considerable evidence indicates that several lifestyle behaviors are known risk factors for many chronic diseases and conditions, including several forms of cancer. Unhealthy diets and physical inactivity, which are risk factors for overweight and obesity, may account for about 25-30 percent of the cancer deaths in men and 20 percent of cancer deaths in women.[8] Overweight and obese children are at increased risk for cancer, especially because they are more likely to become overweight and obese as adults. Currently, about 1 in 3 children in the U.S. are overweight or obese, and fruit/vegetables consumption and physical activity levels are below recommended levels. Obesity disproportionately affects minorities. Therefore, it is imperative that efforts be made to improve the diets and physical activity levels of adults and children in order to reduce obesity and prevent cancer.

Objective 4.1: By December 31, 2014 increase the proportion of Ohio adults age 18 and older who engage in at least 30 minutes of moderate to vigorous physical activity 5 or more days of the week to at least 54%.

Objective 4.2: By December 31, 2014, decrease the proportion of Ohio adults age 18 and older who engaged in no leisure-time physical activity in the preceding month to at least 23%.

Measures:

- 2009 baseline of adults who engage in moderate or vigorous activity is 49%; December 31, 2014 Target is increase to at least 54%
- 2009 baseline of adults not engaging in any leisure time physical activity is 26%; December 31, 2014 Target is decrease to at least 23%

Data Source: Ohio BRFSS

Time Frame: No later than December 31, 2014

Responsible Parties/Partners:

- ODH Office of Healthy Ohio
- Worksite Wellness Programs
- Fitness/Health Clubs
- Ohio Parks and Recreation
- Ohio Department of Transportation
- Ohio Department of Development (city planners)

Strategy 4.2.1: Support worksite programs to promote physical activity

Strategy 4.2.2: Support physical activity and healthy eating programs, specifically for African American and Latino populations

Strategy 4.2.3: Support the increased availability of safe and accessible recreational facilities in the community, as well as the development and operation of community-based recreation centers for all people, including the elderly and disabled

Strategy 4.2.4: Support community-wide campaigns to promote physical activity

Strategy 4.2.5: Encourage mixed-use zoning with homes situated within walking and bicycle-riding distance of attraction, walker-friendly commercial, business, and community facilities

Objective 4.3: By December 31, 2014, increase the proportion of children in grades 9-12 who engage in physical activity for a total of at least 60 minutes per day 7 days of the week to at least 30%.

Measure: 2010 Baseline=25%; December 31, 2014 = 30%

Data Source: Ohio YRBS grades 9-12, Ohio School Health Profiles

Time Frame: No later than December 31, 2014

Responsible Parties/Partners:

- ODH Bureau of Healthy Ohio
- ODH Coordinated School Health Manager
- Ohio Department of Education
- Ohio Parks and Recreation
- Ohio Department of Transportation
- Ohio Department of Development (city planners)

Strategy 4.3.1: Support initiatives that increase the proportion of school districts that provide 30 minutes of physical activity per day

Strategy 4.3.2: Develop a position statement on the importance of physical activity and physical education in schools related to chronic disease prevention and academic success

Strategy 4.3.3: Support initiatives that increase the availability of safe and accessible recreational facilities in communities, and support the development and operation of community-based recreation centers

Strategy 4.3.4: Increase the portion of physical education teachers who receive professional development training in the past two years by 10% (2010 baseline = 78%, Source: Ohio School Health Profiles)

GOAL 5: Increase the Proportion [illegible] Children Who Engage in Healthy [illegible]ors

Objective 5.1: By December 31, 2014 increase the proportion of adults aged 18 and over who consume fruits and vegetables five or more times per day to at least 26%.

Measure: 2009 Baseline=21%; December 31, 2014 Target= at least 26%

Data Source: Ohio BRFSS

Time Frame: No later than December 31, 2014

Responsible Parties/Partners:

- ODH Bureau of Healthy Ohio
- Fitness/Health Clubs
- Worksite Wellness Programs
- ODH Comprehensive Cancer Control Program

Strategy 5.1.1: Support the development and funding of community-wide programs to promote healthy eating, including the daily consumption of 5 or more servings of fruits and vegetables, especially among minorities and populations at high risk

Strategy 5.1.2: Support worksite programs to promote healthy eating, including promoting the daily consumption of 5 or more servings of fruits and vegetables

Strategy 5.1.3: Support worksite policies that require appealing, high quality and affordable healthy foods, especially fruits and vegetables at cafeterias, vending machine, and other worksite dining options

Strategy 5.1.4: Support worksite policies for breastfeeding mothers per Federal regulation

Strategy 5.1.5: Support improved access to fruits and vegetables by promoting corner stores, community gardens and farmers' markets, such as those established through CDC's Creating Healthy Communities program

Strategy 5.1.6: Support the development of social marketing campaigns to promote healthy behaviors for adults

Objective 5.2: By December 31, 2014 increase the proportion of children in grades 9-12 who ate fruits two or more times per day and ate vegetables three or more times per day during the past seven days to at least 12 percent.

Measure: 2011 Baseline= 7 percent; December 31, 2014 Target = 12 percent

Data Source: Ohio YRBS (grades 9-12)

Time Frame: No later than December 31, 2014

Responsible Parties/Partners:

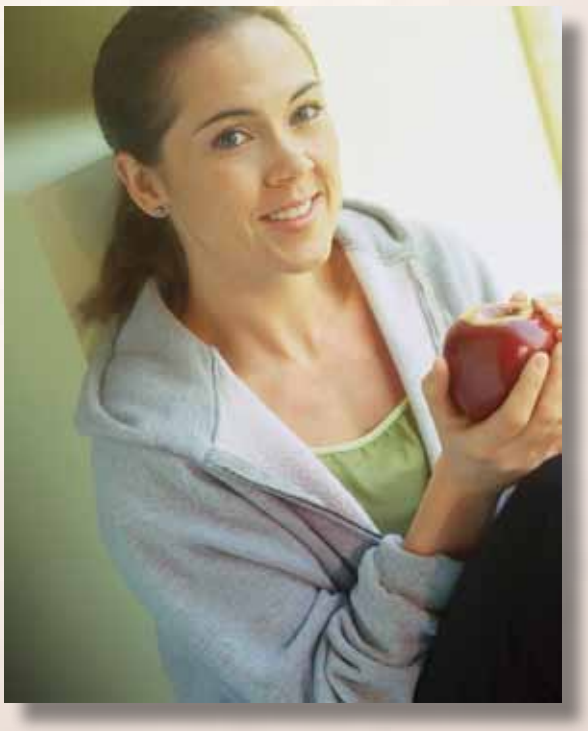
- ODH Bureau of Healthy Ohio
- Ohio Department of Education
- ODH Coordinated School Health Manager
- ODH Comprehensive Cancer Control Program

Strategy 5.2.1: Support community initiatives to promote healthy eating behaviors, including the daily consumption of 5 or more servings of fruits and vegetables, by increasing access through corner stores, farmers markets and community partners

Strategy 5.2.2: Support school-based campaigns to promote healthy, low-fat eating, including promoting the daily consumption of 5 or more servings of fruits and vegetables

Strategy 5.2.3: Support school policies requiring that a variety of healthy choices be provided in vending machines, school stores, and other venues within the schools control

Strategy 5.2.4: Support initiatives that increase the number of districts with model wellness policies that include specific guidance for all food and beverages sold at school, physical activity and physical education functions



GOAL 6: Increase the Vaccination [illegible]es Shown to Reduce the Risk of Cancer.

Objective 6.1: At least 60% of girl's age 13-17 years will have received at least one dose of Human Papillomavirus vaccine by December 31, 2014.

Supporting data:

- The 2010 National Immunization Survey baseline for girl's age 13-17 years is 44.0%

Objective 6.2: At least 50% of girl's age 13-17 years will have received three doses of Human Papillomavirus vaccine by December 31, 2014.

Supporting data:

- The 2010 National Immunization Survey baseline for girls 13-17 years is 31.1%

Objective 6.3: Within three days after birth at least 95% of newborns will receive one birth dose of Hepatitis B vaccine by December 31, 2014.

Supporting data:

- The 2010 National Immunization Survey baseline is 73.5% within three days.

Objective 6.4: At least 95% of infants 19-35 months will receive three doses of hepatitis B vaccine by December 31, 2014.

Supporting data:

- The 2010 National Immunization Survey baseline is 94.8%.

Strategy 6.1.1: Raise awareness of human Papillomavirus (HPV) vaccine through a multi-media approach

Strategy 6.1.2: Increase provider participation and improve completion of vaccination protocols in Ohio's statewide immunization information system (Advisory Committee for Immunization Practices)

Strategy 6.1.3: Promote the universal hepatitis B birth dose program and the importance of hepatitis B vaccine

Responsible Parties/Partners:

- Office of Immunization Program, Ohio Department of Health
- Reproductive Health and Wellness Program, Ohio Department of Health
- Comprehensive Cancer Control Program, Ohio Department of Health

GOAL 7: Reduce Exposure to U[illegible]tion from the Sun and Sun Lamps.

Background:

Skin cancer is the most commonly diagnosed cancer in the United States, with over 1 million cases of non-melanoma diagnosed each year. Scientific studies have shown the relationship between sun exposure and skin cancer and have credited sun exposure as the cause of over 90% of all non-melanoma skin cancers.[9]

Objective 7.1: Reduce the percentage of adults reporting sunburns in the past 12 months.
Source: BRFSS 2004
Baseline: 33.7% 2014 Goal: 30%

> **Strategy 7.1.1:** Increase the proportion of adults aged 18 and older who follow protective measures that may reduce the risk of skin cancer via church-based and local business-based education programs

Objective 7.2: Reduce the percentage of youth (ages 14-17) reporting sunburns in the past 12 months. Source: National Health Interview Survey, 2010
Baseline: 33% 2014
Goal: 30%

> **Strategy 7.2.1:** Increase awareness among youth regarding the dangers of unprotected exposure to UV rays and the recommended practices for sun-protective behavior through sunscreen programs at local high schools

> **Strategy 7.2.2:** Conduct a school health assessment regarding policies on sun exposure on playgrounds, school sporting events, etc.

Objective 7.3: Reduce the percentage of youth (grades 9-12) who have used a tanning booth or sun lamp in the past 12 months.
Source: YRBS 2009
Baseline: 15.6% 2014
Goal: 12%

> **Strategy 7.3.1:** Support initiatives that increase awareness among youth regarding the dangers of indoor tanning beds through structured education programs in high schools using sophisticated software designed to simulate the effects of sun damage at various ages

Responsible Parties/Partners:

- American Cancer Society
- OhioHealth Research Institute
- Center for Appalachia Research in Cancer Education
- Ohio Dermatological Association
- Local schools

SCREENING AND EARLY DETECTION

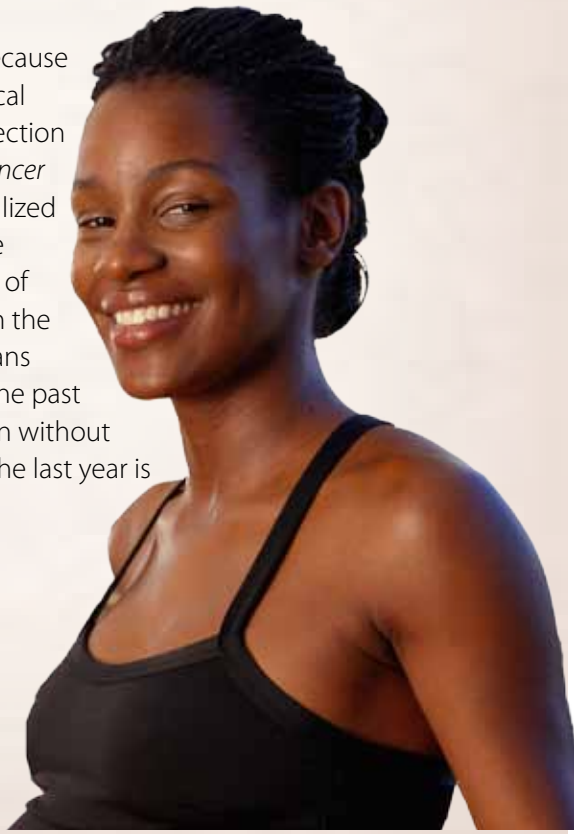
GOAL 8: Improve Screening and [illegible] and Follow-up for Breast, Colorectal, and Cervical

Introduction:
The use of screening tests to detect cancers early provides better opportunities for patients to obtain more effective treatment with fewer side effects. Patients whose cancers are found early and treated in a timely manner are more likely to survive these cancers than are those whose cancers are not found until symptoms appear. Disparities remain for immigrants and those with lower incomes, with less education, without insurance, and lacking a usual health care provider.

Breast Cancer:
Regular use of screening mammograms, followed by timely treatment when breast cancer is diagnosed, can help reduce the chances of dying from breast cancer. For women between the ages of 50 and 69, there is strong evidence that screening lowers this risk by 30 percent. For women in their 40s, the risk can be reduced by about 17 percent.[10]

Objective 8.1: By December 31, 2014, increase the proportion of women aged 40 years and older who have had a mammogram within the past
Baseline (2010 BRFSS): 60%;
Goal: 66%

Supporting data:
Mammography is especially valuable as an early detection tool because it can identify breast cancer at an early stage, usually before physical symptoms develop. Numerous studies have shown that early detection saves lives and increases treatment options. According to *Ohio Cancer Facts & Figures 2010*[7], 68% of breast cancers are diagnosed at a localized stage, for which the five-year survival rate is 98%. According to the 2010 Ohio Behavioral Risk Factor Surveillance Survey (BRFSS), 60% of Ohio women 40 and older reported having had a mammogram in the past year. Also according to the 2010 BRFSS, more African Americans (67%) than whites (59%) reported having had a mammogram in the past year. According to the 2010 Ohio BRFSS, the percentage of women without health insurance who said they have had a mammogram within the last year is 28.4%.



Strategy 8.1.1: Advocate for increased funding for programs that support free and low cost mammography for women with no or limited health care insurance

Strategy 8.1.2: Create strategic partnerships with state and local systems or networks to reach age-appropriate women who have never been screened for breast cancer

Strategy 8.1.3: Improve age-appropriate screening among members of large health plans and employers to impact breast cancer screening

Strategy 8.1.4: Enhance the ability of all healthcare providers to create office policies that ensure the recommendation of early detection screening focusing on women with no or limited health care insurance

Responsible Parties/Partners:

- Ohio Breast and Cervical Cancer Project
- Ohio Breast and Cervical Cancer Coalition
- American Cancer Society
- Commission on Cancer
- Susan G. Komen for the Cure
- OhioHealth Research Institute
- Ohio Commission on Cancer
- Center for Appalachia Research in Cancer Education
- Healthcare Systems
- Employers and Health Plans

Colorectal Cancer:

Colorectal cancer is the third leading cause of cancer death in the US in men and women. Colorectal cancer screening can detect cancerous tumors and polyps, or abnormal cells growth which can develop into colorectal cancer. If colorectal cancer screening reveals a problem, diagnosis and treatment can occur promptly. In addition, finding and removing polyps or other areas of abnormal cell growth may be one of the most effective ways to prevent colorectal cancer development. Also, colorectal cancer is generally more treatable when it is found early, before it has had a chance to spread.

Health care providers may suggest one or more tests for colorectal cancer *screening*, including a *fecal occult blood test* (FOBT); sigmoidoscopy; regular, or standard, *colonoscopy; virtual colonoscopy; double contrast barium enema* (DCBE); Fecal immunochemical test (FIT) or Stool DNA test. People should talk with their health care provider about when to begin screening for colorectal cancer, what tests to have, the benefits and harms of each test, and how often to schedule appointments.

Objective 8.2: By December 31, 2014, Increase the number of adults 50 years or older who receive colorectal cancer screening in accordance with American Cancer Society guidelines. **Baseline** (2010 Ohio BRFSS): 64%; **Goal:** 70% Supporting data:

Colonoscopy and flexible sigmoidoscopy offer the best opportunity to detect colorectal cancer at an early stage, when successful treatment is likely, and to prevent some cancers by detection and removal of polyps. According to the 2010 BRFSS, 53% of Ohioans 50 and older reported having had a sigmoidoscopy or colonoscopy within the past five years. *Ohio Cancer Facts & Figures 2010*[7] states that the relative five-year survival is 90% for colorectal cancer patients diagnosed at an early, localized stage; however, only 43% of cases are diagnosed at this stage. Colorectal cancer is one of the few cancers that can also be prevented through screening because precancerous polyps, from which these cancers usually develop, can be identified and removed. Of the 51,370 people expected to die of colorectal cancers in 2010 in the United States, early detection could save more than half.

According to the 2008 National Health Interview Survey:

- People with no health insurance coverage have significant access barriers and are less likely to be up-to-date with CRC screening compared to their insured counterparts.
- Between 2000 and 2008, there were significant increases in the use of CRC screening within recommended time intervals across race and ethnic groups of insured adults (aged 50 to 64). The largest increases in CRC screening utilization occurred among insured non-Hispanic whites.
- In 2008, the prevalence of colorectal cancer screening varied by race, education, health insurance coverage, and immigration status; those without health insurance, those with less than a high school education, Hispanics, and immigrants who had been in the US for fewer than 10 years were the least likely to have had a colorectal cancer screening test.

Strategy 8.2.1: Advocate for increased funding for programs that support no-cost and low cost CRC screening

Strategy 8.2.2: Develop sources for no-cost or low cost colorectal cancer screening for people without access to medical coverage

Strategy 8.2.3: Create strategic partnerships with state and local systems or networks to reach age-appropriate individuals who should be screened for CRC with focus on groups that experience high mortality rates from CRC cancer

Strategy 8.2.4: Improve utilization among large health plans and employers to impact CRC screening

Strategy 8.2.5: Enhance the ability of all healthcare providers to create office policies that ensure the recommendation of early detection screening with focus on providers that work with groups that experience high mortality rates from CRC

Strategy 8.2.6: Engage in community coalition building and development in priority communities to ensure a comprehensive community-based solution to increasing the early detection of CRC

Responsible Parties/Partners:

- OCCCP
- Ohio Colorectal Cancer Coalition, Healthcare Systems
- Employers
- Health Plans

Objective 8.3: The Ohio Academy of Family Physicians will develop and execute professional education initiatives to increase colorectal cancer screening no later than December 31, 2012.

Supporting Data:

- Consultation with colleagues at the American Cancer Society (ACS) East Central Division and a review of recent peer-reviewed published papers regarding CRC reveals that barriers to physician referrals for screening include, but are not limited to: (a) outdated knowledge; (b) inconsistently followed guidelines; and, (c) inadequate resources and reinforcement.

- To address this critical issue the Comprehensive Cancer Control Program at the Ohio Department of Health has entered into a contract with the Ohio Academy of Family Physicians (OAFP) for an initiative to increase colorectal cancer screening. This contract will fund the development of professional education services for family physician practices which will be effective in assisting those practices in improving their colonoscopy referred patterns and systems.

  Strategy 8.3.1: This evidence-based intervention will focus on OAFP members using the professional education materials developed by the Thomas Jefferson University, Department of Family Medicine in collaboration with the American Cancer Society national office: *How to Increase Colorectal Cancer Screening Rates in Practices: A Primary Care Clinician's Evidence-Based Tool Kit and Guide*. These professional education materials include three evidence-based strategies to increase CRC screening rates: (1) Office policies; (2) Reminder Systems; and, (3) communication. Other activities will include: (4) Establishing a baseline colorectal cancer screening rate for the practice; and, (5) tracking the completion of colorectal cancer screening to detect if an increase in screening is taking place as a result of the professional education intervention.

Responsible Parties/Partners

- Ohio Academy of Family Physicians (OAFP)
- American Cancer Society (ACS) East Central Division
- Ohio Department of Health Cancer Program (OCCCP)

Objective 8.4: Promote cervical cancer screening following nationally recognized guidelines.

Objective 8.5: Ensure appropriate follow-up for women who receive abnormal Pap smear results.

Objective 8.6: Reduce financial barriers to cervical cancer screening and follow-up testing (i.e., colposcopy).

Supporting data:

The OCISS incidence data for the years 2004-2008 indicate about 483 new cases of invasive cervical cancer among Ohio females.[5] About 49% of these cervical cancers are diagnosed late (Regional, Distant) stage, when survival is poorest.[5] The 2004-2008 data indicate about 165 cervical cancer deaths among Ohio females each year.[5]

Significant disparities exist in the cervical cancer incidence and mortality rates by race and ethnicity. The average annual age-adjusted incidence rate per 100,000 for Ohio African American females is 8.6 which is about 10% higher than the white female rate of 7.8 and about 138% higher than the rate of 3.6 for Asian/Pacific Islander females.[5] The average annual age-adjusted cervical cancer death rate per 100,000 is 3.4 for African American females which is 42% higher than the white female death rate of 2.4 and 143% higher than the death rate of 1.4 for Asian/Pacific Islander females.[5]

The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 21-65 with a cervix be screened for cervical cancer and precancerous lesions by Papanicolaou (Pap) smear every three years.[11] The 2010 Ohio Behavioral Risk Factor Survey data for Ohio women aged 18 years and older indicates that about 82% of white women and about 88% of Black women have had a Pap test in the past three years.[12] The Healthy People 2020 target is 93.0%.[13]

These data indicate that invasive cervical cancer remains a significant source of morbidity and mortality for Ohio females. The data also indicate that Ohio will need to aggressively promote cervical cancer screening to meet the 2020 goal of 93.0 percent of females receiving a Pap test in the last 3 years.

Responsible Parties/Partners:

- Ohio Breast and Cervical Program (BCCP)
- Ohio Department of Health Reproductive Health and Wellness Program
- Centers for Community Solutions
- Planned Parenthood

GOAL 9: Promote the Use of Cancer Genetic Services

Background:
Knowledge gained from family history and genetic testing can also play an important role in early detection. A detailed family history can help to identify an inherited predisposition for cancer and can guide people to an appropriate referral for genetic counseling and testing. Individuals who have an elevated risk for cancer based on family history or a genetic test will benefit from tailored advice about their options for prevention and surveillance.

Objective 9.1: By December 31, 2014 provide 175 educational talks to Ohio healthcare professionals annually (about the established referral guidelines (NCCN, ACOG, NSGC) for cancer risk assessment.

Supporting data:

- Use the ODH education database to quantify the number of talks provided to professionals in the state on cancer genetics and show an increase from 2011 to 2014
  (Baseline from 2010 = 163 talks to health care professionals).

  Strategy 9.1.1: Make referral criteria available to providers on ODH and Ohio Partners for Cancer Control (OPCC) websites and educate providers about these resources through mailing(s), and/or newsletters

  Strategy 9.1.2: Bi-annual collaboration with the Ohio Cancer Genetics Network to evaluate and update existing resources

  Strategy 9.1.3: Create, implement and promote continuing education (CE) opportunities for healthcare providers to expand awareness of the impact of family history and genetic factors on cancer risk by developing webinars or soliciting invitations to give presentations as a part of already established professional meetings

  Strategy 9.1.4: Approach healthcare degree granting programs (13 organizations) in Ohio beginning with large physician and physician assistants programs to discuss means for collaboration and in order to plan to more effectively integrate education about cancer genetics into their curriculum

Responsible Parties/Partners: OCGN

Objective 9.2: By December 31, 2014 provide at least 95 outreach and education talks/events annually to enhance public knowledge about the impact of family history and genetics on cancer risk and management.

Supporting data:

- Use the ODH education database to quantify the number of lay talks provided in the state on cancer genetics and show an increase from 2011 to 2014 (Baseline from 2010 = 85 talks to lay public audiences).

Strategy 9.2.1: Make information on underlying genetic and familial causes of common cancers, the importance of genetic counseling and early detection and cancer genetics services in Ohio more readily available to the public through the relevant websites such as OPCC and ODH/ Healthy Ohio, social media and patient-centered mailings and publications (i.e. emails/ mailings and postings on Facebook during family history and various cancer awareness months)

Responsible Parties/Partners: OCGN

Objective 9.3: By December 31, 2014 improve access to cancer risk assessment services, genetic testing and risk-appropriate management options.

Supporting data:

- Identify and increase the number of health plans in Ohio that have policies covering cancer genetic counseling and testing that are in alignment with the USPSTF guidelines.

Strategy 9.3.1: Collaborate with OCGN, Ohio healthcare providers across disciplines and other relevant organizations to develop strategies to increase availability of screening and management for cancer as appropriate based on genetic risk and family history such as compilation of contact information for access to no-cost or low-cost screening services

Strategy 9.3.2: Educate employers, health plan/ insurance personnel and policy makers on the importance of family history and genetics in the risk of cancer and to ensure development of appropriate criteria, coverage and policies for genetic counseling, genetic testing and management options

Strategy 9.3.3: Support efforts to ensure that cancer genetics services are provided by qualified healthcare providers

Responsible Parties/Partners: OCGN

Objective 9.4: By December 31, 2014 increase the number of moderate- and high-risk individuals who receive appropriate cancer screening and referral for cancer genetic services to 3800 patients per year.

Supporting data:

- Use the Ohio Department of Health genetics database to quantify the numbers of patients seen for cancer genetics services in the state from 2011 to 2014 (Baseline from 2010: 3450 patients received cancer genetic counseling)

Strategy 9.4.1: Work with the Ohio Cancer Incidence Surveillance System to identify patients at high risk for hereditary cancer and notify the reporting physicians/hospitals

Strategy 9.4.2: Educate healthcare providers about the implications of a cancer diagnosis for cancer risk among family members

Strategy 9.4.3: Advocate for health insurance coverage of cancer risk assessment

Strategy 9.4.4: Promote a family history cancer risk assessment tool for use in primary care settings

Strategy 9.4.5: Create awareness campaigns regarding the importance of family history as a risk factor for cancer

Responsible Parties/Partners: OCGN

Objective 9.5: By December 31, 2014, develop and execute the Ohio Cancer Genetics Surveillance System, a population-based, state-wide, and web-based system to serve as a central depository for Hereditary Breast and Ovarian Cancer Syndrome and Colorectal Cancer Syndromes.

Background:

- Ohio has historically had a number of genomics-related data sources (the Ohio Cancer Incidence Surveillance System, and the Regional Genetic Center data reports); it is currently not possible to obtain detailed risk assessment information, specific cancer genetics-related diagnosis, referral information, etc., at the state level. Ohio does not currently gather data regarding physician's referrals to appropriate genetic services, according to established recommendations. Despite an interest by the genetic community in Ohio, there is no central depository of data/information on patients with cancer risks/diagnosis to assist genetic centers with grant applications, studies/clinical trials, and targeted education activities that could benefit individual patients and lead to improved public health of Ohioans in the future.

- This system will be housed at the Ohio Department of Health. It will be based on modifications to the MS ACCESS BRCA database developed in Michigan. The Michigan Department of Health has generously agreed to share this ACCESS database with Ohio at no cost. Although this database will be designed to duplicate the BRCA data fields collected in Michigan, Ohio's version will be enhanced to also collect information about patients seen for colorectal cancer syndromes as well. It will be populated by information about patients seen in programs who are partners in the Ohio Cancer Genetics Network (OCGN).

  Strategy 9.5.1: Secure Ohio IT vendor to modify the ACCESS database into a web-based, password-protected secure genetics data system housed on the ODH Gateway. This includes an import routine to allow genetic assessment sites to submit files of patient data to populate the data base.

  Strategy 9.5.2: Work with vendor and OCGN to match Michigan BRCA data fields and add colorectal cancer syndromes to the Ohio Cancer Genetics Surveillance System database

  Strategy 9.5.3: Perform testing on system

  Strategy 9.5.4: Dissemination to OCGN members with training on use

Responsible Parties/Partners:

- ODH Genetics Program
- Ohio Cancer Genetics Network
- ODH Comprehensive Cancer Control Program

CLINICAL TRIALS AND RESEARCH

GOAL 10: Promote Clinical Trials

Objective 10.1: By December 31, 2014, increase adult cancer patient enrollment in clinical trials at the 100 Commission on Cancer (CoC) accredited cancer programs by 2%. 2011 Baseline: 0-2%

Data sources: CoC Accredited Cancer Programs

Responsible Parties/Partners: CoC

Strategy: 10.1.1 The CoC will require cancer programs that diagnose and treat 100-500 or more cancer patients per year to accrue to clinical trials at a rate of 2%. The clinical trial accrual rate for larger cancer programs will be raised from current levels.

Objective 10.2: By December 31, 2014 increase by 2% the adult cancer patient participation in clinical trials at select cancer programs in the Appalachian area of Ohio.

Measure: Select Appalachian cancer programs capable of conducting clinical trials will be assessed as to their current clinical trial accrual percentages. The goal will be to increase clinical trial accrual by 2%.

Data sources: Columbus Community Clinical Oncology Program, American Cancer Society Connection Data Base, and Commission on Cancer accredited cancer programs

Responsible party/Partners:

- Columbus Community Clinical Oncology Program
- CoC

Strategy 10.2.1: Access Columbus Community Clinical Oncology Data Base and American Cancer Society Data Base to determine the number of Appalachian cancer programs capable of participating in clinical trials

Strategy 10.2.2: Develop a program that assesses and addresses barriers to providing clinical trials to the people of Ohio Appalachia

SURVIVORSHIP

GOAL 11: Optimize the Quality of Life for Cancer Survivors and Significant Others through Community-Based Programs and Clinical Linkages

Objective 11.1 By December 31, 2012 identify and engage at least 20 community-based cancer wellness information outlets and psychosocial support services in Ohio to determine where gaps in service exist.

Data Sources: American Cancer Society East Central Division (ACS), National Cancer Support Community Central Ohio

Responsible Parties/Partners:

- Ohio Department of Health (ODH) Comprehensive Cancer Control Program
- OPCC member representatives of community-based cancer wellness organizations, i.e.
  - Cancer Support Community
  - ACS
  - Stewart's Caring Place: Cancer Wellness Center
  - The Gathering Place
- The Leukemia & Lymphoma Society
- Young Survival Coalition

Strategy 11.1.1: Establish a common definition of cancer specific wellness support services using national resources; Establish what are essential services/resources

Strategy 11.1.2: Gather from the American Cancer Society data on cancer specific wellness services in Ohio according to ZIP code and/or county

Strategy 11.1.3: Analyze and collate the data: What services are provided in each location; what locations lack essential services

Strategy 11.1.4: Assess a wellness organization's ability and willingness to provide essential services in adjacent underserved areas by directly contacting the organization

Strategy 11.1.5: Ensure new programs or services are updated in the American Cancer Society's Connection Data Base

Objective 11.2: By December 31, 2014 increase awareness of the importance and the availability of cancer specific community-based psycho-social and wellness services in Ohio to at least three regions of Ohio where gaps in service exist.

Data Sources: ACS Connection Data Base, Program based evaluation, American College of Surgeons Commission on Cancer (CoC), Cancer Support Community Central Ohio

Responsible Parties/Partners:

- ODH CCP
- Cancer Support Community Central Ohio
- CoC
- ACS
- College of Social Work, Ohio State University

Strategy 11.2 .1: Refer cancer patients and families to the ACS National Cancer Information Center , 1-800-227-2345, available 24 hours a day, 365 days a year for access to local programs and services available to them

Objective 11.3: By December 31, 2014, the ODH CCP program will collaborate with the Cancer Support Community Central Ohio to develop one demonstration project, to assess and facilitate the implementation of cancer specific psychosocial support services.

Data Sources: American Cancer Society (Connection Database), Program based evaluation, CoC, Cancer Support Community Central Ohio.

Responsible Parties/Partners:

- ODH CCP
- Cancer Support Community Central Ohio
- CoC
- ACS East Central Division
- College of Social Work, Ohio State University.

Strategy 11.3.1: Develop and disseminate a set of customizable evaluation modules (for use by, community based cancer specific psychosocial support service organizations)

Strategy 11.3.2: Develop and facilitate a statewide "Yearly Meeting" of community based cancer specific psychosocial support service organizations

Meeting agenda to include:

- o Strategic Planning Program development (round table discussion)
- o Successes/Opportunities: Networking opportunity
- o Communication Strategies—Distinguishing differences between national affiliates and independent organizations
- o (Training Component) Evaluation Modules

Strategy 11.3.3: In collaboration with community based specific psychosocial support service organizations and the Commission on Cancer, develop and disseminate a hospital-based Physician Awareness Program - based upon 2012 CoC accreditation standards

Objective 11.4: By December 31, 2014 encourage at least 10% of the 100 CoC accredited cancer programs in Ohio to implement a process to routinely assess and manage palliative care needs and psychosocial distress of a cancer patient on site or by referral.

Measure: Baseline-0; Target-10%

Data sources: CoC Data Base, Facility Information Profile System, ACS

Timeframe: December 2014; Annual reporting

Responsible Parties/Partners: CoC

Strategy: 11.4.1: Assess the number of CoC accredited cancer programs in Ohio that provide palliative care and psychosocial distress assessment and support according to evidence based guidelines

Strategy: 11.4.2: Assess the number of CoC accredited cancer programs in Ohio that provide psychosocial assessment and support according to evidence based guidelines

Strategy: 11.4.3: Implement palliative care assessments and support on site or by referral as a CoC accredited requirement

Strategy: 11.4.4: Implement psychosocial distress assessment and support on site or by referral as a CoC accreditation requirement

Strategy: 11.4.5: Implement palliative care assessments and support on site or by referral as a CoC accredited requirement

PALLIATIVE CARE/PSYCHOSOCIAL DISTRESS ASSESSMENT AND SUPPORT

GOAL 12: Provide Essential Surv gement Tools and Services to Cancer Survivors.

Objective 12.1: By December 31, 2014, increase to 25% the 100 CoC accredited cancer programs in Ohio that provide adult cancer patients with a portable summary of their diagnosis, treatment, subsequent follow-up requirements, possible sequellae, information about supportive services including genetic counseling.

Measure: Baseline 0: 2014 Target 25%

Data sources: Ohio Cancer Liaison Physicians, CoC Cancer Program Managers and Cancer Registrars

Timeframe: Annual Reporting

Responsible Parties/Partner: CoC State Chair

Strategy: 12.1.1: Request, collect, and analyze cancer program data to obtain a baseline for the use of a personal health manager (portable health record)

Strategy: 12.1.2: The CoC will implement the provision of a personal health manager file to cancer patients as an accreditation requirement

GOAL 13: Impact the Quality of Life [illegible] tients by Providing American Cancer Society Informat[illegible] to National, Local and Community Resources, Programs, and [illegible]

Objective 13.1: By December 31, 2014 increase automatic referrals to the American Cancer Society from Ohio hospital based cancer programs serving over 1,000 cancer patients a year and high numbers of under-served patients from 2011 baseline to 50%.

Measures: From 2011 baseline to 50%

Data sources: ACS East Central Division

Timeframe: Achieve contact with 50% of all newly diagnosed cancer patients by 2014.

Responsible Parties/Partners:

- ACS
- Community Partners

Strategy 13.1.1: Utilize Multi-Tier Navigation Model to assist patients and families in accessing programs and services available nationally, statewide and locally

Strategy 13.1.2: Engage CoC accredited hospitals by meeting with the Cancer Liaison Physician and attending the Cancer Committee Meetings

Strategy 13.1.3: Provide cancer patients and caregivers availability to American Cancer Society supportive services such as Look Good Feel Better, I Can Cope and the on line web-based Cancer Survivor Network

Strategy 13.1.4: Provide cancer patient's assistance with transportation to treatment or lodging needs while in treatment

ADVOCACY

GOAL 14: Increase Interest in Canc e, Prevention and Control Activities among State tors and Organizational Policy Makers to Influence Poli s Changes

Objective 14.1: By December 31, 2012 establish a protocol by which the OPCC reviews and reaches decision regarding support for legislation impacting on cancer surveillance, prevention, and control.

Objective 14.2: By December 31, 2014 attend and actively participate in the quarterly meetings of the Ohio General Assembly Cancer Caucus.

Responsible Parties/Partners:

- Easy Central Division
- Ohio Department of Health
- Ohio State University Medical Center
- University Hospitals of Cleveland
- Ohio State Medical Association

Strategy 14.1.1: Actively engage in legislative, regulatory, and statewide policy initiatives that support the goals and objectives of *The Ohio Cancer Prevention and Control Plan 2011-2014*

Strategy 14.2.1: Seek out education opportunities to promote the goals and objectives of *The Ohio Cancer Prevention and Control Plan 2011-2014*

Strategy 14.2.2: Conduct an annual advocacy day to educate the Administrators and Ohio General Assembly on the elements of *The Ohio Cancer Prevention and Control Plan 2011-2014*

Strategy 14.2.3: Provide periodic briefings to the Ohio General Assembly Cancer Caucus on the progress of *The Ohio Cancer Prevention and Control Plan 2011-2014*

APPENDIX A

References/Footnotes

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APPENDIX B

Ohio Partners for Cancer Control
Participation Form – Yes, I Want to Be Involved!

The purpose of Ohio Partners for Cancer Control is to develop and implement *The Ohio Comprehensive Cancer Control Plan 2011-2014*. The partnership invites individuals and organizations with an interest in cancer prevention and control to participate in Ohio Partners for Cancer Control's vision is "a cancer-free future for all Ohioans." By completing this form, you will be added to the partnership's mailing and email list and will be contacted by the Membership Committee.

Name:_____

Credentials and Title:_____

Organization:_____

Address:_____

Phone/Fax:_____

Email Address:_____

My particular area of interest is:

☐ Primary Prevention ☐ Early Detection ☐ Treatment and Care

☐ Research and Clinical Trials ☐ Palliation and Quality of Life ☐ Cancer Survivorship

☐ Data and Surveillance ☐ Other, please note:

☐ I know other individuals/organizations that might be interested in participating in Ohio Partners for Cancer Control. I recommend you contact:

Name:_____

Phone/Email:_____

Please fax this form to Ohio Partners for Cancer Control at 614-564-2409 or mail it to:
Ohio Partners for Cancer Control
246 North High
Columbus, OH 43215

For more information visit ohiocancercontrol.org

APPENDIX C

Listing of OPCC Members and Organizations Represented

Adena Health System	Erin	Trapp
American Cancer Society East Central Division	Angie	Hodges
American Cancer Society East Central Division	Anna	Fetzer
American Cancer Society East Central Division	Ashley	Russell
American Cancer Society East Central Division	LeighAnne	Hehr
American Cancer Society, East Central Division	John	Alduino
American Cancer Society, East Central Division	John	Hoctor
American Cancer Society, East Central Division	Lynne	Ayres
American College of Surgeons (MetroHealth)	Jean	Stevenson
American College of Surgeons, Ohio Chapter	Valeriy	Moysaenko
Appalachia Community Cancer Network	Darla	Fickle
B.A.S.I.C. Circle	David	Abdullah
Cancer Support Community Central Ohio	Skip	Weiler
Cancer Support Community of Central Ohio	Bev	Soult
Cancer Support Community of Central Ohio	Nina	Lewis
Case Comp Cancer Center, Dept of Family Medicine	Susan	Flocke
Case Comprehensive Cancer Center	Gabrielle	Brett
Case Comprehensive Cancer Center	Stan	Gerson
Case Western Univ., School of Medicine	Elizabeth	McKinley
Christians Overcoming Cancer	Mary	Jenkins
Cleveland Clinic Cancer Center at Fairview Hospital	Debra	Pratt
Cleveland Clinic Cancer Center, Fairview	Jean	Ellsworth-Wolk
Columbus Community Clinical Oncology Program	Carol	Kuebler
Columbus Community Clinical Oncology Program	G.H. Rocky	Haddix
Columbus Community Clinical Oncology Program	Sheree	Oxley
Columbus Public Health	Fred	Johnson
Dayton Clinical Oncology Program	Cara	Nolan
Dayton Clinical Oncology Program	Sidney J.	Pinkus
EISAI, Inc.	Todd	Lacksonen
Genesis Healthcare System	Shannon	White
Grant Medical Center	Fran	Feehan
Hillcrest Hospital	Renata	McBride
Individual - Survivor Advocate	Barbara	Beckwith
James Cancer Hospital - Diversity Enhancement/ Ohio Breast and Cervical Cancer Coalition	Chasity	Cooper
Kettering Medical Center	Tammy	Dehaven-Fanz
Komen Northeast Ohio Affiliate	Carrie	Clark
Leukemia and Lymphoma Society	Phillip G.	Tanner
Midwest Care Alliance	Jeff	Lycan
NAACP	Michael W.	McIntyre
National Association of Social Workers, Ohio Chapter	Danielle	Smith
Northeastern Ohio Universities School of Public Health	John	Petrus

Northern Ohio Breast Cancer Coalition Fund	Elizabeth	Schulte
Northwest Ohio Consortium for Public Health	Brian	Fink
Ohio Academy of Family Physicians	Kate	Mahler
Ohio Assoc. of Physician Assistants	Elizabeth	Adamson
Ohio Association of Community Health Centers	Heather	Porter
Ohio Association of Free Clinics	Michelle	Fitzgibbon
Ohio Cancer Genetics Network	Heather	Hampel
Ohio Cancer Genetics Network, Cleveland Clinic	Jill	Polk
Ohio Cancer Registrar's Association	Elayna	Freese
Ohio Commission on Minority Health	Angela	Dawson
Ohio Commission on Minority Health	Bounthanh	Phommasathit
Ohio Commission on Minority Health	Lisa	Stafford
Ohio Dental Association	Kathy	Woodard
Ohio Department of Health	Angela	Abenaim
Ohio Department of Health	Debbie	Wallace
Ohio Department of Health	Donna	Jurden
Ohio Department of Health	Georgette	Haydu
Ohio Department of Health	Holly	Sobotka
Ohio Department of Health	Jenny	Couse
Ohio Department of Health	Marjorie	Jean-Baptiste
Ohio Department of Health	Mary	Lynn
Ohio Department of Health	Melanie	Tidwell
Ohio Department of Health	Robert	Indian
Ohio Department of Health	Sarah	Gudz
Ohio Department of Health	Stephani	Francis
Ohio Dermatological Association	Louis	Barich
Ohio Hispanic Coalition	Jesus	Ovalle
Ohio Hispanic Coalition	Josue	Vicente
Ohio Hospital Association/Mt. Carmel	Dodie	Fankhauser
Ohio KePRO	Carol	Saavedra
Ohio KePRO	Leslie	Crowe
Ohio KePRO	Ronald	Savrin
Ohio Nurses Association	Kathleen	Morris
Ohio Osteopathic Association	Barb	Anderson
Ohio Osteopathic Association	Cheryl	Markino
Ohio Osteopathic Association	Jon	Wills
Ohio Pain Initiative	Ann R.	Hudson
Ohio Pain Initiative	Debbie	Heidrich
Ohio Psychological Association	Michael O.	Ranney
Ohio Public Health Association	Lois	Hall
Ohio Public Health Association	Marisa	Bittoni
Ohio State Association of Occupational Health Nurses	Peggy	Berry
Ohio State Medical Association	Jason	Koma
Ohio State Medical Association	Peter	Lafferty

Ohio State University	James (Jay)	Fisher
Ohio State University Comprehensive Cancer Center	Cathy	Tatum
Ohio State University, School of Public Health	Janet S.	DeMoor
Ohio/WVA Hematology Oncology Society	Dave	Dillahunt
OhioHealth Insurance-Ohio's Medicaid Program	Melissa	Senter
OhioHealth Research Institute	Bill	Hiermer
OhioHealth Research Institute	Melissa	Thomas
Oncology Nursing Society	Ilene	Comeras
OSU Comp Cancer Center - James Cancer Hospital	Stefanie	Wesson
OSU Comprehensive Cancer Center-College of PH	Judy	Harness
OSU Comprehensive Cancer Center-College of PH	Kristine	Browning
OSU Comprehensive Cancer Center-College of PH	Mira	Katz
OSU-James Cancer Hospital & Solove Research Institute	Jennifer	Carlson
Ovarian Cancer Alliance of Ohio	Chris	Gillespie
Premier Community Health	Roberta M.	Taylor
Stewart's Caring Place	Sarah	Tower
Stewart's Caring Place	Stacey	Manes
Summa Health System	Marlo	Schmidt
Survivor	Katherine	Slaughter
Susan G. Komen for the Cure, Columbus	Megan	Knapke
The Gathering Place	Ellen	Heyman
The Gathering Place	Kristina	Austin
University Hospital, Case Medical Center, Human Genetics	Duane	Culler
University Hospitals Case Medical Center, Human Genetics	Georgia	Weisner
University Hospitals Ireland Cancer Center	Hermione	Malone
University of Cincinnati Cancer Center	John	Perentesis
University of Cincinnati Cancer Center	Susan	Waltz
Urban Mission	Frankie	Myles
Wellness Community of Greater Cinci/N KY	Bonnie	Crawford
Young Survival Coalition Central Ohio	Medha	Sutliff
Young Survival Coalition, Central Ohio Office	Jennifer	Whaley

Abbreviation List

Abbreviation	Name
ACOG	American Congress of Obstetrics and Gynecologist
ACS	American Cancer Society
ATS	Adult Tobacco Survey
BCCP	Breast and Cervical Cancer Program
BRFSS	Behavioral Risk Factor Surveillance System
CDBE	Chronic Disease Behavioral Epidemiology
CE	Continuing Education
CoC	American College of Surgeons Commission on Cancer
CPHSI	Center for Public Health Statistics and Informatics
CRC	Colorectal Cancer
DCBE	Double Contrast Barium Enema
FOBT	Fecal Occult Blood Test
HPV	Human Papilloma Virus
NCCN	National Comprehensive Cancer Network
NCHS	National Center for Health Statistics
NPCR	National Program of Cancer Registries
NSGC	National Society of Genetics Counselors
OCCCP	Ohio Comprehensive Cancer Control Program
OCGN	Ohio Cancer Genetics Network
OCISS	Ohio Cancer Incidence Surveillance System
ODH	Ohio Department of Health
ODJFS	Ohio Department of Job & Family Services
OH CBT	Ohio Tobacco Cessation Benefits Team
OMIS	ODH Office of Management Information System
OPCC	Ohio Partners for Cancer Control
SAS	Statistical Analyses System
SEER	Surveillance, Epidemiology, and End Results
The Warehouse	Ohio Public Health Information Warehouse
TUPCP	Tobacco Use Prevention and Control Program
USPSTF	U.S. Preventive Services Task Force
VS	Ohio Vital Statistics
YRBS	Youth Risk Behavior Survey
YTS	Youth Tobacco Survey

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c/o Ohio Comprehensive Cancer Control Program
Ohio Department of Health
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Columbus, Ohio 43215