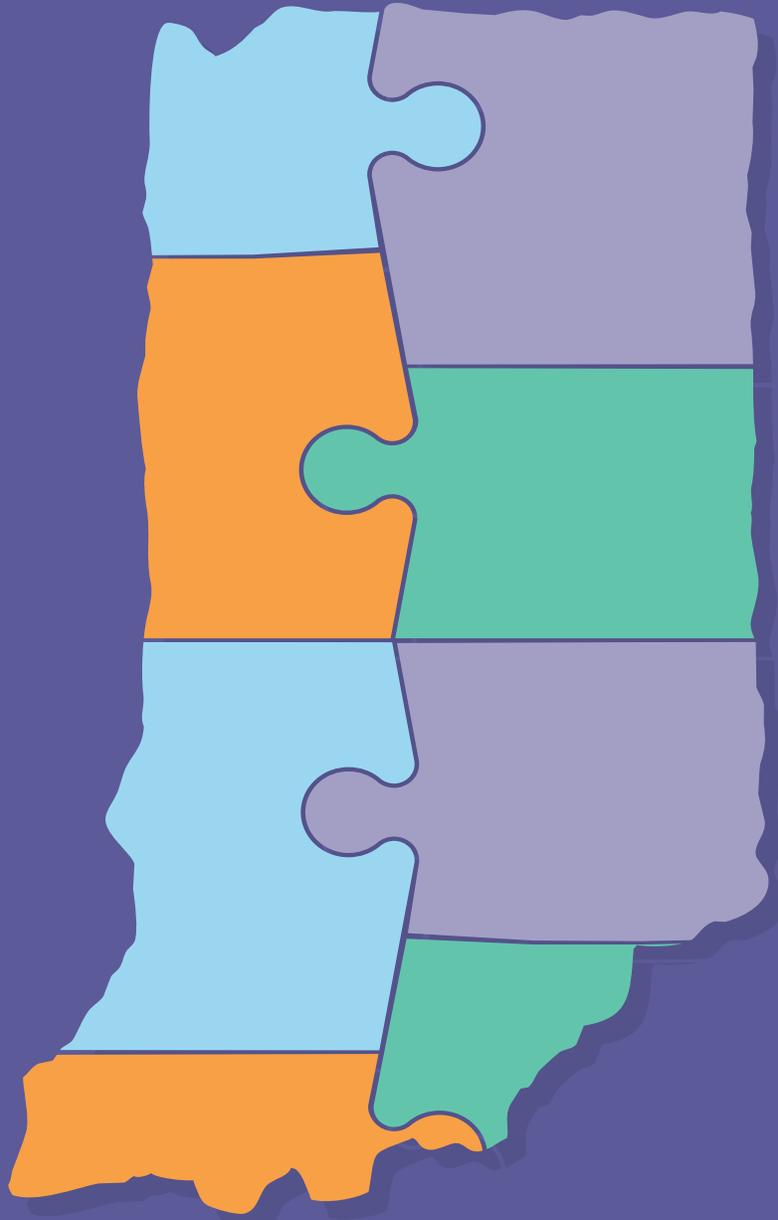


INDIANA

CANCER CONTROL PLAN

2021-2022



ACTION FOR CANCER PREVENTION AND CONTROL



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LETTER FROM INDIANA CANCER CONSORTIUM CHAIRS

Dear Indiana Residents,

Throughout the years, Indiana has made great strides in addressing the burden of cancer. Although our state cancer rates have decreased, cancer is still the second leading cause of death in Indiana. Approximately two in five Indiana residents now living will eventually have cancer—impacting every individual, family, and community throughout the state. Additionally, the global COVID-19 pandemic continues to have a serious impact on the cancer continuum of care.

Developed by the Indiana Cancer Consortium (ICC), the Indiana Cancer Control Plan 2021-2022 is a strategic roadmap for actions that will guide cancer control efforts and promote collaboration between organizations and the citizens of Indiana. This iteration extends and builds upon the 2018-2020 comprehensive plan consisting of four focus areas: primary prevention, early detection, treatment, and survivorship containing supporting objectives and strategies. The 2021-2022 plan specifically addresses four high burden priority areas for Indiana: tobacco and nicotine use, human papillomavirus vaccinations, breast cancer, and colorectal cancer. This plan is for everyone in our state looking for ways to join the fight against cancer.

As co-chairs of the ICC, we ask you to take an active role in reducing the cancer burden in Indiana by:

- Reading this plan to keep informed about this disease.
- Leading a healthy lifestyle through proper nutrition, adequate physical activity, eliminating tobacco, and limiting alcohol consumption.
- Following the recommended screening guidelines and knowing your risks.
- Passing this plan on to your family, friends, neighbors, and co-workers and encouraging them to be proactive about cancer prevention and early detection.

Day by day, as more partners implement the strategies from this plan, extraordinary accomplishments are made. This is the power of our unique cancer control alliance. *Together, we are stronger than cancer.*

Sincerely,

Paul Halverson, DrPH, FACHE
ICC Board of Directors, Chair

Katherine Crawford
ICC Board of Directors, Vice-Chair

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INDIANA CANCER CONSORTIUM

PARTNER ORGANIZATION LIST

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Boone County Health Department
Butler University EPICS Program
Cancer Prevention and Control
Program of Indiana
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Cancer Services of Grant County
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Cancer Support Community Central Indiana
Center for Healing and Hope
Center for Health Equity at the Indiana
Institute on Disability and Community
Central Indiana Prostate Cancer
Foundation, Inc
Chemo Buddies
Clark Memorial Hospital
Colon Cancer Prevention Project
Community Action of Southern Indiana
- Minority Health Initiative
Community Healthcare System
Community Solutions, Inc.
Daviess Community Hospital
Digestive Health Associates
Dubois County Health Department
Eskenazi Health, EMBRACE Program
Esophageal Cancer Education Foundation
Floyd County Tobacco Coalition
Gennesaret Free Clinic
Get Fit Get Healthy
Gilda's Club Evansville
Good Samaritan Hospital
Grace College
Hancock County Tobacco Free Coalition
Harper Cancer Research Institute
Health by Design
HealthVisions Midwest
Healthy Communities Coalition
of Kosciusko County

Healthy Communities of La Porte County
Henry Community Health
Henry County Health Department
Hoosier Cancer Research Network
Indiana Association of School Nurses
Indiana Hospital Association
Indiana Minority Health Coalition
Indiana Primary Health Care Association
Indiana Public Health Association
Indiana Rural Health Association
Indiana Department of Health
Indiana University
Indiana University Health Ball
Memorial Hospital
Indiana University Melvin and
Bren Simon Comprehensive
Cancer Center
Indiana University Northwest
School of Nursing
IU Health Bloomington Hospital
IU National Center of Excellence
in Women's Health
IUPUI Center for HPV Research
Jay County Hospital
Karuna Precision Wellness Center
King's Daughters' Health
Kosciusko County Tobacco Free Coalition
Kristen Forbes EVE Foundation, Inc.
Little Red Door Cancer Agency
Live Well Kosciusko
Madison County Community Health Center
Maple City Health Care Center
Marion County Public Health Department
Marram Health Center
Meals on Wheels of Central Indiana
MHIN, Inc
Monroe County Health Department
North Vernon Plain Dealer
Oncology Hematology Associates
of Southwest Indiana
Outrun the Sun, Inc.
Ovar'coming Together, Inc.

Parkview Comprehensive Cancer Center
Pink Ribbon Connection
Pink-4-Ever Inc.
Purdue Extension, Porter County
Purdue Extension, Wayne County
Purdue University Center
for Cancer Research
Raphael Health Center
Ready Set Quit Tobacco
R.E.D. Alliance
Schneck Medical Center
Smokefree Communities
Spencer County Tobacco Free Coalition
St. Joseph County Health Department
St. Mary's Health
St. Vincent Cancer Care Services
St. Vincent Health, Ascension
Susan G Komen Evansville Tri-State
Susan G. Komen Central Indiana
SV Anderson Regional Cancer Center
The Claire E. and Patrick G. Mackey
Children's Cancer Foundation
The Colon Club
Tobacco Education and Prevention
Coalition for Porter County
Tobacco Free Allen County
TOUCH INC.
United Health Services
University of Southern Indiana College of
Nursing and Health Professions
YMCA of Greater Indianapolis
YMCA of Michiana, Inc.
YMCA of Southwestern IN
YWCA Women's Cancer Program



COLLABORATING TO CONQUER CANCER

The Comprehensive Cancer Control National Partnership is a movement of states, tribes, territories, U.S. Pacific Island Jurisdictions, and local communities working together to reduce the burden of cancer for all people. In the Indiana state, the Indiana Cancer Consortium (ICC) serves as that comprehensive cancer control coalition, responsible for developing, implementing, and evaluating a statewide cancer control plan, which addresses cancer from prevention through end-of-life.

Collaborating to Conquer Cancer is the underlying philosophy and model that guides all ICC efforts, as well as those of our partners across the nation. In Indiana, we are proud to say that Collaborating to Conquer Cancer represents the more than 400 organizational and individual members of the ICC who collaborate to bring together Indiana's cancer community, identify disease challenges facing both state and local communities, and develop evidence-based solutions that make a difference.

The ICC membership plans, contributes, and takes advantage of a full range of free services – including professional trainings, educational publications, funding opportunities, and guidance. By listening to our partners, public health and medical experts, and other interested individuals, we continually evolve to better address the gaps in cancer prevention and control across the state. The larger our coalition grows, the bigger impact and voice we have.

ICC MISSION

The ICC Reduces Indiana's Cancer Burden Through The Coordinated, Collective Actions Of Its Members And The Sharing Of Resources, Knowledge, and Passion.

ORGANIZATIONAL PRIORITIES

- **LEAD** the development, implementation, and evaluation of a comprehensive plan to reduce cancer morbidity and mortality in Indiana.
- **RECOGNIZE** excellence in cancer prevention and control.
- **PROVIDE** guidance on current issues in cancer policy, research, detection, treatment, and survivorship.
- **CONVENE** a multi-sectored and diverse membership to discuss cancer-related challenges facing Indiana.
- **STRENGTHEN** communication, resource sharing, and collaboration to reduce duplication and inefficiency.
- **EDUCATE** Indiana's public health and healthcare workforce to implement evidence-based strategies.
- **ADVOCATE** for strong policy, systems, and environmental changes that decrease cancer risk factors.
- **INCREASE** dedicated funding to cancer prevention and control in Indiana.



WHAT YOU NEED TO KNOW: CANCER IN INDIANA

WORKING TOGETHER, Indiana has made great strides over the past several decades in regards to our cancer burden. Although our state cancer rates have seen decreases, cancer is still the second leading cause of death.



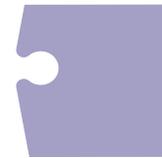
WHAT IS CANCER?

Cancer is a group of diseases characterized by the uncontrolled growth and spread of abnormal cells. The cancer cells form tumors that destroy normal tissue. If cancer cells break away from a tumor, they can travel through the bloodstream or the lymph system to other areas of the body, where they might form new tumors (metastases). If this growth is not controlled, cancer might be fatal.



**APPROXIMATELY 2
IN 5 PEOPLE IN INDIANA**

now living will eventually have cancer. Suggesting that every resident will have a personal connection to cancer in some way.

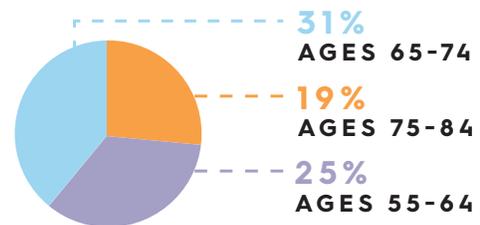


WHO GETS CANCER?

In Indiana, in 2017, **75% (74.6)** of all cancer cases were diagnosed among people ages 55–84.

Individuals who have been exposed to certain external and internal risk factors have an increased risk of developing cancer, such as male smokers, who are about 23 times more likely to develop lung cancer than nonsmokers.

Anyone can get cancer at any age; however middle-aged and older people are more likely to get cancer.¹



WHAT ARE THE MOST COMMON CANCERS?

The most commonly occurring cancers for both the state and the nation are the same. Excluding skin cancers, breast and lung (including bronchus) are the most prevalent cancers among males and females, respectively. Prostate (among men) and colorectal cancers (among both sexes) are the next most common cancers. Annually, lung cancer is responsible for the most cancer related deaths among both sexes.²



TOP CANCERS FOR INDIANA



- Lung & Bronchus
- Lymphoid & blood forming tissues
- Colorectal
- Breast
- Kidney & Urinary Bladder
- Prostate¹

WHAT YOU NEED TO KNOW: CONTINUED

HOW MANY PEOPLE IN INDIANA WILL GET CANCER?

- Nationally, men have nearly a **1 in 2** chance of developing cancer in their lifetime; for women, the lifetime risk of developing cancer is a little more than **1 in 3**.¹
- The American Cancer Society (ACS) estimated 37,940 new cancer cases in 2020. **Approximately 4 new cancer cases every hour of every day.**
- The ACS also estimated 3,630 cancer deaths in 2020. **Approximately 37 people every day.**
- These estimates did not include cases of basal and squamous cell skin cancers and in situ carcinomas (except for in situ urinary bladder cancer cases).

WHAT ARE THE COSTS OF CANCER?

- The overall costs of cancer care are rising. According to the American Cancer Society Cancer Action Network, approximately **\$183 billion** was spent in the U.S. on cancer related health care in 2015. This amount is projected to grow to **\$246 billion** by 2030—an increase of **34%**.²

HOW DOES CANCER INCIDENCE AND MORTALITY IN INDIANA COMPARE WITH THE REST OF THE US?

- Indiana's age-adjusted cancer incidence rate during 2017 was 434.8 per 100,000 people. This was lower than the 2017 national rate of 438.0 per 100,000 people.
- The national incidence rate (438) was higher than the Indiana rate (434.8 per 100,000 people).
 - However, the national mortality rate (153) was lower than the Indiana rate (170.4 per 100,000 people).
- Indiana's age-adjusted mortality rate was 17% higher than the national rate in 2017.
 - This included being **24%** higher among Indiana MALES (**205.8** versus **182** deaths per 100,000 males); and
 - **14%** higher among Indiana FEMALES (**145.1** versus **131** deaths per 100,000 females).³

IS THE CANCER BURDEN IN INDIANA LESSENING?

- In Indiana from 2008 to 2017:
 - Cancer incidence rates **decreased** from 484.1 to **434.8** new cases per 100,000 people.
 - Cancer death rates **decreased** from 194.4 to **170.4** deaths per 100,000 people.
- However, trends varied among the different cancer types.
- These statistics indicate that progress continues to be made in the early detection and treatment of certain cancers, and that the incidence and mortality of some cancers is declining. Even though the rate is going down, the number of new cases and deaths is going up. This happens because the size of our population is growing and aging each year.
- **A significant cancer burden still exists among Indiana residents that requires continued and more targeted cancer control efforts.**⁴

HOW DOES INDIANA TRACK CANCER RISK AND RISK BEHAVIOR DATA?

- The Indiana State Cancer Registry was established in 1987 to compile information on cancer cases and other related data necessary to conduct epidemiological studies of cancer and develop appropriate preventive and control programs. The data in this registry allows for the evaluation of cancer prevention efforts and the measurement of progress toward reaching the state goal of reducing cancer incidence and mortality among Indiana residents.
- Additionally, several data sources are used to describe the burden of risk factors (e.g., obesity) and cancer screening rates among Indiana residents. The Behavioral Risk Factor Surveillance System (BRFSS) is the main source utilized to do this because it provides yearly data that can be used to generate Indiana-specific estimates for a large number of cancer risk and preventative factors. Findings are tracked and compared to other states to monitor Indiana's progress.
- Many baseline and target measures established throughout this plan will be tracked using these two data sources.

Data Sources: (1) National Cancer Institute's Surveillance Epidemiology and End Results database (2) ACSAN The Costs of Cancer 2020 (3) U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2019 submission data (1999-2017): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; www.cdc.gov/cancer/dataviz, released in June 2020 (4) Indiana State Cancer Registry

CANCER DISPARITIES IN INDIANA

The National Cancer Institute defines "cancer health disparities" as adverse differences in cancer measures such as: incidence (new cases), prevalence (all existing cases), mortality (death), survivorship (including quality of life after cancer treatment), financial burden or related health conditions, screening rates, and stage at diagnosis. Cancer disparities can also be seen when outcomes are improving overall but the improvements are not seen in some groups relative to other groups. Population groups that may experience cancer disparities include groups defined by race/ethnicity, disability, gender identity, geographic location, income, education, age, sexual orientation, national origin, and/or other characteristics.

DIFFERENCES IN THE INDIANA CANCER BURDEN EXIST BY:

AGE

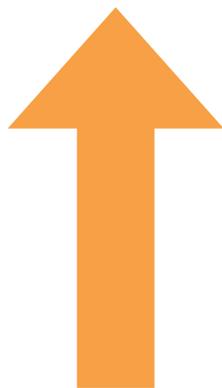
During 2017, nearly 75 (74.6) percent of all cancer cases were diagnosed among people ages 55 to 84.¹

RACE

During 2013 – 2017, the cancer incidence rate for whites was higher than the rate for African-Americans (461.1 vs. 453.7, respectively), but the African-American cancer mortality rate was higher than the rate for whites (195.0 vs. 175.7, respectively).¹

ETHNICITY

In the Hispanic/Latino community, cancer was the leading cause of death for females and the second leading cause of death for males in 2017. During 2013 – 2017, for all cancers combined, incidence and mortality rates were significantly lower among Hispanics than among non-Hispanics.¹



IN INDIANA
Death Rates from ALL
Cancers were
**17.4%
HIGHER**
than the US Rate in 2017.²

CANCER DISPARITIES

CONTINUED

Nationally, cancer health disparities are due to numerous complex factors, which can include inequalities in access to care, such as screening, treatment, or preventive services. People who are poor, lack health insurance, and have limited or no access to quality health care—regardless of ethnic and racial background—often bear a greater burden of disease than the general population.

BARRIERS THAT CONTRIBUTE TO CANCER HEALTH DISPARITIES IN INDIANA INCLUDE:

- Poverty is the largest contributing factor – According to the BRFSS, in 2018, higher education and income levels correlated with a higher likelihood that women aged 21-65 obtained a Pap test within the past three years, women aged 50-74 had a mammogram within the past two years, and adults aged 50-75 had a colorectal cancer screening that met the United States Preventive Services Task Force’s recommendation.
- Lack of health insurance or a personal doctor or health care provider – According to the 2018 Indiana BRFSS adults with healthcare coverage or a personal doctor/health care provider had significantly higher rates of cancer screenings than adults without coverage or a personal doctor.
- Socioeconomic status (income, education).
- Cultural values or beliefs regarding healthcare.
- Discrimination and social inequalities, including communication barriers and provider/patient assumptions.
- Geographic location, including travel distances and transportation to access care.

Cancer disparities can be eliminated if we focus on promoting health equity for everyone. The Centers for Disease Control and Prevention states that “health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.”



INDIANA CANCER CONTROL PLAN

2021 - 2022

The Indiana Cancer Control Plan 2021-2022 identifies the policies, changes, and actions required at all levels, from statewide to individual, to reduce Indiana’s cancer burden. The collaborative processes of the ICC are best reflected through the development and implementation of this plan. A targeted roadmap to coordinate cancer control efforts.

Over the course of 2020 the ICC utilized virtual meetings and statewide town halls to develop this plan. The ICC and its volunteer leadership brought together experts and key stakeholders in the fields of public health, cancer research, and treatment together to identify the most important strategies that, when implemented, can significantly impact cancer in Indiana. Four high-burden priorities in this augmented plan include strategies for action on tobacco use, colorectal cancer, breast cancer and HPV vaccination. This iteration also contains the baseline and updated measures, as well as updated strategies addressing objectives extended from the previous plan.

The emergence of COVID-19 has impacted cancer control. From the risk of infection for those undergoing treatment, to the use and availability of screenings, and the increased use of tele-health. According to the American Cancer Society, an estimated 22 million cancer screenings were cancelled or missed between March and June of 2020 alone. The onset of COVID-19 will remain a challenge to cancer control in 2021-2022.

Day by day, as more partners engage in strategies from this plan, extraordinary accomplishments are made. This is the power of our unique cancer control alliance.

TOGETHER, WE ARE STRONGER THAN CANCER

The Indiana Cancer Control Plan 2021-2022 builds on previous plans, and contains goals, objectives, measures, and strategic actions as defined below.

GOALS

			
GOAL	GOAL	GOAL	GOAL
PRIMARY PREVENTION	EARLY DETECTION	TREATMENT	SURVIVORSHIP
PREVENT Cancer from Occurring	INCREASE Guideline-Based Screening for Early Detection	PROMOTE Shared Decision-Making and Ensure Accessible and Evidence-Based Care	IMPROVE Quality of Life For All Those Affected By Cancer

INDIANA CANCER CONTROL PLAN CONTINUED

OBJECTIVES

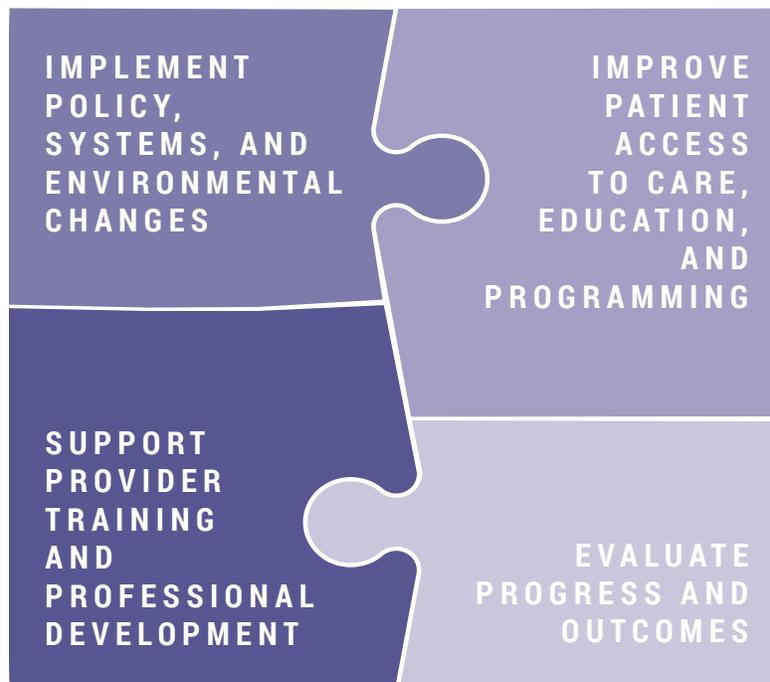
Objectives identify key priorities that will make the most significant impact on Indiana’s cancer burden. Each objective was developed and reviewed by subject matter experts who elevated priorities based on current research, achievability, equitability, effectiveness, and sustainability. There are 12 objectives extended from the 2018 to 2020 plan; however, as priority cancer control topics emerge and evidence increases, other objectives can be added. Most of the objectives are SMART (specific, measurable, attainable, relevant, and time-phased) objectives. However, formulating SMART objectives is not always possible, especially when baseline data is scarce or unavailable. These types of objectives exist throughout the plan and are identified as developmental objectives.

MEASURES

Measures present information to evaluate progress toward specific objectives. Objectives can have primary and secondary measures. If measures are to be identified at a later date, it will be noted. It is expected that each objective will be met by December 31, 2022.

STRATEGIC ACTION CROSS-CUTTING THEMES

Each objective is supported by evidence-based, best, or promising practices, which if implemented will drastically increase the likelihood of meeting the plan’s targets. Strategic actions are policies, programs, communications, interventions, or activities that are categorized by cross-cutting themes. The following identified cross-cutting themes are vital to improving cancer control efforts in each phase of the cancer continuum.



SUMMARY OF OBJECTIVES



GOAL PRIMARY PREVENTION

PREVENT

Cancer from Occurring

1. Increase the percentage of Indiana residents at a healthful weight.
2. Reduce the proportion of Indiana residents who use tobacco.
3. Reduce exposure to UV rays.
4. Increase completion rates of vaccines that have been shown to reduce cancer.
5. Reduce radon exposure.



GOAL EARLY DETECTION

INCREASE

Guideline-Based Screening for Early Detection

1. Increase rates of evidence-based cancer screening.



GOAL TREATMENT

PROMOTE

Shared Decision-Making and Ensure Accessible and Evidence-Based Care

1. Decrease variation in cancer treatments by improving adherence to evidence-based standards of care.
2. Increase participation in clinical trials.
3. Increase the number of updated advance care planning documents for all cancer patients.



GOAL SURVIVORSHIP

IMPROVE

Quality of Life For All Those Affected By Cancer

1. Increase the delivery of comprehensive, individualized survivorship care plans.
2. Decrease the number of reported unhealthy days among cancer survivors.
3. Improve healthy lifestyle behaviors of cancer survivors.

INFLUENCERS TO CONQUER CANCER

To achieve the greatest impact, the objectives and strategic actions recommended throughout this plan need support and engagement from relevant society influencers. Influencers are representatives from sectors of society that have a responsibility to implement these recommended cancer control activities. When working in concert, these influencers will accomplish the proposed targets set forth in this plan, and ultimately, reduce Indiana's cancer burden.

In an effort to lead our partners, the Indiana Cancer Control Plan 2021-2022 outlines influencers that can impact objectives throughout the plan. The list below provides a definition for each influencer.



HEALTH CARE ORGANIZATIONS AND PROVIDERS

Health care organizations and providers have a direct influence on the health and well being of Indiana residents. Health care professionals are trusted and have ample opportunities to promote quality, evidence-based cancer prevention, detection, treatment, and survivorship recommendations. Additionally, hospitals can find areas to improve internal systems and environments to foster stronger collaboration, professional development, and support for cancer patients, survivors, and caretakers.



PAYERS

Insurance partners and other payers, both on and off health exchanges, play a key role in providing access to health care services and other comprehensive cancer control and prevention strategies.



EMPLOYERS

Employers can play a pivotal role in the state of health in Indiana. From internal workplace processes to advocacy, employers have a significant opportunity to aid in cancer prevention, detection, and survivorship issues.



GOVERNMENT

Government agencies are responsible for protecting, maintaining, and improving public health. Reducing Indiana's cancer burden requires the implementation of policy and regulation change, as well as committed leadership from policy-makers and executive officers to join cancer prevention and control efforts. Legislators are key partners in the fight against cancer, as they enact laws that create the environment for healthy choice and change.



CIVIL SOCIETY AND COMMUNITY ORGANIZATIONS

Society and community organizations are often non-profits that can develop, advocate, and sustain policies or programming that will ultimately improve Indiana's cancer outcomes. Along with providing expert guidance, these organizations can represent the interest and needs of Indiana residents affected by cancer.



UNIVERSITIES AND SCHOOLS

Universities and schools have a dual role to play as effective health role models, as well as important partners in the research, policy and communications processes. Schools can enhance the learning of healthy behaviors by establishing good practices, as well as ensure that students and teachers work together to implement strong cancer prevention policies within local communities. They can provide evidence for effective cancer prevention interventions, impact structural change, and ensure research collaboration across institutions and partners, in order to fund innovative cancer-related research and broaden the evidence base for collective policy work. Schools and universities play an additional role in their continued education of medical and health professionals and are often on the cutting-edge of health education.



BIOPHARMACEUTICAL/BIOTECHNOLOGY INDUSTRY

The biopharmaceutical/biotechnology industry plays a critical role in multiple areas of cancer research and clinical care. Strong partnerships with academia and patient advocates work to drive the discovery and clinical development of new therapeutic and diagnostic options for cancer patients, improve access to clinical trials, enable access to investigational therapies, and provide medical education and support programs for approved therapies.



FAITH-BASE ORGANIZATIONS

Places of worship are natural centers for spiritual, emotional, and physical wellness. Spiritual leaders and communities can bring cancer-related education and resources to those in need.



MEDIA

Print, broadcast, digital, and mobile media play a key role in cancer awareness and education. Media channels can help improve the public's interest and knowledge by consistently covering cancer prevention and control issues.



INDIVIDUALS

Indiana residents should be advocates for their own health as well as the health of their families and colleagues. Together, the people of Indiana can influence significant change that will improve access to treatment, care, and healthier environments.



INDIANA'S PRIORITIES: TOBACCO USE

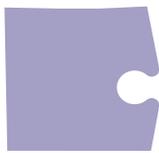
ADDRESSING PRIMARY PREVENTION OBJECTIVE 2

Reduce the proportion of Indiana residents who use tobacco.



IMPLEMENTING POLICY, SYSTEMS, AND ENVIRONMENTAL CHANGES CHANGES

- Advocate for an increase on the price on all tobacco products through a tax parity act and utilize funding to support the state tobacco control program.
- Advocate for state and local smoke-free air laws to promote tobacco free environments; protecting all Hoosiers from second-hand smoke where they work, live, and play.
- Promote the Indiana Tobacco Quitline by integration into EMR health care systems and through outreach efforts to service-related organizations, pharmacies, and employers.
- Promote utilization and implementation of the Indiana Cancer Control Plan for the purpose of incorporating tobacco cessation strategies to state agencies and organizations.



SUPPORTING PROVIDER TRAINING AND PROFESSIONAL DEVELOPMENT

- Enhance screening and treatment protocols of healthcare systems to identify tobacco users at least annually and at every visit, through multiple providers (i.e. pharmacists, certified tobacco treatment specialists, etc.).
- Increase access to and utilization of existing tobacco treatment education and training resources for health care providers.
- Encourage health plans, employers, and health insurance providers to provide best practice tobacco treatment as a health care benefit, including education around and access to pharmacotherapies.
- Promote access to space in healthcare facilities dedicated to tobacco treatment and counseling.



IMPROVING PATIENT ACCESS TO CARE, EDUCATION, AND PROGRAMMING

- Conduct counter-marketing, anti-tobacco campaigns for youth and marginalized communities.
- Encourage statewide school stakeholder organizations and youth-serving organizations to include tobacco prevention efforts in strategic planning, including state established resources.
- Encourage physicians and other healthcare professionals to discuss tobacco cessation practices with patients and refer patients to cessation resources including the Indiana Tobacco Quitline.
- Promote Indiana Tobacco Quitline utilization by educating providers, service-related organizations, and employers about Quitline referral practices.
- Integrate health equity language into all tobacco cessation communication and strategies.
- Promote tobacco cessation strategies among priority groups including African Americans, LGBT populations, pregnant women, Medicaid enrollees, mental illness and substance use disorders populations, individuals living in poverty; low level of education, individuals living with chronic disease, and Indiana's youth population.



EVALUATING PROGRESS AND OUTCOMES

- Maintain and promote surveillance systems to monitor and respond to related adult and youth tobacco use trends.

EMERGING TOPICS IN TOBACCO AND NICOTINE USE

THE IMPACT OF THE COVID-19 PANDEMIC

According to the CDC, current or former cigarette smokers, and those that vape nicotine increase their risk of severe illness from COVID-19. The virus that causes COVID-19 brings new risks for tobacco users as tobacco-related illnesses such as heart disease, stroke, lung cancer and other cancers are among the leading causes of death.¹ Tobacco cessation work is critical to the cancer sphere and must adapt to the current environment and needs while continuing to use evidence and data-based methods.

Despite the challenges presented by the pandemic, tobacco control remains a public health priority. Indiana is one of the 13 states in the tobacco nation (a collection of U.S. states in the South and Midwest with smoking rates that exceed the national average) that has the highest smoking prevalence (top 25%) in the country.² According to the Indiana Department of Health Tobacco Prevention and Cessation Commission, approximately 19.2% of Hoosiers currently smoke and over half of current smokers (52.9%) attempted to quit in the last 12 months (2019 BRFSS). In addressing this public health priority, Indiana must remain vigilant and reinforce the necessity of state-wide collaboration to strengthen previous and implement new methods of tobacco cessation and prevention efforts –including the utilization of the Indiana Tobacco Quitline, virtual and text messaging resources, tobacco treatment specialists, pharmacy cessation integration, and telehealth services.

The CDC Office of Smoking and Health created the “Tobacco Control Vaccine” concept to easily address the evidence-based strategies of tobacco prevention and cessation. Elements include: continuous hard hitting media campaigns, cessation access (or no barriers to treatment), smoke-free environment policies, and tobacco price increases. Additionally, the “vaccine” is supplemented with an increased focus on point-of-sale strategies that target access and exposure to tobacco products. This tobacco control vaccine must be fully implemented as we address the epidemic of tobacco use in Indiana.³

HEALTH EQUITY

Achieving health equity requires valuing everyone equally with focused and ongoing efforts to address avoidable inequities, historical and contemporary injustices, and the elimination of health and healthcare disparities. When fully integrated into a tobacco control program, cultural competence increases a program’s ability to develop, implement, and evaluate policies to reduce tobacco-related disparities.

CDC’s Best Practices defines tobacco-related disparities as: “Differences that exist among population groups with regard to key tobacco-related indicators, including patterns, prevention, and treatment of tobacco use; the risk, incidence, morbidity, mortality, and burden of tobacco related illness; and capacity, infrastructure, and access to resources; and secondhand smoke exposure.”⁴

There are differences in rates of smoking among specific priority populations. The prevalence of smoking among African Americans in Indiana (19.6%) is higher than the smoking prevalence among whites and Hispanics and higher than the overall Indiana adult smoking rate of 19.2% (2019 BRFSS). Additionally, Indiana adults in the younger age groups (18-24 years and 25-34 years) are using e-cigs at much higher rates (17.5% and 11.8%) than those 35 and older (5.1%, 4.6%, 4.6%, and 1.5%) (2018 BRFSS). Considering health equity, priority areas in Indiana’s tobacco prevention and cessation include:

- African Americans
- LGBT Population
- Pregnant Women
- Medicaid Enrollees
- Mental Illness and Substance Use Disorders
- Individuals Living in Poverty; Low Level of Education
- Individuals Living with Chronic Disease
- Youth Population (E-cigarette focus)

Being cognizant of priority populations in Indiana is important in tailoring evidence-based strategies in effort to reduce disparities and increase health equity among Indiana residents.





INDIANA'S PRIORITIES: HUMAN PAPILLOMAVIRUS VACCINATIONS

ADDRESSING PRIMARY PREVENTION OBJECTIVE 4 Increase completion rates for vaccines that have been shown to reduce cancer.



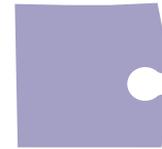
IMPLEMENTING POLICY, SYSTEMS, AND ENVIRONMENTAL CHANGES CHANGES

- Support communication around inclusion of HPV vaccination as part of the vaccination regime for students entering sixth grade.
- Achieve insurer-based incentives for providers who increase their adolescent vaccine completion outcomes to achieve a 95% adolescent vaccination rate in their patient populations.
- Implement provider vaccination reminders into EMR systems as well as patient reminder/recall systems to improve vaccination series completion.
- Advocate for the use of evidence-based reminder recall messaging to increase HPV vaccination completion.
- Advocate for pharmacy-based opportunities to offer HPV vaccinations.



IMPROVING PATIENT ACCESS TO CARE, EDUCATION, AND PROGRAMMING

- Achieve a standing order allowing for all adolescent vaccinations to be covered in non-traditional settings by insurers, Medicaid, Vaccines for Children (VFC), etc. (example settings: pharmacies and schools).
- Improve access to HPV vaccination through programs that bring vaccination to schools and organized child-care settings.
- Conduct educational campaigns to increase public awareness of the link between HPV and cancer and opportunities to access vaccination.
- Collaborate and partner with alternative community groups to increase male vaccination rates.



SUPPORTING PROVIDER TRAINING AND PROFESSIONAL DEVELOPMENT

- Target HPV vaccination communication messaging to pediatricians and family practices who report adolescent vaccinations but not HPV.
- Offer HPV vaccine continuing medical education for primary care, family medicine, obstetrics, oral health, and advanced practice health care providers.
- Encourage public and private insurers to incentivize physicians who complete the entire adolescent vaccine regime (including HPV).
- Encourage clear communication from doctors, nurses, pharmacists and other health care professionals about the negative health impact of HPV infection and the importance of the HPV vaccine to cancer prevention.
- Encourage health care professionals to routinely and strongly recommend HPV vaccination as part of the adolescent vaccination platform at ages 11-12 years (MCV4, HPV, Tdap, and Influenza vaccines).
- Educate oral health providers on how to communicate with parents about HPV vaccination as a preventive measure for cancer at routine cleanings.
- Utilize targeted vaccination messaging to providers and parents in the geographic areas with low vaccination uptake.
- Encourage immediate postpartum vaccination as an opportunity to capture populations with health coverage.



EVALUATING PROGRESS AND OUTCOMES

- Issue a "Cancer Vaccine Report Card" for Indiana with focus on cancer-causing vaccines for preventable diseases (Hep B and HPV).
- Promote the use of data from national surveillance systems.
- Promote data transparency to help providers become aware of their vaccination rates.

EMERGING TOPICS IN HPV VACCINATIONS

THE IMPACT OF THE COVID-19 PANDEMIC

Prior to the COVID-19 pandemic, HPV vaccine series completion rates in Indiana were well-below the national average.¹ The COVID-19 pandemic has significantly interfered with delivery of routine pediatric and adolescent care. Thus, adversely affecting vaccine coverage, particularly for adolescent vaccines routinely recommended as part of the 11-12 year old platform.^{1,2} In Indiana, Tdap, MenACWY, and HepA vaccines are all required for entry into middle school, providing a mechanism for assuring a return to pre-pandemic coverage levels for these vaccines. However, with HPV vaccine not a requirement for Indiana middle school entry, there is a risk that many young adolescents will remain unvaccinated against HPV infection, leaving them vulnerable to later development of HPV cancers, such as cervical, anal, and oropharyngeal cancers. These concerns are well-delineated in a recent commentary published in *Journal of Adolescent Health*.³ As noted in this article, because HPV vaccine is not a required vaccine, clinics and health systems may deprioritize HPV vaccination when efforts are made to improve coverage of other vaccines affected by the COVID-19 pandemic.⁴

Now more than ever it is important to ensure that we make every effort to return to pre-pandemic rates of HPV vaccine administration – and strive to improve upon those rates. Given the disruptions of the ongoing pandemic, we should consider implementation of multiple strategies to get HPV vaccination back on track:

- Encourage clinicians and other clinic personnel to strongly recommend HPV vaccine when eligible young adolescent are administered vaccines required for school-entry;
- Encourage clinics and health systems to implement policies to help to ensure delivery of HPV vaccination (e.g., standing orders and benchmarks);
- Encourage parents to make use of alternative venues for HPV vaccination, such as pharmacies; and
- Use the state's Immunization Information System (IIS) to generate and send out reminder prompts to parents/guardians regarding HPV vaccine initiation and series completion.

HEALTH EQUITY

Barriers to vaccination, in general, fall into three major categories: access to care, financial concerns, and lack of medical trust or understanding. These three factors are often entangled, making it difficult to pinpoint straightforward solutions. Nationwide, HPV vaccine disparities are seen in small cities and non-metropolitan areas, as well as specific ethnic groups such as Native Americans. Factors such as limited healthcare facilities and inconvenient operating hours contribute to this. Financial concerns also play a role, especially for those without health insurance. One of the most successful methods to address these issues includes school-based vaccination clinics, which are a convenient method to vaccinate large numbers of adolescents at one time. These clinics often result in high vaccine uptake and completion rates. In a different vein, the demographic most likely to refuse vaccines due to lack of medical trust or understanding are white, middle- to upper-class families who make more than \$75,000 annually. The most successful intervention for this group includes well-trained medical professionals who provide a strong recommendation for vaccines.

[1] Elam-Evans LD, Yankey D, Singleton JA, et al. National, Regional, State, and Selected Local Area Vaccination Coverage Among Adolescents Aged 13-17 Years - United States, 2019. *MMWR Morb Mortal Wkly Rep* 2020;69:1109-1116.

[2] Hart C. The Effect of COVID-19 on Immunization Rates. Available at: <https://chipsblog.pcc.com/the-effect-of-covid-19-on-immunization-rates> Accessed December 4, 2020.

[3] Gilkey MB, Bednarczyk RA, Gerend MA, et al. Getting Human Papillomavirus Vaccination Back on Track: Protecting Our National Investment in Human Papillomavirus Vaccination in the COVID-19 Era. *J Adolesc Health* 2020;67:633-634.

[4] AMGA. COVID-19 Pulse Survey Results. Available at: <https://www.amga.org/performance-improvement/covid-19/pulse-surveys/vaccination/> Accessed December 4, 2020.



INDIANA'S PRIORITIES: COLORECTAL CANCER

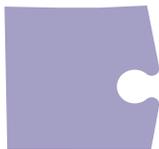
ADDRESSING OBJECTIVES ACROSS THE CONTINUUM OF CARE

Primary Prevention, Early Detection, Treatment, and Survivorship.



IMPLEMENTING POLICY, SYSTEMS, AND ENVIRONMENTAL CHANGES CHANGES

- Encourage healthcare systems to initiate colorectal (CRC) screening campaigns.
- Reduce barriers to screening such as financial costs, transportation, and others created by COVID-19.
- Advocate for policy coverage and increased grant support for CRC screening which facilitates patients undergoing subsequent testing as indicated.
- Advocate for increased insurance coverage for stool-based testing.
- Utilize telehealth platforms to enhance patient connection during surveillance and survivorship.
- Work to promote and support the efforts of healthcare providers and health systems to meet national standards on accreditation, certification, and other recognition for the complex colon and rectal cancer cases.



SUPPORTING PROVIDER TRAINING AND PROFESSIONAL DEVELOPMENT

- Educate providers and staff on all evidence-based screening options for colorectal cancer and recommendations from the United States Preventive Services Task Force and American Cancer Society.
- Educate providers about the effectiveness of stool-based tests for those at low to moderate risk of developing CRC.
- Educate providers and staff on financial resources to share with patients to better navigate financial toxicity associated with treatment.
- Provide educational opportunities focusing on minority populations (African American, LGBTQ+) with high incidence rates.
- Encourage intra- and inter-network access to multidisciplinary tumor board conferences.



IMPROVING PATIENT ACCESS TO CARE, EDUCATION, AND PROGRAMMING

- Increase awareness and accessibility of alternative testing, including less invasive and expensive screening options.
- Provide focused education to underrepresented populations through community partnerships.
- Utilize small and large media and personal messaging campaigns to promote CRC screening options.
- Inform cancer patients about the availability, purpose, and the potential benefits and risks of clinical trials.
- Promote patients to inquire about financial assistance programs and assist patients with reduction of financial toxicity for cancer treatment.
- Improve the quality of life for cancer survivors by providing referrals to services that address socioeconomic (insurance, physical, social, and emotional) needs.
- Provide tools and resources that facilitate culturally competent conversations about advance care and survivorship care planning.



EVALUATING PROGRESS AND OUTCOMES

- Advocate for development of improved CRC personal risk assessment to enhance risk-based screening and surveillance.
- Develop systems to track screening rates.
- Promote development of biomarkers that are CRC specific to improve patient outcomes.
- Develop improved survivorship tracking measures to impact patient outcomes for this phase of cancer patient care.

EMERGING TOPICS IN COLORECTAL CANCER

THE IMPACT OF THE COVID-19 PANDEMIC

There is a prevailing opinion that a colonoscopy is the gold standard when screening patients for colorectal cancer (CRC). While a colonoscopy is a widely recognized tool in the CRC screening toolkit, it is possible that the central focus on this has created a “one size fits all” approach to CRC screening. The difficulty in holding colonoscopies as the gold standard is a limitation of access to alternative approaches. Ideally, the best test for CRC screening is the one a patient can access and best fits their unique needs.

The most recent Indiana BRFSS data (2018) shows a minimal increase in CRC screening activity since its last reporting period. However, the target for CRC screening using sigmoidoscopy or colonoscopy remains at 80% for adults aged 50-75 who have had a colonoscopy, flexible sigmoidoscopy, or blood stool test within the appropriate time frame. In 2016, only 64.6% of Indiana residents participated in any form of CRC screening and in 2018 it was 67.9%. For those having a blood stool test within the past 2 years the rate was 8.8% and the target is 10.4%.

Considering cancer screening, it is critical to address the impact of the COVID-19 pandemic on Colorectal Cancer. When reviewing the impact of COVID-19, the following information was found:

- An estimated 90% drop in colonoscopies and biopsies in March through mid-April compared to the same period in 2019.
- 1.7 million missed colonoscopies estimated from March to June 5. 18,000 missed or delayed diagnoses of colorectal cancer from mid-March through early June.
- 4,500+ excess deaths from CRC over next decade.

All approaches to CRC screening are equally important. We should ensure that barriers to screenings are reduced. Options for stool screening tests (FIT Test or DNA), which can be done at home, are becoming easier to access and more common due to COVID-19. There are behavioral, cultural and socioeconomic factors which impact CRC screening as well. Increasing CRC screening will require overcoming a variety of barriers and the continued impact of the pandemic. Consideration must be put into using multiple screening modalities, employing greater use of non-invasive testing (in-home stool tests), and increasing organized screening events, rather than relying on individual provider recommendations.

SCREENING RECOMMENDATIONS

On October 27, 2020 The United States Preventive Services Task Force (USPSTF) published draft guidelines recommending that colorectal cancer screening begin at 45 years of age for average-risk individuals, a shift from the current USPSTF guidelines that recommend beginning at age 50. This was in direct response to the increase in incidence of early age onset colorectal cancer and aligns with the American Cancer Society's 2018 recommendation that screening begin at age 45. It is important to note that the USPSTF CRC screening recommendations are still in draft form. Insurance will not cover the change in guidelines and clinicians may not recommend screening for those under age 50 until the guidelines are finalized. Recommendation details and evidence supporting this change can be found at <https://www.uspreventiveservicestaskforce.org/uspstf/draft-recommendation/colorectal-cancer-screening3>.

For people at average risk for colorectal cancer, the American Cancer Society recommends starting regular screening at age 45. People at average risk have no family history of colorectal cancer and no conditions that increase their risk for the disease. Screening can be done either with a stool-based test (fecal immunochemical test or Cologuard) or with a direct exam that looks at the colon and rectum (colonoscopy). No matter which test a person chooses, the most important thing is to get screened. ACS's full screening recommendations can be found at cancer.org.

HEALTH EQUITY

As with many health conditions, racial and ethnic disparities exist with colorectal cancer, with African Americans having higher incidence and mortality rates of the disease. African Americans tend to also be diagnosed at more advanced stages. The cause of this is multifactorial, with patient, provider and systemic factors playing a role. Additionally, African Americans are more likely to be impoverished, un- or underinsured and have lower levels of education. This matters as studies have consistently shown that all individuals with lower socioeconomic status, who lack insurance and who have lower levels of educational attainment are more likely to be diagnosed with colorectal cancer than those lacking these disadvantages.



INDIANA'S PRIORITIES: BREAST CANCER

ADDRESSING OBJECTIVES ACROSS THE CONTINUUM OF CARE Primary Prevention, Early Detection, Treatment, and Survivorship.



IMPLEMENTING POLICY, SYSTEMS, AND ENVIRONMENTAL CHANGES CHANGES

- Reduce structural and personal barriers (availability, operational hours, finances, time, etc.), especially barriers presented by COVID-19.
- Increase the implementation of evidence based strategies and quality improvement efforts, including but not limited to patient and provider reminders, patient education, patient navigation, small media and small group education.
- Promote and support the efforts of health care providers and health systems to meet national standards on accreditation, certification, and other recognition.
- Promote recruitment of eligible breast cancer patients for clinical trials in Indiana.
- Advocate for benefits, payment policies, and reimbursement mechanisms to facilitate coverage for evidence-based aspects of care and care plan services.
- Design benefits, worksite policies, payment plans, and reimbursement mechanisms to facilitate coverage for evidence-based aspects of cancer care and care plan services.
- Advocate for funding to support systems to track, measure, and evaluate adherence to key performance standards and effectiveness of programs.



SUPPORTING PROVIDER TRAINING AND PROFESSIONAL DEVELOPMENT

- Educate providers to address racial and socioeconomic disparities surrounding breast cancer mortality, stage of diagnosis, diagnostic testing, and age of diagnosis.
- Collaborate with Indiana's breast cancer awareness organizations to promote existing resources data bases throughout Indiana and increase the utilization of these resources by providers, patients, and survivors.
- Promote informed and shared decision making between providers and patients about the benefits, risks, and options for breast cancer screening and treatment.
- Utilize integrated multidisciplinary team-based care for breast cancer patients and survivors.
- Expand breast cancer screening by individualizing outreach efforts to Indiana's unique community populations.
- Promote utilization of survivorship care plans that are user-friendly for both providers and survivors.



IMPROVING PATIENT ACCESS TO CARE, EDUCATION, AND PROGRAMMING

- Promote education, increased and affordable screening, and diagnostic testing among low-income, uninsured, and underinsured women with an emphasis on reaching minority populations by race/ethnicity, age, and geographic location.
- Expand access to telehealth services in rural areas, low income areas, and those with limited technology.
- Increase knowledge of survivorship issues for the general public, cancer survivors, health care professionals, and policy makers.
- Conduct culturally competent campaigns to disparate populations to increase awareness of the risks of breast cancer, benefits of early detection, and breast cancer screenings options based upon personal risk factors.
- Utilize preventive services campaigns including how providers have made it safe to get screened during COVID-19.
- Promote referrals to evidence-based smoking cessation, rehabilitation, and mental health, and nutrition and physical activity support services throughout the continuum of care.
- Inform cancer patients about the availability, purpose, and the potential benefits and risks of clinical trials.



EVALUATING PROGRESS AND OUTCOMES

- Develop systems to track, measure, and evaluate adherence to key performance standards for non-CoC accredited hospitals.
- Support surveillance systems that increase the use and quality of data.
- Recognize state-based cancer researchers and clinical trial initiatives.
- Develop quality improvement measures to assess baseline rates of end of life care planning.



EMERGING TOPICS IN BREAST CANCER

THE IMPACT OF THE COVID-19 PANDEMIC

The COVID-19 pandemic has significantly impacted breast cancer screening, diagnosis, treatment, and follow-up. The first wave of COVID-19 in March 2020 caused widespread changes and delays in breast cancer care. In an effort to conserve personal protective equipment, hospital resources, and medical staff, breast cancer reconstruction surgeries were postponed for months and screenings were canceled. Patients with hormone-receptor positive breast cancer who had to wait weeks or months for a mastectomy or lumpectomy were given hormonal therapy, chemotherapy, or targeted therapies in the meantime to help slow or stop the growth of cancer. Furthermore, patients undergoing chemotherapy are immunocompromised and at considerably higher risk of contracting COVID-19 and developing serious complications. Across the board, COVID-19's effect on breast cancer care adds additional anxiety and uncertainty to an already arduous journey.

Although it remains unknown how surges in COVID-19 cases will affect breast cancer treatment and screenings moving forward, the healthcare system is better equipped to handle future spikes in COVID-19 cases without the same disruptions to cancer treatment seen during the early months of the pandemic. Despite the delays in screening and treatment, some positive changes have emerged. Shorter hospital stays, increasing the use of telehealth appointments, staggering appointment times to reduce wait times for blood tests or injections, and organizing curbside clinics are changes that ultimately benefit patients.

HEALTH EQUITY

Since the 1980s breast cancer late-stage diagnosis and mortality rates have declined for U.S. women; however, breast cancer continues to have a substantial disparate impact on Black women. In Indiana, Black women have a slightly higher incidence rate and a significantly higher mortality rate than White women. Additionally, Black women are at increased risk for poor breast cancer outcomes due to being diagnosed at a younger age, being diagnosed in the regional or distant disease stage and being diagnosed with more aggressive types of breast cancer, like triple negative breast cancer.

Other possible causes behind these disparities are multi-factorial, including: unfavorable tumor characteristics, higher prevalence of obesity and other health conditions, less access to high-quality prevention, early detection, and treatment and longer intervals between mammograms and between abnormal results and follow-up and differences in treatment adherence. Early conclusions from qualitative studies conducted by Indiana researchers indicate poor interactions with healthcare providers and cultural attitudes and religious beliefs may also be contributing factors.

Despite the continuing racial/ethnic disparities in Indiana and other states, some cities have reversed the trend by implementing community-centered interventions that take into account the wide spectrum of factors leading to disparity. To narrow or eliminate the disparity gap, Indiana should promote and support efforts to:

- Improve screening and treatment adherence for Black women.
- Improve access to timely and affordable diagnostic breast services for Black women.
- Support and fund patient navigators to assist across the breast health continuum of care.
- Address the biological differences in breast cancer among ethnic/racial groups by funding more research and clinical trials that encompass a more diverse patient population.
- Explore and utilize different screening and risk reduction options for Black women as an alternative to screening guidelines for the general population.

MEASURES



GOAL PRIMARY PREVENTION

OBJECTIVE 1:

Increase the percentage of Indiana residents at a healthful weight.

ADULTS

At a healthful weight

BASELINE 31.0%

TARGET 35.3%

ACTUAL 2019 28.8%

YOUTH (10-17)

At a healthful weight

BASELINE 60.3%

TARGET 70.4%

ACTUAL 2019 54.7%

Data Sources: 2016/2019 Behavioral Risk Factor Surveillance System (BRFSS); 2016/2019 National Survey of Children's Health

OBJECTIVE 2:

Reduce the proportion of Indiana residents who use Tobacco.

ADULTS

Who use cigarettes

BASELINE 21.1%

TARGET 18.0%

ACTUAL 2019 19.1%

Who use other tobacco products

BASELINE 4.1%

TARGET 1.7%

ACTUAL 2019 4.6%

YOUTH (13-17)

Current smoking among High School youth

BASELINE 8.7%

TARGET 5.0%

ACTUAL 2018 4.3%

Using Non-Combustible

BASELINE 6.4%

TARGET 3.5%

ACTUAL 2018 20.2%

Using Combustible

BASELINE 14.4%

TARGET 10.0%

ACTUAL 2018 10.1%

Use of e-cigarettes among High School youth

BASELINE 10.5%

TARGET 7.0%

ACTUAL 2018 18.5%

Data Sources: 2016/2019 BRFSS; Indiana Youth Tobacco Survey, 2016/2018

OBJECTIVE 3:

Reduce exposure to UV rays.

ADULTS

Who protect their skin from the sun when spending time outdoors

BASELINE DEVELOPMENTAL

TARGET DEVELOPMENTAL

Who use indoor tanning device in last 12 months

BASELINE DEVELOPMENTAL

TARGET DEVELOPMENTAL

YOUTH (13-17)

Who wear sunscreen most of the time

BASELINE 8.4%

TARGET 11.2%

Who engage in indoor tanning.

BASELINE DEVELOPMENTAL

TARGET DEVELOPMENTAL

Data Sources: 2016 BRFSS; 2015 Youth Risk Behavioral Surveillance System

OBJECTIVE 4:

Increase completion rates for vaccines that have been shown to reduce cancer.

FEMALES (13-17)

HPV Vaccination

BASELINE 43.5%

TARGET 80.0%

ACTUAL 2019 41.5%

MALES (13-17)

HPV Vaccination

BASELINE 24.7%

TARGET 80.0%

ACTUAL 2019 40.9%

MALES & FEMALES (19-35MO)

Hep--B Vaccination

BASELINE 94.5%

TARGET 99.5%

ACTUAL 2018 92.1%

Data Sources: Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, 2017/2018; National Immunization Survey, 2016/2019

OBJECTIVE 5:

Reduce radon exposure.

Number of homes tested for Radon

BASELINE 17,150

TARGET 25,109

ACTUAL 2019 16,535

Percentage of homes that test ABOVE/EQUAL to 4.0 pCi/L that get Mitigation

BASELINE 27.5%

TARGET 44.3%

ACTUAL 2019 12.9%

Data Sources: Indiana Department of Health Environmental Public Health Division 2015/2019



GOAL EARLY DETECTION

OBJECTIVE 1:

Increase rates of evidence-based cancer screening.

BREAST

FEMALES (50-75)

Who have had a mammogram in the past two years

BASELINE 72.5%

TARGET 81.1%

ACTUAL 2018 76.6%

CERVICAL

FEMALES (21-65)

Who have had a pap test within the last three years

BASELINE 74.9%

TARGET 93.0%

ACTUAL 2018 80.6%

COLORECTAL

ADULTS (50-75)

Who have had a colonoscopy, flexible sigmoidoscopy, or blood stool test within the appropriate time frame

BASELINE 64.6%

TARGET 80.0%

ACTUAL 2018 67.9%

LUNG

ADULTS (55-80)

Who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years

BASELINE DEVELOPMENTAL

TARGET DEVELOPMENTAL

ACTUAL 2018 DEVELOPMENTAL

Data Sources: 2016/2018 BRFSS



GOAL TREATMENT

OBJECTIVE 1:

Decrease variation in cancer treatment by improving adherence to evidence-based standards of care.

INDIANA AS A WHOLE

Percent of CoC Hospitals that meet or exceed standards met in scorecard

BASELINE 78.6%

TARGET 100%

Percent of Non-CoC Hospitals that meet or exceed standards met in scorecard

BASELINE DEVELOPMENTAL

TARGET DEVELOPMENTAL

Data Sources: CoC National Cancer Database, Cancer Program Practice Profile Reports, 2014

MEASURES CONTINUED

OBJECTIVE 2:

Increase participation in clinical trials.

Participation in clinical trials

BASELINE 6.2%

TARGET 10.0%

ACTUAL 2018 3.9%

Data Sources: 2016/2018 BRFSS

OBJECTIVE 3:

Increase the number of updated advance care planning documents for all cancer patients.

Number of updated advance care planning documents

BASELINE DEVELOPMENTAL

TARGET DEVELOPMENTAL



GOAL SURVIVORSHIP

OBJECTIVE 1:

Increase the delivery of comprehensive, individualized survivorship care plans.

Delivery of survivorship care plans

BASELINE 32.9%

TARGET 75.0%

ACTUAL 2018 41.0%

Data Sources: 2016/2018 BRFSS

OBJECTIVE 2:

Decrease the number of reported unhealthy days among cancer survivors.

SURVIVORS

Who had the same or fewer poor mental health days over the past 30 days as people without cancer

BASELINE 76.4%

TARGET 82.6%

ACTUAL 2019 77.6%

Who had the same or fewer poor physical health days over the past 30 days as people without cancer

BASELINE 62.2%

TARGET 72.0%

ACTUAL 2019 57.5%

Data Sources: 2016/2019 BRFSS

OBJECTIVE 3:

Improve healthy lifestyle behaviors of cancer survivors.

SURVIVORS

At a healthful weight

BASELINE 28.0%

TARGET 37.6%

ACTUAL 2019 23.8%

Who currently use cigarettes

BASELINE 21.3%

TARGET 10.1%

ACTUAL 2019 18.8%

Data Sources: 2016/2019 BRFSS

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IN_CANCER