

CANCER CONNECTION



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COMPREHENSIVE CANCER CONTROL UPDATE

Indiana Comprehensive Cancer Control Program Applying for Supplemental Funding

The Indiana Comprehensive Cancer Control Program is applying for supplemental funding to support implementation of the Indiana Cancer Control Plan 2010-2014. Funding opportunity number CDC-RFA-DP10, Demonstrating the Capacity of Comprehensive Cancer Control Programs to Implement Policy and Environmental Cancer Control Interventions, is designed to support the development and implementation of a focused policy agenda, with the goal of implementing three to five policy activities within a five-year program period. Policy activities for the program must be evidence based, address a key aspect of cancer control, include at least one intervention addressing primary prevention, and impact the highest burden cancers in the state. The funding opportunity is only available to National Comprehensive Cancer Control Programs. The application deadline is July 26.

ICC Represented at National Comprehensive Cancer Control Leadership Institute

Tom Rich, director of Comprehensive Cancer Control with the American Cancer Society, Great Lakes Division, Inc., Meena Garg, medical director of the Chronic Disease Prevention and Control Division with the Indiana State Department of Health, and Keylee Wright, director of the Indiana Comprehensive Cancer Control Program, attended the Comprehensive Cancer Control Leadership Institute in L.A. from June 8-10. Attendees will share what they learned at the institute with the ICC Steering Committee in July.

Local Cancer Control Efforts

Thank you to St. John's Health System in Anderson for hosting the fourth ICC Regional Meeting on May 26. The goals of the regional meetings include educating local public health leaders about the cancer burden, promoting the ICC, and implementing the Indiana Cancer Control Plan 2010-2014. The next regional meeting will be held in Hartford City (Blackford County) and is tentatively scheduled for September.

ICC Spring Meeting: A Call to Action

Over 50 partners attended the annual spring meeting on April 23 at Fairbanks Hall in Indianapolis. Keylee Wright, director of the Indiana Comprehensive Control Program, reminded partners of their role in implementing the Indiana Cancer Control Plan 2010-2014 with a call to action:

- **Implement**
 - *Read the plan and share it with others
 - *Identify objectives and strategies you and/or your organization are currently implementing and/or plan to implement
- **Commit**
 - *Become a member of the ICC
 - *Complete the online assessment tool (administered electronically by the ICC May 3-21)
- **Collaborate**
 - *Promote the plan
 - *Join an action team and/or committee
 - *Attend semi-annual meetings

Breaking Down Barriers: A Success Story for the ICC Clinical Trials Action Team

The National Comprehensive Cancer Control Program recently published *Stories of Success: National Comprehensive Cancer Control Program, Cancer Control in Action*, which is a collection of success stories from various cancer control programs across the country. Indiana's clinical trials success story was featured in this publication. Please continue below to read the Indiana Cancer Consortium's article. To read stories from other states, please visit <http://www.cdc.gov/cancer/ncccp/state.html>.

Currently, only 3 to 5 percent of adult cancer patients enroll in a clinical trial. Without clinical trial participation, breakthroughs and advanced treatments do not occur. In 2008, 20 states had legislation in place mandating that insurance companies cover the routine patient care costs for cancer patients enrolled in clinical trials. Indiana was not one of those 20 states. The Indiana Cancer Consortium (ICC) decided to address this issue.

The ICC is a statewide network of public and private organizations working to reduce the cancer burden in Indiana. This organization seeks to increase cancer prevention activities; increase early detection of cancer; decrease barriers resulting in disparities of access, screening, and treatment; and increase quality of life for cancer patients through increased communication and collaboration of ICC member organizations. The ICC Steering Committee formed an action team to address barriers to clinical trial participation in Indiana, recruiting subject matter experts to identify solutions. With that, the ICC Clinical Trials Action Team was born—including individuals from various organizations such as the American Cancer Society (ACS), Leukemia and Lymphoma Society (LLS), St. Francis Hospital, Northern Indiana Cancer Research Consortium, and more.

After much debate regarding barriers to enrollment in clinical trials, the ICC Clinical Trials Action Team decided to promote legislation during the 2009 Indiana General Assembly, HB 1382. This legislation would mandate insurance companies cover routine patient care costs for cancer patients enrolled in clinical trials. Routine patient care costs include blood work, physician visits, and services related to the disease, but not necessarily the clinical trial. Such care costs would not include the drugs or research-related expenditures associated with a clinical trial, which typically are incurred by the clinical trial sponsor. During the latter half of 2008, the ICC Clinical Trials Action Team geared up to mobilize support across Indiana and generate interest from state legislators, along with the public.

The legislative process began fairly smoothly. There was a great deal of interest from both chambers, and this issue reached across party lines. Rep. Peggy Welch and Sen. Beverly Gard were the first sponsors of the bill. Both were passionate about getting HB 1382 passed, working together to develop a strategic plan to make this law.

Unfortunately, a minor challenge developed regarding the fiscal impact of HB 1382. The Legislative Services Agency (LSA) solicited top Indiana insurers to configure the cost of this legislation to the state. The insurers reported to LSA that this bill would cost thousands of dollars. The ICC Clinical Trials Action Team knew this number was inaccurate and disputed the insurers' estimate. Numerous studies have shown that routine patient care in clinical trials costs insurance companies about the same, if not less. After the action team configured its estimates and provided data, LSA realized the inaccuracy of the initial figure. In the end, HB 1382 had no fiscal impact whatsoever. This was a small success in the process for the action team.

Toward the end of the legislative process, the insurance companies realized HB 1382 was heavily supported and likely to pass. They worked with ACS and LLS to negotiate the details of the bill. The insurance companies wanted a hold harmless clause so they would not be liable if the clinical trial did not work for the cancer patient. ACS and LLS added it to the legislation. When all parties agreed, the insurance companies supported the bill.

When the legislation went to the floor, it passed unanimously. In fact, one legislator said he had never voted for a mandate before in his career, but he felt it did not make sense to be against this bill. The ICC Clinical Trials Action Team's efforts paid off. HB 1382 was enacted and signed by Gov. Mitch Daniels on May 7, 2009. On July 1, 2009, this legislation became law!

Primary Prevention Action Team Update

The Primary Prevention Action Team will be working with the Immersive Learning Program at Ball State University to develop, implement, and evaluate a health communications campaign for eighth grade students across the state. The purpose of this campaign is to educate students on the need and importance of consistent physical activity. Focus groups will be conducted in order to first gauge what type of communication works best for each student's situation. After the results of the focus groups are compiled, each campaign (for each school) will be designed.

The Primary Prevention Action Team's next meeting is on Tuesday, July 13, at 3 p.m. (EST). All meetings are located at the Indiana Minority Health Coalition at 3737 N. Meridian St., 3rd floor, Indianapolis. If you are unable to attend the meeting in person, there is an option to join via conference call. To join the action team or for more information, please contact Deirdre George Davis at 317-234-2883 or deirdavis@isdh.in.gov.

Clinton Honors Local Schools for Health Initiatives

WIBC—Taylor Bennett/Network Indiana

June 16, 2010—Three central Indiana schools are among 179 throughout the country that were honored by former President Bill Clinton for their efforts to improve students' health.

Perry Meridian High School, Perry Meridian Middle School, and Franklin Central High School – all in Indianapolis – received awards from the Alliance for a Healthier Generation.

The work of the schools includes improving staff wellness, increasing physical activity, and removing unhealthy options from vending machines.

The Alliance provides free assistance to more than 9,000 schools to help them combat childhood obesity. One in three children and adolescents in the U.S. is already obese or overweight. The Healthy Schools program is free to any school in the country. <http://www.wibc.com/news>

A Clean House Means a Fit Body Too, Study Finds

June 3, 2010—FOX NEWS—Dusting, mopping, and vacuuming not only keep your house clean, but these activities may also indicate that you keep your body fit as well, Time.com reported.

NiCole Keith, a physical activity expert at Indiana University, studied 998 African American adults between the ages of 49 and 65 living in two urban areas of St. Louis, Mo. Participants kept records of their physical activities, the quality of their neighborhood and the cleanliness of the interior of their home over the course of a 10-year period.

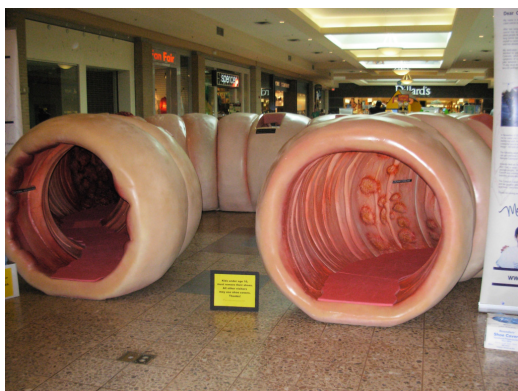
"At the end of the day, the interior condition of their house seemed to be the only thing affecting their physical activity," Keith said. "It is not at all what we expected."

Previous studies showed that environmental factors like the condition of streets, sidewalks, traffic noise, and air quality affected people's level of physical activity. However, these results, which Keith presented Wednesday at the annual meeting of the American College of Sports Medicine in Baltimore, Md., show that they have almost no bearing on a person's physical fitness.

"If you spend your day dusting, cleaning, doing laundry, you're active," said Keith at Wednesday's meeting, adding that some people, "won't take 30 minutes to go for a walk, but they'll take 30 minutes to clean."

The demographic for Keith's study, older African Americans, have been underrepresented in studies like these, despite being disproportionately affected by cardiovascular disease and its risk factors, according to the report.

To read more, please visit http://wellness.blogs.time.com/2010/06/02/what-does-a-clean-house-have-to-do-with-health/?xid=rss-topstories?artId=5647?contType=blog_wellness?chn=us.



Colorectal Cancer Mini-Grants

The Indiana Cancer Consortium (ICC) funded eight colorectal cancer mini-grants to different organizations across the state. These workshops and/or activities occurred during the month of March (Colorectal Cancer Awareness month) and the beginning of April. This was the first year for the mini-grants, and they were extremely successful. In addition, as a result of the colorectal cancer mini-grants, ICC membership increased.

The funded organizations include: Clarian Health-Methodist Cancer Program (Indianapolis), Saint Anthony Memorial (Michigan City), Community Cancer Care (Jasper and Martinsville), Ohio Valley Colon & Rectal Surgeons, Inc. (Evansville), Parkview Foundation (Fort Wayne), Tipton Hospital (Tipton), King's Daughter's Hospital (Madison), and Wishard Health Services (Indianapolis).

To the left, event pictures from the Ohio Valley Colon & Rectal Surgeons, Inc. and Saint Anthony Memorial.

Unite 2 Fight Race Against Prostate Cancer

Little Red Door Cancer Agency's Unite 2 Fight Race Against Prostate Cancer is having a 5K competitive run, 5K non-competitive run/walk, and a one mile family-fun walk sponsored by St. Vincent Health. The event is on Saturday, July 10 and begins at 8 a.m. at the Indiana War Memorial, 431 N. Meridian St., Indianapolis. Visit the Little Red Door Web site to register for the race, start or join a team, set a goal, and begin raising money in support of fighting prostate cancer.

Team registration deadline is Friday, June 25 (registrations may occur up until July 9, but T-shirts will not be guaranteed), and the individual deadline is Wednesday, July 7.

To register or for more information, please visit www.littlreddoor.org.

Prostate Cancer Initiative

Teasa Thompson, newest member of the Indiana Comprehensive Cancer Control Program, will be overseeing the Prostate Cancer Initiative. In addition, she will be working on evaluation and disparities for the Indiana Cancer Consortium. We are glad to have Teasa on board! If you would like more information on the Prostate Cancer Initiative, you can now contact Teasa at 317-233-7448 or tthompson1@isdh.in.gov.

In March and April, the Prostate Cancer Initiative expanded its mini-grant program by awarding 10 mini-grants, representing five different counties across the state. Currently, the Prostate Cancer Initiative is gearing up for the Indiana Black Expo Minority Health Fair. If you are interested in volunteering, please contact Teasa.

Congratulations to Doug Schwartzentruber!

TIME Magazine named Doug Schwartzentruber, M.D., F.A.C.S., medical director of Goshen Health System's Goshen Center for Cancer Care, to the 2010 TIME 100, the magazine's annual list of the 100 most influential people in the world.

The full list and related tributes appear in the May 10 issue of TIME, available on newsstands Friday, April 30, and now at time.com. The list, now in its seventh year, recognizes the activism, innovation, and achievement of the world's most influential individuals.

As managing editor of TIME Magazine, Rick Stengel has said of the list in the past, "The TIME 100 is not a list of the most powerful people in the world, it's not a list of the smartest people in the world, it's a list of the most influential people in the world. They're scientists, they're thinkers, they're philosophers, they're leaders, they're icons, they're artists, they're visionaries. People who are using their ideas, their visions, their actions to transform the world and have an effect on a multitude of people."

Dr. Schwartzentruber first appeared in TIME Magazine following the May 2009 announcement of his breakthrough clinical trial results on the use of a Melanoma vaccine. He later appeared in the magazine's "Year in Health" review article in November 2009, as well as being interviewed by Men's Health Magazine, Bloomberg News, and National Public Radio's Science, among many others.

To view the article in TIME Magazine, please visit www.time.com.

FDA Approves Prostate Cancer Vaccine

Rebecca V. Snowden

The Food and Drug Administration (FDA) has approved Dendreon Corporation's Provenge, a "vaccine" that uses a patient's own immune system to fight advanced prostate cancer that is no longer responding to hormone therapy. While not expected to be a cure, the news offers hope to men with advanced disease, many of whom have few treatment options available to them.

It's been a rocky road to approval. In 2007, the FDA refused to approve the initial drug application, requesting more information about whether the drug prolongs survival. In 2009, Dendreon submitted the drug again, this time with more data.

Today's green-light is based primarily on results from a randomized phase III study showing that men who received Provenge infusions lived an average of about four months longer than men who were getting the placebo (26 months versus 22 months).

Patients receiving Provenge reported few side effects, and those they did report – chills, fever, headache, fatigue, nausea, joint aches, and back pain – usually went away within a few days.

The vaccine is made by removing some of a patient's white blood cells and sending them to a lab, where they are activated by exposing them to a protein found on prostate cancer cells. The cells are then given back to the patient about three days later, in a process similar to a blood transfusion. This is done three times, with about two weeks in between each dose.

To read the full article, please visit the American Cancer Society's Web site at http://www.cancer.org/docroot/NWS/content/NWS_1_1x_FDA_Approves_Prostate_Cancer_Vaccine.asp.



Benita Kimbrough Breast Cancer

I was diagnosed with stage II breast cancer in August of 2006.

I was experiencing pain in my breast and scheduled an appointment with my gynecologist. Based upon my symptoms, she referred me to St. Margaret's Hospital Guild for a mammogram.

After my mammogram, I was told, 'to have a seat while the doctor reads the x-rays; if something was found, she'd be out to talk to me.' The x-ray technician came out and told me an ultrasound was needed to confirm the results of the x-ray. The ultrasound confirmed some small cysts in the breast. The ultrasound alone couldn't determine if the findings were actually cysts, so I had a biopsy that day. I consented to the biopsy because, at that point, I was very concerned.

The results of the biopsy confirmed cancer. My oncologist explained everything step by step, what could happen with treatment and what could happen if treatment was declined. I was relieved when I heard the news, but also sad and disappointed. I wondered, 'why me...after all the things I've done for other people in my life?' I thought about all the things I wouldn't be able to do with my grandchildren and how I would break the news to them and my husband, daughter, mother, and siblings. I wasn't as concerned with breaking the hearts of the adults in my life, but the children...

After receiving the news, I said to myself, 'I'm not going to claim this at all. I've beat other things in life thus far. I'll conquer cancer and the good Lord will help me.'

I don't know how I would've survived without my husband and my two beautiful granddaughters. They were with me all the way through, from beginning to end. It's important to have people close to you while you're going through this battle, to keep your mind off treatments, surgery, and radiation.

My experience with cancer has been really great. I had family to support me. I had been there for my mother through her battle with cancer. I saw how strong she was, and she's still here with me at 81-years young. I learned to never give up on your dreams and never take life for granted.

Quality of Life Action Team Update

The Quality of Life Action Team is planning a half-day seminar for the fall of 2010. The purpose of this seminar is to gather and educate providers (primary care physicians, oncologists, oncology nurses, oncology organizations, and physicians' organizations) regarding hospice and palliative care.

The action team recently put together a list of resources for survivors, cancer professionals, and physicians. This resource has been developed to provide the most recent information on quality of life materials. Topics that are covered include support services, survivorship, cancer-specific, and general resources. The resource guide is available on the ICC Web site at www.indianacancer.org.

The next Quality of Life Action Team meeting is on Monday, July 12, at 11 a.m. (EST). The meetings are held at the Clarian Medical Tower, 1633 N. Capitol Ave., Suite 301. If you are unable to attend the meeting in person, there is an option to join via conference call. To join the action team or for more information, please contact Deirdre George Davis at 317-234-2883 or deirdavis@isdh.in.gov.

ICC Data Committee Update

The data committee submitted an article for the May/June edition of the Indiana Epidemiology Newsletter published by the Indiana State Department of Health (ISDH). This article will be the first submission from a consecutive series of cancer articles to be featured in the bi-monthly editions of the newsletter this year.

The data committee is also refining and enhancing the data sources that appear on the Indiana Cancer Consortium Web site and will be adding GIS maps that feature geographic and spatial cancer data in Indiana.

The next committee meeting will be on Wednesday, July 14, at 10 a.m. at ISDH (2 N. Meridian St.). For more information, please contact Teasa Thompson at 317-233-7448 or tthompson1@isdh.in.gov.

Using Metrics to Improve Population Health

Robert M. Pestronk

Introduction:

The Mobilizing Action for Community Health (MATCH) project proposes an incentive system that would reward improved health at the population level. Such incentives depend on metrics, but how should metrics be selected?

A logic model with theoretical, philosophical, or political grounding is an essential first step. A model conceptualizes the production of population health, and metrics are chosen on the basis of that conceptualization. To achieve population health, for example, should we seek improvements in access to care, in medical or disease conditions, or in the social, political, and economic underpinnings of society itself? Metrics are the yardstick by which assumptions in the model will be tested. They measure evidence of actual inputs, outputs, and outcomes. When choosing metrics associated with incentives, we must decide what type or magnitude of change we seek.

What population's health should improve? Metrics can be applied to many units of analysis: a random collection of people; a family; an economic class or racial group; a neighborhood, city, region, or country; a commercial enterprise; or a subpopulation in any of these populations. Data must be available for the unit of analysis.

Although we can envision models (and metrics) that account for the range of political, social, and economic constructs thought necessary to improve population health, we must decide whether metrics should be selected for all constructs — or whether it is even politically possible to apply incentives across a broad range of areas. American culture is highly pluralistic and politically resistant to such a large-scale, comprehensive approach. No single body controls all these aspects of American public, private, personal, and organizational life enough to hold accountable all entities to which potential incentives apply.

It may be wiser to choose metrics associated with better health for a specific economic, racial, or ethnic group, for example, than for all groups collectively. Even this narrower focus on one group's health can be politically challenging if it is seen to be at the expense of another group or stigmatizes that group.

To finish this article, please visit

http://www.cdc.gov/pcd/issues/2010/jul/10_0018.htm?s_cid=pcd74a70_e.

Disparities in Cancer Outcomes: The Role of Socioeconomic Status

Susan M. Rawl, Ph.D., R.N., F.A.A.N.

Associate Professor, Indiana University School of Nursing

The Indiana Cancer Consortium has adopted the objective to enhance understanding of the important, but complex, issue of disparities in cancer outcomes. This, the third in a series of articles on this topic, addresses disparities based on socioeconomic status.

Since the Healthy People 2000 initiative, the U.S. has been increasingly focused on the goal of eliminating health disparities. In 2003, the Institute of Medicine report on *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* proposed that disparities are caused by a complex interplay of economic, social, and cultural factors.¹ Socioeconomic factors such as income, education, occupation, and health insurance have been consistently linked to disparities in cancer care and outcomes. These factors also influence where a person lives which, as described in the last issue of this newsletter, can further compound disparities.² Almost 20 years ago, the director of the National Cancer Institute declared that poverty was a carcinogen.

Socioeconomic status (SES) is widely defined as the social and economic standing of an individual and has been typically measured by an individual's income, education, and occupation.^{3,4} These factors, as well as availability of adequate health insurance, have been shown to be directly related to cancer disparities and outcomes. In recent years, researchers examining health disparities have focused on "area-level" SES, which refers to the economic, educational, occupational, or class status of a particular geographic area. Area-level SES can be computed for a defined geographic area ranging in size from an entire state to a specific census tract or neighborhood. Examples of area-level SES measures include per capita income, percent of people living below poverty level, percent of people who own their home, average home value, percent of single-parent families, and percent of unemployed persons.³

Trends in Mortality and SES

While significant progress has been made in reducing cancer mortality over the last two decades, it is increasingly clear that factors that contribute to this decline vary greatly by social class in the U.S. In 1975, the death rate for all cancers combined was 2 percent higher among American men living in poorer counties compared to more affluent counties; by 1999, the cancer death rate was 13 percent higher among men in poorer counties.⁵ Little difference was observed in prostate cancer mortality between poor and affluent counties between 1975 and 1989. However, by 1999, men in poorer counties were experiencing a 22 percent higher death rate from prostate cancer than their affluent counterparts.⁵ Declines in cancer mortality have been much steeper for college graduates than for high school graduates, with declines minimal for those with less than a high school education.⁶ Death rates for all cancers among African American and white men with 12 or fewer years of education are more than twice the rates for men with higher educational levels.⁷ Among women, death rates from all cancers was 3 percent lower in poorer counties between 1975 and 1989 compared to more affluent ones; by 1999, it was 3 percent higher. Women living in poorer counties experienced a 71 percent higher mortality rate from cervical cancer during the 1990s.⁵

Cancer Risk Factors and SES

Several modifiable cancer risk factors vary by SES including smoking, physical activity, and obesity. Persons with lower SES are more likely to engage in behaviors that increase cancer risk in part because marketing strategies target these populations and their environments provide fewer opportunities for physical activity and access to fresh fruits and vegetables.⁷ Cigarette smoking prevalence varies by educational levels with the

highest prevalence among those with less education (attended or completed high school). Regardless of race or ethnicity, men and women with lower incomes (less than twice the poverty level) are more likely to smoke than those with higher incomes.⁸ There are differences in the prevalence of obesity by level of education and income, but differences are greater among women than men. Prevalence of obesity is 12.4 percent among women with more than 16 years of education compared to 32 percent among women with eight or fewer years of education. SES influences the quality and types of food people eat, the environments in which they live, and the type of work they engage in—each of which may contribute to disparities in cancer incidence and mortality.⁹

Screening/Early Detection and SES

Differences in use of recommended screening tests has been observed by education and health insurance status. While 57 percent of non-Hispanic white women reported having a mammogram within the last year, only 28 percent of women who lacked health insurance had this test in the past year. People with less education and no health insurance coverage had the lowest rates of colorectal cancer screening with fecal occult blood tests or endoscopy.⁸

Access to Quality Cancer Care and SES

Access to high quality cancer care varies significantly by SES and cancer treatment disparities have been well documented. Women with early stage (I & II) breast cancer who resided in poorer census tracts were less likely to be treated with breast conserving surgery and radiation than women in more affluent areas.⁵ Analyses of SEER (Surveillance Epidemiology and End Results) data showed that patients with metastatic lung cancer and lower SES were less likely to be seen by an oncologist and received less chemotherapy than those with higher SES.¹⁰ Breast cancer patients without health insurance were less likely to undergo surgery¹¹ and low SES was an independent predictor of worse survival among patients who received resection for pancreatic cancer.¹² These and other data demonstrate that unequal access to care for economic reasons is an important factor in treatment disparities.⁸

It is important to note that many SES factors are closely related to race and ethnicity. A relatively higher proportion of African Americans are poor compared to other racial/ethnic groups. Higher proportions of African Americans (20 percent) and Hispanics (32 percent) do not have health insurance compared to 11 percent of whites.⁹ While studies have established that SES influences cancer outcomes and access to care, and since it is unlikely that income, education and occupational disparities will be eliminated in the near future, the challenge remains to discover exactly how SES influences cancer risk, risk-reducing behaviors, incidence, mortality, treatment, and survival. Understanding these mechanisms can inform policy decisions and development of effective interventions to reduce cancer disparities.

References

1. Institute of Medicine (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington DC: National Academies Press, 2003.
2. Miller, A. (2010). Disparities in cancer outcomes: Geographic location influences. *Indiana Cancer Consortium Cancer Connection*, 8 (2): 4-5.
3. Shavers, V. (2007). Measurement of socioeconomic status in health disparities research. *Journal of the National Medical Association*, 99 (9): 1013-1023.
4. Oakes, M. and Rossi, P. (2003). The measurement of SES in health research: Current practice and steps toward a new approach. *Social Science & Medicine*, 56: 769-784.
5. Singh, G., Miller, B., Hankey B., Edwards, B. (2003). *Area socioeconomic variations in U.S. cancer incidence, mortality, stage, treatment and survival, 1975-1999*. NCI Surveillance Monograph Series, Number 4. Bethesda, MD: National Cancer Institute, 2003. NIH Publication No. 03-5417.
6. Byers, T. (2010). Two decades of declining cancer mortality: Progress with disparity. *Annual Review of Public Health*, 31: 121-132.
7. American Cancer Society (2010). *Cancer Facts & Figures 2010*. Atlanta: American Cancer Society.
8. Ward, E., Jemal, A., Cokkinides, V., Singh, G., Cardinez, C., Ghafoor, A., Thun, M. (2004). Cancer disparities by race/ethnicity and socioeconomic status. *Cancer: A Cancer Journal for Clinicians*, 54: 78-93.
9. Brawley, O. and Berger, M. (2008). Cancer and disparities in health: Perspectives on health statistics and research questions. *Cancer (Suppl.)*, 113 (7): 1744-1754.
10. Earle, C., Neumann, P., Gelber, R., Weinstein, M., Weeks, J. (2002). Impact of referral patterns on the use of chemotherapy for lung cancer. *Journal of Clinical Oncology*, 20: 1786-92.
11. Roetzheim, R., Gonzalez, E., Ferrante, J., Pal, N., Van Durme, D., Krischner, J. (2000). Effects of health insurance and race on breast carcinoma treatments and outcomes. *Cancer*, 89: 2202-13.
12. Lim, J., Chien, M., Earle, C. (2003). Prognostic factors following curative resection for pancreatic adenocarcinoma: a population-based, linked database analysis of 396 patients. *Annals of Surgery*, 237: 74-85.