



Cancer Connection

Indiana Cancer Control Week

To increase awareness of the burden of cancer in Indiana and—more importantly—to empower Hoosiers to fight cancer, Indiana Cancer Control Week is Jan. 25-29, 2010. The ICC will kick off the week with a joint press conference and the release of the Indiana Cancer Control Plan 2010-2014.

We need your help to make the most impact!

Please facilitate activities in your community to promote Indiana Cancer Control Week; such as sending a press release to your local media outlets, writing a letter to the editor, and forwarding the Indiana Cancer Control Plan 2010-2014 to partners and stakeholders.

We are in the process of assembling a member toolkit to assist with local Indiana Cancer Control Week activities.

The toolkit will include:







- Indiana Cancer Control Plan 2010-2014
- Press release template
- Letter to the editor template
- Talking points
- Cancer Facts & Figures 2009

Upon its completion, you will receive the toolkit via the ICC listserv and it will also be available on the ICC Web site at www.indianacancer.org.

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2009 in Review

<ul style="list-style-type: none"> • Jan. 21—ICC announces new leadership • Jan. 22—ICC hosts first regional meeting in Bloomington <p>January 2009</p>	 <ul style="list-style-type: none"> • March 1-31—ICC participates in CDC Screen for Life: National Colorectal Cancer Action Campaign <p>March 2009</p>	<ul style="list-style-type: none"> • May 7—Gov. Mitch Daniels signs into law HB 1382 requiring health insurers to cover routine care costs associated with clinical trial participation for cancer patients • May 11—ASCO releases news article regarding HB 1382 <p>May 2009</p>	<ul style="list-style-type: none"> • Sept. 16-17—ICC hosts two-day site visit with CDC program consultant, Annette Gardner • Sept. 29—ICC hosts second regional meeting in South Bend <p>September 2009</p>	<ul style="list-style-type: none"> • Nov. 4—Draft Indiana Cancer Control Plan 2010-2014 is presented at ICC Fall Meeting • Nov. 16—ICC receives notification of 2010 Behavioral Risk Factor Surveillance System supplemental funding award <p>November 2009</p>
<ul style="list-style-type: none"> • Feb. 15—ICC founder and steering committee chair, Dr. Stephen D. Williams, loses his battle with cancer  <p>February 2009</p>	<ul style="list-style-type: none"> • April 6—Health disparities is focus of ICC Spring Meeting • April 6-30—ICC members identify priority objectives from revised Indiana Cancer Control Plan • April 15-17—ICC presents poster at the CDC National Comprehensive Cancer Control Program Director's Business Meeting <p>April 2009</p>	 <p>Indiana Cancer Consortium</p> <p>July 2009</p> <ul style="list-style-type: none"> • July 1—HB 1382 becomes law 	 <p>October 2009</p> <ul style="list-style-type: none"> • Oct. 22—<i>Breaking Down Barriers: A Success Story for the ICC Clinical Trials Action Team</i> is selected to be included in the 2010 CDC National Comprehensive Cancer Control Program success story publication • Oct. 24—<i>First For Men Only Fellowship Brunch</i> held at Eastern Star Baptist Church 	

What Cancer Patients and Survivors Should Know about the Flu

Living with cancer increases your risk for complications from the flu. If you have cancer now or have had cancer in the past, you are at higher risk for complications from both seasonal and 2009 H1N1 flu (also called influenza or "swine flu"), including hospitalization and death.

What should adult cancer patients and survivors know about the 2009–2010 flu season?

Flu activity is increasing in most of the U.S., with most states reporting widespread flu activity. This flu season, the Centers for Disease Control and Prevention (CDC) expects both 2009 H1N1 flu and seasonal flu to circulate and cause illness. Some people, including cancer patients and survivors, are more likely to get flu complications that could result in hospitalization and death.

Are cancer patients and survivors more likely to get the flu than others?

We do not know if cancer patients and survivors are at greater risk for **infection** with either 2009 H1N1 flu or seasonal flu. However, we do know that cancer patients and survivors are at higher risk for **complications** from both seasonal and 2009 H1N1 flu, including hospitalization and death.

What can cancer patients and survivors do to protect themselves from 2009 H1N1 and seasonal flu?

Like everyone, cancer patients and survivors should take these everyday steps to help reduce the spread of flu:

- Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.
- Wash your hands often with soap and water. If soap and water are not available, use an alcohol-based hand sanitizer.
- Avoid touching your eyes, nose, or mouth. Germs spread this way.
- Try to stay at least six feet away from people who appear ill.
- If you are sick with flu-like illness, stay home at least 24 hours after your fever is gone except to get medical care or for other necessities. Your fever should be gone without the use of a fever-reducing medicine. Keep away from others as much as possible to keep from making them sick.
- Follow public health advice regarding school closures, avoiding crowds, and other social distancing measures.
- Be prepared in case you get sick with a supply of over-the-counter medicines, alcohol-based hand sanitizer, and tissues.

Other important steps to take:

- Stay informed by visiting CDC's 2009 H1N1 flu site often.
- Develop a plan in advance with your doctor about what to do if you get sick (when you should call your doctor, whether you will need antiviral medication, and how to get a prescription for antiviral medication quickly if needed).
- Make sure your vaccinations are up-to-date.
- Keep a written record of the type of cancer you have, treatment you have received and when you received it, the name and contact information for your doctor, and a list of medicines you are taking.

Should cancer patients and survivors be vaccinated against the 2009 H1N1 virus?

Yes. People with cancer or a history of cancer should receive the H1N1 flu shot, not the nasal spray vaccine. The seasonal flu vaccine is not expected to protect against 2009 H1N1 flu. People who live with or care for cancer patients and survivors also should be vaccinated against 2009 H1N1 flu.

CDC's Advisory Committee on Immunization Practices recommends that certain groups receive the 2009 H1N1 flu vaccine as soon as possible. This group includes cancer patients and survivors.

Should cancer patients and survivors be vaccinated against seasonal flu?

Yes. People with cancer or a history of cancer should receive the seasonal flu shot, not the nasal spray vaccine. People who live with or care for cancer patients and survivors also should be vaccinated against seasonal flu. The 2009 H1N1 flu vaccine is not expected to protect against seasonal flu.

For more information on these and other topics pertaining to the flu, please visit the CDC H1N1 site at www.cdc.gov/cancer/flu.

What are the symptoms of 2009 H1N1 and seasonal flu?

Symptoms of the flu include fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills, and fatigue. Some people may have vomiting and diarrhea. People may be infected with the flu, including 2009 H1N1, and have respiratory symptoms without a fever.

Upcoming Health Awareness Months and Events

January	Cervical Cancer	Healthy Weight Week (Jan. 17-23) Indiana Cancer Control Week (Jan. 25-29)
February	Clinical Trials	
March	Colorectal Cancer Nutrition	Kick Butts Day (March 24)

Primary Prevention Action Team

Chairs: Erin Wyatt and Tisha Reid

The primary prevention action team is focusing on a new objective beginning in 2010. The priority objective is to increase the percentage of high school students in Indiana who engage in 60 minutes or more of moderate or vigorous physical activity daily. The action team's strategy is to increase the awareness of the importance of physical activity for health promotion and disease prevention for students.

If you are interested in joining in these efforts, please contact Lindsey Bouza at lbouza@isdh.in.gov or 317-233-7448. The next meeting for the primary prevention action team is Jan. 12 from 3 to 4 p.m. at the Indiana Minority Health Coalition.

Quality of Life Action Team

Chairs: Jane Berby-Todd and Adrienne May

The quality of life action team is working to increase access to resources for cancer survivors. This is a priority objective for the ICC. The action team is working on updating a Web resources list as well as coordinating a half-day seminar to provide education to primary care physicians and nurse practitioners on end-of-life care issues.

Please contact Lindsey Bouza at lbouza@isdh.in.gov if you would like to participate. The action team's next meeting is Jan. 11 from 1 to 2 p.m. at Clarian Medical Tower.

Colorectal Cancer Awareness Mini-Grants

Colorectal cancer was the third leading cause of cancer death in Indiana in 2006. To address this largely preventable health problem, the ICC is pleased to present the availability of funds to increase the percentage of Hoosiers who receive colorectal cancer screenings. Grant awards of **up to \$2500** will be distributed to select organizations to implement the colorectal cancer screening objective from the Indiana Cancer Control Plan 2010-2014.

A completed application must be received in the ICC office by close of business on Friday, Jan. 29, 2010. For more information regarding this funding opportunity, please visit the ICC's Web site at www.indianacancer.org.

Indiana Prostate Cancer Initiative

The Indiana Prostate Cancer Initiative, in collaboration with the American Cancer Society Body & Soul Program, hosted the first annual *For Men Only Fellowship Brunch*, on Oct. 24, 2009. The keynote address was given by prostate cancer survivor, Pastor Jeffrey Johnson (of Eastern Star Baptist Church). In addition to Pastor Johnson's testimonial/survivor story, Dr. Louise Gogans gave a presentation on the specific nutritional needs of men; and Dr. Azarius Longberger facilitated a comprehensive discussion on men's health, which included but was not limited to cancer, urology health, diabetes, heart disease, lifestyle choices (such as smoking and improper diet), and how they all relate to one another. At the end of the program, survivor stories were shared, including one story from a 14-year old young man, who recently lost his dad to prostate cancer. The Rev. Charles R. Williams Prostate Mobile Unit was in attendance. More than 40 men chose to be screened.

The 2010 Prostate Cancer Mini-Grant request for proposals is scheduled to be released on Jan. 13, 2010.

If you have any questions, please contact Deirdre George Davis at 317-234-2883 or deirdavis@isdh.in.gov.

Gender and Health Literacy Influence Colorectal Cancer Screening Knowledge Among African-Americans

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Colorectal cancer (CRC) is the third leading cause of cancer-related death for both men and women in the U.S. African-Americans have the highest CRC incidence and mortality rates of any racial or ethnic group, with incidence 20 percent higher and mortality rates 45 percent higher in blacks compared to whites [2]. In 2009, an estimated 16,520 new cases of CRC occurred amongst African-Americans, with a projected 7,120 deaths [1].

Despite efforts to decrease CRC mortality in African-Americans through screening, the disparity gap continues to widen. The overall five-year survival rate for African-Americans has improved nearly 10 percent in the past 35 years, but was a smaller improvement when compared to whites (15 percent) during the same time period [1]. Lower five-year survival rates reflect disparities in access to and receipt of care [1]. Barriers to CRC screening also contribute to increased mortality rates and low survival rates in African-Americans.

One of the most powerful weapons in preventing CRC is regular screening. Screening finds polyps early, allowing for their removal before they turn into cancer. Finding CRC early, when it is highly curable has resulted in more than 1 million survivors in the U.S. [3].

Prevention and early detection of CRC are possible through screening, but African-Americans have low rates of participation in screening. Lack of knowledge about testing options, the importance of screening, and the treatability of CRC when it is detected early are among the many barriers to CRC screening [2]. Other barriers include lack of time, inconvenience, lack of interest, cost, and inadequate provider-patient communication about CRC screening, including lack of physician's recommendation for testing. The most common reason given for not being tested was lack of a physician's recommendation [2].

Lack of knowledge about CRC is often a major barrier to screening in African-Americans. In 2009, a secondary analysis of baseline data from an ongoing randomized trial testing interventions to promote CRC screening was conducted to explore relationships among demographic characteristics, CRC knowledge, and health literacy among low-income African-Americans. The results of the study revealed that CRC knowledge among African-Americans is related to low health literacy, and surprisingly to gender.

Data were collected via telephone interviews from 138 African-Americans aged 51-79 years, who were not adherent to CRC screening guidelines. Participant demographic characteristics, responses to an 11-item CRC knowledge scale, and the seven-item Rapid Estimate of Adult Literacy in Medicine (REALM) Short Form were analyzed using Pearson correlations and chi-square tests. CRC knowledge levels for both men and women were found to be low with a mean score of 3.7 (s.d.=2.3) observed. Significantly greater proportions of women did not know that: 1) older people are more likely to develop CRC ($p<.05$); 2) African-Americans are more likely to develop CRC ($p<.05$); 3) women are just as likely to develop CRC as men ($p<.05$); and 4) finding and removing polyps is the best way to reduce incidences of CRC ($p<.05$). Lower health literacy also related to CRC knowledge among African-Americans. Significantly greater proportions of individuals with lower health literacy scores did not know: 1) what a polyp was ($p<.01$); 2) what is examined during a colonoscopy ($p<.01$); or 3) that finding and removing polyps is the best way to prevent CRC ($p<.01$).

This study demonstrated that African-Americans' knowledge about CRC and screening is very limited. Women are less knowledgeable about some issues than men, as are people with low health literacy. To reduce CRC health disparities affecting African-Americans, interventions are needed to improve CRC knowledge, focusing special attention on African-American women and individuals with low health literacy. Interventions will also need to address health beliefs to increase screening in this vulnerable population.

References:

1. American Cancer Society. (2009). *Cancer facts & figures for African-Americans 2009-2010*. Retrieved from <http://www.cancer.org>
2. American Cancer Society. (2008). *Colorectal cancer facts & figures 2008-2010*. Retrieved from <http://www.cancer.org>
3. American Cancer Society. (2008). *Colorectal cancer: Early detection*. Retrieved from www.cancer.org

Making Strides in Cancer Care: Offering Hope to the Community

Community Cancer Research Foundation



The Community Cancer Research Foundation located in Munster, Ind., works to bring the latest advances in detection, diagnosis, treatment, education, and prevention of cancer to area patients. Through the Foundation's efforts, area residents have access to clinical research trials from around the world.

The Foundation sponsors research trials at three hospitals within the Community Healthcare System: Community Hospital in Munster, Ind., St. Catherine Hospital in East Chicago, Ind., and St. Mary Medical Center in Hobart, Ind. As part of Community Healthcare System, the Foundation helps support the area's largest cancer treatment and research programs by providing links to the National Cancer Institute and major international research cooperatives. More than 30 trials are available, offering local patients access to treatments for breast, lung, ovarian and colon cancers, lymphoma, adult leukemia, and multiple myeloma.

Through Foundation-sponsored trials, local patients have been among the first to benefit from treatments that help improve survival and are less invasive. Among the Foundation's milestones:

- Enrolled area women in the largest national breast cancer prevention trial, which established a new treatment option for women at increased risk.
- Participated in the National PET Registry, evaluating the use of PET scans for cancer care. The data collected through the registry validated the importance of PET scans and led Medicare to increase its payment coverage for these tests.
- Enrolled area cancer patients in a study for the treatment of metastatic colorectal cancer, which has since become the standard of care, improving survival.
- Enrolled area women with Her2 positive breast cancer in studies evaluating medications found to improve survival.
- Contributed hundreds of tissue and blood specimen samples to help increase knowledge of the makeup of cancer and how different proteins are expressed on cancer cells. This data is being used to develop medications that target cancer more effectively, causing fewer side effects.
- Enrolled patients in a study evaluating a medication for metastatic lung cancer found to improve disease-free survival.
- Provided genetic screening for women diagnosed at high risk for breast cancer through the hospitals of the Community Healthcare System.
- Assisted with the Bone Marrow Transplant Registry drive to secure nearly 500 new donors.

Besides establishing a portal to important cancer trials and studies, the Foundation sponsors many community outreach programs for the public and educational forums for area medical professionals to further awareness about the issues affecting cancer care.

Building on its mission to improve cancer care, the Foundation also established the Cancer Resource Centre, providing valuable support resources to patients and their families. The Cancer Resource Centre, located in Munster, Ind., complements the advanced cancer treatment options available through the three hospitals. The Centre is open to everyone who needs help in coping with a cancer diagnosis. All services at the Centre are free-of-charge; individuals do not need to be patients of the hospitals of Community Healthcare System. The therapeutic environment of the Centre promotes healing of the body, mind, and spirit with complementary therapies, education, and support services. The Centre's Healing Garden helps to bring beauty into the lives of those who are coping with cancer. Among the shady oak, graceful birch trees, and serene waterfalls, patients can tap into all their senses and experience the healing qualities of nature.

For more information about the Community Cancer Research Foundation, please visit www.mycrrf.com.

An Introduction to Cancer Health Disparities

Patrick Monahan, Associate Professor, Division of Biostatistics, IU Simon Cancer Center

Did you know that health disparities exist in cancer? What do we mean by that? The ICC defines cancer health disparities as differences in the incidence (chance of developing), prevalence (chance of currently having), mortality (chance of dying), and burden of cancer and related adverse health conditions that exist among specific population groups. These population groups may be characterized by gender, age, ethnicity, education, income, social class, disability, geographic location, or sexual orientation. In this article, we will provide a general introduction to some of the most fascinating, yet troubling, topics associated with cancer health disparities. Much of the information in this article comes from the American Cancer Society's *Cancer Facts and Figures 2009* publication, available at www.cancer.org. Subsequent ICC newsletter articles will provide a four-part series describing cancer disparities for specific population groups.

Cancer health disparities are complex and interrelated. People with lower education and lower income are more likely to die from cancer, and this is true for all races. To illustrate, data from the American Cancer Society shows that, among both African-Americans and Whites living in the U.S., the chance of dying from cancer is *twice* as great for men with 12 or fewer years of education as compared to men with more years of education. Similarly, the cancer death rate is approximately 1.5 times greater for women with 12 or fewer years of education as compared to women with more years of education. Unfortunately, education and income are quite interconnected, and this certainly complicates the picture of cancer health disparities. In general, though, it is thought that education and income disparities are related to not only knowledge, but also opportunities to engage in behaviors that decrease cancer risk, such as regular physical activity, access to fresh fruits and vegetables for healthy eating, and health care utilization.

In terms of race and ethnic disparities, African-Americans are more likely to develop and die from cancer than any other racial/ethnic group. In fact, the U.S. cancer death rate is 36 percent higher for African-American males as compared to White males, while the cancer death rate is 17 percent higher for African-American females as compared to White females. African-Americans also have a higher chance of developing and dying from the most common cancers. There are, however, some notable exceptions found with regard to chances of developing breast cancer and chances of developing and dying from lung cancer whereby African-American women demonstrate slightly lower rates as compared to White women. On the other hand, the chance of dying from kidney cancer is slightly lower for African-Americans, as compared to Whites, across both genders. Hispanic and Asian-Americans also appear to have lower chances of developing most common types of cancers, although they do demonstrate higher rates of developing cancers associated with infection (e.g., uterine, cervix, liver, and stomach cancer).

Scientists believe that biologic or inherited differences make a minor contribution to racial and ethnic disparities. Rather, they argue that the greatest contributions to cancer-related disparities stem from factors related to early detection and prevention and high-quality treatment, including education, wealth, inadequate housing, standard of living, social and cultural barriers, racial bias, and inadequate health insurance. Many groups, including the ICC, are doing everything they can to decrease these cancer health disparities. Awareness is a critical first step in this regard. We hope this series of articles will shed light on the nature of cancer health disparities. Please stay tuned for future ICC newsletter articles which will discuss disparities as they relate to geographic location, age, gender, disability, and sexual orientation.

Breastfeeding: A Cancer Control Strategy

Erin Bentley Wyatt, M.S.N., R.N., O.C.N.®, C.B.C.N., C.L.S.

The basic and natural act of breastfeeding provides superior nutrition for infants, a strong emotional bond for mother and child, and protection against common childhood illnesses. Recent research reports it provides cardiovascular benefits for lactating women (Schwartz, Ray, Steube, Allison, Ness, Freiburg, & Cauley, 2009). Vast evidence also indicates breastfeeding reduces the risk of several cancers.

Studies show that breastfeeding can reduce the risk for breast cancer, ovarian cancer, and perhaps endometrial cancer in lactating women. It is also thought that children who are breastfed have a lower risk for childhood obesity (Koletzko, von Kries, Closa, Escribano, Scaglioni, Giovannini, Beyer, Demmelmair, Anton, Gruszfeld, Dobrzanska, Sengier, Langhendries, Rolland Cachera, & Grote, 2009), and obesity is a long established risk factor for cancer.

An early study on breastfeeding and breast cancer described breast cancer incidence in women from Hong Kong who, by custom, only used their right breast to breastfeed. Findings showed that the unused breast had a higher risk for breast cancer and the right breast may have been protected from breast cancer (Ing, Petrakis, & Ho, 1977). Research shows that for every 12 months a woman breastfeeds her baby, her relative risk for breast cancer is decreased by 4.3 percent (Beral, Bull, Doll, Peto, & Reeves, 2002). The longer a woman breastfeeds her child and the more children she breastfeeds add to a reduction in risk for the aggressive basal-like breast cancer, also called triple negative breast cancer (Millikan, Newman, Moorman, Conway, & Smith, 2008). One study estimated that more than two-thirds of basal-like breast cancer could be prevented within the younger African-American community if more women breastfed (Millikan et al.).

Studies also suggest that breastfeeding helps reduce the risk of ovarian cancer. Breastfeeding suppresses ovulation, which is thought to protect against ovarian cancer (Riman, Nilsson, & Persson, 2004). The longer a woman breastfeeds, the lower her risk for ovarian cancer. The most significant risk reduction for ovarian cancer was seen when breastfeeding was continued for 18 months (Danforth, Tworoger, Hecht, Rosner, Colditz, & Hankinson, 2007).

According to the National Cancer Institute (2009), breastfeeding also may offer protection from endometrial cancer. The temporary cessation of ovulation during breastfeeding is thought to be the protective mechanism against the disease. One study showed that an increased duration in breastfeeding provided somewhere between 58 to 72 percent in risk reduction for uterine cancer (Salazar-Martinez, Lazcano-Ponce, Gonzalez Lira-Lira et al., 1999). A Wisconsin study showed that if breastfeeding occurred within three previous decades or for the first time after age 30, the risk for endometrial cancer was reduced by 50 percent (Newcomb & Trentham-Dietz, 2000).

Breastfeeding offers the most benefits and most protection from cancer when it is done for an extended period of time. According to the Centers for Disease Control and Prevention Breastfeeding Report Card – United States, 2009, the percentage of women in Indiana who have ever breastfed is 71.1, which does not meet the Healthy People 2010 goal of 75 percent. Findings show that 37.2 percent of Indiana women breastfeed for six months, and only 18.9 percent are still breastfeeding after 12 months. Women exclusively breastfeeding at three months were listed at 28.9 percent, and 10.6 percent at six months.

Although breastfeeding is the natural way to provide nourishment for babies, women who intend to breastfeed can have difficulty doing it. If the woman does not receive adequate support for breastfeeding, she may decide to quit earlier than planned. Mothers trust that their healthcare providers are breastfeeding experts; although, there is no real curricula for breastfeeding in medical or nursing schools. Many physicians and nurses are providing their patients with misinformation about breastfeeding. Much information for healthcare providers exists and can be obtained from the Indiana Perinatal Network at <http://indianaperinatal.org>. Women facing barriers to successful breastfeeding can obtain assistance from International Board Certified Lactation Consultants and from mother-to-mother support groups such as La Leche League International.

The more supportive we are of women in our community who breastfeed, the greater the possibility that cancer rates can be decreased and the health of women and children be improved.

Editor's note: Please refer to www.indianacancer.org for a complete list of sources cited in this story under the News and Announcements tab.

The Robeson County Outreach, Screening, and Education (ROSE) Project

A Best Practice Intervention

Need: Several large studies conducted worldwide show that breast cancer screening with mammograms reduces the number of breast cancer-related deaths in women aged 40 to 69, particularly in women over the age of 50 years. The National Cancer Institute recommends that women aged 40 and older have a screening mammogram (X-ray of the breasts) every one to two years.

Description: The goal of the ROSE Project is to use lay health advisors (LHAs) to deliver an individualized, home-based health education intervention to improve rates of mammography screening in a population of women who are traditionally underserved by cancer control efforts—specifically, low-income Caucasian, African-American, and Native-American women living in rural areas. LHAs are minority residents in the community with a background in health care or the social sciences who have received training to deliver the program.

The ROSE Project consists of three in-person home visits 30 to 90 minutes in duration with two follow-up phone calls to assist in making a mammography appointment and discuss any remaining barriers to obtaining a mammogram, and two postcard reminders that address the woman's stage of change in relation to obtaining a mammogram and offer assistance in setting up a mammogram appointment. The intervention is delivered over a 10- to 14-month period.

Implementation Guide: The Implementation Guide is a resource for implementing this program. It provides important information about the staffing and functions necessary for administering this program in the user's setting. Additionally, the steps needed to carry out the research-tested program, relevant program materials, and information for evaluating the program are included. The Implementation Guide can be viewed and downloaded by clicking [HERE](#).

Time Required: LHAs must successfully complete one week of intensive training, participate in follow-up weekly phone or in-person meetings with an LHA supervisor, and attend additional follow-up training sessions during the program.

Implementation occurs over a 10- to 14-month period and involves:

- First home visit: up to 60 minutes
- Second home visit: up to 90 minutes
- Two follow-up phone calls (during months two and six): no duration specified
- Two follow-up postcard reminders (during months four and eight)
- Third and final home visit (during months 10 through 14): up to 90 minutes

For complete program details, please visit the National Cancer Institute Research Tested Interventions Programs:
<http://rtips.cancer.gov/rtips/index.do>
[programId=264649&topicId=102265&cgId=](http://rtips.cancer.gov/rtips/index.do?programId=264649&topicId=102265&cgId=)

Intended Audience: The intervention targets minority and low-income women living in rural areas who are over 40 years old.

Suitable Settings: The intervention is delivered in the home of each individual and includes follow-up phone calls and mailings.

About the Study: A randomized clinical study evaluated the effects of the ROSE Project intervention versus a comparison condition, in which participants received a physician letter and a National Cancer Institute brochure on cervical cancer. The primary outcome of interest was the rate of mammography utilization among study participants. Additional outcomes of interest included perceived barriers, beliefs, and knowledge related to mammography screening.

Key Findings: Among women assigned to the intervention group, 42.5 percent had medical record-verified mammography in the 12 months prior to follow-up, compared with 27.3 percent of women assigned to the comparison group ($p < .001$). By racial group, more African-American intervention group women than African-American comparison group women ($p = .008$), more Native-American intervention group women than Native-American comparison group women ($p = .002$), and more Caucasian intervention group women than Caucasian comparison group women ($p = .024$) obtained a record-verified mammogram in the 12 months prior to follow-up assessment.

-Women assigned to the intervention group had a lower average barrier score at follow-up than women assigned to the comparison group ($p < .001$).

-Women assigned to the intervention group had a higher (i.e., improved) average belief score at follow-up than women assigned to the comparison group ($p = .004$).

-Knowledge scores increased significantly from baseline to follow-up for both intervention group women ($p = .002$) and comparison group women ($p < .001$). However, knowledge scores at follow-up were not significantly different between the two groups after adjusting for baseline.

Surviving Colorectal Cancer Ruth Lambert

I am a survivor of stage 3 colon cancer. I was surprisingly diagnosed on June 30, 2008 when I was rushed to the hospital in Detroit. I was in Detroit attending the graduation open house for my great nephew. I was in shock when I heard the diagnosis, the stage of the cancer, and the size of the tumor. I said, "Oh no, how can this be because I get my regular checkups? I am scheduled for my next colonoscopy in October." I also thought, 'What I am going to do? I am so tired after providing care and support to my husband who was diagnosed with prostate cancer and had surgery April 15, 2008?'

My experience with cancer has been unbelievable. It has been a journey lead by God. I was fully supported by my friends, colleagues, specifically Minister Melody Boone, my sorority (Delta Sigma Theta Sorority), church, my husband, Samuel, and our two daughters, Theata Tennon and LaWanda Girton, who both live out of town and were with me the whole time I was in the hospital (15 days) in Detroit. My oncologist and care team in Detroit were wonderful and assured me they'd removed the entire diseased tumor. I was cancer free. Chemotherapy was an optional preventive measure. After discussion with my family, I decided to get a second opinion from a doctor in Detroit. He recommended chemotherapy and asked if I wanted to get set up for the service. My response was, "No, I am going home to Indianapolis once my doctor releases me."

After arriving back home in Indianapolis, I called my friend, Ms. Rivienne Shedd-Steele, who works at the IU Cancer Pavilion, and told her I needed services. She told me not to worry, she would help me get set up and I would get the best services ever. She was exactly right. She called me back and had an appointment scheduled for me with Dr. Patrick Loehrer. The day of the appointment she met me and my family and escorted us to Dr. Loehrer's office. We allowed her to participate in the consultation session. I have received outstanding care at the IU Simon Cancer Center. The staff, particularly Dr. Loehrer and Lora Risley, made the journey so easy. I was extremely blessed to have such wonderful care and support. The chemotherapy facility is lovely, and has a relaxed, friendly and homey atmosphere. The staff is very professional, compassionate, kind, and caring.

I have learned that you never know what tomorrow will bring so you must trust in God and live each day to its fullest. I have learned to relax, meditate, and take more time for myself. I have learned that I have a lot of people and friends who care for me more than I had ever imagined. I can truly say that I have gotten my flowers while I live. My message to others is to take care of yourself, spend time with your family and friends, always get your physical checkups, and if by chance, you have a bout with cancer, the IU Simon Cancer Center is the place to go.



Ruth Lambert
Ph.D., C.F.L.E.

- Colon Cancer
- Age 66
- Resides in Indianapolis
- IU Simon Cancer Center

Event Calendar



Jan. 19	8th Annual Indiana Rural Health Public Policy Forum, Indianapolis
Jan. 19	Sabbatical Speaker Talks: "Geographic Technologies and Health Behavior Research" at IUPUI
Jan. 19-Feb. 23	Chronic Lymphocytic Leukemia, Telephone Support Group, Tuesdays 7 to 8 p.m.
Jan. 25-29	Indiana Cancer Control Week
Jan. 29, Feb. 26, March 26	Teen Night at the Wellness Community: For teens 12 - 18 years old. Meets the last Friday of each month, 6 to 8 p.m.
Feb. 11	Blood Cancer: 101 – Located at 911 East 86th St., Indianapolis, 6 to 8 p.m.
Feb. 20	2010 Pink Tie Ball (sponsored by Komen Indy), Indianapolis
March 26-27	Butler University Relay for Life
March 30	InSOPHE, Health Literacy & Clear Communication at Ball State University
March 30	Non-Hodgkin and Hodgkin Lymphoma: Updates in Research and Treatment, 6 to 8 p.m.
Ongoing Mondays	Cancer Support Group, Mondays from 6 to 8 p.m. at Southport Presbyterian Church, 7525 McFarland Blvd., Room CE-28, Indianapolis (Co-sponsored by St. Francis and the Wellness Community)

ICC Committees

The ICC action teams and coordinating committees work to enhance the capacity of the ICC, its member organizations, and other concerned individuals and organizations by focusing on specific cancer-related priorities in Indiana. For more information on how to participate in any of the following committees, please contact us at admin@indianacancer.org. ICC meetings for the coordinating committees, as well as the action teams, are now posted on the ICC Web site. Please visit www.indianacancer.org for the most up-to-date calendar information.

Advocacy Committee

Chair: Jerry King

The advocacy committee works to articulate and advocate for ICC priority cancer-related public policy issues.

Membership Committee

Chair: Sara Edgerton

The membership committees works to increase and diversify the membership of the ICC.

Data Committee

Chair: Vacant

The data committee supports the action teams and committees within the ICC and focuses on increasing the quantity, quality, and availability of complete and timely cancer-related data.

Prostate Cancer Coordinating Committee

Chair: David Caldwell

The prostate cancer coordinating committee is determined to educate Hoosier men on the importance of regular check-ups and communication with their doctors to determine their need for prostate cancer screening.

ICC Membership

The ICC is composed of public, private, and voluntary organizations. ICC membership is open to all organizations and individuals interested in cancer prevention, early detection, treatment, promoting quality of life, accessing cancer-related data, or advocating for change regarding cancer issues. The ICC is an action-oriented organization. To meet the goal of reducing the cancer burden in Indiana, members make a commitment to collaborate together to implement specific strategies identified in the Indiana Cancer Control Plan 2010-2014.

Benefits of ICC Membership include:

- networking and collaboration with other organizations committed to cancer control in Indiana,
- participation in statewide efforts to make a difference in cancer care and outcomes, and
- professional education and information.

To become an ICC member, complete a membership application located at www.indianacancer.org. The registration application can be completed online or downloaded in PDF format. Please complete the form and fax or mail to the number or address shown on the application. New members will receive confirmation upon receipt of registration and should begin receiving ICC updates and other news of interest immediately.