THE
ARKANSAS
CANCER
COALITION

ARKANSAS CANCER PLAN

A FRAMEWORK FOR ACTION

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Arkansas Cancer Coalition

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THE ARKANSAS CANCER PLAN

Executive Summary

Cancer is a devastating disease – in fact it is a group of 100 different diseases. The most common cancers in Arkansas are lung, prostate, breast, colorectal, and skin. One in every two men and one in every three women in Arkansas will be diagnosed with cancer during their lifetime. The impact on cancer patients, on their families, and on their communities is immeasurable. According to the Cancer Facts & Figures for 2007 from the American Cancer Society, 6,240 Arkansans will die from cancer in 2007. The economic, psychological and social costs are staggering.

Recognizing the need to dramatically impact the cancer burden, the Arkansas Cancer Coalition, Arkansas' statewide comprehensive cancer control partnership, has updated the Arkansas Cancer Plan. The new plan reflects emerging needs, new issues in cancer prevention, detection and care, and an enhanced understanding of the process, an understanding that has been gained from years of experience working with stakeholder organizations in the state.

After many months of discussion, review of the science, and reflection on past successes, it remains clear that the burden of cancer in Arkansas can be dramatically reduced if evidence-based practices in prevention, early detection, and care are made available to all Arkansans. Thus, the goal of the Arkansas Cancer Plan is to coordinate and advance specific, proven cancer control strategies across the state by putting into practice, goals and objectives in the following areas:

- Prevention
- Screening and Detection
- Treatment
- Cancer Disparities
- Clinical Trials
- Healthcare Workforce Development
- Survivorship
- Palliative Care
- Professional Education
- Surveillance and Reporting
- Evaluation

The purpose of the Arkansas Cancer Plan is to serve as an outline for what can and should be done at the state and local levels for cancer prevention, detection, and care efforts in Arkansas. It identifies activities for coordinated action by government, the private sector, the non-profit sector, Arkansas' communities and people. This Plan is a living document – published in a loose-leaf binder for easy updating, and will serve as a guide for individuals and organizations in the fight against cancer.

CHAPTER 1

PREVENTION

I. Decrease Tobacco Use and Exposure to Tobacco Smoke

Background

Smoking remains the most preventable cause of death in our society. Since the first Surgeon General's report on smoking and health was published in 1964, there have been more than 12 million premature deaths attributable to smoking in the United States.[1] Worldwide in 2000 alone, about 4.8 million smoking-related premature deaths occurred.[2]

Each year, smoking accounts for an estimated 438,000 premature deaths; 38,000 deaths in nonsmokers as a result of exposure to secondhand smoke; and $167 billion in healthcare expenditures and productivity losses. Smoking is a significant contributing factor for an estimated one third of all cancer deaths.[3]

A recent US Surgeon General's report on reducing tobacco use outlined the goals and components of comprehensive statewide tobacco control programs.[4] The goal of comprehensive tobacco control programs is to reduce disease, disability, and death related to tobacco use by 1) preventing the initiation of tobacco use among youth, 2) promoting quitting among young people and adults, 3) eliminating nonsmokers' exposure to secondhand smoke, and 4) identifying and eliminating the disparities related to tobacco use and its effects among different population groups.[5] The Centers for Disease Control and Prevention (CDC) has recommended funding guidelines for comprehensive tobacco use prevention and cessation programs for all 50 states and the District of Columbia. In 2004, only four states (Arkansas, Delaware, Maine, and Mississippi) invested at least the minimum per capita amount recommended for tobacco control programs.[6]

The Arkansas Department of Health's Tobacco Prevention and Cessation Branch (TPCB) has adopted the CDC's Best Practices, and continues to search for effective methods to address health disparities in Arkansas. Collaborative efforts have occurred between TPCB, the Arkansas Department of Health (ADH) Office of Minority Health and the University of Arkansas at Pine Bluff (UAPB) Minority Sub-recipient Grant Office. These efforts will continue to address effective ways to reach population groups who are disparately affected by tobacco. To prevent initiation, the Arkansas Tobacco Control Board will continue to conduct compliance checks and educate merchants on how to be in compliance with the state law. School-based programs will continue to work within schools to strengthen their infrastructure by implementing evidence-based curricula, implementing and enforcing comprehensive school policies, and using media to disseminate anti-tobacco messages.

The major focus has been eliminating secondhand smoke by educating our community programs on the effectiveness of clean indoor air, and promoting and providing cessation services by having an extensive media campaign to promote the quitline. Efforts to go "smoke-free" in a statewide movement have been largely successful and now the focus is shifting to education and enforcement of Arkansas' Clean Indoor Air Law. (Appendix A)

Figure 1: Tobacco Use in Arkansas 2005

Adult Smokers / Youth Tobacco Use	23.7%[7]
Ever tried cigarette smoking	63%
Smoked cigarettes during past month	26%
Smoked cigarettes on greater than or equal to 20 days during the past month	13%
Used smokeless tobacco during the past month	14%
Smoked cigars during the past month[8]	18%

Hometown Health Initiative Blueprint –
Fast Facts on Tobacco Use

- Men who smoke increase their risk of death from lung cancer by more than 22 times and from bronchitis and emphysema by nearly 10 times.
- Women who smoke increase their risk of dying from lung cancer by nearly 12 times and the risk of dying from bronchitis and emphysema by more than 10 times.
- Smoking triples the risk of dying from heart disease among middle-aged men and women.
- Annually, exposure to secondhand smoke causes an estimated 3,000 deaths from lung cancer among American adults. Scientific studies also link secondhand smoke with heart disease.
- Nearly 70% of the 46.5 million American adults who smoke cigarettes want to quit, but few are able to quit permanently without help.[9]

Disparate Burden

There is a disparate burden of tobacco use by race. African American males have the highest smoking rate (27.0 percent in 2002) of all racial/ethnic groups surveyed in the US. African American females reported smoking at a rate of 18.5 percent in 2002. The white male smoking rate in 2002 was 25.2 percent and 20.7 percent for females.

For more than a decade, African American youth have had the lowest prevalence of cigarette smoking compared with other racial and ethnic groups. According to the Youth Risk Behavior Surveillance Survey (YRBSS), the prevalence of current cigarette smoking among African American high school students increased between 1991-1997 and then decreased until 2001. As of 2005, 14.0 percent of African American boys and 11.8 percent of African American girls smoke cigarettes.

In 2001, approximately 22.8 percent of all adults in the US were current smokers; among Hispanic adults, 16.0 percent were identified as current cigarette smokers.[10] In 2001, Hispanic female youths smoked at a rate of 26.0 percent and Hispanic male youths smoked at a rate of 27.2 percent. Also in 2001, the proportion of students who had tried cigarette smoking, at least for one or two puffs, was similar between Hispanics (69.3 percent) and white non-Hispanics (64.8 percent). However, only 7.3 percent of the Hispanic youths smoked cigarettes frequently, while 17.2 percent of the white non-Hispanic youths reported frequent smoking.[11]

Lung cancer disproportionately affects some population subgroups. An estimated 19,180 cases of lung cancer were expected to occur among African Americans in 2005, accounting for about 14 percent of cancer diagnoses in this group. The average incidence rate of cancers of the lung and bronchus during 1997-2001 was 47 percent higher in African American men than in white men. Lung cancer deaths between 1997-2001 was 36 percent higher in African Americans compared to whites.

Because of lower smoking rates, lung cancer rates were 50 percent lower in Hispanic adults than those in non-Hispanics between 1992-1999. During those years, there was a significant decrease in the rates of new cases among Hispanic men and women of 3.1 percent per year, on average.[12]

Options

The Arkansas Department of Health's Tobacco Prevention and Cessation Branch coordinates a comprehensive effort, with multiple partnerships at the local and state levels. (See Appendix B for list of local partners.)

The following strategies align with those already in place across the state, and are intended to reinforce the current activities:

- Promote and encourage a comprehensive tobacco-free law in public places and encourage voluntary change towards smoke-free homes, cars, and private establishments. (Public places may include all forms of public transportation, stadiums, arenas, public libraries, airports, etc.)
- Encourage the development of policies in the workplace that eliminate a person's exposure to deadly secondhand smoke.
- Promote smoke-free homes, vehicles, and private establishments.
- Promote enforcement of tobacco-free policies and tobacco prevention activities at all school events, on or off campus.
- Promote youth advocacy and empowerment to influence social norms and policies.
- Decrease youth access to tobacco products by increasing enforcement efforts on illegal sales to minors.
- Decrease pro-tobacco use influences in public places, at public events, and in commercial establishments (especially those frequented by youth).
- Increase youth awareness of the hazards of tobacco and decrease youth social acceptance of tobacco.
- Promote family, parent, and positive role model collaborations with youth organizations.
- Promote and encourage cessation among adults (aged 18 and over).
- Promote environmental change by encouraging employers and healthcare organizations to adopt tobacco-free environments.
- Promote youth cessation programs.
- Identify disparities among population groups.
- Promote tobacco prevention and cessation to special populations.
- Provide technical assistance to minority communities.

Priorities for Change

Lung Cancer

- Reduce deaths from lung cancer in Arkansas from 102.6 men per 100,000, age-adjusted to the 2000 US standard population, to 97.5 men per 100,000; and from 44.8 women per 100,000, age-adjusted to the 2000 US standard population to 42.6 women per 100,000 population. (Healthy People 2010 goal is an overall rate of 44.9 deaths by the year 2010. The goal set by Healthy People 2010 in the year 2000 was a 22 percent decrease in lung cancer deaths overall. In the two years remaining, Arkansas' goal is to reduce overall deaths by 5%. Lung cancer death rates in the US were 76.3 men per 100,000 and 40.9 women per 100,000 in 2002.)

--American Cancer Society Facts & Figures, 2006
--Healthy People 2010

Tobacco Use

- Reduce adult tobacco use from 25.7% to 12% by 2010. (Healthy People 2010 Target is 12% by 2010)
- Reduce youth tobacco use from 25.9% to 21% by 2010. (Healthy People 2010 Target is 21% by 2010.)

Tobacco Control and Prevention

Goal A: Decrease Tobacco Use and Exposure to Secondhand Tobacco Smoke (SHS)

Objective 1: Promote and encourage a comprehensive tobacco-free law in all public places and encourage voluntary change towards smoke-free homes, cars, and private establishments (Public places may include all forms of public transportation, stadiums, arenas, public libraries, airports, etc.) through:

- **Strategy 1 –** Framing secondhand smoke as a health issue, not an economic or political issue.
- **Strategy 2 –** Implementing media and social marketing campaigns that provide the public with general information and education on the hazards of SHS exposure and benefits of smoke-free environments.
- **Strategy 3 –** Contrasting the hazards of secondhand smoke and the benefits of smoke-free environments in those campaigns.

Objective 2: Encourage the development of policies in the workplace that eliminate a person's exposure to dangerous secondhand smoke through:

- **Strategy 1 –** Educational campaigns on the hazards of SHS exposure and benefits of smoke-free environments.
- **Strategy 2 –** Training local coalitions and interested advocates on the hazards of SHS exposure and benefits of smoke-free environments.
- **Strategy 3 –** Identifying preemptive language that weakens secondhand smoke policies.

Objective 3: Promote smoke-free homes and vehicles and move private establishments toward voluntary social changes through:

- **Strategy 1 –** Development of specialized media campaigns that provide the public with personal references and cultural awareness of the benefits of smoke-free environments.
- **Strategy 2 –** Assistance for individuals who want to implement voluntary smoke-free policies to protect their families, friends and constituents from exposure to secondhand smoke.
- **Strategy 3 –** Promotion and support of Arkansas Act 13 – An Act to Protect Children Restrained in Child Passenger Safety Seats in Arkansas from Secondhand Smoke (Appendix C).

Goal B: Prevent Initiation of Tobacco Use Among Youth

Objective 1: Promote enforcement of tobacco-free policies and tobacco prevention activities at public and private schools, kindergarten through 12th grade, and do so at all school events, on or off campus through:

- **Strategy 1 –** Development and enforcement of tobacco-free school policies.
- **Strategy 2 –** Development and enforcement of policies that prohibit tobacco advertising (signs, t-shirts, caps, etc.) on school campuses and at school events.
- **Strategy 3 –** Continuous assessment of enforcement practices of school tobacco use policies.
- **Strategy 4 –** Collaboration with school administrators and community nurses to develop effective strategies toward tobacco-free schools by involving staff and local coalitions.
- **Strategy 5 –** Promoting and encouraging school policies that implement tobacco prevention programming/curricula and allowing release time for teachers to attend tobacco prevention trainings.

Objective 2: Promote youth advocacy and empowerment to influence social norms and policies by:

- **Strategy 1 –** Providing skill-building activities and technical assistance to youth organizations.
- **Strategy 2 –** Collaborating with youth to conduct media events/activities.
- **Strategy 3 –** Encouraging youth to advocate for tobacco control activities and policies in their schools and communities.
- **Strategy 4 –** Providing education and technical assistance

to Hometown Health Improvement Coalitions as they promote healthy behaviors in children and adolescents.

Objective 3: Decrease youth access to tobacco products by initiating enforcement efforts on illegal sales to minors through:

- **Strategy 1** – Education of business owners, employees and local decision makers about the consequences of illegal sales (laws, store policies, employee education, etc.)
- **Strategy 2** – Support of community policies, which prohibit youth access (minimum age requirement, removal of self-service displays, removal of or decreasing number of "point-of-sale" advertisements, clerk assisted sales, etc.)

Objective 4: Decrease pro-tobacco use influences in public places, at public events, and in commercial establishments (prioritizing those frequented by youth) through:

- **Strategy 1** – Community efforts to prohibit tobacco industry sponsorship (sporting or community events).
- **Strategy 2** – Eliminating/reducing tobacco industry corporate gifts to organizations and contributions of pro-tobacco merchandise to youth organizations.
- **Strategy 3** – Educational and counter-marketing campaigns to expose industry tactics that target youth and parents.
- **Strategy 4** – Community education about industry advertising and promotion campaigns targeting minority youth communities.
- **Strategy 5** – Voluntary policies to reduce or restrict placement of "point-of-sale" advertising.

Objective 5: Increase youth awareness of the hazards of tobacco and decrease youth social acceptance of tobacco by:

- **Strategy 1** – Funding school-based programs.
- **Strategy 2** – Grassroots efforts and media awareness campaigns focusing on youth prevention through Students Working Against Tobacco (SWAT) and the Arkansans for Drug Free Youth (ADFY) YES Teams.

Objective 6: Promote family, parent, and positive role model collaborations with youth organizations that:

- **Strategy 1** – Promote active involvement in tobacco prevention activities and efforts.
- **Strategy 2** – Educate local youth organizations to develop public information campaigns targeting families.
- **Strategy 3** – Promote discussions at home about tobacco use.
- **Strategy 4** – Fund youth organizations that involve parents in tobacco control initiatives.

Goal C: Promote Cessation Among Youth and Adults

Objective 1: Promote and encourage cessation among adults aged 18 and over by:

- **Strategy 1** – Conducting media campaigns targeting adults to increase the awareness of tobacco-related illnesses and to decrease social acceptance of tobacco use.
- **Strategy 2** – Promoting local cessation services and the statewide quitline (1-866-NOW-QUIT).
- **Strategy 3** – Encouraging cessation among priority population groups (pregnant women, obese people aged 18 and over, and people in active treatment for cancer).
- **Strategy 4** – Conducting media campaigns to the general population/target population promoting quitting before and during pregnancy.

Objective 2: Promote environmental change by encouraging employers and healthcare organizations to:

- **Strategy 1** – Provide access to cessation services and to include insurance coverage for nicotine replacement therapy (NRT) and other pharmaceutical aids.
- **Strategy 2** – Assist healthcare organizations in adopting policies that institutionalize effective standards of care (5 A Day Model, etc.) for quitting.

Objective 3: Promote youth cessation programs by:

- **Strategy 1** – Enhancing the SOS (Stamp Out Smoking) website to promote cessation services for all tobacco products.
- **Strategy 2** – Conducting a unique marketing campaign for youth and other peer-to-peer support programs and encouraging youth to quit.
- **Strategy 3** – Facilitating the inclusion of tobacco cessation treatment within other substance abuse treatment programs.
- **Strategy 4** – Developing a web-based cessation service for all age groups.

Goal D: Identify and Eliminate Disparities Among Different Population Groups

Objective 1: Identify disparities among population groups and partner with constituents from diverse communities:

- **Strategy 1** – By forming an inclusive workgroup to assist in developing a strategic plan.
- **Strategy 2** – By providing ongoing training on methods to effectively reach groups targeted by the tobacco industry.

Objective 2: Promote tobacco prevention and cessation to special populations by:

- **Strategy 1** – Providing statewide media and counter-marketing campaigns aimed at targeted industry groups.
- **Strategy 2** – Providing funding opportunities for communities to promote prevention and cessation resources to disparately affected population groups.

Objective 3: Provide technical assistance to minority communities by:

- **Strategy 1 –** Working with the ADH Office of Minority Health and funding existing minority coalitions.
- **Strategy 2 –** Collaborating with the Minority Health Commission to reach disparately affected population groups.
- **Strategy 3 –** Providing technical assistance to the University of Arkansas at Pine Bluff (UAPB) and its local coalitions.
- **Strategy 4 –** Empowering constituents to recognize disparities within their communities and build capacity for change.
- **Strategy 5 –** Providing education and technical assistance to Hometown Health coalitions.

[1] US Department of Health and Human Services. The Health Consequences of Smoking – A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2004.
[2] Ezzati M., Lopez A. Estimates of global mortality attributable to smoking in 2000. *Lancet*, 2003; 362:847-852.
[3] American Cancer Society. *Cancer Prevention and Early Detection Facts and Figures*, 2006
[4] US Dept of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta, Georgia: US Dept of Health and Human Services, CDC, NCCDPHP, Office on Smoking and Health; 2000.
[5] CDC. Annual smoking-attributable mortality, years of potential life lost, and productivity losses – United States, 1997-2001. *Morbidity and Mortality Weekly Report* (MMWR) 2005.
[6] See Note #3.
[7] Behavioral Risk Factor Surveillance System (BRFSS), Arkansas 2005. Access at http://apps.nccd.cdc.gov/brfss.
[8] Youth Risk Behavior Surveillance Survey (YRBSS), Arkansas 2005. Access at http://www.cdc.gov/yrbss or call 800-CDC-INFO.
[9] Healthy Arkansas, For a Better State of Health Brochure, 2004.
[10] National Center for Health Statistics, *National Health Interview Survey*, 2001.
[11] Centers for Disease Control. Youth Risk Behavior Surveillance Survey– United States, 2001. *MMWR 2002*; 5d1 (SS04): 1-64.
[12] Ries LAF, Eisner MP, Kosary CL, et al. (eds). SEER Cancer Statistics Review, 1973-1999. National Cancer Institute, Bethesda, MD, http://seer.cancer.gov/1973_1999, 2002.

II. Promote Cancer Prevention and Healthy Lifestyles Through Nutrition and Physical Activity

Background

Maintenance of a healthy weight, a healthy diet that is high in fiber and low in fat, regular physical activity and avoidance of alcoholic beverages may prevent as much as a third of all cancers.[1] Obesity also increases the risk of many other chronic diseases as well.

These lifestyle factors are important to cancer prevention because they are modifiable. However, poor choices in nutrition, limited physical activity, and excess body weight are the norm rather than the exception.

In response to the fact that the proportion of children ages 6-19 who are overweight has multiplied drastically over the past three decades, Arkansas health professionals and policy makers have collaborated to create a structure to first measure just how much of a change there has been, and then take action to reverse that trend. Act 1220, passed in 2003 by the Arkansas Legislature laid the groundwork for what has become a model for the nation for raising awareness regarding the health risks of obesity, and educating children, their parents and the systems that are meant to care for them.

Obesity is best measured by the Body Mass Index (BMI), which is a formula that takes into account one's weight and height. An adult is defined as overweight if his/her body mass index falls between 25-30 and is defined as obese if it is 30 or above. A body mass index over 25 is closely associated with increased morbidity and mortality.

Individuals whose diets are rich in fruits and vegetables generally have a lower BMI. They also have a lower risk for cancers of the colon, mouth, pharynx, esophagus, stomach, lungs, and possibly prostate. Experts recommend between five and nine servings of fruits and vegetables daily. Eating a diet rich in fruits and vegetables can hinge on more than just a willingness to make healthy choices. However, dietary selections may come down to issues of both affordability and availability.

Another important factor in the risk of chronic disease and cancer is lack of physical activity. An estimated 20 to 30 percent of the most common cancers may be related to excess weight and physical inactivity. Recent studies indicate that being overweight or obese may also increase the risk of death from many cancers, accounting for up to 14 percent of cancer deaths in men and 20 percent in women. Obesity prevention can reduce the risk for many of the most common cancers such as colon and postmenopausal uterine, breast cancers, and some uncommon cancers such as renal cell. Regular physical activity is also associated with reduced risk of heart disease, high blood pressure, diabetes, obesity, and certain cancers. Despite the benefits, only one in four children engages in the recommended level of daily physical activity (30 minutes of moderate activity or 20 minutes of vigorous activity.)[2]

The self-reported rate of Arkansas adults being at risk for health problems related to being overweight was 31.8 percent

in 1996. In 2005, according to a report published by Trust for America's Health (Healthy Americans), *F as in Fat: How Obesity Policies are Failing in America, 2005*, Arkansas was ranked 11th in the US in highest rate of adult obesity at 25 percent. It ranked 8th in the US in highest rate of obese and overweight adults combined at 61.7 percent.[3]

Overweight and At Risk for Overweight in Youth
Act 1220 (Appendix D)

Overweight and Obesity in Adults
Act 724 (Appendix E)

Disparate Burden

It is recognized that many of these lifestyle risk factors occur disproportionately among some subgroups in Arkansas. The percentage of Arkansans that consume five or more fruits and vegetables a day is lower than the national average as is the average for exercise. According to the 2005 Behavioral Risk Factor Surveillance Survey (BRFSS) prevalence data, 56.7 percent of African Americans surveyed said yes to the question, "During the past month, did you participate in any physical activity?" In 2005 the national percentage was 67.8 percent.

Twenty-one percent of whites, 20.7 percent of Hispanics, and 18.8 percent of African Americans reported that they did consume five or more servings of fruits and vegetables per day in 2005. The 2005 national percentages were whites – 23.5 percent, Hispanic – 20.4 percent, and African American – 21.5 percent.

Seventy-one percent of Arkansas whites, 59.6 percent of Arkansas Hispanics, and 56.7 percent of African Americans living in Arkansas said that they had participated in some physical activity during the past month. The 2005 national percentages for physical activity during the past month were whites – 77.8 percent, Hispanics – 66.9 percent, and African Americans – 67.8 percent.

Options

Arkansas has developed a comprehensive plan that coordinates statewide action to educate people of the dangers of being overweight or obese, and the numerous benefits of a healthy diet and a physically active lifestyle. The plan which engages multiple partnerships at the local, regional and state levels, is implemented by the Arkansas Department of Health, and is fully supported by the Arkansas Cancer Coalition (ARCC).

Plan objectives are as follows:

- Implement a statewide media campaign, to increase public awareness of the effects of obesity and physical inactivity on health.
- Establish a Healthy Community Award.
- Utilize worksites as health promotion venues, reaching adult Arkansans for the purpose of creating a culture of health, and changing unhealthy behaviors around smoking, obesity, and physical inactivity.
- Establish a clearinghouse for model worksite wellness programs.
- Assist businesses interested in implementing a worksite wellness program which addresses smoking, obesity, and physical inactivity.
- Support businesses in providing an environment friendly to accomplishing individual goals relative to changing behavior.
- Establish community level interventions that promote healthy eating, encourage appropriate exercise and discourage smoking among aging Arkansans.
- Create incentives for state employees for healthier behavior.

Priorities for Change

Physical Activity

- Increase the percentage of children and adolescents who have engaged in at least 30 minutes of moderate physical activity on five or more of the previous seven days from 31% to 44.9% by 2010. (Healthy People 2010 Target is 44.9%)
- Increase the percentage of adults who engage in 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week from 46.4% to 50% by 2010.

Nutrition

- Increase the percentage of persons aged 2 years and older who consume at least two daily servings of fruit from 28% to 75% by 2010.
- Increase the percentage of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third being dark green or orange vegetables from 3% to 50% by 2010.

Obesity

- Reduce the proportion of adults who are obese from 26.9% to 25% by 2010. (National target is 15%, down from 23% in 1994. In 2006, 25.1% of Americans reported in the BRFSS that they were obese.)

Healthy Lifestyles Through Nutrition and Physical Activity

Goal E: Promote Cancer Prevention and Healthy Lifestyles Through Nutrition and Physical Activity.

Objective 1: Implement a statewide media campaign, to increase public awareness of the effects of obesity and physical inactivity on health. (All Arkansans)

- **Strategy 1** – Ensure continuation of BMI assessments in all public schools, as required by Arkansas Act 1220. (Statewide – Children in Schools)
- **Strategy 2** – Support evaluation of Arkansas Act 1220. (Statewide – Children in Schools)
- **Strategy 3** – Provide technical assistance and support to School Nutrition and Physical Activity Advisory Committees to be established in each school district. (Community – Children in Schools)
- **Strategy 4** – Promote pilot programs to determine the effect on BMI of limiting availability of high calorie foods and beverages at school. (Community – Children in Schools)
  - **Action 1** – Follow up on recommendations for vending machines remaining in place.
  - **Action 2** – Promote healthier foods and beverages for lunches and snacks.
- **Strategy 5** – Promote pilot programs to determine if promoting physical activity affects BMI. (Children in Schools)
  - **Action 1** – Incorporate physical activity in the schools, three to five days per week.
- **Strategy 6** – Partner with the Department of Human Services, Division of Aging and Adult Services and other organizations that serve aging Arkansans to provide education about smoking, obesity and physical inactivity. (Statewide – Aging Arkansans)

Goal F: Create Community Environments That Are Conducive to Physical Activity.

Objective 1: Establish a Healthy Community Award. (All Arkansans)

Objective 2: Utilize worksites as health promotion venues, reaching adult Arkansans for the purpose of creating a culture of health, and changing unhealthy behaviors around smoking, obesity, and physical inactivity. (Statewide – Adults in Workplaces)

Objective 3: Establish a clearinghouse for model worksite wellness programs. (Statewide – Adults in Workplaces)

Objective 4: Assist businesses interested in implementing a worksite wellness program which addresses smoking, obesity, and physical inactivity. (Community – Adults in Workplaces)

Objective 5: Support businesses in providing an environment friendly to accomplishing individual goals relative to changing behavior. (Community – Adults in Workplaces)

Objective 6: Establish community level interventions that promote healthy eating, encourage appropriate exercise and discourage smoking among aging Arkansans. (Community – Aging Arkansans)

Objective 7: Create incentives for state employees for healthier behavior. (Statewide – State Employees)

[1] Byers T, Mouchawar J, Marks J. The American Cancer Society Challenge Goals: How Far Can Cancer Rates Decline in the US by the Year 2015? Cancer. 1999

[2] Montana Comprehensive Cancer Control Plan 2006-2011. Prevention.

[3] Trust for America's Health Reports. F as in Fat: How Obesity Policies are Failing in America, 2005. Access at http://healthyamericans.org/reports/obesty2005/release/php?StateID=AR

III. Promote and Encourage Protective Behaviors from Sun and UV Exposure

Background

Skin cancer is the most commonly occurring cancer in the United States. Most of the deaths from skin cancer annually (an estimated 10,850 nationally in 2007), are due to melanoma. Melanoma, while only accounting for 5 percent of all skin cancers, is the most deadly form of skin cancer and is responsible for 75 percent of all skin cancer deaths.[1] Melanoma is primarily a disease with rates more than 20 times higher in whites than in African Americans.[2]

The number of melanoma cases diagnosed in the US, as well as in Arkansas, is increasing. The American Cancer Society estimates that in 2007, 550 cases of melanoma will be diagnosed in Arkansas. That is up 53 percent from 1997, when the number of cases diagnosed was approximately 360.

Melanomas develop more often when the skin has been damaged by exposure to ultraviolet radiation (sunlight). Nearly all skin cancers are preventable by limiting direct exposure to the sun.

While skin cancer is generally associated with populations of advanced age, one in four people who develop melanoma are under the age of 40. It is now the most common cancer in women between the ages of 25 and 29.[3] Cutaneous malignant melanoma is the most rapidly increasing cancer in whites[4] and there was a 50 percent increase in the death rate from 1969 to 1999. Most of that increase was seen in men 65 and older, with rates in this group rising over 150 percent.[5] The risk of melanoma is higher for whites because skin pigment has a protective effect.[6] Melanoma can spread to other parts of the body if diagnosed late. Survival depends upon the stage of the melanoma at diagnosis.

The major cause of skin cancer is unprotected exposure to ultraviolet radiation from the sun or tanning lamps in combination with genetic risk factors. Ultraviolet radiation (UVR) is commonly divided into three bands: UVA, UVB, and UVC. UVC is completely absorbed in the stratosphere before reaching the earth's surface. The rays of UVB are shorter and are the primary cause of tanning and sunburn. The longer rays of UVA penetrate the skin more deeply and contribute to wrinkling of the skin as well as tanning. Besides sunburn, skin cancer, and wrinkling, other negative effects of UVR include cataracts, macular degeneration, and immune system depression.[7]

Skin aging and cancer are delayed effects of sun exposure that don't typically emerge until many years after exposure. Unfortunately, since the injury is not immediately visible, young people are often unaware of the damage being caused by tanning. Physicians and scientists are especially concerned that cases of skin cancer will continue to increase as people who are tanning now in their teens and twenties reach middle age. Medical professionals agree that exposure to the sun's ultraviolet rays appears to be the most important factor in the development of skin cancer. In addition, disruption of the earth's ozone layer by pollution may cause rising levels of exposure to UVR. Nationally, the rate of melanoma has been rising about 3 percent annually,[8] although there is evidence that the rate is leveling off.

According to the United States Preventive Services Task Force (USPSTF), the evidence is lacking that skin examination by healthcare professionals is effective in reducing mortality or morbidity from skin cancer. Additionally, the USPSTF found that benefits from screening are unproven even in high-risk populations. However healthcare professionals should be aware that fair-skinned men and women over age 65, patients with atypical moles and those with more than 50 moles are groups at substantially increased risk for melanoma. Also healthcare professionals should remain alert for skin lesions with malignant features noted in the context of physical examinations performed for other purposes.[9]

Disparate Burden

Although anyone can develop skin cancer, the risk is greatest for people who have one or more of the following characteristics:

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

Options

- Promote distribution and use of existing sun-safety materials through promotional pieces placed in journals, newsletters, websites, and other media that target populations at high risk for skin cancer.
- Increase awareness among youth regarding the dangers of unprotected exposure to UV rays and the corresponding recommended practices for reducing skin cancer risk.
- Collect data on sun exposure behaviors in youth.
- Develop community-based interventions to increase sun protective behaviors in youth.
- Explore funding options from Centers for Disease Control and Prevention, private foundations, sun product manufacturers and retailers, and through legislation to increase the Arkansas Department of Health Cancer Control budget.
- Increase the number and type of public park/recreation sun protection policies.
- Develop a gold standard or best practices model for occupational safety plans emphasizing sun protection for outdoor workers.
- Survey public schools and daycare facilities to determine their policies regarding whether and how much skin cancer education is provided to parents and caregivers of young children.
- Partner with insurance providers to send educational materials to policyholders regarding sun safety.

Priorities for Change

Protective Measures

Increase the proportion of adults aged 18 and older who follow protective measures that may reduce the risk of skin cancer.

(Healthy People 2010 Target is 75% from baseline of 47%)

Protective measures are as follows:

- Avoid the sun between 10 am and 4 pm.
- Wear sun-protective clothing when exposed to sunlight.
- Use sunscreen with a sun-protective factor (SPF) of 15 or higher.
- Avoid artificial sources of ultraviolet light.

Sun Safety

Goal G: Promote and Encourage Protective Behaviors from Sun and UV Exposure.

Objective 1: Promote distribution and use of existing sun-safety materials through promotional pieces placed in journals, newsletters, websites, and other media that target populations at high risk for skin cancer.

- **Strategy 1 –** Identify at-risk populations.
- **Strategy 2 –** Collaborate with sunscreen manufacturers to do product promotions. Provide flyers regarding the issue. Provide tents, screens, and school "parachutes."
- **Strategy 3 –** Develop community-based interventions.
- **Strategy 4 –** Promote "Slip-Slap-Slop," a skin safety campaign developed in Australia that encourages people to "slip" on a shirt, "slop" on sunscreen, and "slap" on a hat. Suggested sponsors: the Department of Education, the Department of Parks and Tourism, and City Chambers of Commerce.
- **Strategy 5 –** Partner with insurance providers to send educational materials to policyholders regarding sun safety.

Objective 2: Increase awareness among youth regarding the dangers of unprotected exposure to UV rays and the corresponding recommended practices for reducing skin cancer risk.

- **Strategy 1 –** Include sunscreen program to schools, K-12.
- **Strategy 2 –** Assess available shade on elementary school playgrounds.
- **Strategy 3 –** Look at school policies on sun exposure on playgrounds, etc.
- **Strategy 4 –** Educate communities on the dangers of unprotected exposure.

Objective 3: Collect data on sun exposure behaviors in youth.

- **Strategy 1 –** Conduct a needs assessment.
- **Strategy 2 –** Check community/school programs on sun exposure behaviors. Utilize data from CDC on skin cancer and sun safety.
- **Strategy 3 –** Disseminate data collected and provide a synopsis of need.

Objective 4: Develop community-based interventions to increase sun safety behaviors in youth.

- **Strategy 1 –** Support sunscreen education programs and partnerships with PTAs.
- **Strategy 2 –** Implement a "shade project" collaboration between the schools and communities (PTA/PTO). Have sunscreen listed as an optional school supply.

Goal H: Explore Areas of Policy Change Regarding Sun Exposure and UV Protection.

Objective 1: Explore funding options from Centers for Disease Control and Prevention, private foundations, sun product manufacturers and retailers, and through legislation to increase the Arkansas Department of Health Cancer Control budget.

- **Strategy 1 –** Explore partnerships with sunglass companies and prominent figures.
- **Strategy 2 –** Find matching funds from organizations that address sun safety. Use CDC website on skin cancer for technical assistance.

Objective 2: Increase the number and type of public park/recreation sun protection policies.

- **Strategy 1 –** Explore existing ADH policies and requirements for children (licensing).
- **Strategy 2 –** Partner with local civic groups such as the Lions Club.
- **Strategy 3 –** Implement a "statewide policy" on providing sunscreen to children or sun exposure education especially in daycares and K-12.

Objective 3: Develop a gold standard or best practices model for occupational safety plans emphasizing sun protection for outdoor workers.

- **Strategy 1 –** Collaborate with retailers (Wal-Mart) to do reminders to purchase sunscreen.
- **Strategy 2 –** Revisit OSHA Guideline standards/rules and regulations.

Goal I: Identify Champions of Prevention Behaviors Among Organizations That Serve Pre-Elementary Aged Children.

Objective 1: Survey daycare facilities regarding their policies on providing skin cancer education to parents and caregivers of young children.

- **Strategy 1 –** Find out about structural sun protection available at these facilities as well as sun-safe policies.

[1] Rigel D, Melanoma update – 2001. The *Skin Cancer Foundation Journal* 2001 (XIX):13-14.
[2] American Cancer Society. What are the risk factors for melanoma? (Access at http://www.cancer.org/docroot/CRI/content/CRI_2_4_2X_What_are_the_risk_factors_for_melanoma_50.asp?sitearea=.)
[3] See Note 1.
[4] See Note 1.
[5] Geller AC, Miller DR, Annas GD, et.al. Melanoma incidence and mortality among US whites, 1969-1999. *JAMA* 2002 Oct 9; 288(14):1719-20.
[6] See Note 5.
[7] US Environmental Protection Agency. The sun, UV, and you – a guide to sun-wise behavior. Publication number EPA430-K-99-035, June 1999.
[8] See note 1.
[9] Berg AO. Screening for skin cancer: recommendations and rationale. *Am J Prev Med* 2001 Apr; 20(3 Suppl):44.

CHAPTER 2

SCREENING AND DETECTION

I. Breast Cancer

Background

According to the American Cancer Society 2007 Cancer Facts & Figures, an estimated 180,510 new cases of invasive breast cancer will occur among women in the US in 2007; 1,830 of those cases are estimated to occur in Arkansas women. Breast cancer is the most frequently diagnosed cancer in women, after basal and squamous cell skin cancers. Breast cancer incidence rates increased rapidly in the 1980s, mainly due to increased use of mammography, which can detect breast cancers up to two years before they can be felt. The gradual increase in breast cancer since that time has been confined to women aged 50 and older. Although breast cancer is widely thought of as a woman's disease, approximately 1 percent of all breast cancers are diagnosed in men each year.[1]

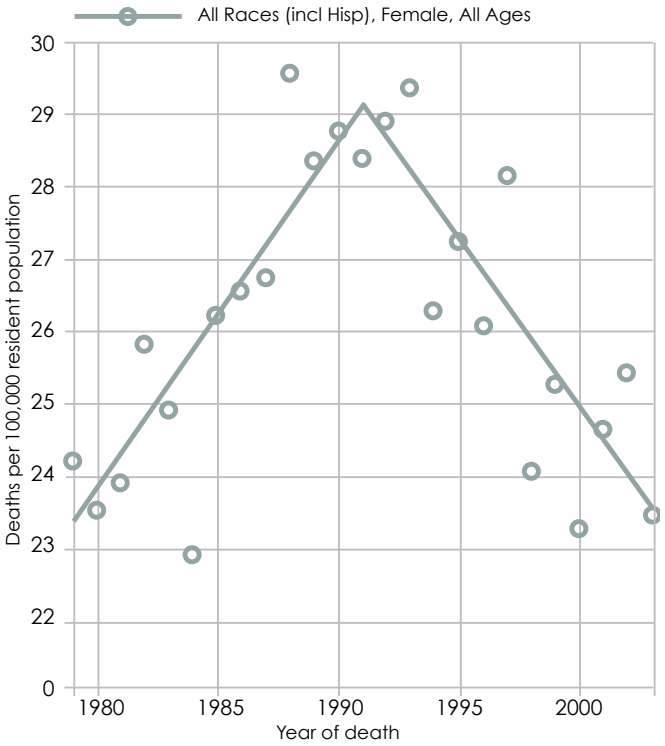
After gender, age is the biggest risk factor for breast cancer, with 77 percent of diagnoses among women over 50.[2] Other factors that impact a woman's risk of developing breast cancer (as noted on the Arkansas BreastCare website) are:

- Family history of breast cancer – especially at an early age.
- Breast cancer genes – about five percent to 10 percent of breast cancers are thought to be inherited.
- Personal history of breast cancer – a woman who has had cancer in one breast is more likely to develop it in the other breast or in remaining breast tissue.
- History of breast disease – women who have a history of certain types of non-cancerous tumors and cysts in their breasts are more likely to develop breast cancer.
- Hormonal factors – women who start their periods at a young age, start menopause at a late age, have their first child later in life, or have no full-term pregnancies may have an increased risk of breast cancer.

Over the past 20 years, with the increase of mammography and improved treatments, the death rate from breast cancer has significantly decreased (see Figure 2). Despite this decrease, breast cancer is still the second leading cancer killer for women in Arkansas with an estimated 390 breast cancer deaths in 2006.[3]

Studies have shown repeatedly over the past 20 years that mammography is the best way to detect breast cancer in its earliest stages. Several national organizations recommend breast cancer screening annually for women 40 and older. Getting a

Figure 2: Historical Trends (1979-2003)
Breast Cancer Mortality of All Ages, Arkansas



Created by statecancerprofiles.cancer.gov on 11/30/2006 6:45 p.m. Regression lines calculated using the Joinpoint Regression Program.
Source: Death data provided by the National Vital Statistics System public use data file. Death rates calculated by the National Cancer Institute using SEER*Stat. Death rates are age-adjusted to the 2000 US standard population by 5-year age groups. Population counts for denominators are based on Census populations as modified by NCI.

Figure 3: Historical Trends (1979-2003)
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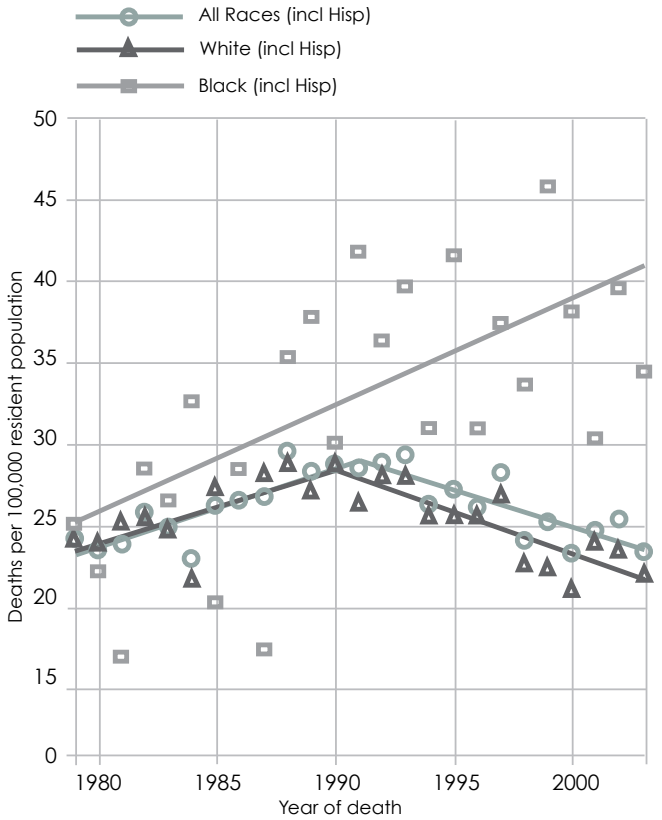


Created by statecancerprofiles.cancer.gov on 11/30/2006 6:45 p.m. Regression lines calculated using the Joinpoint Regression Program.
Source: Death data provided by the National Vital Statistics System public use data file. Death rates calculated by the National Cancer Institute using SEER*Stat. Death rates are age-adjusted to the 2000 US standard population by 5-year age groups. Population counts for denominators are based on Census populations as modified by NCI.

mammogram annually can increase ten-year survivorship by 75-80 percent for women aged 40 and older.[4]

Arkansas has one of the lowest mammography screening rates in the country, yet has managed to stay slightly below the national death rate, (Arkansas at 24.4 per 100,000 vs. the national rate of 26.0 per 100,000.)[5]

BreastCare is a program of the Arkansas Department of Health that provides free screening, diagnosis, and treatment services for qualified Arkansas women (as determined by income and health insurance status) in addition to public and professional education.

Disparate Burden

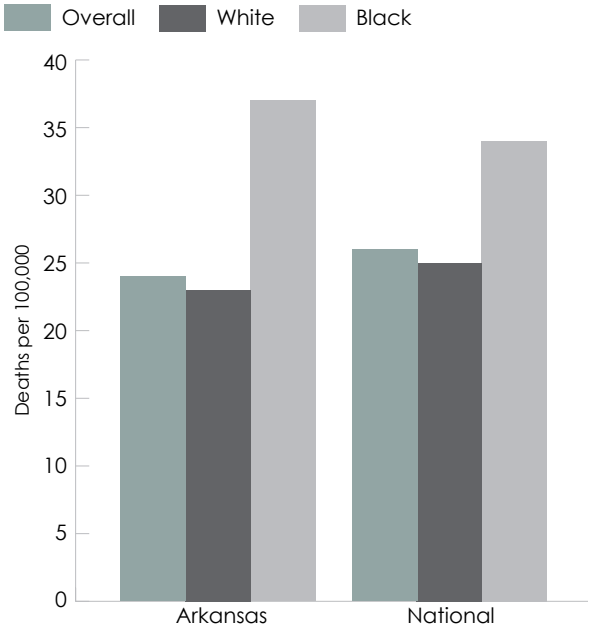
In Arkansas, white women are diagnosed more often with breast cancer than African American women. (100.7 cases diagnosed per 100,000 for African American women compared to 121.5 diagnosed cases per 100,000 for white women between years 1999-2003) However, African American women are more likely to die from the disease. (37.0 deaths per 100,000 African American women compared to 22.5 deaths per 100,000 white women for years 1999-2003.) This disparity may be due to diagnoses at a later stage of disease for African American women or a higher frequency of more aggressive tumors. Also, screening rates among underserved populations are lower than the general population due to many barriers. Access is a significant barrier in rural and low socio-economic status populations. Studies also document that people who lack healthcare insurance have reduced access to preventive services and are less likely to get timely cancer screening examinations.[6]

Clinicians and the healthcare system play a major role in influencing patient participation in cancer screening and in ensuring quality services. Research on barriers related to cancer screening in the population shows that multiple factors – public policy, organizational systems, practice settings, clinicians, and the patients themselves – enable cancer screening and that a diverse set of intervention strategies targeted at each of these factors can improve cancer screening rates.[7]

Options

- Public Education for Breast Cancer Screening – Increase knowledge and improve attitudes of all women with regards to the importance of breast cancer screening.
- Provider Referral/Promotion for Breast Cancer Screening – Increase the proportion of primary care providers who recommend regular mammograms to their patients.

Figure 4: National Trends – Breast Cancer



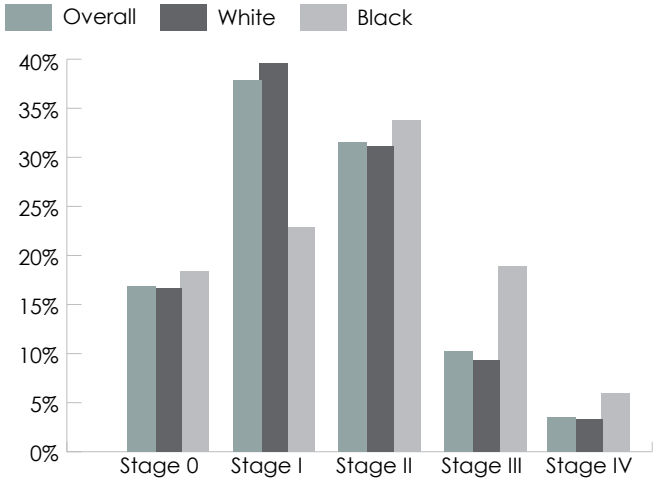
Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Office of Analysis and Epidemiology(OAE), Compressed Mortality File (CMF) compiled from CMF 1999-2003, Series 20, No. 2I 2006 on CDC WONDER On-line Database.

Figure 5: Arkansas Female Breast Cancer Stage Distribution by Race (2003)

Stage	All Races	White	Black
Stage 0	16.9%	16.7%	18.4%
Stage I	37.9%	39.6%	22.9%
Stage II	31.5%	31.1%	33.8%
Stage III	10.2%	9.3%	18.9%
Stage IV	3.5%	3.3%	6.0%

Source: Arkansas Central Cancer Registry, 11/30/06.

Figure 6: Arkansas Female Breast Cancer Stage Distribution by Race (2003)



Source: Arkansas Central Cancer Registry, 11/30/06.

- Access to Services for Breast Cancer Screening – Increase the availability of breast cancer screening to populations facing geographic, economic, or cultural barriers.
- Access to Follow-up Care – Educate women about their risk of breast cancer and the need to return routinely for appropriate re-screening and/or diagnostic testing.

Priorities for Change

Reduce deaths from female breast cancer

- Reduce deaths from female breast cancer from 24.2 deaths per 100,000 females to 22.3 deaths per 100,000 females by 2010. (Healthy People 2010 target is 22.3 deaths per 100,000 females, baseline 27.9 breast cancer deaths per 100,000 females in 1998)

Increase proportion of women aged 40 and older who have received a mammogram within the preceding two years

- Increase the rate of mammography screening in underserved women aged 40 and over from 65.1% to 68.1% by 2010. (Healthy People target is 70%, baseline is 67% in 1998)

Follow-up care

- Improve the rate and promptness of screening follow-up in underserved women aged 40 and over. (Currently there is no statewide system for follow-up, especially among underserved women. For further review, MQSA, Mammography Quality Standards Act, mandates for follow-up on abnormal mammograms see www.fda.gov/cdrh/mammography)

Quality Assurance of breast cancer screening and follow-up

- Evaluate and raise the quality of screening in mammography facilities. For further review: MQSA regulations requiring mammography facilities to calculate rates of false positives and false negatives.

Breast Cancer Screening and Detection

Goal A: Promote and Increase the Appropriate Utilization of High-Quality Breast Cancer Screening and Follow-up Services

Objective 1: Public Education for Breast Cancer Screening – Increase knowledge and improve attitudes of all women with regards to the importance of breast cancer screening.

- **Strategy 1** – Promote campaigns to educate the public about the importance of mammography.
  - **Action 1** – Increase awareness among all women 40 and older of the importance of regular breast cancer screening (e.g., Susan G. Komen activities, Southern Living At Home parties, BreastCare ads).
  - **Action 2** – Promote increased breast cancer screening among disparate and hard-to-reach populations (e.g., Susan G. Komen activities, BreastCare initiatives to raise percent of program-eligible women screened, Esperanza y Vida, Witness Project).
- **Strategy 2** – Support BreastCare.
  - **Action 1** – Partner with BreastCare on public education initiatives in order to support statewide media messages with community-based information/education activities.
  - **Action 2** – Participate in BreastCare initiated partnership activities (e.g., Pink Carnation Sundays).

Objective 2: Provider Referral/Promotion for Breast Cancer Screening – Increase the proportion of primary care providers who recommend regular mammograms to their patients.

- **Strategy 1** – Educate healthcare professionals about appropriate screening principles and techniques.
  - **Action 1** – Provide appropriate and consistently updated information on ARCC and BreastCare websites.
  - **Action 2** – Send updated information to all BreastCare providers (over 1,800) and offer training opportunities.

  - **Action 3** – Promote screening principles and techniques as part of pre-service curriculum.
- **Strategy 2** – Assess current screening practices.
  - **Action 1** – Provide easy access to coalition-related websites, and keep websites updated with most current information.
  - **Action 2** – Establish, implement, and evaluate quality management measures for BreastCare providers.
- **Strategy 3** – Educate healthcare professionals about how to identify high-risk women and the importance of doing so.
  - **Action 1** – BreastCare will provide updates to their network of providers through regular communication, (e.g., Quarterly Provider Update Newsletter, Remittance Advice messages provided with service payments).
  - **Action 2** – Promote screening principles and techniques as part of pre-service curriculum.

Objective 3: Access to Services for Breast Cancer Screening – Increase the availability of breast cancer screening to populations facing geographic, economic or cultural barriers.

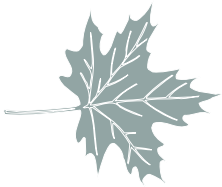
- **Strategy 1** – Partner with community-based organizations to promote breast cancer screening programs for at-risk and underserved populations.
  - **Action 1** – Support partnerships with organizations whose primary purpose is to promote breast cancer screening among disparate populations (e.g., Witness Project, Esparanza y Vida, BreastCare).
  - **Action 2** – Support funding for organizations that reach disparate populations (e.g., Community Cancer Networks, Hometown Health Coalitions).
- **Strategy 2** – Monitor and distribute information on Arkansas legislation that requires insurance coverage for regular screening mammography of age-appropriate women.
- **Strategy 3** – Promote age-appropriate screenings at worksites across the state.
  - **Action 1** – Seek support (funding, in-kind, or education) to provide onsite-screening services.
  - **Action 2** – Ensure that women who are screened in a worksite setting are provided a "medical care home."
- **Strategy 4** – Increase the proportion of mammography screening sites that offer expanded clinic hours as needed.
  - **Action 1** – Identify areas where extended or after-hours services would result in increased mammography screening among targeted populations.
  - **Action 2** – Promote after hours screening with identified mammographers.
  - **Action 3** – Evaluate target population utilization and provider satisfaction.
- **Strategy 5** – Promote the use of community-based transportation services.
  - **Action 1** – Support partnerships with organizations whose primary purpose is to promote breast cancer screening among disparate populations, (e.g., Witness Project, Esparanza y Vida, BreastCare).
  - **Action 2** – Encourage these organizations (see Action 1) to provide free transportation to breast cancer screening as needed and appropriate.

Objective 4: Access to Follow-up Care – Educate women about their risk of breast cancer and the need to return routinely for appropriate re-screening and/or diagnostic testing.

- **Strategy 1** – Encourage women to schedule annual breast cancer screening.
  - **Action 1** – Encourage providers of clinical breast exams and mammograms to send reminders to their patients.
  - **Action 2** – Support partners who schedule annual breast cancer screening exams to communicate consistent messages.
  - **Action 3** – Promote appropriate re-screening guidelines through media campaigns (radio, TV, and print).
- **Strategy 2** – Identify or develop educational materials with tailored messages for women with screening mammogram abnormalities to explain in detail diagnostic options and agencies providing them.
  - **Action 1** – Support partners who provide messages to women that encourage exploring options for diagnosis and treatment of abnormalities (e.g., BreastCare).
  - **Action 2** – Promote appropriate re-screening guidelines through media campaigns (radio, TV and print).

[1]American Cancer Society. *Facts & Figures 2007*.
[2]American Cancer Society. *Breast Cancer Detailed Guide*, Atlanta, Georgia: American Cancer Society, Revised 7/12/2006. Access at http://documents.cancer.org/104.00/104.00.pdf
[3]See Note #1.
[4]*US Preventive Services Task Force Screening for Breast Cancer; Recommendations and Rationale*. Rockville, Maryland: Agency for Healthcare Research and Quality, 2002.
[5]See Note #1.
[6]Institute of Medicine. Care without Coverage: Too Little, Too Late. Access at http://books.nap.edu/html/care_without/reportbrief.pdf
[7]American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures* 2006. Atlanta, Georgia: American Cancer Society.

II. Cervical Cancer



Background

Cervical cancer is rare as compared to the number and incidence of other cancers, with only 11,150 cases estimated to be diagnosed in the United States in 2007, with 130 of those cases in Arkansas. Rates are higher among women aged 40 and older. The good news is that cervical cancer is preventable and curable if detected early. Screening women using the Papanicolaou (Pap) test can prevent cervical cancer from developing most of the time by finding and removing lesions at an early stage before they become cancerous.

Doctors recommend that women begin having regular Pap tests and pelvic exams at the age of 21, or within three years of the first time they have sexual intercourse – whichever happens first. National guidelines recommend that after a woman has a Pap test each year for three years in a row, and test results show there are no problems, she can then get the Pap test once every two to three years.

Risk factors for cervical cancer are (as listed on the Arkansas BreastCare website www.arbreastcare.com):

- Sexual behavior: cervical cancer is closely linked to sexually transmitted infections with certain types of Human Papillomavirus (HPV)
- Sex at early age
- Multiple sexual partners or sex with persons who have had several partners
- Cigarette smoking

Reducing Risk

Human Papillomavirus (HPV)

Recently, the US Food and Drug Administration (FDA) approved a vaccine for Human Papillomavirus (HPV) for females nine to 26 years of age to prevent cervical cancer caused by HPV. Further, CDC's National Immunization Program (NIP) and the federal Advisory Committee on Immunization Practices (ACIP) have recommended the use of the HPV vaccine. In support of the FDA, CDC's NIP, and ACIP, CDC's Division of Cancer Prevention and Control offers the following statement about HPV and cervical cancer:

- Regular cervical cancer screening (Pap test) is recommended for all women (starting within three years of when a woman begins sexual activity or at age 21, whichever comes first).
- HPV vaccination for females aged nine to 26 is supported.
- HPV vaccination for women aged 27 or older is not recommended.
- All women receiving the HPV vaccine should continue to receive regular cervical cancer screening (Pap tests) according to established screening recommendations.

Note: HPV vaccination does not substitute for routine cervical cancer screening (Pap test). This vaccine is not intended to treat cervical cancers.

More specific information and recommendations about the HPV vaccine are available from the ACIP (http://www.cdc.gov/nip/ACIP/).

Disparate Burden

Hispanic, African American, Asian and Native American women are among populations with higher incidence and mortality rates of cervical cancer. Overall, African Americans and Hispanics/Latinas are more likely to develop and die from cervical cancer than any other racial or ethnic population.

Arkansas ranks third in the nation for cervical cancer incidence and mortality, according to the 2001, US Cancer Statistics publication. The mortality rate for African American women is more than twice that for white women. And the mortality rate for Hispanic women in Arkansas is almost three times that for Hispanic women in the United States.

Figure 7: Cervical Cancer Rates in the US

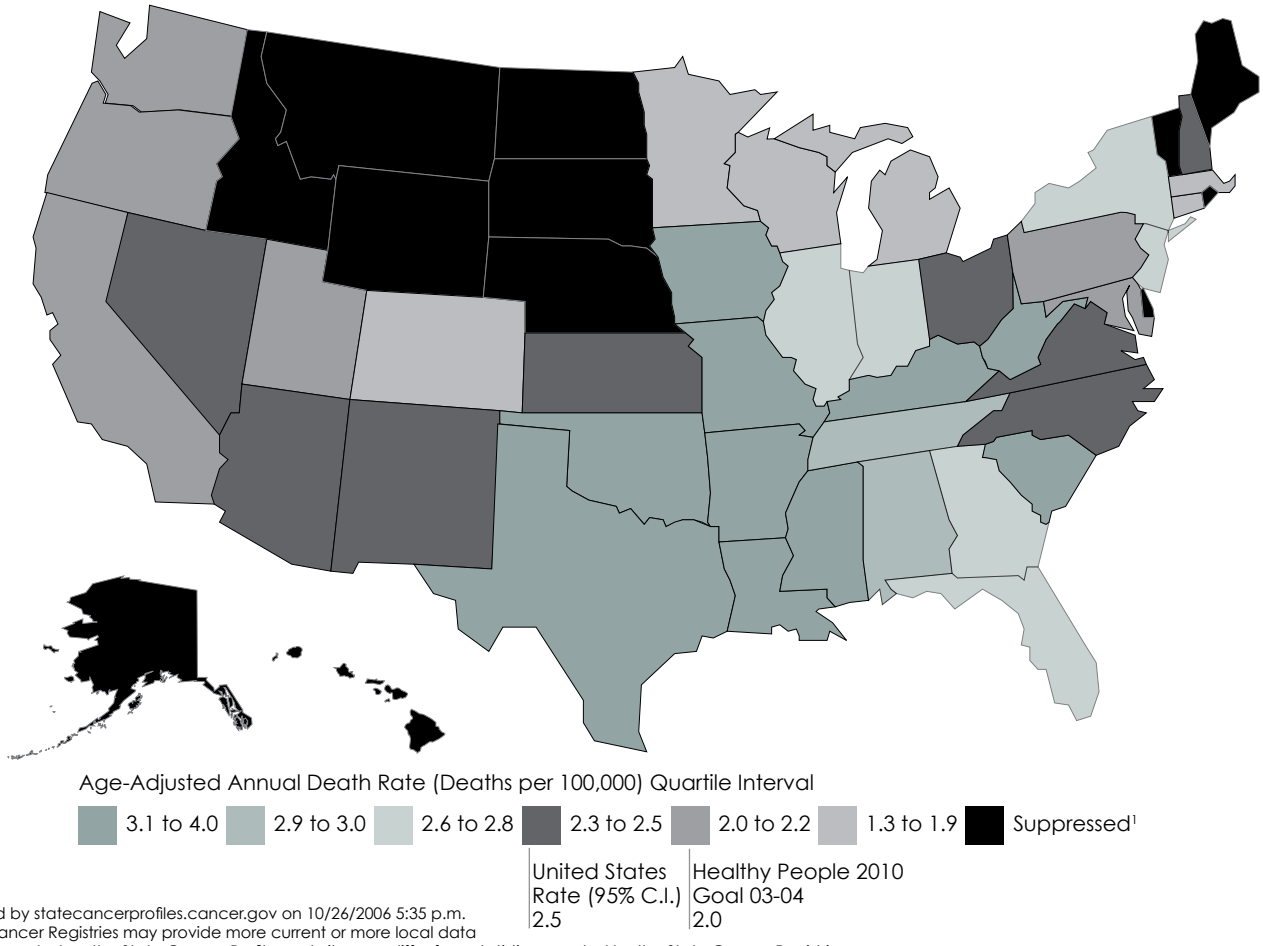
	Incidence Rate	Death Rate
(Per 100,000, age-adjusted to the 2000 US standard population)		
African American	11.1	5.3
American Indian	4.9	2.6
Asian American	8.9	2.7
Hispanic/Latina	15.8	3.5
White	8.7	2.5

Source: American Cancer Society Facts & Figures, 2006

Options

- Close funding gaps for cervical cancer screening and decrease wait for follow-up for abnormal Pap test results.
- Prevent cervical cancer by vaccination against HPV infections.
- Prevent cervical cancer by increasing screening through a widespread public information campaign.
- Educate health professionals about cervical cancer risks and the barriers to cervical cancer screening and treatment.
- Promote research on cervical cancer prevention and the barriers to screening, diagnosis, and treatment for women in Arkansas.

Figure 8: Age-Adjusted Death Rates for United States, 2003 Cervix All Races (includes Hispanic), Female, All Ages



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State Cancer Registries may provide more current or more local data
Data presented on the State Cancer Profiles website may differ from statistics reported by the State Cancer Registries.
[1]Data may have been suppressed to ensure confidentiality and stability of rate estimates. Healthy People 2010 Goal 03-04: Reduce the death rate from cancer of the uterine cervix to 2.0. Healthy People 2010 Objectives provided by the Centers for Disease Control and Prevention.
Source: Death data provided by the National Vital Statistics System public use data file. Death rates calculated by the National Cancer Institute using SEER*Stat. Death rates are age-adjusted to the 2000 US standard population by 5-year age groups (the Healthy People 2010 goals are based on rates adjusted using different methods but the differences should be minimal). Population counts for denominators are based on census populations as modified by NCI.

Priorities for Change

Reduce deaths from cervical cancer

- Reduce deaths from cervical cancer from 3.7 per 100,000 females (2003) to 2.0 per 100,000 females by 2010. (Healthy People 2010 Target is 2.0 per 100,000 females from 3.0 per 100,000 females in 1998.)

Increase cervical cancer screening rates

- Increase the number of women 18 years and older that have received a Pap test from 81.4% to 86% by 2010. (Healthy People 2010 Target is 97% from 92% in 1998)

Cervical Cancer Screening and Detection

The following goals, objectives, and strategies have been developed by the Arkansas Cervical Cancer Taskforce:

Goal B: Promote and Increase the Appropriate Utilization of High Quality Cervical Cancer Prevention, Screening and Follow-up Services.

Objective 1: Close funding gaps for cervical cancer screening and decrease wait for follow-up for abnormal Pap test results.

Identified Strengths:

- BreastCare provides qualified women who are under/uninsured and are aged 40 and older with cervical cancer screening, diagnosis, and treatment.
- BreastCare also covers treatment for qualified women under age 40 who have been diagnosed with cervical cancer or certain pre-cancerous conditions.

Identified Gaps:

- In 2004, Arkansas was the lowest in the nation for women being screened for cervical cancer.

- Women who are under/uninsured and younger than age 40 have no payment source for diagnostic tests after an abnormal Pap test.

- **Strategy 1** – Apply for benefits of the Family Planning Medicaid Waiver Program from the federal government. These benefits will cover all cervical cancer screening, diagnosis and treatment for women under age 40 who qualify for this waiver.
- **Strategy 2** – If the Medicaid benefits are not approved as recommended above, then expand BreastCare funding to cover all under/uninsured women who are not covered by Medicaid for cervical cancer screening and treatment.
- **Strategy 3** – Provide funding for tracking and active follow-up of women with abnormal Pap tests through successful resolution of any abnormalities.
- **Strategy 4** – Encourage all public health providers to use liquid-based Pap tests. This state-of-the-art technology provides immediate follow-up for abnormal Pap results as well as HPV DNA testing – reducing tracking and follow-up problems.

Objective 2: Prevent cervical cancer by vaccination against HPV infections.

Identified Strength:
- The Arkansas Department of Health has requested HPV vaccine and will prioritize the immunization of Vaccines for Children (VFC) eligible females prior to their entering the 7th (seventh) grade.
- Almost 100 percent of Arkansas healthcare providers responding to the survey said they would recommend the vaccine.

Identified Gap:
- Although federal funding for the VFC Program will cover HPV vaccinations for females ages 9-18, current Arkansas funding for HPV vaccination targets only 11-12 year olds.
- Funding has not yet been identified to cover the cost of vaccinations for young adults age 19 and older.

- **Strategy 1** – Expand Medicaid Waiver to include coverage for HPV vaccine.
- **Strategy 2** – Require HPV vaccination for all 9-12 year old females, allowing the same exemption that is given for all required vaccines.
- **Strategy 3** – Encourage all private Arkansas health insurers to pay for HPV immunizations among approved populations.
- **Strategy 4** – Support the implementation of a multi-phased plan, as supported by research, to maximize the HPV vaccinated population in Arkansas.

Objective 3: Prevent cervical cancer through a widespread public information campaign.

Identified Strength:
- Through research, BreastCare has identified the most effective types of media campaigns that educate women in Arkansas and is funding such campaigns.
- National media campaigns are reinforcing the BreastCare cervical cancer message about the importance of yearly exams, follow-up, treatment and HPV vaccination. National media campaigns focus on HPV and cervical cancer.

Identified Gap:
- Research has shown that most women do not get regular Pap tests because they just do not think about it or they do not think a yearly exam is necessary.

- **Strategy 1** – Support a broad educational campaign to increase knowledge about preventing cervical cancer that is language appropriate, culturally competent and inclusive of all groups that are affected.

Objective 4: Educate health professionals about cervical cancer risks and the barriers to cervical cancer screening and treatment.

Identified Strength:
- Arkansas healthcare providers who reported were aware and concerned about the gaps in access to care for cervical cancer.
- Additionally, some reportedly recommended education and training to improve communication and trust with patients.

Identified Gap:
- Seventy-two percent (72%) of healthcare professionals responding to the survey were not aware that Arkansas ranked third (3rd) lowest among states for women receiving yearly Pap tests.
- Physicians responding indicated that the low screening rate may be partly due to physicians not recommending the Pap test.

- **Strategy 1** – Engage medical and nursing professionals and their professional organizations in an effort to improve cervical cancer screening, diagnosis, and treatment.

Objective 5: Promote research on cervical cancer prevention and the barriers to screening, diagnosis, and treatment for women in Arkansas.

Identified Strength:

- Researchers at the University of Arkansas for Medical Sciences are actively engaged in conducting research across many biomedical aspects of cervical cancer and the mechanisms of the disease.

Identified Gap:

- Research is needed to identify factors that influence disparities in new case incidence and death rates for women with disabilities, African American women, Hispanic women, women in poverty, and older women.
- Research-based programs are needed to help positively impact the factors that influence these disparities.

- **Strategy 1** – Support research that examines disparities in incidence and mortality rates and barriers to adequate cervical cancer prevention.
- **Strategy 2** – Support and evaluate pilot programs offering best-practice interventions that eliminate identified disparities and barriers.

III. Ovarian Cancer

Background

Ovarian cancer accounts for about three percent of all cancers among women and ranks second among gynecologic cancers, following cancer of the uterus. During 1985-2002, ovarian cancer incidence declined at a rate of 0.7 percent per year.[1] Ovarian cancer has significance because in the US, more women die of ovarian cancer each year than of cervical and endometrial cancers combined. Survival rates have not greatly improved and screening methods (such as the serum CA-125 blood test and transvaginal ultrasound) have not been proved to decrease the death rate.[2]

Ovarian cancer can sometimes be associated with known risk factors for the disease. Many risk factors are modifiable though not all can be avoided. Factors thought to increase risk for ovarian cancer are:

- **Age:** The risk of developing ovarian cancer increases as a woman gets older.
- **Family History of Ovarian Cancer:** A woman whose mother or sister has had ovarian cancer has a higher than average risk of developing ovarian cancer.
- **Hormone Replacement Therapy/Hormone Therapy:** Hormone replacement therapy, also called hormone therapy, may be associated with an increased risk of ovarian cancer in postmenopausal women.
- **Fertility Drug Use:** Fertility drug use has been associated with an increased risk of ovarian cancer.
- **Other:** Other risk factors that have been suggested for ovarian cancer are the use of talcum powder in the area between the vagina and the anus and eating a high-fat diet. The exact relationship remains unclear.

Factors thought to decrease risk for ovarian cancer are:

- **Oral Contraceptives:** Studies suggest that the use of oral contraceptives may reduce the risk of developing ovarian cancer. The longer you use oral contraceptives the lower your risk might be. The decrease in risk may last for a long time after the use of oral contraceptives has ended.
- **Childbearing and Breast-feeding:** Women who have had at least one child are less likely to develop ovarian cancer than women who have never had children. Studies have also shown that women who breast-feed are less likely to develop ovarian cancer.
- **Tubal Ligation or Hysterectomy:** Studies have shown that women who have undergone tubal ligation (sterilization) or hysterectomy are at decreased risk of developing ovarian cancer.

Note:

Prophylactic Oophorectomy: Benefits

Based on solid evidence, prophylactic bilateral oophorectomy is associated with a decreased risk of ovarian cancer. Peritoneal carcinomatosis has been reported following prophylactic removal of the ovaries. Prophylactic oophorectomy, along with salpingo-oophorectomy, is generally reserved for women at high risk of developing ovarian cancer, such as women who have a deleterious mutation in the BRCA1 or BRCA2 genes, and/or women whose mother or sister has had ovarian cancer.

Prophylactic Oophorectomy: Harms

Prophylactic oophorectomy among women who are pre-menopausal at the time of surgery is associated with infertility, vasomotor symptoms, decreased sexual interest, vaginal dryness, urinary frequency, decreased bone mineral density, and increased cardiovascular disease.

(Source: National Institutes of Health. PDQ Ovarian Cancer Prevention.)

According to the American Cancer Society Facts & Figures 2007, 22,430 women will be diagnosed and 15,280 will die of ovarian cancer in the US in 2007. One hundred forty of those deaths will occur in Arkansas. No screening tests have been shown to reduce the risk of dying from ovarian cancer,

even though there are several methods being tested, including transvaginal ultrasound and the measurement of tumor markers such as CA-125. According to the US Preventive Services Task Force (USPSTF) routine screening for ovarian cancer is not recommended. The USPSTF found fair evidence that screening with serum CA-125 level or transvaginal ultrasound can detect ovarian cancer at an earlier stage than can be detected in the absence of screening; however, the USPSTF found fair evidence that earlier detection would likely have a small effect, at best, on mortality from ovarian cancer. Because of the low prevalence of ovarian cancer and the invasive nature of diagnostic testing after a positive screening test, there is fair evidence that screening could likely lead to important harms. The USPSTF concluded that the potential harms outweigh the potential benefits.[3]

What are the harms of screening?

Because of the low incidence of ovarian cancer in the general US population, the positive predictive value (PPV) of screening is low. The Health Technology Assessment (HTA) in the United Kingdom evidence review estimated that using annual ultrasound screening, only 0.6 percent of those recalled for abnormal results, and three percent undergoing surgery, have cancer.[4] The PPV for CA 125-based multi-modal screening was estimated as one percent for initial recall and 15 percent for surgery. An estimated three percent to 12 percent of screened women will be recalled for further testing and assessment, resulting in potential distress and anxiety to otherwise healthy women.[5] Approximately 0.5 percent to one percent of women will suffer a significant complication because of surgery, based on reports from published studies.[6]

(Source: US Preventive Services Task Force, May 2004)

Disparate Burden

White females experience a higher incidence rate of ovarian cancer at 15.0 per 100,000 females age adjusted to the 2000 US population standard than African Americans with an incidence rate of 10.3 per 100,000 females. However, African American women die at a higher rate than their white counterparts at 9.2 deaths per 100,000 African American women vs. 7.5 deaths per 100,000 in whites.

Options

The most crucial need for controlling this cancer is effective prevention or early detection in high-risk women. The ARCC Ovarian Cancer Taskforce plans to monitor developments in these important research areas and will form recommendations as new evidence becomes available. The Taskforce also places a high priority on promoting the awareness of the signs and symptoms of ovarian cancer.

- Report every six months to the Early Detection Interest Group on the status of research and screening recommendations for ovarian cancer.
- Public Awareness – Obtain information for developing awareness initiatives.
- Identify and maintain an inventory of those organizations and programs that engage in or support ovarian cancer control-related activities.
- Monitor and coordinate ovarian cancer control activities.

Priorities for Change

Reduce deaths from ovarian cancer

- Because there are currently no widely accepted screening methods for detecting ovarian cancer early, there are no 2010 goals for the US. As educational interventions become more prevalent, benchmarks may be set. Until then, the Ovarian Cancer Taskforce will strive to educate women about the risk factors and symptoms, and work to ensure quality care upon diagnosis.

Ovarian Cancer Screening and Detection

Goal C: Monitor Ongoing Research Regarding the Possible Efficacy of Screening/Detection Methods for Ovarian Cancer. Formulate and Distribute Recommendations as Warranted By That Research.

Objective 1: Report every six months to the Early Detection Interest Group on the status of research and screening recommendations for ovarian cancer.

- **Strategy 1** – Gather and review studies on the methods and efficacy of ovarian cancer screening.
- **Strategy 2** – Monitor the position statements of national and state-level organizations.

Goal D: Promote Awareness of the Signs, Symptoms, and Risk Factors of Ovarian Cancer.

Objective 1: Public Awareness – Obtain information for developing awareness initiatives.

- **Strategy 1** – Work with agencies to obtain appropriate awareness and education materials.

- **Action 1** – BreastCare will secure information about the risk factors for ovarian cancer and place it on the website and have available at health fairs and other educational events.
- **Strategy 2** – Work with universities to obtain appropriate awareness and education materials.

Goal E: Coordinate, Facilitate, and Monitor Ovarian Cancer Control Activities in Arkansas.

Objective 1: Identify and maintain an inventory of those organizations and programs that engage in or support ovarian cancer control-related activities.

- **Strategy 1** – Identify, on a continuing basis, cancer control organizations and activities in Arkansas.

Objective 2: Monitor and coordinate ovarian cancer control activities.

- **Strategy 1** – Keep apprised of, and disseminate information on, the activities of organizations engaged in implementation or supporting ovarian cancer awareness.

[1] American Cancer Society. *Facts & Figures 2006.*
[2] National Institutes of Health. PDQ Ovarian Cancer Prevention. Access at http://www.cancer.gov/cancertopics/pdq/prevention/ovarian/patient/page 2.
[3] US Preventive Services Task Force. *Screening for Ovarian Cancer*. Recommendations and Rationale. Rockville, MD: Agency for Healthcare Research and Quality 2004.
[4] Bell R, Petticrew M, Sheldon T. The performance of screening tests for ovarian cancer: results of a systematic review. *Brit J Obstet-Gynecol 1998;* 105(11):1136-47.
[5] Bell R, Petticrew M, Luengo S, Sheldon TA. Screening for ovarian cancer a systematic review. *Health Technol Assess 1998*; 2(2): iiv, 1-84. Review.
[6] See note #4.

IV. Colorectal Cancer

Background

According to the American Cancer Society, an estimated 112,340 cases of colon and 41,420 cases of rectal cancer are expected to occur in the US in 2007. Colorectal cancer is the third most common cancer in both men and women. Incidence rates decreased nationally by 1.8 percent per year during 1998-2002. The recent decrease partly reflects increased screening and polyp removal, which prevents progression of polyps to cancer. Colorectal cancer incidence rates have been decreasing since 1985, from 66 to 52 per 100,000 in 2002.[1]

In Arkansas, 60.1 males out of 100,000, and 43.4 females out of 100,000 are expected to be diagnosed in 2007, while 26.1 males and 18.0 females (out of 100,000) will die of the disease. The death rate for males in Arkansas is slightly above the national average (24.3) as is the rate for Arkansas females – (national rate, 17.0).[2]

Risk factors for colorectal cancer include the following:

- Family history of the disease
- A history of large (greater than one centimeter) adenomatous colon polyps
- A history of inflammatory bowel disease such as ulcerative colitis and Crohn's disease
- Tobacco use
- Alcohol consumption
- Being overweight
- And perhaps high dietary intake of red meat and dietary animal fat and low levels of physical activity.[3]

Screening

At this time, screening to detect colorectal cancer at an early stage consists of either visualizing the inside of the colon or testing for blood in the stool. The colon can be viewed directly either with a colonoscope (a fiber-optic, lighted instrument that views the entire colon from the rectum to the cecum, that is, from end to the beginning of the large intestine) or a flexible sigmoidoscope (a similar, shorter instrument that views the rectum and descending colon, or, the last third of the colon), or visualized with a double-contrast barium enema X-ray exam. During a colonoscopy, any polyp or other suspicious area can be biopsied or removed entirely and sent to the laboratory for diagnosis. Another type of routine testing is the fecal occult blood test (FOBT) – a home test kit that identifies hidden blood in feces samples taken over three days.[4]

The American Cancer Society[5], the American College of Gastroenterology[6], and the US Preventive Services Task Force[7] all recommend screening for colorectal cancer beginning at age 50 for those at average risk and earlier for those at increased risk.

Legislative Action

Summary – Colorectal Cancer Act of 2005, Act 2336 (Appendix F)

Act 2336 of 2005, which supports the Colorectal Cancer

Control and Research Program is intended to support research and cancer control activities to:

- Assess the endoscopic resources in state,
- Plan and implement a program to increase screening rates, and
- Evaluate a program's effectiveness in increasing screening.

The long-term goal of the Colorectal Cancer Control and Research Program is to reduce the physical and economic burden of colorectal cancer in this state.

The Act mandates insurance coverage for:

- Persons 50 and older
- Persons less than 50 and at high risk
- Persons experiencing the following symptoms:
  - Bleeding from the rectum
  - A change in bowel habits.

Employers shall offer healthcare policies that include colorectal cancer screening.

- Screening includes:
  - Annual FOBT
  - Flexible sigmoidoscopy
  - Double contrast barium enema
  - Colonoscopy every 10 years
- Screenings are limited to the following guidelines:
  - If colonoscopy is normal – follow-up in 10 years
  - If one or more polyps – follow-up in three years
  - If single tubular adenoma is found – follow-up in five years
  - Large sessile adenomas – follow-up in six months

Access to screening may include payment vouchers for underinsured and uninsured patients.

Arkansas Colorectal Cancer Demonstration Project

The passage of the Colorectal Cancer Act of 2005, Act 2336, provided some funding for research and screening for colorectal cancer control. The ARCC has been able to collaborate with the Arkansas Department of Health (ADH) and the UAMS Winthrop P. Rockefeller Cancer Institute to provide funding, guidance and community resources to help develop a pilot program. This program provides education and training for primary care physicians and no-cost screening for patients who meet program guidelines and have no insurance. Other components of the project include assessment of resources in the state that will enable Arkansas residents to obtain colorectal screening examinations and laboratory tests.

Disparate Burden

Although Arkansas' mortality rate is close to that of the US, the impact of colorectal cancer on African Americans must be further examined. From 1990 until 2000, the colorectal cancer mortality rate has been significantly higher for African Americans than for the rest of Arkansas and the nation. African Americans have a death rate over this time period that is 46 percent higher than whites.[8] For Hispanic populations, both males and females experience lower rates of colorectal cancer than non-Hispanics.

Among women, African Americans had the greatest risk for colorectal cancer and Hispanic women were less likely than white women to be diagnosed with or die from colorectal cancer.

Figure 9: Incidence Rates for Colorectal Cancer 1995-1999

Hispanic males	Non-Hispanic males	Hispanic females	Non-Hispanic females
43.8	64.1	29.4	47.2

Mortality Rates for Colorectal Cancer 1995-1999

Hispanic males	Non-Hispanic males	Hispanic females	Non-Hispanic females
16.4	26.2	10.3	18.3

Source: Cancer Facts & Figures for Hispanics/Latinos 2003-2005

Options

- Increase colorectal cancer screening rates and help decrease the number of avoidable deaths from colorectal cancer.
- Devise systems or promote system changes that will increase colorectal cancer screening, particularly for minority and underserved populations.
- Engage community groups to bring together local healthcare providers and residents to enhance education and screening rates in rural areas of the state.
- Influence legislation that will support increased colorectal screening.
- Ensure that patients who receive positive test results and are in need of further services receive timely and appropriate follow-up care.
- Reduce racial disparities in colorectal cancer incidence and mortality.

Priorities for Change

Reduce deaths from colorectal cancer

- Reduce deaths from colorectal cancer from 21.4 per 100,000 age adjusted to the 2000 standard population, to 15 per 100,000 by 2010. (Healthy People 2010 Target is 13.9 deaths per 100,000 by 2010, down from a 1998 baseline of 21.1 age adjusted to the 2000 standard population)

Increase colorectal cancer screening rates 1) ever screened 2) Sigmoidoscopy or Colonoscopy

- Increase the rate of adults aged 50 years and older who have received a fecal occult blood test (FOBT) within the preceding two years from 16.5% to 35% by 2010. (Healthy People 2010 baseline from 1998 is 35% with a target of 50%)
- Increase adults aged 50 years and older who have ever received a sigmoidoscipy or colonoscopy from 37.4% to 42%. (Healthy People 2010 target is 50% from a baseline of 37% in 1998)

Follow-up care

- Estimated rates for follow-up care will be collected from the colorectal cancer demonstration project and will be made available at that time. Currently, there is no other colorectal cancer follow-up data available for comparison.

Colorectal Cancer Screening and Detection

Goal F: Increase Colorectal Cancer Screening Rates and Help Decrease the Number of Avoidable Deaths From Colorectal Cancer.

Objective 1: Increase public awareness about colorectal cancer.

- **Strategy 1 –** Assess current colorectal cancer screening practices and capacity in Arkansas.
- **Strategy 2 –** Assess current colorectal cancer need in Arkansas. (Residents for whom screening is appropriate, either by age or level of risk, subtracted from the capacity of screening facilities in the state.)
- **Strategy 3 –** Identify, or develop, and test culturally appropriate educational materials and facilitate dissemination of the materials in communities, work sites, and organizations with significant minority populations.
- **Strategy 4 –** Make available through public health agencies learner-appropriate educational materials to inform those 50 years and older of the prevalence and risk of colorectal cancer and available screening methods.
- **Strategy 5 –** Make available through the Internet learner-appropriate education materials to inform those 50 years and older of the prevalence and risk of colorectal cancer.
- **Strategy 6 –** Support and promote targeted intervention programs that promote colorectal cancer screening.

Objective 2: Devise systems or promote system changes that will increase colorectal cancer screening, particularly for minority and underserved populations.

- **Strategy 1 –** Establish and/or promote patient navigator programs to address specific social barriers to colorectal cancer screening in order to a) improve care in underserved populations, and b) define more fully the navigator role and its effectiveness.
- **Strategy 2 –** Develop professional education campaign for healthcare providers that includes information about medical office reminder/follow-up systems and the use of follow-up plans in patient charts as well as colorectal cancer screening guidelines and procedures.
- **Strategy 3 –** Develop regional colorectal cancer screening referral lists.

Objective 3: Engage community groups to bring together local healthcare providers and residents to enhance education and screening rates in rural areas of the state.

- **Strategy 1 –** Partner with community-based organizations to promote education and colorectal cancer screening programs for at-risk and underserved populations.
  - **Action 1 –** Identify underserved areas in Arkansas.
  - **Action 2 –** Identify possible cultural barriers to getting screened.
  - **Action 3 –** Develop culturally appropriate information and disseminate at community locations.
  - **Action 4 –** Coordinate a forum or panel of people from the community which includes healthcare providers that can talk about colorectal cancer screening in a culturally appropriate way.
  - **Action 5 –** Hire community outreach people to work with the identified target population.

Objective 4: Influence legislation that will support increased colorectal screening.

- **Strategy 1 –** Continue to educate state legislators about the importance of including colorectal cancer screening as a mandated, covered benefit by insurance companies that sell individual and group policies in the state.
- **Strategy 2 –** Work with insurers and government officials to increase coverage for colorectal cancer screening.

Objective 5: Ensure that patients who receive positive test results and are in need of further services receive timely and appropriate follow-up care.

- **Strategy 1 –** Encourage the acquisition of financial support for follow-up care for those who are at or below 200% of poverty level and have no other coverage.
- **Strategy 2 –** Work to secure the provision of state supported diagnostic and treatment services comparable to the Arkansas BreastCare program (very successful breast and cervical cancer screening and treatment program).
- **Strategy 3 –** Collect data that monitors follow-up care to be used in assessing appropriateness of care.

Objective 6: Reduce racial disparities in colorectal cancer incidence and mortality.

- **Strategy 1 –** Identify existing or facilitate additional research with African American adults over age 50 to identify barriers to early detection.
- **Strategy 2 –** Identify existing or facilitate additional research with Hispanic/Latino adults over age 50 to identify barriers to early detection.
- **Strategy 3 –** Conduct community participatory research with Hispanic, Native American, and other minority populations to assess cultural beliefs and barriers to colorectal cancer screening.

[1] American Cancer Society. *Facts & Figures 2007.* Atlanta: American Cancer Society, 2006.
[2] See Note #1.
[3] DeCosse, JJ, Tsioulias GJ, Jacobson JS. Colorectal cancer detection, treatment, and rehabilitation. *CA-A Cancer Journal for Clinicians 1994*; 44:27-42.
[4] The Maryland Comprehensive Cancer Control Plan: Our Call to Action 2004-2008. pp 194.
[5] Smith RA,Cokkinides V, Wyre HJ. American Cancer Society guidelines for early detection of cancer, 2004. *CA Cancer J Clin 2003*; 53:27-43.
[6] Rex DK, John DA, Liberman DA, Burt RW, Sonnenberg A. Colorectal cancer prevention 2000: screening recommendations of the American College of Gastroenterology. *Am J Gastronenterol 2000*; 95:868-77.
[7] United States Preventive Services Task Force. Screening for colorectal cancer in adults at average risk: recommendations from the United States Preventive Services Task Force. *Ann Intern Med 2002*;137:132-41.
[8] Nash CR, Ochoa ER. Arkansas racial and ethnic health disparity study report. Presented to the AR Minority Health Commission, Spring 2004, section MH-6, pp 89.

V. Prostate Cancer

Background

According to the American Cancer Society, an estimated 218,890 cases of prostate cancer will be diagnosed in 2007, with 1,960 of those cases being in Arkansas. It is estimated that 300 Arkansas men will lose their lives to prostate cancer in 2007.[1]

Whether to recommend screening for prostate cancer among asymptomatic men is a difficult public health issue. The prevention of mortality and morbidity from this disease through screening and early detection is controversial, and there is currently no consensus among major medical and health organizations in the United States about recommendations for screening.[2] Additional areas of concern are the side effects of treatment, such as impotence and incontinence, as well as the question of whether and for whom treatments are effective or necessary.

Prostate cancer risk factors include:

- **Age**. The older a man is, the greater his risk for getting prostate cancer.
- **Family History**. A man with a father, brother, or son who has had prostate cancer is two to three times more likely to develop the disease himself.
- **Race**. Prostate cancer is more common in some racial and ethnic groups than in others, but medical experts do not know why. Prostate cancer is more common among African American men than among white men. It is less common among Hispanic, Asian, Pacific Islander, and Native American men.[3]

Researchers are trying to determine the causes of prostate cancer and whether it can be prevented. They do not yet agree on the factors that can influence a man's risk of developing the disease. Some of the factors under study include:

- Herbal supplements
- Lycopene (an antioxidant abundant in red tomatoes and processed tomato products)
- Diets high in animal fat or low in fruits and vegetables
- Vitamin E and selenium
- Men's hormone levels
- Environmental agents (pesticide residues on foods, and industrial and occupational exposures)
- Physical inactivity
- Overweight and obesity [4,5,6]

The Arkansas Prostate Cancer Foundation (APCF)

In 2000, six community leaders who were prostate cancer survivors, and a medical advisory committee of physicians from around the state, formed the Arkansas Prostate Cancer Foundation. The Foundation's mission is to promote awareness, encourage timely detection, and support improved treatment of prostate cancer in Arkansas. APCF also provides support to those affected by prostate cancer.

Education, survivor support, and timely detection are top priorities for the APCF. The Foundation sponsors public education programs throughout the state at health fairs, industrial worksites, and churches. The Foundation's Prostate Health Resource Center in Little Rock is a first stop for newly diagnosed men and their families, as well as an ongoing source of information and support for prostate cancer survivors. The APCF website, www.arprostatecancer.org, continues to provide prostate cancer information and support that is available at any time. The toll-free number that is also available is 1-800-338-1383.

The APCF provides free screening on its mobile unit collaborating with health departments, churches, local physicians, nurses, and other community-based organizations. The Patient Navigation program ensures that all patients with suspicious findings receive information and assistance to help them obtain follow-up care, timely diagnosis, and treatment. Goals of the program are to save lives from prostate cancer, eliminate barriers to care, and ensure timely delivery of services.

In spite of the disagreement among some professionals regarding screening and treatment issues, the facts remain that prostate cancer is the second leading cause of cancer death in men, that disparate groups have a higher death rate, and that the overall death rate has been steadily decreasing. The position of the Arkansas Prostate Cancer Foundation is that awareness and education are becoming recognized as effective means to move Arkansans through the continuum of medical care to ensure timely intervention—from abnormal screening to cancer treatment. The Foundation believes that access to prostate cancer education, screening, and treatment should be available to all men in Arkansas, especially those experiencing disparities. The APCF Campaign against Prostate Cancer provides messages to motivate men and expedite access to screening, diagnosis, and treatment.

Disparate Burden

Prostate cancer is an important health problem in Arkansas because it is the number two cancer killer of Arkansas men, according to the American Cancer Society Facts and Figures. Although death rates have been declining among white and African American men since the early 1990s, rates in African American men remain more than twice as high as rates in white men.[7] Not only does prostate cancer occur more often in African American men, prostate cancer incidence also increases with age, and family history of the disease. There is a two to four-fold increased risk among men with one first degree relative with prostate cancer.[8]

In Arkansas, the prostate cancer incidence rate for African American men is 55 percent higher than white men, and they die at a rate that is 176 percent higher than whites[9]. It is important that cancer control experts in the state continue to find ways to educate Arkansas men and provide access to physician experts with whom Arkansans can make informed decisions.

Options

- Increase public education about prostate cancer.
- Monitor the science regarding the effectiveness of primary and secondary prevention interventions in reducing prostate cancer mortality.
- Promote informed decision making about screening.
- Promote education regarding treatment and support services especially in the underserved populations.

Priorities for Change

Reduce deaths from prostate cancer

- Reduce deaths from prostate cancer from 36.8 per 100,000 males in 1998, to 33.12 per 100,000 (age-adjusted to the 2000 US standard population) by 2010. (There are no Healthy People 2010 objectives for prostate cancer screening.)
- Increase early stage diagnosis to 89% in whites and African Americans by 2010.
  - Based on 2004 data, 87% of whites are diagnosed at an early stage (stage I and II) of disease, and 13% of whites are diagnosed at a late stage (stage III and IV) of disease, compared to 82% of African Americans who are diagnosed at an early stage and 18% of African Americans who are diagnosed at a late stage.

Prostate Cancer Screening and Detection

Goal G: Educate Men and Their Families About Prostate Cancer and Issues Related to Screening and Treatment.

Objective 1: Increase public education about prostate cancer.

- **Strategy 1** – Develop an education campaign to raise awareness of prostate cancer.
  - **Action 1** – Support the Arkansas Prostate Cancer Foundation as it convenes key stakeholders, advocacy groups, healthcare organizations, and other partners to develop a campaign.
  - **Action 2** – Provide information on 1) who is at risk, 2) the role of early detection, 3) guidelines for early detection, and 4) how to talk to a healthcare provider about the benefits and limitations of early detection and treatment of prostate cancer.
  - **Action 3** – Enlist statewide media support with identified community groups to provide consumer-centered awareness messages.
  - **Action 4** – Accelerate awareness and education during September, National Prostate Cancer Awareness Month, with media releases, interviews, materials, etc.
  - **Action 5** – Educate African American men and men with a family history of prostate cancer in a first-degree relative about prostate cancer prevention and early detection.

Objective 2: Monitor the science regarding the effectiveness of primary and secondary prevention interventions in reducing prostate cancer mortality.

- **Strategy 1 –** Gather and review studies on the efficacy of prostate cancer screening.
- **Strategy 2 –** Present annual updates on information gathered to the Early Detection Interest Group.

Objective 3: Promote informed decision making about screening.

- **Strategy 1 –** Convey the benefits and risks of screening to healthcare professionals, community leaders, the general public, and men to be screened.
- **Strategy 2 –** Disseminate the "Get the Facts About Prostate Cancer" to healthcare providers who screen men for prostate cancer.
- **Strategy 3 –** Encourage documentation of informed consent prior to prostate cancer screening.
- **Strategy 4 –** Develop questions regarding 1) informed decision making for prostate cancer screening, and 2) whether men have discussed prostate cancer with their physician, to add to the BRFSS survey in order to measure the extent to which providers are discussing the benefits and risks of prostate cancer screening with men.

Objective 4: Promote education regarding treatment and support services especially in the underserved populations.

- **Strategy 1 –** Educate patients about prostate cancer treatment options, including watchful waiting.
- **Strategy 2 –** Educate patients that they may seek a second opinion from various specialists after diagnosis regarding different treatment options.
- **Strategy 3 –** Educate patients about their right to ask questions regarding the expertise of the provider in treating prostate cancer (e.g., the number of procedures performed, complication rates, etc.)
- **Strategy 4 –** Disseminate information about support groups and other resources for patients diagnosed with prostate cancer and their loved ones.
- **Strategy 5 –** Encourage support for prostate cancer patients through treatment.
- **Strategy 6 –** Advocate for funding for the treatment of uninsured patients diagnosed with prostate cancer.

[1] American Cancer Society. *Cancer Facts and Figures 2007*. Atlanta: The American Cancer Society, 2006.
[2] NC Advisory Committee on Cancer Coordination and Control. North Carolina Cancer Control Plan, 2001-2006, pp 183.
[3] Bostwick DG, Burke HB, Djakiew D. Euling S, Ho S, Landolph J, et al. Human prostate cancer risk factors. *Cancer 2004*; 101 (10 Suppl);2371-2490.
[4] US Preventive Services Task Force. Screening for prostate cancer: recommendation and rationale. *Annals of Internal Medicine* 2002;137:915-916.
[5] Vainio H, Bianchini F. eds. *IARC Handbooks of Cancer Prevention, Vol 6: Weight Control and Physical Activity*. Lyon Frankc: IARC Press; 2002.
[6] See note #1
[7] See note #1.
[8] Whittemore AS, Wu AH, Kolonel LN, John EM, Fallagher RP, Howe GR, West DW, Stamey T. Family history and prostate cancer risk in black, white and Asian men in the United States and Canada. *Amer Journal of Epidemiology* 1995; 141:732-740.
[9] Arkansas Central Cancer Registry, Access at http://www.healthyarkansas.com/arkcancer/arkcancer.html

CHAPTER 3

ACCESS TO TREATMENT

Background

Cancer is a complex group of diseases. Different cancers behave differently and respond to different treatments. Treatment choices depend upon the type and state of cancer as well as a variety of individual factors that include age, health, cultural, and personal preferences. Care is comprised of various services, resources, and technology.[1]

Several factors can interfere with access to effective cancer treatment and care. In Arkansas, limitations on the quality of available care, lack of patient knowledge, insurance coverage and socioeconomic status and inadequate provider-patient communication are all potential issues affecting cancer treatment.

High Quality Cancer Care

American College of Surgeons

One indicator of high quality care is accreditation through the American College of Surgeons (ACoS) Commission on Cancer. Accredited hospitals ensure quality care through various cancer-related programs including prevention, detection, pretreatment evaluation, staging, optimal treatment, rehabilitation, surveillance for recurrent disease, support services, and end-of-life care. Currently, there are six ACoS approved hospital cancer treatment centers throughout Arkansas (Appendix G).

Arkansas Foundation for Medical Care (AFMC)

AFMC is a nonprofit corporation that is dedicated to clinical evaluation and improvement of healthcare in Arkansas. The organization is governed by a community-based board of directors. The volunteer board of directors is comprised of physicians, hospital and business representatives, consumers and other healthcare providers from across the state. AFMC serves as an additional source of continuing education for medical providers in the state. More information about AFMC can be found at www.afmc.org.

Since 1993, AFMC has carried out the CMS (Center for Medicare & Medicaid Services) Health Care Quality Improvement Program (HCQIP). In that time over 50 healthcare quality improvement projects have been implemented in hospitals, clinics, and physicians' offices. AFMC, at CMS direction, has recently begun work in both the nursing home and home health environment as well. Working closely with these entities as well as with Arkansas communities, AFMC promotes high quality, yet cost-effective healthcare for patients through provider and consumer education. AFMC's projects have served Arkansas by focusing on timely, clinically significant issues affecting the state's Medicare and Medicaid populations.

What AFMC Does

AFMC develops and promotes cooperative quality improvement projects involving hospitals, nursing homes, home health agencies, physicians and other stakeholders in order to improve the delivery, quality and cost-effectiveness of healthcare provided for Medicare and Medicaid beneficiaries. AFMC's past and present projects have opened many doors for Arkansas healthcare, including:

- More efficient administrative processes
- Lower costs
- Better quality of care leading to shorter stays
- Improved outcomes of care for patients

AFMC brings improvement initiatives to Arkansans that truly impact their lives. Collaborating with AFMC on any of the new projects will enable organizations to participate in a national initiative while helping to raise the standard of healthcare right here at home.

To contact AFMC, go to: http://www.afmc.org/HTML/programs/quality_improve/contact_qi.aspx

Financial Access to Treatment

Lack of adequate insurance is a large barrier to medical care in the US, as well as cancer care in Arkansas. According to the Arkansas Minority Health Commission in 2004, private health insurance was reported by 71 percent of whites and by approximately 50 percent of Hispanics, African Americans, and American Indians.[2] Individuals without insurance receive fewer inpatient and outpatient services[3] and are less likely to receive treatment consistent with national guidelines. Those without insurance have been found to have higher mortality than those with private insurance or Medicare.[4] Increasing insurance coverage will improve access to cancer-related care and services in rural areas, since rural residents are more likely than average to be uninsured.[5]

Access to Information

Unmet needs for information and assistance in understanding one's own medical situation often lead to non-compliance with the recommended treatment and follow-up care. In addition, a lack of information and understanding contributes negatively to patients' quality of life and increases anxiety about their condition.[6] In order to fully utilize state-of-the-art services, cancer patients and their families must be aware of available services. Maximizing utilization of services means empowering patients and their families by ensuring that they know and understand their options.

Geographic Access to Treatment

The healthcare workforce is a critical contributor to the health and healthcare of a community. This workforce is at the front line of ensuring that good health is obtainable and that high quality, cost effective care is available when needed. Therefore the workforce must not only be well trained in many aspects of community and individual health, but it must also be distributed in the community in such a way as to ensure the health of all people.[7]

Many Arkansans live in Medically Underserved Areas (MUAs) and Health Professional Shortage Areas (HPSAs). These areas may have shortages of primary medical, dental, or mental health providers and may consist of urban or rural areas. MUAs may include a whole county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services. More than half (58 percent) of the state's population lives in areas designated as MUAs. Some part of 71 counties in the state are designated as MUAs, and 58 counties (77 percent) are wholly designated as MUAs, indicating that 100 percent of the residents in those counties have limited access to medical care of all types.[8]

Disparate Burden

The HPSA (Health Professional Shortage Areas) criteria requires three basic determinations: 1) the geographic area involved must be realistic for the delivery of health services, 2) a specified population-to-practitioner ratio representing shortage must be exceeded within the area, and 3) resources in contiguous areas must be shown to be over utilized, excessively distant, or otherwise inaccessible. At least some portion of 48 of Arkansas' 75 counties is designated as a HPSA.

Options

- Increase the number of hospitals in Arkansas with cancer programs accredited by the American College of Surgeons Commission on Cancer.
- Increase the percentage of radiation therapy and other treatment facilities offering low-cost transportation services to patients.
- Support the efforts to establish linkages among rural providers and urban cancer centers so that optimal care is more accessible to rural cancer patients.
- Increase patient utilization of cancer treatment education resources.

Priorities for Change

American College of Surgeons Commission on Cancer Accreditation

- Increase the number of hospitals in Arkansas who are accredited by the American College of Surgeons Commission on Cancer from 6 to 9, by 2010.
- Decrease the number of Arkansans who have no health insurance from 18% (2001-2002 Current Population Surveys, Families USA) to 15% by 2010.

Access

Goal A: Ensure That Arkansans Affected By Cancer Are Aware Of and Have Access To, Appropriate, High Quality Care.

Objective 1: Increase the number of hospitals in Arkansas with cancer programs accredited by the American College of Surgeons Commission on Cancer.

- **Strategy 1 –** Form a workgroup to develop strategies to identify existing barriers to increasing the number of hospitals that become accredited cancer centers.
- **Strategy 2 –** Based on the barriers identified in Strategy 1, implement a plan to increase the number of hospitals with accredited cancer programs.

Objective 2: Increase the percentage of radiation therapy and other treatment facilities offering low-cost transportation services to patients.

- **Strategy 1 –** Identify barriers to provision of low-cost transportation.
- **Strategy 2 –** Based on the barriers identified, partner with groups across the state to discuss and plan how to eliminate these barriers.

Objective 3: Support the efforts to establish linkages among rural providers and urban cancer centers so that optimal care is more accessible to rural cancer patients.

- **Strategy 1 –** Work with state partners, (i.e., The Cancer Institute of Arkansas, and the American Cancer Society), to educate the public on the importance of access to treatment if a positive diagnosis is received.
- **Strategy 2 –** Host bi-annual Dialogues on Cancer at the Arkansas State Capitol building where cancer survivors who represent underserved populations join with state legislators, physicians, and public health professionals in a formal sharing of information. Testimony given will become a part of a permanent record to be used to inform in a most personal way, the decisions of policymakers on access and quality issues and to help frame the debate regarding universal access.
- **Strategy 3 –** Build a collection of actual stories of cancer patients who are uninsured or underinsured to be used to build support among advocacy and non-profit organizations as well as among private sector entities.

Objective 4: Increase patient utilization of cancer treatment education resources.

- **Strategy 1 –** Survey and assess the availability and utilization of hospital-based, culturally and linguistically appropriate patient education resources.
- **Strategy 2 –** Encourage the use of cancer treatment education resources by healthcare professionals.
- **Strategy 3 –** Include information and links to treatment-related resources on the Arkansas Cancer Coalition website.
- **Strategy 4 –** Implement web-based resources for integrative therapies within medical and community organizations.

[1] Montana Cancer Control Coalition. Montana Comprehensive Cancer Control Plan 2006-2011.
[2] Nash CR, Ochoa ER. Arkansas racial and ethnic health disparity study report. Presented to the AR Minority Health Commission, Spring 2004, unpublished report.
[3] Davis K, Rowland D. Uninsured and underserved: inequalities in healthcare in the United States. *Milbank Mem Fund Q Health Soc.* 1983;61:149-176.
[4] O'Malley MS, Earp JA, Hawley ST, Schell MJ, Mathews HF, Mitchell J. The association of race/ethnicity, socioeconomic status, and physician recommendation for mammography: who gets the message about breast cancer screening? *Am J Public Health.* 2001; 91:49-54.
[5] McDavid K, Tucker TC, Sloggett A, Coleman MP. Cancer survival in Kentucky and health insurance coverage. *Arch Intern Med.* 2003; 163:2135-2144.
[6] Shelby RA, Taylor KL, Kerner JF, Coleman E, Blum D. The role of community-based and philanthropic organizations in meeting cancer patient and caregiver needs. *CA Cancer J Clin* 2002;52:229-46.
[7] See Note #2.
[8] Phillips MM, Balamurugan A. The burden of diabetes in Arkansas: Surveillance Report.

CHAPTER 4

CLINICAL TRIALS

Background

According to the National Cancer Institute's website (www.cancer.gov), clinical trials are research studies in which people help doctors find ways to improve health and cancer care. Each study tries to answer scientific questions and to find better ways to prevent, diagnose, or treat cancer. A clinical trial is one of the final stages of a long and careful cancer research process. Studies are done with cancer patients to find out whether promising approaches to cancer prevention, diagnosis, and treatment are safe and effective.

There are five different types of clinical trials:

- **Treatment trials** test new treatments (like a new cancer drug, new approaches to surgery or radiation therapy, new combinations of treatments or new methods such as gene therapy).
- **Prevention trials** test new approaches, such as medicines, vitamins, minerals, or other supplements that doctors believe may lower the risk of a certain type of cancer. These trials look for the best way to prevent cancer in people who have never had cancer or to prevent cancer from coming back or a new cancer occurring in people who have already had cancer.
- **Screening trials** test the best way to find cancer, especially in its early stages.
- **Diagnostic trials** seek to find new ways of detecting cancer in people before they have any symptoms.
- **Quality of Life trials** (also called Supportive Cancer trials) explore ways to improve comfort and quality of life for cancer patients.

Most clinical research that involves the testing of a new drug progresses in an orderly series of steps, called phases. This allows researchers to ask and answer questions in a way that results in reliable information about the drug and protects the patients. Clinical trials are usually classified into one of three phases:

- **Phase I trials:** These first studies in people evaluate how a new drug should be given (by mouth, injected into the blood, or injected into the muscle), how often, and what dose is safe. A phase I trial usually enrolls only a small number of patients, sometimes as few as a dozen.
- **Phase II trials:** A phase II trial continues to test the safety of the drug, and begins to evaluate how well the new drug works. Phase II studies usually focus on a particular type of cancer.
- **Phase III trials:** These studies test a new drug, a new combination of drugs, or a new surgical procedure in comparison to the current standard. A participant will usually be assigned to the standard group or the new group at random (called randomization). Phase III trials often enroll large numbers of people and may be conducted at many doctors' offices, clinics, and cancer centers nationwide.

For additional information, go to www.cancer.gov.

The American Cancer Society also has a free and confidential Clinical Trials Matching Service program that helps patients, their families, and healthcare workers find clinical trials most appropriate to a patient's medical and personal situation. If you need assistance in finding a clinical trial, call 1-800-303-5691 or go to http://www.cancer.org.

Disparate Burden

Certain populations, such as those that are low income, elderly, racial/ethnic minorities or those who live in rural areas have the smallest percentage of clinical trial participants. Unfortunately, these same populations also bear a disproportionate burden of cancer morbidity and mortality. Without adequate representation of these populations in clinical trials, researchers cannot learn about potential differences among groups and cannot ensure the generalization of results. In addition, participation in clinical trials increases access to state-of-the-art cancer care, a critical factor in many minority and underrepresented populations that suffer disproportionately from cancer.[1]

Cultural barriers, language/linguistic differences, and low literacy among minority and underserved populations contribute greatly to the low numbers of minority participation

in cancer clinical trials. Many people from various ethnic and cultural backgrounds may have views that differ from Western medicine. As a result, some beliefs regarding health and disease, family involvement in decisions about treatment and views regarding traditional healers, religion and alternative medicine may make clinical trials a less desirable option.

Language and literacy factors also pose a serious barrier to provider-patient communications and attempts to recruit patients into clinical trials. For example, the initial consent form for the STAR trial, a national breast cancer prevention trial, was over eight pages long and required a 10th grade reading level.

There are also practical obstacles. Transportation to and from a trial, particularly if it is located in a distant location, can be a barrier for many underserved patients. Individuals with low incomes may find it difficult to take time off from work, find childcare or manage other family responsibilities while participating in a trial.[2]

Options

- Create an education campaign for healthcare professionals and patient advocacy organizations to increase awareness of and participation in cancer clinical trials.
- Provide a webpage with information regarding cancer clinical trials.
- Advocate for policy change for third-party payers in Arkansas to cover standard care costs associated with treatment under a cancer clinical trial.
- Increase awareness among healthcare professionals and consumers of the existence and efficacy of prevention trials, and share with Coalition's prevention groups.

Priorities for Change

- Increase the US adult participation in cancer clinical trials from 3-5% (National Cancer Institute: http://cancer.gov/clinicaltrials/) to 7% by 2010.
- Initiate legislation or special agreements that require health plans to pay the cost of routine medical care for clinical trial participants.

Cancer Clinical Trials

Goal A: Increase Awareness of and Participation in Cancer Clinical Trials.

Objective 1: Create an educational campaign for healthcare professionals and patient advocacy organizations to increase awareness of and participation in cancer clinical trials.

- **Strategy 1 –** Develop and implement a multi-tiered professional education campaign to publicize the benefits of cancer clinical trial enrollment and the importance of referring patients to clinical trials.
  - **Action 1 –** Identify and convene key stakeholders in each region of the state.
  - **Action 2 –** Identify and increase use of existing educational resources.
  - **Action 3 –** Use a speakers' bureau to address healthcare professionals and organizations regarding the benefits of cancer clinical trial enrollment.
- **Strategy 2 –** Re-convene cancer clinical trials pilot network.

Objective 2: Provide a webpage with information regarding cancer clinical trials.

- **Strategy 1 –** Create a webpage on the ARCC website as a central repository for links to on-line information about cancer clinical trials, for use by healthcare professionals and consumers.
  - **Action 1 –** Conduct a comprehensive review of existing on-line cancer clinical trial resources.
  - **Action 2 –** Identify resources for webpage development.
  - **Action 3 –** Monitor usage of the webpage.

Objective 3: Advocate for policy change for third-party payers in Arkansas to cover standard care costs associated with treatment under a cancer clinical trial.

- **Strategy 1 –** Assess coverage of standard care costs associated with clinical trials in Arkansas.
- **Strategy 2 –** Develop a background paper to justify coverage of standard care costs associated with treatment under a cancer clinical trial.
- **Strategy 3 –** Raise awareness of the need to cover standard care costs associated with treatment under a cancer clinical trial (Include clarification of Medicare Coverage).

Objective 4: Increase awareness among healthcare professionals and consumers of the existence and efficacy of prevention trials, and share with Coalition's prevention groups.

[1] Intercultural Cancer Council's Clinical Trials Webpage, 2006. Access at http://iccnetwork.org/cancerfacts/cfs11.htm.
[2] See note #1.

CHAPTER 5

DISPARITIES

Background

Cancer health disparities are differences in the incidence, prevalence, mortality, and burden of cancer and related adverse health conditions that exist among specific population groups in the United States. These population groups may be characterized by gender, age, race, ethnicity, education, income, social class, disability, geographic, location, or sexual orientation.[1]

The unequal burden of disease in our society is not just a scientific and medical challenge. It also presents a moral and ethical dilemma for the state and nation. The ARCC Disparities Interest Group convened and over a period of time, built a common vision of how it thought cancer health disparities could be reduced or eliminated. Because racial/ethnic minorities and the disadvantaged in the state are diagnosed with cancer later and have a shorter survival than non-minorities, the Interest Group embarked upon a mission to address important issues such as:

- Culturally competent and evidence-based interventions,
- High-quality and efficiency of service delivery,
- Culturally competent recruitment, retention, and intervention methodologies,
- Improved access to state-of-the-art cancer care, including clinical trials, and to adequate insurance coverage.

Establishing a centralized entity or organization for the oversight of the process from planning to implementation to evaluation requires solid commitment from a number of partners. And the first step to obtaining that commitment is the education of the participants. The goal and objectives below are meant to begin to steer the focus of public health and clinical programs alike toward a coordinated cancer health disparities approach. Existing data should be reviewed to ensure that they are consistent at the very least with the demographic categories used in government to define our current understanding of disparities. Where feasible, new measures, such as those based on life experiences and cultural factors, should be incorporated.[2]

Arkansas Center for Public Health Improvement Cooperative Agreement

In September 2007, the Arkansas Department of Health (ADH) received notification of selection to participate in the Centers for Disease Control and Prevention's (CDC) Assessment Initiative. The Assessment Initiative was started in 1992 and is now in its third five-year funding cycle. It is a cooperative program between the CDC and state health departments that supports the development of innovative systems and methods to improve the way data are used to provide information for public health and policy decision-making.

Figure 10: Arkansas Population by Race and Ethnicity, 2005

Caucasian	81.3%
Black or African American	15.7%
Hispanic or Latino (of any race)	4.7%
American Indian	0.7%
Asian	1.0%
Pacific Islanders	0.1%
All Arkansans living below the poverty level	16.0%

The effort in Arkansas will be led by the Center for Public Health Practice and will focus on community health assessment practices by bringing together representation from ADH programs: health statistics, chronic disease, infectious disease, and Hometown Health Improvement, and a strong team of external partners including academic institutions and representatives from specific communities such as the Marshallese, Hispanic/Latino and African American communities. This team of partners will work to achieve the following goals: (1) to improve the processes and outcomes of community health assessments; (2) to develop tools and methods to complete community health assessments throughout the state, particularly targeting hard to reach

populations; (3) to test, implement and evaluate community health assessment tools; (4) to identify and secure resources that will sustain the community health assessment activities; and (5) to disseminate tools and methods to other states that may benefit from the work in Arkansas.

Options

- Increase public and community awareness about cancer health disparities and cancer prevention, screening, and treatment in Arkansas.
- Support and promote the development of healthcare programs designed to reduce cancer disparities among targeted populations in Arkansas.
- Increase cancer disparities documentation and intervention on a systematic basis in Arkansas.

Priorities for Change

Raise the level and quality of cancer care so as to reduce the gap between mortality rates of whites and minority populations.

- Develop a system to monitor and document cancer disparities in Arkansas by 2010.
- Review by agency the recommendations put forth in the study report submitted by Creshelle R. Nash, MD, MPH, and Eduardo R. Ochoa, Jr. MD, in 2004: Arkansas Racial and Ethnic Health Disparity by 2008. (Access at: http://brfss.arkansas.gov/pdf/ar_racialethnichealth_disparitystudy.pdf.)

Disparities Elimination

Goal A: Reduce Cancer Control Disparities in Arkansas

Objective 1: Increase public and community awareness about cancer health disparities and cancer prevention, screening, and treatment in Arkansas.

- **Strategy 1 –** Collaborate with government agencies, academic health centers, community and faith-based organizations, and private entities to educate the public about topics relating to health disparities and cancer including:
  - The importance of social, economic, cultural, and environmental factors in influencing personal and community health.
  - The role of behavioral and biological factors in determining cancer risk.
  - Types of current interventions that can reduce/modify risks for developing cancer or the progression of cancer.
- **Strategy 2 –** Disseminate current and accurate information about cancer prevention, screening, early detection, and treatment, including complementary and alternative therapies to minority and underserved populations in Arkansas.
  - **Action 1 –** Identify "best practices" for health communication and interventions for specific minority populations.
  - **Action 2 –** Utilize existing educational resources and modify as appropriate to educate community members in a variety of settings including healthcare, schools, social, and faith-based institutions.

Objective 2: Support and promote the development of healthcare programs designed to reduce cancer disparities among targeted populations in Arkansas.

- **Strategy 1 –** Work in partnership with local Community Health Centers and Area Health Education Centers to promote cancer prevention, screening, and treatment programs aimed at disparate populations.
- **Strategy 2 –** Collaborate with the Cancer Institute of Arkansas's Cancer Community Outreach Center and its grant activities to increase the number of minority and underserved healthcare professionals including researchers involved in cancer research.

Objective 3: Increase cancer disparities documentation and intervention on a systematic basis in Arkansas.

- **Strategy 1 –** Support ongoing surveillance efforts and disparities research.
- **Strategy 2 –** Produce a status report on cancer disparities in Arkansas every two years and disseminate the report to key stakeholders including communities, media, healthcare and social service organizations, and policy makers.
- **Strategy 3 –** Expand and enforce cancer data collection and reporting on racial/ethnic minorities and use sub-population groups where possible.
- **Strategy 4 –** Provide technical assistance to community-based groups that monitor industrial and commercial environments.

[1] National Cancer Institute, Division of Cancer Control and Population Sciences.

[2] Trans-HHS Cancer Health Disparities Progress Review Group. Making cancer health disparities history. Submitted to the Secretary, US Department of Health and Human Services, pp.7.

CHAPTER 6

WORKFORCE DEVELOPMENT

Background

A strong cancer workforce is necessary if we are to achieve the major goals and objectives outlined in the state's cancer plan. The workforce must have sufficient people in all disciplines and points on the continuum of care. They must be well trained, maintain their currency in both knowledge and skill and there must be an ongoing supply of new people to replace those leaving the workforce.

The statistics below highlight both the magnitude of "supply" issues facing the cancer workforce and of the "demand" issues on the healthcare system. Important shortages exist nationally in cancer-related clinical and public health professions including nurses, oncologists, radiation oncologists, pharmacists, researchers/scientists, Certified Tumor Registrars (CTRs) and imaging technologists.

According to national experts:

- "We need about 1.2 million nurses in the next 10 years. We need about 3.4 million healthcare workers." (Elaine L. Chao, US Secretary of Labor)
- Approximately 60% of the 185,000 RNs who have joined the workforce since 2002 are over 50 years old. (2006 – Peter I. Buerhaus, PhD; Valerie Potter, professor of nursing; Vanderbilt Medical Center)
- Approximately 25% of clinical social work positions are vacant in California. (2005 – National Association of Social Workers)
- The average age of a public health worker is 46.6 years; many public health agencies currently face a 20% vacancy rate. (2004 – American Public Health Association)
- Imaging services demand projected to increase by 140% over the next 20 years. (2004 – Association of State and Tribal Health Organization)

The current and projected general workforce shortage in health disciplines is magnified when addressing cancer due to the fact that it is now the most common cause of death by disease claiming the lives of a half a million people per year. And, while cancer survival rates are improving, the number of people with cancer is increasing due to an aging population.

Several forces have been identified that add or draw professionals away from the health workforce:

Positive Forces

- high school and college student recruitment
- career re-entry
- career change
- foreign recruitment
- semi-recruitment

Negative Forces

- low visibility
- lack of incentives
- burn out
- other career choices
- retirement
- pay
- educational requirements
- access to programs
- cost of tuition

As experts study the statistics and forces at play affecting the cancer workforce several observations have become apparent:

- Cancer health workforce needs are universal and wide spread across discipline, continuum of care, and geography.
- Solutions for various recruitment and retention needs are often local or regional in nature.
- Ongoing quality management and continuing education is a pre-requisite to keep pace with scientific development and the social complexity of cancer.
- The workforce development pipeline spans issues of education, training, licensing, recruitment, and retention.
- Health workforce problems and solutions are felt more intensely in the context of an aging population.

Cancer workforce issues are often thought of as part of specific cancer problems. For example, if we choose to expand

our efforts in colorectal cancer early detection, we think about the types and numbers of people required to conduct the tests. Workforce needs are important to address for all of the objectives we include in our CCC plans. However, it is also critically important for us to think systematically and strategically about cancer workforce issues broadly and how our longer-term workforce needs will be met.

--Overview taken from Module Pre-work materials from the Comprehensive Cancer Control Leadership Institutes, Phase III, Workforce Module. 2006

Arkansas reflects the national trends. The workforce trends may have a greater impact in Arkansas, though, since the state already has an older and less healthy population. According to a report published recently by the University of Arkansas for Medical Sciences (UAMS), Arkansas already has one of the oldest populations in the country. By 2025, the state is projected to have the fifth highest percentage of adults 65 or older in the nation. Arkansas has also consistently ranked as one of the unhealthiest states – translating to increased need for healthcare. The state is ahead of the national average for obesity and the number of smokers. Arkansas is also ahead of the national average for diabetes and high blood pressure, and leads the nation in deaths due to stroke. When researchers surveyed Arkansas hospitals in 2003, they found thousands of unfilled healthcare jobs. The situation is expected to worsen as baby boomer health professionals leave the workforce.

Also according to the UAMS report, compared to the rest of the country, Arkansas ranks near the bottom for the number of physicians and nurses per capita, as well as for many other healthcare professions. This illustrates both potential healthcare access problems for patients as well as the inability to meet current demand.

In the US Department of Health and Human Services' state-by-state round-up of the healthcare workforce in 2000, Arkansas ranked 48th among the 50 states for physicians per capita, with 154 physicians per 100,000 population. This was well below the national ratio of 198 physicians per capita. The state's position had slipped from 1998, when the agency ranked Arkansas 44th with 157 physicians per capita.

At this time, the picture looks bleak. However the news isn't all bad. In 2000, Arkansas had the eighth highest number of pharmacists per capita in the nation with 88.9. That figure was up from 1998, when the state was ranked 26th for pharmacists per capita. Even though experts say that the profession is not matching demand, that demand being fueled by rising numbers of prescriptions and an aging population that will likely need even more medications in the future, this is an area where recruitment activities and currency maintenance can be impacted positively by 1) raising awareness among high schools and colleges around the state of the growing shortages in numbers of health professionals, 2) working to encourage student enrollment in allied health fields and medical schools, and 3) implementing incentive programs that encourage the newly trained to remain in Arkansas.

In recent years, UAMS leadership has launched numerous initiatives to position the state's only academic health sciences center to continue to play a lead role in producing healthcare professionals for the state. Plans are already in the works to increase facilities and recruit new faculty members to facilitate the increased enrollment. Historically, UAMS has produced the majority of Arkansas' doctors, along with many of its nurses, pharmacists, and other healthcare professionals. Nearly 80 percent of UAMS' medical students stay in Arkansas after graduation as teachers, researchers or medical practitioners. By investing in the development of programs and services, UAMS seeks to meet the increased demand for healthcare professionals.

There are also six American College of Surgeons (ACoS) Commission on Cancer approved hospital cancer programs in Arkansas.

Figure 11: ACoS Approved Cancer Programs 2007

Conway Regional Medical Center	Conway, AR
Washington Regional Medical Center	Fayetteville, AR
Sparks Regional Medical Center	Fort Smith, AR
St. Edward Mercy Medical Center	Fort Smith, AR
St. Joseph's Mercy Health Center	Hot Springs, AR
Central Arkansas Veterans Healthcare System	Little Rock, AR

Oncology programs earning recognition from the Commission on Cancer of the American College of Surgeons offer high-quality cancer care. Only one in four hospitals that treat cancer receive this special approval. It recognizes the quality of comprehensive cancer care available at a facility and offers a commitment that a patient will have access to all of the various medical specialists who are involved in the diagnosis and treatment of cancer.

Receiving care at a Commission on Cancer approved cancer program ensures that patients will receive:

- Quality care close to home.
- Comprehensive care offering a range of state-of-the-art services and equipment.
- A multi-specialty team approach to coordinate the best treatment options available to cancer patients.
- Access to cancer-related information, education, and support.
- A cancer registry that collects data on type and stage of cancers and treatment results, and offers lifelong patient follow-up care.
- Ongoing monitoring and improvement of care.
- Information about ongoing clinical trials and new treatment options.

Approval by the Commission on Cancer is given only to those facilities that have voluntarily committed to provide

the best in diagnosis and treatment of cancers. To meet the standards necessary for Commission approval, each cancer program, and the organization that controls it, must undergo a rigorous evaluation process and a review of its performance. In order to maintain approval, facilities with approved cancer programs must undergo an on-site review every three years.

The Approved Hospital Cancer Program encourages hospitals, treatment centers, and other facilities to improve their quality of patient care through various cancer-related programs. These programs are concerned with prevention, early diagnosis, pretreatment evaluation, staging, optimal treatment, rehabilitation, surveillance for recurrent disease and multiple primary tumors, psychosocial support, and care at the end of life. This availability of a full range of medical services involved in the diagnosis and treatment of cancer at approved cancer programs has resulted in approximately 80 percent of all newly diagnosed cancer patients being treated in Commission on Cancer approved cancer programs.

--Adapted from the Commission on Cancer webpage: http://www.facs.org/cancer/onlyprograms.html

Winthrop P. Rockefeller Cancer Institute

Founded in 1984, the UAMS Winthrop P. Rockefeller Cancer Institute directs all cancer research for the University of Arkansas for Medical Sciences and its affiliated institutions. Cancer Institute scientists are committed to reducing cancer incidence, mortality, and morbidity in Arkansas and the surrounding region. The Cancer Institute's approach is simple – discovery in our labs, development of new treatment strategies, and delivery of these new strategies to our clinics. Cancer Institute research moves from the laboratory bench to the patient's bedside. The bottom line for the patients is that the research fuels innovative treatment options.

The Winthrop P. Rockefeller Cancer Institute accomplishes this through focused research programs, shared resources and specialized labs to support institute research. Current Cancer Institute research programs include:

- Multiple Myeloma and Bone
- Cell Differentiation and Signaling
- Molecular Signatures and Cancer Therapeutics
- Aging and Cancer

The Winthrop P. Rockefeller Cancer Institute is working toward becoming a National Cancer Institute (NCI) designated cancer center. NCI cancer center designation requires the development and maintenance of a Protocol Review and Monitoring Committee (PRMC). The PRMC focuses on scientific merit, feasibility, use of cancer center resources, and clinical trial priorities. The PRMC reviews all clinical cancer studies conducted under the auspices of the Cancer Institute, regardless of whether the research involves use of Cancer Institute shared resources. All new protocols are reviewed and must receive full PRMC approval [in addition to the Institutional Review Board (IRB) approval] before they can be activated. Ongoing studies are monitored for protocol accrual.

The purpose of the Protocol Review and Monitoring Committee is to promote the scientific value of the clinical cancer studies that are being carried out at the The Cancer Institute of Arkansas. The PRMC does this by reviewing studies for scientific merit before they are activated to ensure that interpretable results and important cancer questions are likely to result. The committee was formally established in 1994 and consists of approximately 20 members with broad representation from clinical specialties, support services, biostatistics, and Cancer Institute shared resources.

Figure 12: Arkansas Hospital Association (AHA) Hospitals by the Numbers

Hospitals Licensed in Arkansas	104
Arkansas Hospital Members of AHA	98
Urban Hospitals	26
Rural Hospitals	21
Critical Access Hospitals	28
Psychiatric Hospitals	8
Long Term Hospitals	5
Specialty Hospitals	6
Rehabilitation Hospitals	2
VA Hospitals	2
Non-Hospital Members	3
Arkansas AHA Members	101
Out-of-State Members	2

Figure 13: Utilization and Financial Indicators Community Hospitals, 2004

Admissions	382,836
Inpatient Days	2,050,766
Outpatient Visits	4,842,303
Births	36,734
Total Employees	48,537
Payroll	$1,528,324,259
Billed Charges	$10,375,89,039
Total Amount Collected	$4,014,406,025
Operating Costs	$4,015,475,758
Cost of Charity Care Provided	$92,722,120
Patient Service Margin	(0.03%)
Other Operating Revenues	$134,780,857
Operating Margin	3.22%

AHA Members by Legislative District	1st	2nd	3rd	4th
	23	30	21	27

The PRMC has the authority to approve or disapprove new protocols based on scientific priorities, patient availability, available resources, as well as to terminate studies prematurely.

--http://www.acrc.uams.edu/cancer_research/prmc_faq.asp
--http://cancercenters.cancer.gov/

For information on other Arkansas Hospitals, access the Arkansas Hospital Association (AHA) website at: http://www.arkhospitals.org/statsindexsummer2006.htm. Statistics are available on the site for Arkansas Hospitals, Community Hospitals, and issues regarding uncompensated care costs, Medicare rates and updates, and a profile of the uninsured in Arkansas.

Information on Radiation Therapy in Arkansas may be accessed by calling:

1) Central Arkansas Radiation Therapy Institute, serving Little Rock, North Little Rock, Searcy, Conway and Mountain Home, http://www.carti.com, at (800) 482-8561 Extension 610.

2) North Arkansas Radiation Therapy Institute, serving Springdale and Fayetteville, AR http://narti.org, (479) 361-2585

3) Claude Parrish Radiation Therapy Institute in Harrison, AR at (870) 365-2244.

4) Denver Roller Radiation Therapy Institute in Mountain Home, AR at (870) 424-2200.

Options

- Maintain, promote, and expand the Arkansas Cancer Coalition partnership.
- Develop active membership lists and alerts.
- Use C-Change to educate collegiate setting. (Definition of C-Change is in the glossary)
- Identify other professional development materials and techniques.
- Identify methods to retain cancer workforce.
- Develop tracking tool to evaluate how numbers in healthcare workforce change/grow over time.

Priorities for Change

- Increase number of students, particularly minority students entering the allied health fields, medical schools.
- Increase the number of students, particularly minority students graduating from allied health/medical schools that stay in the state to practice.
- Increase the number of students, particularly minority students entering the field of public health.

The following baseline data elements should be developed in order to enable the tracking of progress in workforce development.

- Number of minority students entering allied health fields, medical schools, etc., and number that stay in Arkansas to practice.
- Numbers of public health workers by age, tenure, and location.
- Numbers entering oncology nursing, family practice, internal medicine, general medicine, endoscopy, oncology, radiation oncology, and radiation technology, to show growth over time, along with mammography and radiation therapy facilities.

Workforce Development

Goal A: Develop and Maintain Active Partnerships

Objective 1: Maintain, promote, and expand the Arkansas Cancer Coalition partnership.

Objective 2: Develop active membership lists and alerts.

- **Strategy 1 –** Survey members for correct contact information, Coalition affiliation, and interest areas.
- **Strategy 2 –** Place membership list on the website and make it available to all members.

Goal B: Develop Plans and Programs to Enhance the Key Elements of a Comprehensive Cancer Workforce Pipeline to and From Rural and Underserved Communities.

Objective 1 : Use C-Change to educate collegiate setting.

- **Strategy 1 –** Make cancer workforce development a priority.

Objective 2: Identify other professional development materials and techniques.

- **Strategy 1 –** Support and promote mentoring programs.
- **Strategy 2 –** Invest professional education funds in pre-service curricula.
- **Strategy 3 –** Develop resources/tools listing that can be printed on demand from the Coalition's website.

Objective 3: Identify methods to retain cancer workforce.

- **Strategy 1 –** Assess Arkansas-specific cancer workforce supply and demand.

Objective 4: Develop tracking tool to evaluate how numbers of healthcare workforce change/grow over time.

CHAPTER 7

SURVIVORSHIP

Background

The idea that cancer survival begins on the day of diagnosis is replacing the longstanding belief that survival begins once a patient is in remission. Survivorship is no longer equated with long-term survival or cure.[1]

In cancer, survivorship covers the physical, psychosocial, and economic issues of cancer, from diagnosis until the end of life. It includes issues related to the ability to get healthcare and follow-up treatment, late effects of treatment, subsequent cancers, and quality of life. Although some cancer survivors recover with a renewed sense of life and purpose, what has often not been recognized is the toll taken by both cancer and its treatment on health, functioning, sense of security, and well being. Long-lasting effects of treatment may be apparent shortly after its completion or arise years later. Personal relationships change and adaptations to routines and work may be needed. Perhaps most importantly, the survivor's healthcare is forever altered.[2]

In 2001, the number of people in the United States living with cancer reached nearly ten million, up from three million in 1971. Sixty-four percent of adults diagnosed with cancer today will be alive five years after their diagnosis and nearly 75 percent of those who had childhood cancer will be alive after 10 years.[3] This reduction in numbers of deaths is largely due to the implementation of prevention and early detection efforts for certain cancers, increased screening of the general population and those at risk for developing these diseases, and advances in research and clinical care.

By gaining a better understanding of the issues facing cancer survivors, researchers, healthcare and public health professionals can continue to enhance efforts to improve the lives of cancer survivors. Providing survivors with more complete medical records and detailed information about their diagnosis and treatment can help to improve follow-up care and help resolve a number of related issues. Greater attention to common concerns within the survivorship community may also help to bring about positive changes, including reforms in insurance coverage for survivors and legal reforms ensuring better protections and resources for survivors and their caregivers.[4]

The issue of survivorship has been studied by a variety of experts and advocates, and plans for action for addressing the issues faced by cancer survivors, their families, and caregivers are being developed[5] by the Cancer Institute and others. It is the intent of the Arkansas Cancer Coalition to chart a course based on these plans for how the public health community, and more specifically, the cancer control community can more effectively and comprehensively address cancer survivorship.

Options

- Enhance access to information and resources for Arkansas cancer survivors, their friends, and families.
- Reduce the financial burden on cancer survivors and their families.
- Address the needs of long-term cancer survivors in Arkansas.
- Support implementation of The Cancer Institute's Survivorship Plan for Rural Arkansans.

Priorities for Change

Survivorship

- Increase the proportion of survivors who are living five years or longer after diagnosis from 59% (Healthy People 2010 baseline in 1998) to 70%. (Healthy People 2010 target)

Cancer Mortality

- Reduce overall cancer death rate in Arkansas from 221.2 per 100,000, age-adjusted to the 2000 US standard population[6] to 159.9% per 100,000. (Healthy People 2010 target, down from 202.4 in 1998)

Survivorship

Goal A: Enhance the Quality of Life for All Cancer Survivors in Arkansas.

Objective 1: Enhance access to information and resources for Arkansas cancer survivors, their friends, and families.

- **Strategy 1 –** Support and promote the NCI Cancer Information Service toll-free telephone center.
- **Strategy 2 –** Build "Toolkits" of information links that can be used in a virtual environment such as the Cancer Institute and partners' websites, as well as in public libraries and other venues around the state.
- **Strategy 3 –** Identify patient navigator tools and systems for use in Arkansas, and assess who else is doing patient navigation in the state.
- **Strategy 4 –** Support and promote the development of a multimedia public service campaign to empower the public to be informed, proactive consumers of healthcare and to ask their doctors about appropriate cancer prevention and screening.

Objective 2: Reduce the financial burden on cancer survivors and their families.

- **Strategy 1 –** Examine the cost of cancer services and advocate for a statewide financial aid system to help offset the expense of cancer diagnosis and treatment services.
- **Strategy 2 –** Initiate a review of the Arkansas Medicaid system with attention to cancer costs.
- **Strategy 3 –** Work to establish a paid medical leave program based on the best practices of existing programs.
- **Strategy 4 –** Promote user-friendly transportation assistance programs to help patients get to and from treatment and medical appointments, support groups, education sessions, and other support services. Coordinate with existing transportation services and consider incentives such as tax credits for companies donating transportation services for cancer patients.

Objective 3: Address the needs of long-term cancer survivors in Arkansas.

- **Strategy 1 –** Encourage and provide funding for survivorship research.
- **Strategy 2 –** Encourage the development of long-term survivorship clinics in Arkansas for both childhood and adult cancer survivors. These clinics should be designed to follow survivors after treatment and to provide them with comprehensive care to address the unique needs of cancer survivors.
- **Strategy 3 –** Educate oncologists, family practice physicians, and other healthcare providers about long-term survivorship issues.
- **Strategy 4 –** Research and promote programs that address occupational issues of cancer survivors such as job retraining and workplace reintegration.

Objective 4: Support implementation of the The Cancer Institute's Cancer Survivorship Plan for Rural Arkansans. NOTE: This project was designed as a pilot study that will run approximately two years. The intention is to secure outcome data that can be used for application to grant agencies as well as help in the design of a survivorship plan.

- **Strategy 1:** Improve the quality of care for survivors of cancer addressing the following domains: 1) quality of life, 2) health education and self-care capacity, 3) psychological function, and 4) health care utilization.
- **Strategy 2:** Improve communication among the following: the patient, oncology team, primary care team, and community team.
- **Strategy 3:** Reduce workload on oncology practices for survivorship care.
- **Strategy 4:** Create a system that is user friendly.
- **Strategy 5:** Gain support of oncology and primary care, community and the patients.
- **Strategy 6:** Identify "champions" willing to work on pilot project and promote it with colleagues.
- **Strategy 7:** Generate data that can be used to test feasibility and refine elements of the project prior to grant submission.
- **Strategy 8:** Work toward application for external grant funding.

[1] Gerlach RW, Gambosi JR, Bowen TH. Cancer survivors' needs reported by survivors and their families. *Journal of Cancer Education* 1990; 5:63-70.
[2] National Academy of Sciences. From: Cancer patient to cancer survivor: lost in translation. Access at http://books.nap.adu/catelog/11468.html
[3] National Cancer Institute. NCI Health Information Tip Sheet. Access at http://www.cancer.gov/newscenter/tip-sheet-cancer-survivorship/
[4] See Note #2.
[5] Lance Armstrong Foundation. A national action plan for cancer survivorship: advancing public health strategies. April 2004.
[6] Rates are averaged per 100,000 population.

CHAPTER 8

PALLIATIVE CARE

Background

Palliative care is both a philosophy of care and an organized, highly structured system for delivering care. The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of disease or the need for other therapies. Palliative care expands traditional disease-model medical treatments to include the goals of enhancing quality of life, helping with decision-making, and providing opportunities for personal growth. Palliative care can be rendered along with life-prolonging treatment or as the main focus of care. Such care is appropriate to those suffering with many conditions, including cancer.[1]

There is no argument that palliative care should be integrated into cancer care from diagnosis to death, but significant barriers – attitudinal, behavioral, cultural, educational, and legal – still limit this needed care for a large proportion of people with cancer. Even into the twenty-first century, according to a background paper written by the Institute of Medicine, *Improving Palliative Care for Cancer, June 2001*, we ignored palliative care in cancer research "in accepting a single-minded focus on research toward cure, we have inadvertently devalued the critical need to care for and support patients with advanced disease."

In more recent years, palliative care has grown in response to an aging population and a clinical interest in effective care for chronic and life-ending illnesses. Integrating palliative care is a major challenge for healthcare in the US. Palliative care is a critical aspect of patient care and all patients should have access to practitioners who are skilled and knowledgeable about best practices.[2]

Cancer Pain Management

The under treatment of pain is an escalating public health concern. Pain is the primary reason people consult their doctor, yet more than an estimated 50 million Americans continue to suffer with persistent pain – often needlessly and silently. Prevailing myths about the experience and treatment of pain further impede access to timely, quality pain management.[3]

NOTE: Chronic pain is a part of life for over 50 percent of all cancer patients and survivors and for more than 75 percent of those with advanced stages of the disease – figures that have remained unchanged for decades, despite advances in therapeutic options to address pain. In an unprecedented effort to promote better pain control, Susan G. Komen Breast Cancer Foundation (now Susan G. Komen for the Cure), the Lance Armstrong Foundation (LAF) and the American Cancer Society announced in 2006, joint funding of a nationwide project to evaluate pain management policies in the states.

These organizations, which represent the nation's leading information and advocacy groups for people with cancer, are currently funding a three-year grant to the Pain & Policy Studies Group (PPSG) at the University of Wisconsin Comprehensive Cancer Center to examine policies that govern pain management practices for cancer patients in all 50 states and the District of Columbia.

An earlier report written by the PPSG and supported by The Robert Wood Johnson Foundation (updated in 2004) gave Arkansas a C+ along with eight other states around positive and negative provisions in state pain policies.

Positive provision criteria that identify policy language with the potential to enhance pain management were as follows:

- The use of some controlled substances is recognized as necessary for the public's health.
- Pain management is recognized as part of general medical practice.
- Medical use of opioids is recognized as legitimate professional practice.
- Pain management is encouraged.
- Practitioners' concerns about regulatory scrutiny are addressed.

- Prescription amount alone is recognized as insufficient to determine the legitimacy of prescribing.
- Physical dependence or analgesic tolerance are not confused with "addiction."
- Other provisions that may enhance pain management should be considered.

Negative provision criteria that identify policy language with the potential to impede pain management include:

- Opioids are considered a treatment of last resort.
- Medical use of opioids is implied to be outside legitimate professional practice.
- The belief that opioids hasten death is perpetuated.
- Physical dependence or analgesic tolerance are confused with "addiction."
- Medical decisions are restricted:
  - based on patient characteristics,
  - mandated consultation, and
  - restrictions regarding quantity prescribed or dispensed.
- Length of prescription validity is restricted.
- Practitioners are subject to additional prescription requirements.
- Other provisions that may impede pain management should be considered.
- Provisions that are ambiguous should be removed.

Source: Pain & Policy Studies Report, Achieving Balance: State Pain Policy – A Progress Report Card, Updated February 2004

In 2003, 35 percent of states scored around the average (thereby earning a grade of C), while 41 percent scored above the average and 24 percent fell below the average. No state received an A or F. As stated earlier, Arkansas received a C+ in 2003, and was unchanged since 2000. Sixteen states did show improvement between 2000 and 2003, and the driving force behind that change was state healthcare regulatory boards that adopted policies encouraging pain management or palliative care.

Many pain experts and advocates argue that pain care will not improve until there is a major shift in perceptions about pain and pain management. According to Myra Christopher, Center for Practical Bioethics, "People need to know that pain can be managed, and it can be managed in a way that does not cause them to become addicted to pain medications. At the same time, those of us who are advocating for better treatment of pain cannot ignore the fact that the misuse and abuse of drugs in this country is a problem."[4]

Christopher and others urge medical and regulatory professionals to examine the treatment of pain within a broader social context to figure out how to best balance the needs of society, while also ensuring timely access to pain medications for those living with pain.

Disparate Burden

Although control of pain can improve a person's quality of life, cancer pain often goes untreated, under treated, or improperly treated. Some population groups – including the elderly, women and members of racial and ethnic minorities – are more likely to be under treated for cancer pain than others. For example, a study of under treatment of pain among cancer patients in nursing homes found that while half of all patients in pain were receiving opioids, only 13 percent of patients aged 85 and older were receiving these medications. The study also found that African American patients in daily pain were 1.6 times as likely to receive no medication for pain relief.[5] A study of pain management in adult outpatients of all ages with advanced cancer found that the likelihood of receiving inadequate pain relief varied by race/ethnicity, age and sex.[6] Predictors of inadequate pain management included minority status, age of 70 years or older, and female sex. The same study also found that patients seen at centers that mostly treated minorities were three times as likely as those treated elsewhere to have inadequate pain management.[7]

Options

- Increase the number of palliative cancer health providers in Arkansas.
- Assess reimbursement for palliative care services.
- Reorganize the Arkansas Pain Initiative Team.
- Perform a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis on the state's current pain management regulations.
- Increase public awareness of palliative care.
- Expand provider education related to palliative care.

Priorities for Change

Palliative Care Providers

- Increase number of certified palliative care providers in Arkansas from 11 to 14* by 2010. (Certification by the American Board of Internal Medicine)

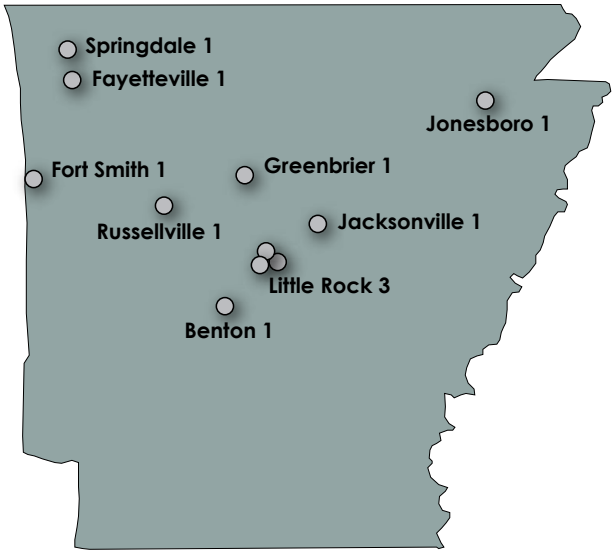
**Strive to assure that all Arkansans have access to a palliative care provider within 75 miles of their home.*

Palliative Care

Goal A: Increase Access to Palliative Care

Objective 1: Increase the number of palliative cancer health providers in Arkansas.

Figure 14: Arkansas Palliative Care providers



Source: American Board of Hospice and Palliative Medicine (ABHPM) website: www.abhpm.org/Locator.aspx

- **Strategy 1 –** Identify patient access to certified health care providers in palliative care throughout Arkansas.
- **Strategy 2 –** Create a plan to promote certification of palliative cancer providers throughout the state, particularly in underserved areas.

Objective 2: Assess reimbursement for palliative care services.

- **Strategy 1 –** Identify reimbursement models that promote expanded access to palliative care.
  - **Action 1 –** Identify top insurance providers in the state to determine palliative care reimbursement mechanisms.
  - **Action 2 –** Identify change needed in those mechanisms.
- **Strategy 2 –** Advocate for provider reimbursement for longer, more extensive care required in palliative care.
- **Strategy 3 –** Promote Medicare's reimbursement of hospice care.

[1] National Consensus Project for Quality Palliative Care (2004). Clinical practice guidelines for quality palliative care. //www.nationalconsensusproject.org
[2] See Note #1
[3] American Pain Foundation. Pain across the lifespan. The Pain Community News, Fall 2006, Vol. 6 Issue 2.
[4] See Note #3.

Objective 3: Reorganize the Arkansas Pain Initiative Team.

- **Strategy 1 –** Contact original and former members and assess interest level.
- **Strategy 2 –** Conduct a brainstorming meeting in order to gauge levels of expertise, interest, and support for the Arkansas Pain Initiative. Include the State Pharmacological Society, the State Medical Board, the AR Nurses Association, and the State's Association for Licensed Clinical Social Work.
- **Strategy 3 –** Report back to the appropriate interest groups of ARCC.

Objective 4: Perform a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis on the state's current pain management regulations.

- **Strategy 1 –** Determine the legal status of pain management in Arkansas.

Goal B: Provide Education that will Enhance the Understanding of Palliative Care in the Treatment Continuum.

Objective 1: Increase public awareness of palliative care.

- **Strategy 1 –** Work with existing community-based organizations to develop a comprehensive end-of-life awareness campaign for specific populations.
- **Strategy 2 –** Establish a media campaign to increase knowledge of palliative care issues to the public.

Objective 2: Expand provider education related to palliative care.

- **Strategy 1 –** Establish interdisciplinary education on palliative care concepts in university and college curricula.
- **Strategy 2 –** Provide and promote palliative care continuing education for providers that care for cancer patients.

[5] Bernabei R, Gambassi G, Lapane K. Management of pain in elderly patients with cancer. SAGE Study Group. Systematic Assessment of Geriatric Drug Use via Epidemiology. *JAMA*. Jun 17 1998;279(23):1877-1882.
[6] American Cancer Society. *Facts & Figures 2007*.
[7] Cleeland CS, Gonin R, Hatfield AK et al. Pain and its treatment in outpatients with metastatic cancer. *N Engl J Med.* Mar 3 1994;330(9):592-596.

CHAPTER 9

PROFESSIONAL EDUCATION

Background

Healthcare professionals are the critical link in ensuring that people obtain timely cancer screenings, reduce their risks of developing cancer, receive the best treatment for their situation, and for helping navigate the healthcare system. Healthcare professionals are often the primary source of information for Arkansans regarding cancer prevention and early detection, and have a responsibility to remind their patients about risk reduction and the need for cancer screenings.

Among the healthcare professionals who need to be most active in cancer prevention and early detection are physicians, nurses, nurse practitioners, physician assistants, dentists, dental hygienists, and dietitians. Healthcare professionals must be well-trained, active players in cancer prevention and control. Furthermore, they should be motivated and have local service capabilities to put screening guidelines into practice.

Healthcare professionals need easy access to cancer education, such as through the Internet, teleconferencing, and interactive educational software. These media are also especially valuable in providing continuing education for healthcare professionals who reside in rural communities or who have difficulty taking time away from their solo practices. The Internet and educational interactive software are practical methods for obtaining cancer information since they can be accessed at the professional's convenience, any time of the day and any day of the week. Teleconferencing allows for individuals who cannot travel to obtain the information and to interact simultaneously with the presenters.

University of Arkansas for Medical Sciences Department of Family & Preventive Medicine-Continuing Medical Education (UAMS DFPM-CME)

The University of Arkansas for Medical Sciences Department of Family and Preventive Medicine, Continuing Medical Education (UAMS DFPM-CME) has been a leader in providing continuing education via interactive television (ITV) for rural providers. Providing workshops in rural areas has been shown to be an effective method of reaching healthcare providers in rural areas.

The Arkansas Cancer Coalition has contracted with the UAMS DFPM-CME since 2001. DFPM-CME's goal is to provide quality CME (continuing medical education) and CE (continuing education) programs for physicians, pharmacists, nurses, and physician assistants who are involved in primary care. They provide educational resources to 43 different distant learning sites in Arkansas via interactive television, as well as live educational lectures on the UAMS campus. To better reflect the needs of the audience, programs are based on the feedback of participants. Because the programs are constantly evaluated, DFPM-CME has continued to help ARCC respond to the expectations of its membership and accomplish the Coalition's goal of enhancing healthcare professionals' knowledge, skills, and practices regarding cancer prevention and early detection.

Arkansas Foundation for Medical Care (AFMC)

Another source of continuing education is the AFMC. AFMC is a nonprofit corporation dedicated to the clinical evaluation and improvement of healthcare in Arkansas.

The community-based board of directors includes physicians and representatives from hospitals and other healthcare providers, as well as business and consumers across the state.

Winthrop P. Rockefeller Cancer Institute

The Winthrop P. Rockefeller Cancer Institute hosts special events to provide education regarding cancer and cancer research. These programs include tours of the institute, and provide cancer education programs and fellowships. To explore the Cancer Institute's educational resources and to learn more about these programs, visit the online calendar at http://www.acrc.uams.edu/med_professionals/prof_education.asp.

Community Health Nurse Specialists and Community Health Promotion Specialists

The collaboration among the Community Health Nurse Specialists (CHNS), the Community Health Promotion Specialists (CHPS), and the Arkansas Department of Education (ADE), also results in professional development and training on a variety of topics germane to cancer prevention and control issues. The CHNSs and the CHPSs are charged with providing technical assistance throughout the state to School Wellness Committees that work to improve the health of the students, teachers, and staff by emphasizing physical activity, good nutrition, and tobacco prevention messages. In conjunction with this technical assistance, the CHNSs and CHPSs also coordinate, facilitate and provide training for school nurses and teachers on topics such as health education standards and the implementation of tobacco prevention curricula.

Some examples from 2006 include:

- Over 5,500 continuing education hours were provided for school nurses statewide on topics such as: screening and measurement procedures for scoliosis, vision, hearing and Body Mass Index, pandemic influenza planning, asthma, and assistance for children with special needs.
- Also provided by CHNSs were 1,211 continuing education certificates for school nurses. The continuing education contact hours were specific to school nursing issues and were provided at no cost to the school nurses.

This collaborative effort also includes the partnership between ADE, the Arkansas Department of Health (ADH), and Arkansas Advocates for Children and Families that promotes and facilitates the implementation of Coordinated School Health (CSH) Programs. (CSH is an evidence-based CDC model that addresses eight components:

1) Physical education, 2) Health education, 3) Health services/counseling, 4) Psychological and social sciences, 5) Healthy school environment, 6) Health promotion for faculty and staff, 7) Parent and community involvement, and 8) Nutrition/food service.)

The partnership was originally created to ensure open communication between the agencies and to coordinate the assistance school districts receive from those agencies. This organized team has not only assisted school districts who wish to implement CSH, but they have offered an open channel for communication to and from funding agencies as they have supported the legislatively mandated School Wellness committees statewide. The partnership represents a unique vehicle for providing support, professional education, and resources to some of the most important groups that can actually affect the future of cancer and chronic disease prevention and control.

Figure 15: National Data from Healthy People 2010

Increase in Counseling About Tobacco Use Cessation, Physical Activity, and Cancer Screening	1988 Baseline (unless noted)	2010 Target
Internists who counsel about smoking cessation	50	85
Family physicians who counsel about smoking cessation	43	85
Dentists who counsel about smoking cessation	59 (1997)	85
Primary care providers who counsel about blood stool tests	56	85
Primary care providers who counsel about proctoscopic examinations	23	85
Primary care providers who counsel about mammograms	37	85
Primary care providers who counsel about Pap tests	55	85
Primary care providers who counsel about physical activity	22 (1995)	85

Options

- Encourage healthcare professionals to acquire knowledge and skills needed to prevent and detect cancer.
- Encourage healthcare professionals to routinely offer cancer prevention and early detection services to patients and families during healthcare visits. (See Figure 15)
- Facilitate statewide, multi-institutional coordination and collaboration to provide continuing education programs for healthcare professionals who provide oncology services.

Priorities for Change

- Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening (see Figure 15 National Data from Healthy People 2010).

Professional Education

Goal A: Enhance Healthcare Professionals' Knowledge, Skills, and Practices Regarding Cancer Prevention and Early Detection.

Objective 1: Encourage healthcare professionals to acquire knowledge and skills needed to prevent and detect cancer.

- **Strategy 1** – Assess the distribution of healthcare professionals with advanced training in prevention and early detection.

- **Strategy 2 –** Assess the availability of advanced training in cancer prevention education, screening and diagnosis for healthcare professionals.
- **Strategy 3 –** Support the evaluation of the factors that enhance healthcare professionals' participation in cancer prevention, screening, and diagnostic training programs.
- **Strategy 4 –** Stimulate the development and use of innovative approaches to cancer education, such as the Internet, teleconferencing, and interactive educational software.
- **Strategy 5 –** Develop and evaluate strategies to encourage primary care providers, especially those who provide services to low-income and medically underserved families, to obtain special training in cancer prevention, screening and diagnostic techniques.
- **Strategy 6 –** Document and promote ways in which telemedicine can be an effective approach to cancer diagnosis and treatment.

Objective 2: Encourage healthcare professionals to routinely offer cancer prevention and early detection services to patients and families during healthcare visits.

- **Strategy 1 –** Determine, where possible, healthcare professionals' adherence to the American Cancer Society's prevention and early detection guidelines.
- **Strategy 2 –** Ensure that healthcare professionals have sufficient training and resources to provide timely cancer risk assessment, prevention education, screening, and diagnostic services.
- **Strategy 3 –** Provide training opportunities for healthcare professionals on effective cancer counseling methods and educational materials for their patients.
- **Strategy 4 –** Ensure that healthcare professionals have ready access to cancer prevention materials that are appropriate for their patient populations.

Objective 3: Facilitate statewide, multi-institutional coordination and collaboration to provide continuing education programs for healthcare professionals who provide oncology services.

- **Strategy 1 –** Support and promote continuing statewide, multi-institutional physician oncology education, nurse oncology education, and dental oncology education programs to:
  - Assess the oncology education needs of physicians, nurses, and dentists.
  - Identify, support, and encourage updates in oncology education programs for physicians, nurses, and dentists.
  - Advise professional and governmental policymakers on oncology education policy and funding needs and priorities.
  - Monitor and continue to strengthen physician, nurse, and dental oncology education initiatives.
- **Strategy 2 –** Assess the need for oncology specialists within other healthcare disciplines, develop training programs, and establish networks to address identified needs.

CHAPTER 10

SURVEILLANCE AND REPORTING

Background

Cancer surveillance activities in Arkansas can be grouped into two main categories: morbidity and mortality information, and risk behavior information. The Arkansas Department of Health, Division of Vital Records and the Arkansas Central Cancer Registry conduct surveillance of cancer and mortality. Cancer mortality data are gathered from death certificates.

Surveillance data provide the background and make the case for priority setting and program management in cancer control. According to the National Cancer Institute, a truly comprehensive cancer surveillance system would embrace the entire life cycle from birth to death and would include cancer data regarding healthy people, the newly diagnosed, patients receiving treatment, and those living with and dying of the disease.

The goal of surveillance data is to identify and prioritize at-risk populations for prevention strategies, early-detection programs, and research. Data are also crucial to determine access to the best treatment and to improve quality of life throughout the continuum of cancer and at the end of life.[1]

It is important to have accurate and timely data to make informed decisions on how to best use resources to address the cancer burden. The term "surveillance" is used to describe the systematic collection, analysis, and interpretation of health data for planning, implementing, and evaluating health programs. All aspects of comprehensive cancer control programs from defining the burden of cancer and guiding planning activities, to monitoring changes and evaluating intervention efforts rely on the availability of strong and relevant surveillance activities. [2]

Arkansas Central Cancer Registry

The Arkansas Central Cancer Registry (ACCR), was originally established in 1938 by the Arkansas General Assembly. While the Registry collected minimal data on cancer cases in the state, it was not funded by the state until 1945. By 1970, the data collected were computerized; but due to a state funding crisis in 1979, the ACCR was eliminated.

In 1989, Arkansas again authorized a state cancer registry to be located at the Arkansas Department of Health, although funding was not available to staff the Registry or collect the data. In 1992, the US Congress passed the "Cancer Registries Amendment Act" (Public Law 102-515), which provided federal funding for state cancer registries. The law was carried out through efforts by the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. Funding for a cancer program in Arkansas began in 1994, when the first federal funds were awarded through the National Program for Cancer Registries (NPCR).

In 1994, the Arkansas Board of Health mandated cancer as a reportable disease in the State of Arkansas. With the help of the cancer registries across the state, January 1, 1996, the first cancer data since 1979 were collected in Arkansas.

Source: The Arkansas Central Cancer Registry. Arkansas Department of Health. Cancer in Arkansas: Cancer Incidence & Mortality, 1996-1998.

Disparate Burden

Data show that there is a disparate burden of cancer in Arkansas. However, the assumption may also be made that race and ethnicity are underreported to the Arkansas Central Cancer Registry and other surveillance systems. Therefore it follows that there are less reliable data on cancer incidence, treatment, and risk factors for racial and ethnic groups in the state – particularly for Hispanics, Asians, and Pacific Islanders. Even for African American Arkansans, it is difficult to assess the cancer burden, as well as to develop appropriate interventions for cancer prevention, detection, and treatment. Collection, classification, and reporting of cancer-related data must be improved. More can be done within research to increase the understanding of disparate burden and cancer. Only then will we have more than just clues as to what variables are causing the disparities. Reliable data will also speak to which interventions should be implemented.

Options

- Develop, maintain, and enhance data systems to ensure accurate, timely, and complete information needed for the prevention and control of cancer.
- Expand access to and analysis of the databases used for cancer surveillance in Arkansas in order to better serve users, stakeholders, researchers and the public.
- Improve racial and ethnic cancer data collection in Arkansas.
- Advocate for state funding of and support for the Arkansas Central Cancer Registry through legislation and policy development.

Priorities for Changes

Expand Data Collection

- Expand cancer-related data collection that is Arkansas specific.
  - Follow up on discussions regarding the reporting of data on all Medicaid cancer patients with goal of receiving 100% of Medicaid cancer patient data by 2008. Convene discussions regarding the reporting of Medicare data on all Medicare cancer patients by 2008.

Increase hospital reporting

- Increase the number of hospitals that report electronically to ACCR from 81 to 85 (100%) by 2008.
- Increase the number of hospitals that report to the ACCR monthly, and within four to six months after patient is diagnosed, from approximately 10 to 85 by 2010.
- Increase the number of non-hospital entities that report monthly, and within four to six months after patient is diagnosed, to the ACCR from 122 to 250 of 297 facilities by 2010.

Cancer Surveillance

Goal A: Fully Implement Cancer Surveillance – the Development, Collection, Analysis, and Dissemination of Cancer Information – in Arkansas.

Objective 1: Develop, maintain, and enhance data systems to ensure accurate, timely, and complete information needed for the prevention and control of cancer.

- **Strategy 1 –** Continue to support the Arkansas Central Cancer Registry on issues related to data quality, data use and data dissemination.
- **Strategy 2 –** Promote continued funding and support for existing cancer-related data collection.
  - **Action 1 –** Actively search for and make application to grants to provide sustainable funding for cancer-related data collection.
- **Strategy 3 –** Facilitate standardized measurement of race, ethnicity, and geographic area in databases that can be used for cancer surveillance in Arkansas.
- **Strategy 4 –** Provide training opportunities for cancer registrars and other collectors of cancer-related data.
- **Strategy 5 –** Explore barriers as to why hospitals do not have an in-house tumor registry.

Objective 2: Expand access to and analysis of the databases used for cancer surveillance in Arkansas in order to better serve users, stakeholders, researchers and the public.

- **Strategy 1 –** Pursue the creation of a public-use (non-confidential) data file for databases that are used for cancer surveillance in Arkansas.
- **Strategy 2 –** Develop and maintain a master distribution list of cancer reports.
- **Strategy 3 –** Develop a list of priority research questions about specific Arkansas cancer problems; share these research questions with potential funding sources, the statewide academic health centers, researchers, health leaders, and others.
- **Strategy 4 –** Develop a guide/report that reviews, aggregates, and summarizes methodologies that local and state health agencies and others could use to address small numbers issues and assessment of disparities, while maximizing information and maintaining privacy.
- **Strategy 5 –** Establish feedback mechanisms by which users of cancer surveillance system information can provide suggestions, including their unmet needs for information, and other comments.

Objective 3: Improve racial and ethnic cancer data collection in Arkansas.

- **Strategy 1 –** Publish African American and Hispanic/Latino-specific cancer incidence and mortality rates for Arkansas.
  - **Action 1 –** Evaluate the quality and completeness of African American and Hispanic/Latino cancer data collected in Arkansas.
  - **Action 2 –** Participate in future calls hosted by NAACCR for racial and ethnic data collection.
  - **Action 3 –** Publish guidelines for reporting African American and Hispanic/Latino data in the most appropriate way possible with identified limitations.
- **Strategy 2 –** Compile data from ancillary sources about cancer risk behaviors, health insurance, and cancer treatment related to cancer disparities across race and ethnic groups.

- **Action 1 –** Look specifically at BRFSS, health insurance coverage, and treatment data.
- **Action 2 –** Summarize available data applicable to racial and ethnic groups and gaps/weaknesses in data. Report findings where race and ethnicity group composites are available.
- **Action 3 –** Make recommendations for improving the applicability of databases for tracking and evaluating known disparities in cancer incidence and mortality.

[1] California Dialogue on Cancer. Comprehensive Cancer Control in California, 2004.

Objective 4: Advocate for funding of and support for the Arkansas Central Cancer Registry through legislation and policy development.

- **Strategy 1 –** Identify, engage, and involve interested public and private parties, institutions, and agencies to garner ongoing support.
- **Strategy 2 –** Educate legislators and staff about the importance of sustaining a strong registry and strengthening reporting requirements.

[2] Alaska Native Tribal Health Consortium Cancer Program. Comprehensive Cancer Plan for the Tribal Health System, 2005-2010.

APPENDIX A

Stricken language would be deleted from and underlined language would be added to present law.
Act 8 of the 1st Extraordinary Session

State of Arkansas | *As Engrossed: S4/4/06 H4/6/06* | Call Item 27
85th General Assembly | A Bill
First Extraordinary Session, 2006 | SENATE BILL 19

By: Senators Steele, Miller, *Womack*
By: Representatives Rosenbaum, George, Bradford

For An Act To Be Entitled

THE ARKANSAS CLEAN INDOOR AIR ACT OF 2006; AN ACT TO PROTECT WORKERS IN ARKANSAS FROM SECONDHAND SMOKE IN THE WORKPLACE; AN ACT TO PROTECT THE CITIZENS OF ARKANSAS FROM SECONDHAND SMOKE IN PUBLIC PLACES; AND FOR OTHER PURPOSES.

Subtitle

THE ARKANSAS CLEAN INDOOR AIR ACT OF 2006.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 27, is amended to add an additional subchapter as follows:

20-27-1801. Title.

This subchapter shall be known as the "Arkansas Clean Indoor Air Act of 2006".

20-27-1802. Findings.

(1) Information available to the General Assembly based upon scientific research data has shown that nonsmokers often receive damage to their health from the smoking of tobacco by others;

(2) Direct smoking of tobacco and indirect smoking of tobacco through inhaling the smoke of those who are smoking nearby are major causes of preventable diseases and death;

(3) Secondhand smoke is a known cause of lung cancer, heart

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1 disease, chronic lung ailments such as bronchitis and asthma, particularly in
2 children, and low birth-weight births;
3 (4) Implementing laws that prohibit tobacco usage in certain
4 public areas, buildings, and facilities is an effective approach to reducing
5 secondhand smoke exposure among nonsmokers; and
6 (5) It is therefore declared to be the public policy of the
7 State of Arkansas that the rights of Arkansans be protected in the manner
8 provided in this subchapter.
9
10 20-27-1803. Definitions.
11 As used in this subchapter:
12 (1) "Bar" means an establishment that is devoted to the serving
13 of alcoholic beverages for consumption by guests on the premises and in which
14 the serving of food is only incidental to the consumption of those beverages,
15 including, but not limited to:
16 (A) Taverns;
17 (B) Nightclubs;
18 (C) Cocktail lounges; and
19 (D) Cabarets;
20 (2) "Business" means any corporation, sole proprietorship,
21 partnership, limited partnership, professional corporation, enterprise,
22 franchise, association, trust, joint venture, or other entity, whether for
23 profit or nonprofit;
24 (3) "Employee" means an individual who is employed by a business
25 in consideration for direct or indirect monetary wages or profit;
26 (4) "Employer" means an individual or a business that employs
27 one (1) or more individuals;
28 (5) "Enclosed area" means all space between a floor and ceiling
29 that is enclosed on all sides by solid walls or windows, exclusive of
30 doorways, that extend from the floor to the ceiling;
31 (6)(A) "Health care facility" means an office or institution
32 providing care or treatment of diseases, whether physical, mental, or
33 emotional, or other medical, physiological, or psychological conditions,
34 including weight control clinics, homes for the chronically ill,
35 laboratories, and offices of surgeons, chiropractors, physical therapists,
36 physicians, dentists, and all specialists within these professions.

1 (B) "Health care facility" includes the building or
2 buildings in which a medical facility operates, together with all property
3 owned or operated by a medical facility that is contiguous to the building or
4 buildings in which medical services are provided.
5 (C) "Health care facility" does not include:
6 (i) Medical facilities under § 20-27-704 et seq.;
7 (ii) Psychiatric hospitals as defined by the Division
8 of Health of the Department of Health and Human Services' rules for hospitals
9 and related institutions; or
10 (iii) Long-term care facilities;
11 (7) "Infiltrate" means to permeate an enclosed area by passing
12 through its walls, ceilings, floors, windows, or ventilation systems to the
13 extent that an individual can smell secondhand smoke;
14 (8) "Local governing authority" means a county or municipal
15 corporation of the state;
16 (9)(A) "Place of employment" means an enclosed area under the
17 control of a public or private employer that employees utilize during the
18 course of employment, including, but not limited to:
19 (i) Work areas;
20 (ii) Employee lounges;
21 (iii) Restrooms;
22 (iv) Conference rooms;
23 (v) Meeting rooms;
24 (vi) Classrooms;
25 (vii) Employee cafeterias; and
26 (viii) Hallways.
27 (B) A private residence is not a place of employment
28 unless it is used as a licensed child care, adult day care, or health care
29 facility;
30 (10)(A) "Public place" means an enclosed area to which the
31 public is invited or in which the public is permitted, including, but not
32 limited to:
33 (i) Banks;
34 (ii) Bars;
35 (iii) Educational facilities;
36 (iv) Health care facilities;

1 (v) Laundromats;
2 (vi) Public transportation facilities;
3 (vii) Reception areas;
4 (viii) Restaurants;
5 (ix) Retail food production and marketing
6 establishments;
7 (x) Retail service establishments;
8 (xi) Retail stores;
9 (xii) Shopping malls;
10 (xiii) Sports arenas;
11 (xiv) Theaters; and
12 (xv) Waiting rooms.
13 (B) A private residence is not a public place unless it is
14 used as a licensed child care, adult day care, or health care facility;
15 (11)(A) "Restaurant" means:
16 (i) An eating establishment that gives or offers for
17 sale food to the public, guests, or employees; and
18 (ii) A kitchen or a catering facility in which food
19 is prepared on the premises for serving elsewhere.
20 (B) "Restaurant" includes, but is not limited to:
21 (i) Coffee shops;
22 (ii) Cafeterias;
23 (iii) Sandwich stands; and
24 (iv) Private and public school cafeterias.
25 (C) "Restaurant" does include a bar area within any
26 restaurant;
27 (12) "Retail tobacco store" means a retail store utilized
28 primarily for the sale of tobacco products and accessories and in which the
29 sale of other products is merely incidental;
30 (13) "Secondhand smoke" means smoke:
31 (A) Emitted from lighted, smoldering, or burning tobacco
32 when the person smoking is not inhaling;
33 (B) Emitted at the mouthpiece during puff drawing; and
34 (C) Exhaled by the person smoking;
35 (14) "Service line" means an indoor line in which one (1) or
36 more persons are waiting for or receiving service of any kind, whether or not

1 the service involves the exchange of money;
2 (15) "Shopping mall" means an enclosed public walkway or hall
3 area that serves to connect retail or professional establishments;
4 (16) "Smoking" means inhaling, exhaling, burning, or carrying
5 any:
6 (A) Lighted tobacco product, including cigarettes, cigars,
7 and pipe tobacco; and
8 (B) Other lighted combustible plant material; and
9 (17) "Sports arena" means a stadium, sports pavilion, gymnasium,
10 health spa, boxing arena, swimming pool, roller and ice rink, bowling alley,
11 and other similar place where members of the general public assemble to
12 engage in physical exercise, participate in athletic competition, or witness
13 sports or other events.
14
15 20-27-1804. Prohibitions on smoking.
16 (a) Upon the effective date of this act, smoking is prohibited in all
17 vehicles and enclosed areas owned, leased, or operated by the State of
18 Arkansas, its agencies and authorities, and any political subdivision of the
19 state, municipal corporation, or local board or authority created by general,
20 local, or special act of the General Assembly or by ordinance or resolution
21 of the governing body of a county or municipal corporation individually or
22 jointly with other political subdivisions or municipalities of the state.
23 (b)(1) Smoking is prohibited in all public places and enclosed areas
24 within places of employment, including, but not limited to;
25 (A) Common work areas;
26 (B) Auditoriums;
27 (C) Classrooms;
28 (D) Conference and meeting rooms;
29 (E) Private offices;
30 (F) Elevators;
31 (G) Hallways;
32 (H) Health care facilities;
33 (I) Cafeterias;
34 (J) Employee lounges;
35 (K) Stairs;
36 (L) Restrooms; and

1 (M) All other enclosed areas.
2 (2) An individual, person, entity, or business subject to the
3 smoking prohibitions of this section shall not discriminate or retaliate in
4 any manner against a person for making a complaint of a violation of this
5 section or furnishing information concerning a violation to a person, entity,
6 or business or to an enforcement authority.
7 (3) The prohibitions on smoking in subsections (a) and (b) of
8 this section and the provisions of subdivision (b)(2) of this section shall
9 be communicated to all current employees by their employer within thirty (30)
10 days of the effective date of this act, and to each prospective employee upon
11 application for employment.
12
13 20-27-1805. Exemptions.
14 An owner or operator of any of the following areas may exempt itself
15 from this subchapter:
16 (1) Private residences, except when used as a licensed child
17 care, adult daycare, or health care facility;
18 (2)(A) Hotel and motel rooms that are rented to guests and are
19 designated as smoking rooms.
20 (B)*However, if a hotel or motel has more than twenty-five*
21 *(25) guest rooms*, not more than twenty percent (20%) of rooms rented to
22 guests in a hotel or motel may be designated as exempt from this subchapter;
23 *(3)(A) All workplaces of any employer with fewer than three (3)*
24 *employees.*
25 *(B) This exemption does not apply to any public place;*
26 (4) A retail tobacco store, if secondhand smoke from the store
27 does not infiltrate into areas where smoking is prohibited under this
28 subchapter;
29 (5) Areas within long-term care facilities that are designated
30 by the facility as a smoking area or for supervised patient smoking only;
31 (6) Outdoor areas of places of employment;
32 (7) All workplaces of any manufacturer, importer, or wholesaler
33 of tobacco products, of any tobacco leaf dealer or processor, and all tobacco
34 storage facilities; and
35 (8)(A) All restaurants and bars licensed by the State of
36 Arkansas that prohibit at all times all persons less than twenty-one (21)

1 years of age from entering the premises, if secondhand smoke does not
2 infiltrate into areas where smoking is prohibited under this subchapter.
3 (B) All restaurants and bars that are exempt under this
4 subdivision (8) shall prominently display a health warning sign as defined by
5 the State Board of Health; and
6 (9) Designated smoking areas on the gaming floor of any
7 franchisee of the Arkansas Racing Commission.
8
9 20-27-1806. Notice of prohibition of smoking.
10 (a) "No Smoking" signs or the international "No Smoking" symbol
11 consisting of a pictorial representation of a burning cigarette enclosed in a
12 red circle with a red bar across it may be clearly and conspicuously posted
13 by the owner, operator, manager, or other person in control in every public
14 place and place of employment where smoking is prohibited by this subchapter.
15 (b) The owner, operator, manager, or other person in control of any
16 area where smoking is prohibited by this subchapter shall remove all ashtrays
17 from the area, unless an ashtray is permanently affixed to an existing
18 structure before the effective date of this act.
19 (c) The Department of Health and Human Services may treat a violation
20 of this section as a deficiency to be assessed against any licensee or
21 facility over which it has statutory jurisdiction.
22
23 20-27-1807. Rules - Promulgation and enforcement authority.
24 (a) The State Board of Health may adopt reasonable rules and
25 regulations that it determines are necessary or useful to carry out the
26 purposes or facilitate enforcement of this subchapter.
27 (b)(1) The Department of Health and Human Services and its authorized
28 agents may enforce compliance with this subchapter and any rules and
29 regulations adopted and promulgated under this subchapter by the board.
30 (2) Under rules of the board, the department and its authorized
31 agents may enter upon and inspect the premises of any public place or
32 enclosed area within a place of employment at any reasonable time and in a
33 reasonable manner.
34
35 20-27-1808. Subchapter deemed cumulative.
36 (a) This subchapter is cumulative to and does not prohibit the

enactment of any other general or local laws, rules, or regulations of state or local governing authorities or local ordinances prohibiting smoking that are more restrictive than or are in direct conflict with this subchapter.

(b) This subchapter may not be construed to permit smoking where it is otherwise restricted by other applicable laws or employer policies.

20-27-1809. Penalties.

Any person who violates any provision of this subchapter is guilty of a violation and upon conviction shall be punished by a fine of not less than one hundred dollars ($100) nor more than five hundred dollars ($500).

SECTION 2. Arkansas Code §§ 20-27-701 through 20-27-703 are repealed:

~~20-27-701. Public policy.~~

~~(a) Information available to the General Assembly based upon scientific research data has shown that nonsmokers often receive damage to their health from the smoking of tobacco by others.~~

~~(b) It is therefore declared to be the public policy of the State of Arkansas that the rights of nonsmokers be protected in the manner provided in this subchapter.~~

~~20-27-702. Penalty.~~

~~Any person violating this subchapter shall be guilty of a violation and upon conviction shall be punished by a fine of not less than ten dollars ($10.00) nor more than one hundred dollars ($100).~~

~~20-27-703. Public smoking prohibited – Exceptions.~~

~~(a) Smoking of tobacco or products containing tobacco in any form in a doctor's or dentist's waiting room, in hospital corridors, in nurses' stations in hospitals and clinics, in all hospital rooms, except private patient rooms in this state, and on school buses is prohibited.~~

~~(b) The provisions of this subchapter shall not prohibit smoking in any of the aforementioned areas if the smoking is assigned to areas designated as smoking areas.~~

~~(c) The provisions of this subchapter shall not apply to hotels, motels, and restaurants.~~

/s/ Steele

APPROVED: 4/7/2006

APPENDIX B

LOCAL TOBACCO PREVENTION AND EDUCATION PARTNERS

Sub Grantee	Program Coordinator	Address	telephone	fax	email
City of Melbourne for Izard County Hometown Health	Linda Moser	P.O. Box 91 Sage, AR 72556	(870) 368-5510	(870) 368-7060	lmoser@centurytel.net
Community Service Inc. for Alcohol, Tobacco and Other Drug Prevention Coalition	Jessica Allred/ Terry Love	P.O. Box 679 Morrilton, AR 72110	(501) 354-4589	(501) 354-5410	jallred@communityserviceinc.com; tlove@communityserviceinc.com
Community Service Inc. for Human Service Coalition of Faulkner County	Stephanie Cowden/ Terry Love	818 North Creek Drive Conway, AR 72032	(501) 327-9788	(501) 327-9843	scowden@communityserviceinc.com; tlove@communityserviceinc.com
Community Service Inc. for River Valley Prevention Coalition	Janet Cook / Terry Love	1505 South Oswego Avenue Russellville, AR 72802	(479) 967-3370	(479) 967-2775	jcook@communityserviceinc.com; tlove@communityserviceinc.com
Healthy Connections, Inc. for Vision 20/20 Quality of Life Coalition	Hilda Douglas	1201 South Mena Street Mena, AR 71953	(479) 394-2332 ext. 217	(479) 437-3454	hdouglas@sbcglobal.net
Lee County Family Resource Center	Lois Boyd	71 East Chestnut Street Marianna, AR 72360	(870) 295-5136		
Madison County Health Coalition	Brenda Patterson	P.O. Box 336 Huntsville, AR 72740	(479) 738-2612	(479) 738-1586	Brenda@madisoncountyhealth.com
North Arkansas Partnership for Health Education for Newton County Tobacco Education Coalition	Debralee Alexander	P.O. Box 200 Jasper, AR 72641	(870) 446-6022	(870) 446-6437	dalexander@northark.edu
North Arkansas Partnership for Health Education for Baxter County Tobacco Control Coalition	Allen Hundley	213 E. Sixth Street, Suite 40 Mt. Home, AR 72653	(870) 425-4400	(870) 424-6965	bctcc@alltel.net
North Arkansas Partnership for Health Education for Tobacco Free Boone County	Hollie Teague	303 N. Main St. Harrison, AR 72601	(870) 391-3526	(870) 391-3177	hteague@northark.edu
Northwest Arkansas Tobacco Free Coalition	Michelle Manning	614 East Emma Suite M428 Springdale, AR 72764	(479) 872-5350	(479) 927-2752	mmanning@jtlshop.jonesnet.org
Ozark Health Foundation for Ozark Mountain Health Network in Van Buren County	Shelly Hink	P.O. Box 206 Clinton, AR 72031	(501) 745-7004 ext 106	(501) 745-4203	shelly.hink@myozarkhealth.com; robin.corley@myozarkhealth.com
Ozark Health Foundation for Ozark Mountain Health Network in Searcy County	Renee Kyle	136 Valley Dr. Marshall, AR 72650	(870) 448-5733 or (870) 448-7125	(870) 448-3392	renee.bmrhc@yahoo.com; robin.corley@myozarkhealth.com
Paris School District for Tri-County Coalition (Logan Franklin & Crawford Counties)	Sheila Young	602 North 10th Paris, AR 72855	(479) 963-6531 ext. 3	(479) 963-1065	syoung@paris.k12.ar.us
Rogers Development Foundation, Inc for Drug Free Rogers Lowell Coalition	Megan Cuddy	317 West Walnut Rogers, AR 72756	(479) 619-3188	(479) 636-5485	megan@rogerslowell.com
Share Foundation for Union County Tobacco Free Coalition	Deb Crawford	501 N. Timberlane El Dorado, AR 71730	(870) 864-5121	(870) 864-5121	deb@prideyouthprograms.org
Tobacco Free Marion County	Julie Anderson	P.O. Box 188 Pyatt, AR 72672	(870) 427-2620	(870) 427-2620	tfmc@marioncounty.com
Tree of Preventive Health Maintenance, Inc. for River Valley Tobacco Free Coalition	Mona Clemons	412 South 17th, Suite 1 Fort Smith, AR 72902	(479) 782-3260	(479) 782-2959	rvtfc@cox-internet.com
UAMS - AHEC Southwest for Breathe Easy ArkTex Tobacco Control Coalition	Gary Miller	300 East 6th Street Texarkana, AR 71854	(870) 779-6010	(870) 779-6113	MillerGaryD@uams.edu
University of Arkansas-Monticello for Drew County Hometown Health Coalition	Ranelle Eubanks	UAM Box 3478 Monticello, AR 71656	(870) 460-1033	(870) 460-1933	eubanksr@uamont.edu
WE CARE, Inc. for Communities of Excellence for Tobacco Control/ Southeast Pulaski County	Patricia Jackson	P.O. Box 208 Wrightsville, AR 72183	(501) 897-5096	(501) 897-0523	wecare@aristotle.net
Woman's Council on African American Affairs Tobacco Prevention Coalition	Joyce Raynor	2416 South Chester Street Little Rock, AR 72206	(501) 372-3800	(501) 372-2150	hhscenter@sbcglobal.net

Stricken language would be deleted from and underlined language would be added to present law.
Act 13 of the 1st Extraordinary Session

State of Arkansas | *As Engrossed: H4/6/06* | Call Item27
85th General Assembly | A Bill
First Extraordinary Session, 2006 | HOUSE BILL 1046

By: Representatives Mathis, *Wills, Saunders, George*
By: Senator T. Smith

For An Act To Be Entitled

AN ACT TO PROTECT CHILDREN RESTRAINED IN CHILD PASSENGER SAFETY SEATS IN ARKANSAS FROM SECONDHAND SMOKE; AND FOR OTHER PURPOSES.

Subtitle

THE ARKANSAS PROTECTION FROM SECONDHAND SMOKE FOR CHILDREN ACT OF 2006.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Title.
This subchapter shall be known and may be cited as the "Arkansas Protection From Secondhand Smoke for Children Act of 2006".

SECTION 2. Definition.
As used in this subchapter "motor vehicle" means any motor vehicle, except a school bus, church bus, and other public conveyance, which is *required by federal or state law or regulation to be equipped with a passenger* restraint system.

SECTION 3. Tobacco use – Prohibitions.
Upon the effective date of this act, smoking is prohibited in all motor vehicles in which a child who is less than six (6) years of age and who weighs less than sixty pounds (60 lbs.) is restrained in a child passenger safety seat properly secured to the vehicle in accordance with § 27-34-101 et seq.

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SECTION 4. Penalty.

(a) A person who violates this subchapter is guilty of a violation and upon conviction shall be punished by a fine not to exceed twenty-five dollars ($25.00).

(b) If a person is convicted, pleads guilty, pleads nolo contendere, or forfeits bond for violation of this subchapter, no court costs pursuant to § 16-10-305 or other costs or fees shall be assessed.

(c) Any person who proves to the court that he or she has entered into a smoking cessation program may have his or her fine eliminated for a first offense violation of this subchapter.

/s/ Mathis, et al.

APPROVED: 4/10/2006

Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

State of Arkansas *As Engrossed: H3/3/03 H3/10/03 H3/12/03 S4/1/03*
84th General Assembly **A Bill** **Act 1220 of 2003**
Regular Session, 2003 HOUSE BILL 1583

By: Representatives Bradford, Biggs, Cleveland, Milligan
By: Senators Bisbee, Argue

For An Act To Be Entitled

AN ACT TO CREATE A CHILD HEALTH ADVISORY COMMITTEE; TO COORDINATE STATEWIDE EFFORTS TO COMBAT CHILDHOOD OBESITY AND RELATED ILLNESSES; TO IMPROVE THE HEALTH OF THE NEXT GENERATION OF ARKANSANS; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO CREATE A CHILD HEALTH ADVISORY COMMITTEE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 7, Subchapter 1 is amended to add three (3) additional sections to read as follows:

6-7-117. Committee - Creation.

(a) There is created a Child Health Advisory Committee to consist of *fifteen (15)* members.

(b)(1) The Director of the Department of Health shall appoint:

(A) One (1) member to represent the Department of Health;

(B) One (1) member to represent the Arkansas Dietetic Association;

(C) One (1) member to represent the Arkansas Academy of Pediatrics;

(D) One (1) member to represent the Arkansas Academy of Family Practice;

(E) One (1) member to represent the Arkansas Association

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1 for Health, Physical Education, Recreation, and Dance;
2 (F) One (1) member to represent jointly the Arkansas Heart
3 Association, the American Cancer Society, and the American Lung Association;
4 (G) One (1) member to represent the Arkansas School of
5 Public Health of the University of Arkansas for Medical Sciences;
6 (H) One (1) member to represent the Arkansas Center for
7 Health Improvement;
8 (I) One (1) member to represent the Arkansas Advocates for
9 *Children and Family; and*
10 *(J) One (1) member to represent the University of Arkansas*
11 *Cooperative Extension Service.*
12 (2) The Director of the Department of Education shall appoint:
13 (A) One (1) member to represent the Department of
14 Education;
15 (B) One (1) member to represent the Arkansas School Food
16 Service Association;
17 (C) One (1) member to represent the Arkansas School Nurses
18 Association;
19 (D) One (1) member to represent the Arkansas Association
20 of Education Administrators; and
21 (E) One (1) member to represent the Arkansas Parent
22 Teacher Association.
23 (c) Terms of committee members shall be three (3) years except for the
24 initial members whose terms shall be determined by lot so as to stagger terms
25 to equalize as nearly as possible the number of members to be appointed each
26 year.
27 (d) If a vacancy occurs, the officer who made the original appointment
28 shall appoint a person who represents the same constituency as the member
29 being replaced.
30 (e) The committee shall elect one (1) of its members to act as chair
31 for a term of one (1) year.
32 (f) A majority of the members shall constitute a quorum for the
33 transaction of business.
34 (g) The committee shall meet at least monthly.
35 (h) The Department of Health shall provide office space and staff for
36 the committee.

1 (i) Members of the committee shall serve without pay but may receive
2 expense reimbursement in accordance with § 25-16-902, if funds are available.
3
4 6-7-118. Powers and duties.
5 (a) The Child Health Advisory Committee shall meet at least once per
6 month and make recommendations to the State Board of Education and the State
7 Board of Health consistent with the intent and purpose of §§ 6-7-117 through
8 6-7-119.
9 (b) The Committee shall develop nutrition and physical activity
10 standards and policy recommendations with consideration of the following:
11 (1) Foods sold individually in school cafeterias but outside the
12 regulated National School Lunch Program;
13 (2) Competitive foods as defined by the United States Department
14 of Agriculture, as in existence on January 1, 2003, and offered at schools
15 typically through vending machines, student stores, school fundraisers, food
16 carts, or food concessions;
17 (3) The continuing professional development of food service
18 staff;
19 (4) The expenditure of funds derived from competitive food and
20 beverage contracts;
21 (5) Physical education and activity;
22 (6) Systems to ensure the implementation of nutrition and
23 physical activity standards; and
24 (7) The monitoring and evaluating or results and reporting of
25 outcomes.
26
27 6-17-119. Nutrition and physical activity standards - Implementation.
28 (a) The State Board of Education, after having consulted the committee
29 and the State Board of Health, shall promulgate appropriate rules and
30 regulations to ensure that nutrition and physical activity standards are
31 implemented to provide students with the skills, opportunities, and
32 encouragement to adopt healthy lifestyles.
33 (b) Beginning with the 2003-2004 school year, the Department of
34 Health, in consultation with the Department of Education, shall:
35 *(1) Employ one (1) qualified community health promotion*
36 *professional, with training, experience, or both, in nutrition, chronic*

1 *disease, or another related field to be housed within the Department of*
2 *Health to plan, develop, implement, and evaluate pilot or model programs to*
3 *support schools and communities, if funds are available;*
4 *(2) Employ one (1) statewide health promotion consultant to be housed*
5 *within the Department of Education, if funds are available;*
6 *(3) Employ one (1) person as a community health promotion*
7 *specialist to support implementation of pilot or model programs in schools*
8 *and communities in nutrition and physical activity in several distinct*
9 *geographical areas of the state, if funds are available; and*
10 *(4) Not use more than five percent (5%) of the annual Department*
11 *of Health Master Settlement Agreement funds for the salaries or programs*
12 *created under this subsection (b).*
13 *(c)* Beginning with the 2003-2004 school year, every school district
14 shall:
15 (1) Prohibit, for elementary school students, in-school access
16 to vending machines offering food and beverages;
17
18 *(2)* Require schools to include as part of the annual report to
19 parents and the community the amounts and specific sources of funds received
20 and expenditures made from competitive food and beverage contracts;
21 *(3) Require school to include as part of the student report card to*
22 *parents an annual body mass index percentile by age for each student; and*
23 *(4) Require schools to annually provide parents with an*
24 *explanation of the possible health effects of body mass index, nutrition and*
25 *physical activity.*
26 *(d) Beginning with the 2004-2005 school year, the Department of*
27 Education shall:
28 (1) Begin the implementation of standards developed by the
29 committee and approved by the Department of Education; and
30 (2) Annually monitor and evaluate the implementation and
31 effectiveness of the nutrition and physical education standards.
32 *(e)* Beginning with the 2004-2005 school year, every school district
33 shall:
34 (1) Convene a school nutrition and physical activity advisory
35 committee that shall include members from school district governing boards,
36 school administrators, food service personnel, teacher organizations,

1 parents, students, and professional groups such as nurses and community
2 members, to:
3 (A) Help raise awareness of the importance of nutrition
4 and physical activity; and
5 (B) Assist in the development of local policies that
6 address issues and goals, including, but not limited to, the following:
7 (i) Assisting with the implementation of nutrition
8 and physical activity standards developed by the committee with the approval
9 of the Department of Education and the State Board of Health;
10 (ii) Integrating nutrition and physical activity
11 into the overall curriculum;
12 (iii) Ensuring that professional development for
13 staff includes nutrition and physical activity issues;
14 (iv) Ensuring that students receive nutrition
15 education and engage in healthful levels of vigorous physical activity;
16 (v) Improving the quality of physical education
17 curricula and increasing training of physical education teachers;
18 (vi) Enforcing existing physical education
19 requirements; and
20 (vii) Pursuing contracts that both encourage healthy
21 eating by students and reduce school dependence on profits from the sale of
22 *foods of minimal nutritional value;*
23 (2) Begin the implementation of standards developed by the
24 committee with the approval of the Department of Education and the State
25 Board of Health; and
26 (3) Require that goals and objectives for nutrition and physical
27 activity be incorporated into the annual school planning and reporting
28 process.
29 *(f)* The Department of Education and the Department of Health shall
30 report annually on progress in implementing nutrition and physical education
31 standards to the cochairs of the House and Senate Interim Committees on
32 Public Health, Welfare, and Labor.
33
34 */s/ Bradford*
35
36 ***APPROVED: 4/10/2003***

Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

Act 724 of the Regular Session

State of Arkansas *As Engrossed: H2/24/05*

85th General Assembly **A Bill**

Regular Session, 2005 HOUSE BILL 1279

By: Representative Chesterfield

For An Act To Be Entitled

AN ACT TO PROVIDE INCENTIVES FOR THE IMPROVEMENT OF STATE EMPLOYEE HEALTH; TO PROVIDE LEAVE FOR *STATE EMPLOYEES WHO PARTICIPATE IN THE HEALTHY EMPLOYEE LIFESTYLE PROGRAM; TO PROVIDE AREAS FOR WALKING* EXERCISE AT STATE AGENCY FACILITIES; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO PROVIDE INCENTIVES FOR THE IMPROVEMENT OF STATE EMPLOYEE HEALTH.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 21, Chapter 4, Subchapter 2 is amended to add an additional section to read as follows:

21-4-216. Leave of absence for participation in the Healthy Employee Lifestyle Program.

(a) For purposes of this section:

(1) "Healthy Employee Lifestyle Program" means the incentive program of the Department of Health and the Department of Human Services that will reward regular exercise, good nutrition, and other healthy lifestyle choices;

(2) " State agency" means a department, agency, bureau, including the Bureau of Legislative Research, board, or commission of any branch of state government; and

(3) "State employee" means a full-time employee of the State of

02-24-2005 08:54 MGF054

1 *Arkansas or any branch, department, agency, board, bureau, including the*
2 *Bureau of Legislative Research , or commission of the state government.*
3 *(b)(1) Upon completion of the pilot program to be conducted by the*
4 *Department of Health and the Department of Human Services, the Department of*
5 *Health and Department of Human Services shall:*
6 *(A) Make the Healthy Employee Lifestyle Program available*
7 *to all agency directors; and*
8 *(B) Assist the agencies in its implementation.*
9 *(2) Upon completion of the pilot program, every state agency*
10 *director shall consider making the Healthy Employee Lifestyle Program*
11 *available to its employees.*
12 *(c)(1) At the discretion of the agency director, a state employee may*
13 *be granted paid leave of up to three (3) days per calendar year for*
14 *satisfactory compliance with the Healthy Employee Lifestyle Program.*
15 *(2) The leave shall be used in the calendar year in which it was*
16 *granted.*
17 *(3) The leave is not compensable at termination.*
18 *(d) Each state agency shall if practicable identify and maintain in or*
19 *near each agency building an area or areas that state employees may use for*
20 *walking exercise.*
21
22 */s/ Chesterfield*
23
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25 ***APPROVED: 3/09/2005***
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Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

Act 2236 of the Regular Session

1 State of Arkansas *As Engrossed: H4/1/05*
2 85th General Assembly **A Bill**
3 Regular Session, 2005 HOUSE BILL 2781
4
5 By: Representative Elliott
6 By: Senators Steele, Critcher, Whitaker
7
8
9 **For An Act To Be Entitled**
10 THE COLORECTAL CANCER ACT OF 2005; AND FOR OTHER
11 PURPOSES.
12
13 **Subtitle**
14 THE COLORECTAL CANCER ACT OF 2005.
15
16
17 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
18
19 SECTION 1. Arkansas Code Title 20, Chapter 15, is amended to add an
20 additional subchapter to read as follows:
21 20-15-1701. Title.
22 This subchapter shall be known and may be cited as the "Colorectal
23 Cancer Act of 2005".
24
25 20-15-1702. Findings and purpose.
26 (a) The General Assembly finds that:
27 *(1) Colorectal cancer is a significant threat to the health of*
28 *Arkansas residents;*
29 *(2) Colorectal cancer is more likely to occur as people get*
30 *older. More than ninety percent (90%) of people with this disease are*
31 *diagnosed after age fifty (50);*
32 *(3) In Arkansas, it is estimated that one thousand six hundred*
33 *thirty (1,630) new cases of cancer of the colon and rectum will occur in*
34 *2005;*
35 *(4) Colorectal cancer exacts an enormous economic toll on our*

04-01-2005 14:17 DLP209

1 society in direct medical costs and indirect costs, such as lost work due to
2 illness and shortened lives among experienced workers;
3 (5) Colorectal cancer is largely preventable; and
4 (6) Screening for colorectal cancer can identify the precursors
5 of cancer before the disease begins and the precursors can be removed, thus
6 preventing the emergence of any colorectal cancer.
7 (b) This subchapter is intended to reduce the physical and economic
8 burden of colorectal cancer in Arkansas by supporting research and cancer
9 control activities.
10 20-15-1703. Colorectal Cancer Control and Research Program --
11 Demonstration Project.
12 (a) There is established within the Arkansas Cancer Research Center at
13 the University of Arkansas for Medical Sciences in collaboration with the
14 Department of Health a Colorectal Cancer Control and Research Program.
15 (b)(1) The first phase of this program shall be the Colorectal Cancer
16 Control Demonstration Project.
17 (2) The goal of the demonstration project is to:
18 (A) Assess the resources in this state that will enable
19 Arkansas residents to obtain colorectal screening examinations and laboratory
20 tests, to include a fecal occult blood test, double contrast barium enema,
21 flexible sigmoidoscopy, and colonoscopy; and
22 (B) Plan and implement an educational and screening
23 intervention program.
24 (c) The demonstration project shall be established at the Arkansas
25 Cancer Research Center at the University of Arkansas for Medical Sciences and
26 shall consist of the following:
27 (1) An assessment will be made to:
28 (A) Identify the number of facilities in the state that
29 provide double contrast barium enema, flexible sigmoidoscopy, and
30 colonoscopy;
31 (B) Identify physicians, including family practioners,
32 gastroenterologists, and surgical endoscopists who perform colonoscopy in the
33 state and the regions of the state in which they practice;
34 (C) Evaluate differences in cost across facilities as
35 compared to Medicare payment for procedures; and
36 (D) Identify and evaluate available resources for follow-

1 *up diagnostics and treatment as needed;*
2 *(2)(A) Education and screening intervention to demonstrate the*
3 *effectiveness of providing education and access to screening in order to*
4 *increase the number of Arkansas residents who obtain screening.*
5 *(B)(i) The education and screening intervention segment of*
6 *the demonstration project will enroll Arkansas residents over fifty (50)*
7 *years of age from multiple sites who are identified as having the highest*
8 *colorectal cancer incidence and mortality in each of the five (5) regions of*
9 *the state through the Department of Health's Hometown Health Initiative.*
10 *(ii) The number of individuals to be enrolled shall*
11 *be determined by the extent of funding available.*
12 *(iii) The project segment will study three (3)*
13 *approaches to education and screening as follows:*
14 *(a) Provision of an educational intervention*
15 *designed to teach the individual about the need to seek screening;*
16 *(b) Provision of access to screening with no*
17 *educational intervention; and*
18 *(c) Provision of educational intervention and*
19 *access together.*
20 *(iv)(a) Access to screening may include payment*
21 *vouchers for those patients determined to be underinsured or uninsured.*
22 *(b) The vouchers shall be redeemable by*
23 *project participants for screening services obtained through participating*
24 *physicians in each of the five (5) regions; and*
25 *(3)(A) Evaluation at the end of the demonstration period by*
26 *project leaders to identify the program's effectiveness in increasing the*
27 *number of individuals who obtained screening for colorectal cancer.*
28 *(B) The program evaluation information, coupled with the*
29 *results of the assessment of screening resources in this state, will help to*
30 *establish strategies for meeting the long-term goal under subsection (d) of*
31 *this section.*
32 *(d)(1) The Colorectal Cancer Control and Research Program will build*
33 *on the results of the demonstration program to meet the long-term goal of the*
34 *program.*
35 *(2) The long-term goal of the Colorectal Cancer Control and*
36 *Research Program is to reduce the physical and economic burden of colorectal*

1 *cancer in this state by:*
2 *(A) Supporting research efforts into the cause, cure,*
3 *treatment, early detection, and prevention of colorectal cancer and the*
4 *survivorship of individuals diagnosed with colorectal cancer;*
5 *(B) Supporting research and educational activities that*
6 *will inform the public of the value of colorectal cancer screening and will*
7 *result in improved methods to promote screening and early detection;*
8 *(C) Supporting policy research to review and analyze long-*
9 *term successes and future opportunities for reducing the burden of colorectal*
10 *cancer through legislation;*
11 *(D) Providing for the full continuum of care, prevention,*
12 *early detection, diagnosis, treatment, and cure of colorectal cancer; and*
13 *(E)) Requiring providers to offer a wide range of*
14 *colorectal cancer screening options.*
15 *(e)(1) The program shall provide for the full continuum of care,*
16 prevention, early detection, diagnosis, treatment, cure of colorectal
17 cancer, and survivorship.
18 (2) The program shall be administered to provide:
19 (A) Colorectal cancer education and awareness to promote
20 prevention and early detection;
21 (B) Colorectal cancer surveillance activities across the
22 state;
23 (C) Screening for colorectal cancer with special focus on
24 persons fifty (50) years of age and older and persons at high risk for
25 colorectal cancer;
26 (D) After-screening, medical referrals, and financial
27 assistance for services necessary to follow up abnormal screening exams;
28 (E) Necessary advocacy and financial assistance to ensure
29 the persons obtain necessary treatment if a positive diagnosis is made; and
30 (F) Obtain information from health care insurers and
31 providers concerning the extent of colorectal cancer screening, treatment,
32 and insurance coverage.
33
34 SECTION 2. Arkansas Code Title 23, Chapter 79, is amended to add an
35 additional subchapter to read as follows:
36 23-79-1101. Definitions.

1 As used in this subchapter:
2 (1) "Covered person" means a person who is and continues to
3 remain eligible for coverage under a health care policy and is covered under
4 a health care policy;
5 *(2)(A)* "Health care policy" means:
6 *(i) An individual or group health insurance policy*
7 providing coverage on an expense-incurred basis;
8 *(ii) An individual or group service or indemnity type*
9 contract issued by a nonprofit corporation;
10 *(iii) An individual or group service contract issued by a*
11 health maintenance organization;
12 *(iv) A group accident and sickness insurance policy issued*
13 by a fraternal benefit society, a nonprofit hospital service corporation, a
14 nonprofit medical service corporation, a group health care plan, a health
15 maintenance organization, or any similar entity; and
16 *(v) A policy issued by or in connection with:*
17 *(a) The Arkansas medical assistance program and its*
18 contracted insurers, whether providing services on a managed-care or fee-for-
19 service basis;
20 *(b) The state employees' and public school* teachers'
21 health insurance programs;
22 *(c) A self-insured group arrangement to the extent*
23 not preempted by federal law; and
24 *(d) A managed health care delivery entity of any*
25 *type or description.*
26 *(B) "Health care policy" does not include an accident-*
27 *only, specified disease, hospital indemnity, Medicare supplement, long-term*
28 *care, disability income, or other limited benefit health insurance policy;*
29 *and*
30 (3) "Persons at high risk for colorectal cancer" means:
31 *(A) Individuals over fifty (50) years of age or who face a*
32 *high risk for colorectal cancer because of:*
33 *(i) The presence of polyps on a previous*
34 *colonoscopy, barium enema, or flexible sigmoidoscopy;*
35 *(ii) Family history of colorectal cancer in close*
36 *relatives of parents, brothers, sisters, or children;*

1 *(iii) Genetic alterations of hereditary nonpolyposis*
2 *colon cancer or familial adenomatous polyposis;*
3 *(iv) Personal history of colorectal cancer,*
4 *ulcerative colitis, or Crohn's disease; or*
5 *(v)* The presence of any appropriate recognized gene
6 markers for colorectal cancer or other predisposing factors; and
7 (B) Any additional or expanded definition of "persons at
8 high risk for colorectal cancer" as recognized by medical science and
9 determined by the Director of the Department of Health in consultation with
10 the University of Arkansas for Medical Sciences.
11
12 23-79-1102. Coverage - Applicability.
13 (a) A health care policy subject to this subchapter executed,
14 delivered, issued for delivery, continued, or renewed in this state on or
15 after August 1, 2005, shall include colorectal cancer examinations and
16 laboratory tests within the policy's coverage.
17 (b) The coverage shall include colorectal cancer examinations and
18 laboratory tests for:
19 (1) Covered persons who are fifty (50) years of age or older;
20 (2) Covered persons who are less than fifty (50) years of age
21 and at high risk for colorectal cancer according to American Cancer Society
22 colorectal cancer screening guidelines as they existed on January 1, 2005;
23 and
24 (3) Covered persons experiencing *the following symptoms* of
25 colorectal cancer as determined by a physician licensed under the Arkansas
26 Medical Practices *Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401*
27 *et seq.:*
28 *(A) Bleeding from the rectum or blood in the stool; or*
29 *(B) A change in bowel habits, such as diarrhea,*
30 *constipation, or narrowing of the stool, that lasts more than five (5) days.*
31 (c) After August 1, 2005, each employer that offers a health care
32 policy to employees shall offer all eligible employees at the time of hiring
33 or health care policy renewal a policy that includes colorectal cancer
34 examinations and laboratory tests within the coverage of the employee's
35 health care policy.
36 *(d)(1) The colorectal screening shall involve an examination of the*

1 *entire colon, including:*
2 *(A) The following examinations or laboratory tests, or*
3 *both:*
4 *(i) An annual fecal occult blood test utilizing the*
5 *take-home multiple sample method, or an annual fecal immunochemical test in*
6 *conjunction with a flexible sigmoidoscopy every five (5) years;*
7 *(ii) A double-contrast barium enema every five (5)*
8 *years; or*
9 *(iii) A colonoscopy every ten (10) years; and*
10 *(B)* Any additional medically recognized screening tests
11 for colorectal cancer required by the Director of the Department of Health,
12 determined in consultation with appropriate health care organizations.
13 (2) The covered person shall determine the choice of screening
14 strategies in consultation with a health care provider.
15 *(3) Colorectal screening examinations shall be according to the*
16 *choices and frequency provided by this subsection (d) for all other covered*
17 *persons.*
18 *(e) Screenings shall be limited to the following guidelines for the*
19 *management or subsequent need for follow-up colonoscopy:*
20 *(1) If the initial colonoscopy is normal follow-up is*
21 *recommended in ten (10) years;*
22 *(2) For individuals with one (1) or more neoplastic polyps,*
23 *adenomatous polyps, assuming that the initial colonoscopy was complete to the*
24 *cecum and adequate preparation and removal of all visualized polyps follow-up*
25 *is recommended in three (3) years;*
26 *(3) If single tubular adenoma of less than one centimeter (< 1*
27 *cm) is found follow-up is recommended in five (5) years; and*
28 *(4) For patients with large sessile adenomas greater than three*
29 *centimeters (> 3 cm), especially if removed in piecemeal fashion, follow-up*
30 *is recommended in six (6) months or until complete polyp removal is verified*
31 *by colonoscopy.*
32
33 23-79-1103. Certain activities not prohibited.
34 (a) This subchapter does not prohibit the issuance of policies that
35 provide benefits greater than those required by § 23-79-1102 or more
36 favorable to the insured than those required by § 23-79-1102.

1 (b) This subchapter does not prohibit the payment of different levels
2 of benefits or from having differences in coinsurance percentages applicable
3 to benefit levels for services provided by preferred and nonpreferred
4 providers as otherwise authorized by law relating to preferred provider
5 arrangements.
6
7 23-79-1104. Exclusions and reductions -- Benefits subject to annual
8 deductible and co-insurance.
9 (a) Except as provided in subsection (b) of this section, the coverage
10 offered under § 23-79-1102 may contain any exclusions, reductions, or other
11 limitations approved by the Insurance Commissioner concerning coverages,
12 deductibles, or coinsurance provisions.
13 (b) The benefits provided in this subchapter shall be subject to the
14 same annual deductible or coinsurance established for all other covered
15 benefits within a health care policy.
16
17 23-79-1105. Coverage by participating providers -- Selection criteria
18 and utilization protocols -- Maximum benefits -- Exclusions.
19 (a)(1) This subchapter does not require and shall not be construed to
20 require the coverage of services by providers who are not designated as
21 covered providers or that are not selected as a participating provider by a
22 group health benefit plan or insurer having a participating network of
23 service providers.
24 (2) This subchapter does not expand the list or designation of
25 participating providers as specified in any health benefit plan.
26 (b) Insurers or other issuers of any health benefit plan covered by
27 this subchapter may continue to establish and apply selection criteria and
28 utilization protocols for health care providers including:
29 (1) The designation of types of providers for which coverage is
30 provided; and
31 (2) Credentialing criteria used in the selection of providers.
32 (c) A health care policy that provides coverage for the services
33 offered under this subchapter may contain provisions for maximum benefits and
34 coinsurance limitations, deductibles, exclusions, and utilization review
35 protocols to the extent that the provisions are not inconsistent with the
36 requirements of this subchapter.

1
2 23-79-1106. Additional benefit costs.
3 The issuer of a health care policy shall conform its policies,
4 contracts, or certificates issued on or after August 1, 2005, and may adjust
5 its premium cost to reflect the additional benefit cost.
6
7 23-79-1107. Cost-sharing.
8 (a) To encourage colorectal cancer screenings, patients and health
9 care providers may not be required to meet burdensome criteria or overcome
10 significant obstacles to obtain coverage.
11 (b) An individual shall not be required to pay an additional
12 deductible or coinsurance for testing that is greater than an annual
13 deductible or coinsurance established for similar benefits.
14 (c) If the program or contract does not cover a similar benefit, a
15 deductible or coinsurance may not be set at a level that materially
16 diminishes the value of the colorectal cancer benefit required under this
17 subchapter.
18 (d) Reimbursement to health care providers for colorectal cancer
19 screenings provided under this section shall be equal to or greater than
20 reimbursement to health care providers under Medicare, Title XVII of the
21 Social Security Act, 42 U.S.C. § 1395 et seq., as it existed on January 1,
22 2005.
23
24 23-79-1108. Referrals to participating providers.
25 A health care policy is not required to provide a referral under this
26 subchapter to a nonparticipating health care provider unless the plan or
27 carrier does not have a participating health care provider that is available
28 and accessible to administer the screening, examination, or treatment of
29 colorectal cancer.
30
31 23-79-1109. Payment of nonparticipating providers.
32 If a health care policy refers an individual under this subchapter to a
33 nonparticipating health care provider, then services provided under the
34 approved screening exam or resulting treatment, if any, shall be provided at
35 no additional cost to the individual beyond what the individual would
36 otherwise pay to a participating health care provider.

SECTION 3. EMERGENCY CLAUSE. It is hereby found and determined that colorectal cancer is a leading cause of death among Arkansas residents; that this number of deaths will increase as our population grows older; that colorectal cancer is a preventable disease; that information barriers result in Arkansas residents being unaware of the risk of colorectal cancer or the value of screening, prevention, and early detection; that financial barriers prevent some Arkansas residents from taking advantage of screening; and that there is a lack of funding to provide for screening, diagnostic, and treatment services for persons at risk of colorectal cancer. Therefore, this act being necessary for the preservation of the public peace, health, and safety shall be in full force and effect from and after August 1, 2005.

/s/ Elliott

APPROVED: 4/13/2005

APPENDIX G

American College of Surgeons - Approved Cancer Programs 2007

Conway Regional Medical Center
(Community Hospital Cancer Program)
2302 College Avenue
Conway AR, 72034
Phone: (501) 329-3831
Fax: (501) 450-2103
Website: www.conwayregional.org
Facility Accreditation: JCAHO

Washington Regional Medical Center
(Community Hospital Cancer Program)
3215 North Hills Blvd.
Fayetteville AR, 72703
Phone: (479) 713-1000
Fax: (479) 713-1013
Website: www.wregional.com
Facility Accreditation: JCAHO

Sparks Regional Medical Center
(Community Hospital Comprehensive Cancer Program)
1311 South I Street
Fort Smith AR, 72901-4995
Phone: (479) 441-4000
Fax: (479) 441-5420
Website: www.sparks.org
Facility Accreditation: JCAHO

St. Edward Mercy Medical Center
(Community Hospital Comprehensive Cancer Program)
7301 Rogers Avenue
Fort Smith AR, 72903
Phone: (479) 484-6000
Fax: n/a
Website: www.stedwardmercy.com
Facility Accreditation: JCAHO

St. Joseph's Mercy Health Center
(Community Hospital Comprehensive Cancer Program)
300 Werner Street
Hot Springs AR, 71913-6406
Phone: (501) 622-1000
Fax: (501) 622-2334
Website: www.saintjosephs.com
Facility Accreditation: JCAHO

Central Arkansas Veterans Healthcare System
(Veterans Affairs Cancer Program)
4300 West Seventh Street
Little Rock AR, 72205-5484
Phone: (501) 257-1000
Fax: (501) 257-6867
Website: www.va.gov/sta
Facility Accreditation: JCAHO

TERMINOLOGY

ACoS: American College of Surgeons

ACS: American Cancer Society

ACCR: Arkansas Central Cancer Registry

Age-adjusted mortality rate: A standardizing procedure for rates or measures of association in which the effects of differences in composition for variables(s) among populations being compared have been removed by mathematical procedures. Most often, adjustment is performed on rates. Age is the variable for which adjustment is most often carried out.

Adjuvant therapy: Chemotherapy drugs (including hormones) given after surgery or radiation or both to help prevent the cancer from coming back.

Alternative medicine: Therapeutic approaches taken in place of traditional medicine and used to treat or ameliorate disease.

Asymptomatic: Presenting no signs or symptoms of disease.

Baseline: An initial or known value (e.g. Body Mass Index) in which later measurements can be compared.

Basic research: Molecular or cellular level studies.

Benign: Non-cancerous tumor.

Bias: In general, any factor that distorts the true nature of an event or observation. In clinical investigations, a bias is any systematic factor other than the intervention of interest that affects the magnitude (i.e., tends to increase or decrease) an observed difference in the outcomes of a treatment group and a control group.

Body Mass Index (BMI): Weight in kilograms divided by height in meters squared, and offers an easily obtainable quantification of the relationship between height and weight.

C-Change: C-Change is comprised of the nation's key cancer leaders from government, business, and nonprofit sectors. These cancer leaders share the vision of a future where cancer is prevented, detected early, and cured or is managed successfully as a chronic illness.

Cancer: A general term for more than 100 diseases that are characterized by uncontrolled, abnormal growth of cells. Cancer cells can spread locally or through the blood stream and lymphatic system to other parts of the body. All cancers have the capacity to move and form secondary tumors at other sites in the body.

Carcinogen: Any substance that is known to cause cancer.

Case-control studies: A study that compares two groups of people; those with the disease or condition under study (cases) and a very similar group of people who do not have the disease or condition (controls). Researchers study the medical and lifestyle histories of the people in each group to learn what factors may be associated with the disease or condition. For example, one group may have been exposed to a particular substance that the other was not. Also called a retrospective study.

Chemotherapy regimen: A treatment program for cancer, using drugs.

Chronic disease: A disease or condition that persists or progresses over a long period of time.

Clinical trials: Research studies that involve patients. Each study is designed to find better ways to prevent, detect, diagnose, or treat cancer and to answer scientific questions.

Cognitive: Pertaining to the mental activities associated with thinking, learning, and memory.

Cohort: Any designated group followed or traced for a period, as in an epidemiological study.

Cohort studies: A research study that compares a particular outcome (such as lung cancer) in groups of individuals who are alike in many ways but differ by a certain characteristic (for example, female nurses who smoke compared with those who do not smoke).

Complementary medicine: Practices often used to enhance or complement standard treatments and not recognized as standard of conventional medical approaches. Complementary medicine may include dietary supplements, mega-dose vitamins, herbal preparations, special teas, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation.

TERMINOLOGY

CT scan: A series of detailed pictures of areas inside the body taken from different angles; the pictures are created by a computer linked to an X-ray machine. Also called computerized tomography and computerized axial tomography (CAT) scan.

Culturally competent: Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

Demography: The study of populations, especially with reference to size and density, fertility, mortality, growth, age distribution, migration, and vital statistics and the interaction of all of these with social and economic conditions.

Digital Rectal Exam (DRE): An exam to detect cancer. A healthcare provider inserts a lubricated, gloved finger into the rectum and feels for abnormal areas.

DFPM-CME: University of Arkansas for Medical Sciences, Department of Family and Preventive Medicine, Continuing Medical Education.

Dysplasia: Abnormal pathological development of cells indicating possibility of malignancy.

Epidemic: Affecting or tending to affect a disproportionately large number of individuals within a population, community, or region at the same time.

Epidemiology: The study of disease incidence and distribution in populations, as well as the relationship between environment and disease. Cancer epidemiology is the study of cancer incidence and distribution in the population and of how physical surroundings, occupational hazards, and personal habits such as tobacco use and diet may contribute to the development of cancer.

Ethnicity: A group that shares a common ancestry, history, or culture.

Fecal Occult Blood Test (FOBT): A test to check for small amounts of hidden blood in the stool.

Five-year survival: Five-year survival is a term commonly used as the statistical basis for successful treatment. A patient with cancer is generally considered cured after five or more years without recurrence of disease.

Genetic: Inherited; having to do with information that is passed from parents to offspring through genes in sperm and egg cells.

Genetic susceptibility: An inherited increase in the risk of developing a disease.

Healthcare professional: Practitioners in disease prevention, detection, treatment, and rehabilitation are known as healthcare professionals. They include physicians, nurses, dentists, dietitians, health educators, social workers, and therapists, among others.

Health disparities: Differences in the incidence, prevalence, mortality and burden of cancer and related adverse health conditions that exist among specific population groups in the United States.

High risk: When the chance for developing cancer is greater for an individual or a group of people than it is for the general population, that individual or group is considered to be at high risk. People may be considered to be at high risk from many factors or combination of factors, including a family history of disease, personal habits, or exposure to carcinogens in the environment or in the workplace.

Human Papillomavirus (HPV): More than 100 types of viruses that cause various human warts (as the common warts of the extremities, plantar warts, and genital warts) including some associated with the production of cancer. More than 30 of these papillomaviruses are sexually transmitted and high-risk HPV include types: 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68, and 69. HPVs are now recognized as the major cause of cervical cancer.

Incidence: Incidence is the number of times a disease occurs in a given population. Cancer incidence is the number of new cases of cancer diagnosed each year. The Arkansas Central Cancer Registry, housed at the Arkansas Department of Health, maintains cancer incidence data in Arkansas.

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Incidence rate: A measure of the rate at which new events occur in the population. The number of new cases of a specified disease diagnosed or reported during a defined period of time, is the numerator, and the number of persons in the stated population in which the cases occurred is the denominator.

Ionizing radiation: Radiation of sufficient energy to dissociate atoms or molecules into electrically charged atoms or radicals in the irradiated material, e.g. X-rays.

Linguistically appropriate: Healthcare services that are respectful of and responsive to linguistic needs.

Magnetic Resonance Imaging: Magnetic Resonance Imaging (MRI) is an imaging method that uses magnetic fields, radio waves, and a computer to produce a detailed cross-sectional picture of the inside of the body.

Malignancy (or malignant): Cancerous; can invade nearby tissue and spread to other parts of the body.

Mammogram: An X-ray of the breast.

Managed Care: Any system that manages healthcare delivery to control costs.

Master Settlement Agreement: In 1998, 46 states and the four major tobacco companies signed the Master Settlement Agreement (MSA), which stipulated that the tobacco companies pay states $206 billion over 25 years and take steps to reduce youth smoking. The remaining states settled separately.

Medically Underserved Areas: Medically Underserved Areas (MUA) are areas within the United States that have limited or no access to primary healthcare.

Melanoma: Cancer of the cells that produce pigment in the skin. Melanoma usually begins in a mole.

Metastatic cancer: Cancer that has spread from the place in which it started to other parts of the body.

Morbidity: Any departure, subjective or objective, from a state of physiological or psychological well being. In this sense, sickness, illness, and morbid condition are similarly defined and synonymous.

Mortality rate: A rate expressing the proportion of a population who die of a disease, or of all causes. The numerator is the number of persons dying; the denominator is the total population (usually the midyear population) in which the deaths occurred. The unit of time is usually a calendar year. To produce a rate that is a manageable whole number, the fraction is usually multiplied by 1,000 to produce a rate per 1,000. This rate is also called the "crude death rate."

Multidisciplinary: Involving many particular fields of study.

Obesity: A condition in which a person has abnormally high amounts of unhealthy body fat; medically defined as a Body Mass Index of 30 or higher.

Palliative care: Care that does not alter the course of a disease, but improves the quality of life.

Pap Smear: A cytological test developed by the late George N. Papanicolaou for the detection of cervical cancer and changes in the cervix that may lead to cancer.

Perforation: Abnormal opening in an organ.

Preexisting condition: A health condition (other than a pregnancy) or medical problem that was diagnosed or treated during a specified timeframe prior to enrollment in a new health insurance plan. Some preexisting conditions may be excluded from coverage during a specified timeframe after the effective date of coverage in a new health plan.

Prevalence: In medical terminology, prevalence typically has been defined as the number of cases of a disease that are present in a population at a point in time. In the case of smoking prevalence in a population, the term is used to define the number of people in that population who are regular smokers.

Primary prevention: The reduction or control of factors believed to be causative for a health problem and includes reducing risk factors such as smoking to prevent lung cancer or sex education to reduce sexually transmitted diseases, and environmental exposures such as reducing ambient lead to prevent intellectual impairment. This category also includes health-service interventions, such as vaccinations or such preventive "therapy" tools as fluoridated water supplies or dental sealants.

Priority population: The Agency for Healthcare Research and Quality's definition includes low income groups; minority groups; women; children; the elderly; and individuals with special healthcare needs, including individuals with disabilities and individuals who need chronic care or end-of-life healthcare.

Proliferation: Multiplying or increasing in number; In biology, cell proliferation occurs by a process known as cell division.

Prostate-Specific Antigen: A protein whose level in the blood goes up in some men who have prostate cancer or benign prostatic hyperplasia. Also known as PSA.

Psychosocial: Involving both psychological and social aspects of a person.

Quality of life: In cancer treatment, quality of life is the concept of ensuring that cancer patients are able to lead the most comfortable and productive lives possible during and after treatment. New treatment techniques and social and emotional support groups are adding to the quality of life for cancer patients as well as to their survival.

Radiation tattoo: The areas marked with either a temporary or permanent marker showing where the radiation should be aimed.

Radon: A radioactive gas that is released by uranium, a substance found in soil and rock. When too much radon is breathed in, it can damage lung cells and lead to lung cancer.

Randomized clinical trials: A study in which the participants are assigned by chance to separate groups that compare different treatments; neither the researchers nor the participants can choose which group. Using chance to assign people to groups means that the groups will be similar and that the treatment they receive can be compared objectively.

Remission: The partial or complete disappearance of signs and symptoms of disease.

Risk factor: Anything that has been identified as increasing an individual's chance of getting a disease is a risk factor.

School Wellness Committees: Committees formed in each individual school district in the state to provide support and technical assistance to schools based on the recommendations from the Child Health Advisory Committees. The Child Health Advisory Committees were created through ACT 1220 of 2003, to address childhood obesity and develop statewide nutrition and physical activity standards.

Secondary prevention: Involves early detection and treatment, such as mammography for detecting breast cancer or Pap tests for detecting cervical cancer.

Secondhand smoke: Smoke that comes from the burning end of a cigarette and smoke that is exhaled by smokers. Also called ETS or environmental tobacco smoke. Inhaling ETS is called involuntary or passive smoking.

Sensitivity: The proportion of truly diseased persons in the screened population who are identified as diseased by the screening test. Sensitivity is a measure of the probability that any given case will be identified by the test (also called the true positive rate).

Sigmoidoscopy: A procedure in which a physician or healthcare provider looks inside the rectum and the lower part of the colon (sigmoid colon) through a flexible lighted tube. The physician may collect samples of tissue or cells for closer examination (also called proctosigmoidoscopy).

Socioeconomic: Of, relating to, or involving a combination of social and economic factors.

Specificity: The proportion of persons without disease who correctly test negative. It is a measure of the probability of correctly identifying a non-diseased person with a screening test (also called the true negative rate).

Squamous cells: Flat cells that look like fish scales; these cells make up most of the epidermis or surface of the skin, the lining of hollow organs, and the digestive and respiratory tract passages.

Stage: A distinct phase in the course of a disease. Stages of cancer are typically defined by containment or spread of the tumor: in situ, localized, regional or distant spread.

Staging: Doing exams and tests to learn the extent of the cancer, especially whether it has spread from its original site to other parts of the body.

Surveillance: Close and continuous observation, screening, and testing of those at risk for a disease.

Survival: Average period of time from diagnosis to death.

Survivorship: (as defined by the National Coalition for Cancer Survivorship (NCCS) and the Office of Cancer Survivorship at NCI): The experience of living with, through, or beyond cancer; a continual, ongoing process that begins at the moment of diagnosis and continues for the remainder of life; composed of stages or phases of survival.

Systems approach: Working with systems, which are defined as a network of interdependent parts that work together to try to accomplish the goals of the system. Systems have a quality of interdependence where the changes in one aspect of the system reverberate and create impact throughout the system. Some examples of systems are a school district, a business, a community, a church, or hospital. Working with systems can provide the best utilization of volunteers, staff, and other resources in achieving a common goal.

Tertiary prevention: Involves providing appropriate supportive and rehabilitative services to minimize morbidity and maximize quality of life, such as rehabilitation from injuries. It includes preventing secondary complications.

Translational research: The research needed to move the fruits of research into provider and community practice; also described as moving from lab bench to bedside.

Toxin: A poison produced by certain animals, plants, or bacteria.

UALR: University of Arkansas at Little Rock

UAMS: University of Arkansas for Medical Sciences

Ultrasound: Ultrasound uses high frequency sound waves and their echoes to create a picture of the interior of the body. A microphone-like instrument called a transducer that emits and receives sound waves is passed over the part of the body being examined. The echo patterns are converted by a computer to an image that is viewed on a monitor.

Winthrop P. Rockefeller Cancer Institute: Formerly the Arkansas Cancer Research Center (ACRC).

Years of Life Lost: The number of potential years of life lost by each cancer death occurring before age 75.

What Can You Do?

The Arkansas Cancer Plan: Our Call to Action

The Arkansas Cancer Plan 2007, A Framework for Action lays out 24 broad goals that will make significant progress in reducing the burden of cancer among all Arkansans. To accomplish these goals, everyone needs to be involved in the effort. The Arkansas Cancer Coalition and their constituent groups will work to achieve these goals, and there are things that each of us can begin to do right now to help work toward the mission of making cancer history for all Arkansans.

Below are a few examples of what you can do to help work toward the goals presented here. Use these examples, and think of other actions you can take to reduce the burden of cancer throughout Arkansas. Fill in the blank spaces with your own ideas. Share your ideas by sending them to the Arkansas Cancer Coalition, 901 N. University Avenue, Little Rock, AR 72207, Attention: Executive Director

If you are a hospital

Ensure that your cancer cases are reported in a timely way.
Provide meeting space for cancer support groups.
Collaborate to sponsor community screening programs.
Acquire of maintain American College or Surgeons accreditation.
OR_____

If you are a local health department

Provide cancer awareness information to citizens.
Collaborate in community walking campaigns.
Work with physicians to promote screening programs and cancer reporting.
Provide space for survivor support groups.
OR_____

If you are a community-based organization

Provide cancer awareness information to constituents.
Promote cancer screening among clients.
Encourage participation in clinical trials.
Collaborate to provide community prevention programs.
OR_____

If you are a professional organization

Provide cancer awareness information to constituents.
Promote cancer screening among clients.
Encourage participation in clinical trials.
Collaborate to provide community prevention programs.
OR_____

If you are an employer

Provide healthy foods in vending machines and cafeterias.
Encourage employees to increase physical activity.
Collaborate with hospitals to host screening events.
OR_____

If you are a school or university

Include cancer prevention messages in health classes.
Provide healthy foods in vending machines and cafeterias.
Increase physical education requirements.
Make your entire campus moke-free.
OR_____

If you are a faith-based organization

Provide cancer prevention information to members.
Learn how to provide healthy potlucks and meals at meetings.
Open your building for walking clubs in cold weather.
Encourage members to get cancer screening tests on time.
OR_____

If you are a physician

Make sure patients get appropriate cancer screening tests.
Refer patients to smoking cessation classes and nutrition programs.
Be sure your cancer cases are reported in a timely way.
Find out how to enroll patients in clinical trials.
Make earlier referrals to hospice for end-of-life care.
OR_____

If you are a legislator

Secure funding for comprehensive cancer control.
Raise constituents' awareness about cancer prevention and control programs in your district or help establish new programs where needed.
Sponsor or support legislation that promotes cancer prevention and control.
Ensure that all Arkansans have access to health care and to cancer early detection screening services.
Ensure that tobacco settlement funds are used for tobacco and cancer control purposes.
OR_____

If you are an Arkansan

Stop smoking or never start.
Eat more fruits and vegetables and maintain a healthy weight.
Increase your daily physical activity.
Know when to be screened and do it on schedule.
Support smoke-free environment legislation.
If diagnosed, consider enrolling in a clinical trial.
Show your support and care for those who are diagnosed with cancer.
Volunteer with your hospital, health department, faith community, or local American Cancer Society.
OR_____

We are not powerless against cancer! Each of us can DO many things each day that will ultimately reduce both our own personal risk of cancer, and in turn, Arkansas' overall cancer burden. In the end, we will look back and say that we had a part in "making cancer history for all Arkansans!"

Adapted from the Ohio Cancer Plan: 2010 with permission generously granted from the Ohio Partners for Cancer Control.