



A National Cancer Institute Designated Cancer Center



Cancer in South Carolina

Changing What's Possible.





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- The population trend over the next 30 years will produce double the number of new cancer cases
- Early diagnosis improves 'capture' rates
- Aging population increases total cases

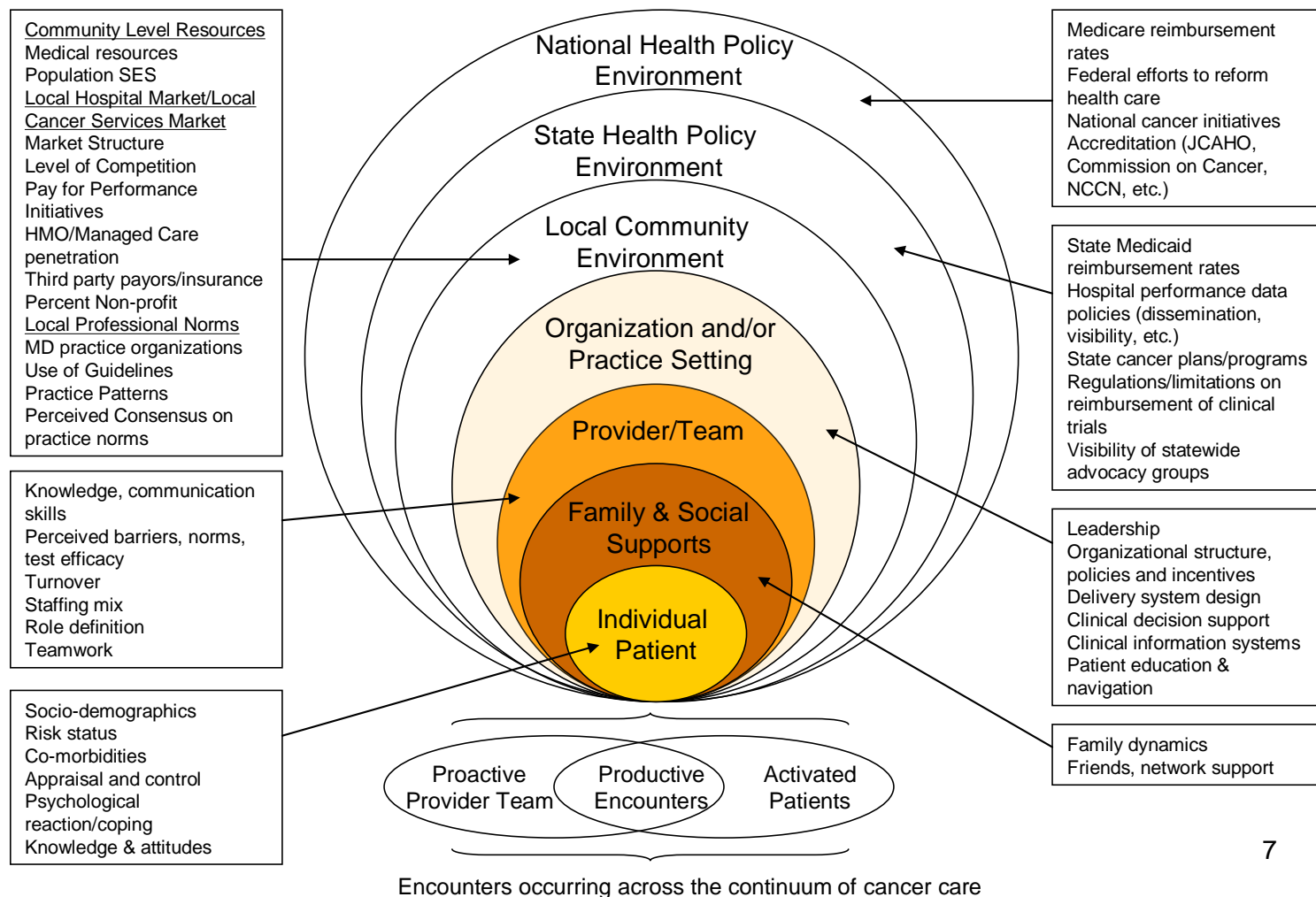
- Cancer is currently the **#2** cause of death in South Carolina.
- As death from heart disease continues to decline and as we continue to age, cancer will become the **#1** cause of death.

With continued improvement in screening and treatment options, the number of survivors will double.

Lifestyle risks: Smoking, obesity, lack of physical exercise, diet all account for over half of new cancer cases.

Lung, breast, colorectal and prostate are the most common disease sites for all racial and ethnic populations, accounting for over 50% of all newly diagnosed cancers.

Within our system there are layers of influence upon the process of care



Adapted from Zapka et al 2008 (22)

Changing What's Possible.

Healthy People 2020 Project

While general in nature, the goals of the project align with the **SCCA goals**:

- Action must be taken if the United States is to achieve better health by the year 2020
- Developed under the leadership of a Federal Interagency Workgroup, Healthy People 2020 framework is the product of an exhaustive collaborative process among HHS and other Federal agencies, public stakeholders, and Secretary's Advisory Committees on Health Promotion in Disease Prevention Objective for 2020

Vision

A society in which all people live long, healthy lives

Mission

Healthy People 2020 strives to:

- Identify nationwide health improvement priorities;
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress;
- Provide measurable objectives and goals that are applicable at the national, state, and local levels;
- Engage multiple sectors to take action to strengthen policies and improve practices that are driven by the best available evidence and knowledge;
- Identify critical research, evaluation and data collection needs.

Overarching Goals

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.

Objectives Retained As Is From Healthy People 2010

- Reduce the overall cancer death rate
- Reduce the lung cancer death rate
- Reduce the female breast cancer death rate
- Reduce the death rate from cancer of the uterine cervix
- Reduce the colorectal cancer death rate
- Reduce the oropharyngeal cancer death rate

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- Reduce prostate cancer death rate
- Reduce the rate of melanoma cancer
- Increase provider counseling about cancer prevention
- Increase the number of central population-based registries from the 50 states and the District of Columbia that capture case information on at least 95% of the expected number of reportable cancers
- Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis.

Objectives Retained But Modified From Healthy People 2010

- Reduce the rate of sunburn
- Increase physician counseling about currently recommended screening for colorectal cancer
- Increase the proportion of women aged 18 years and older who receive a cervical cancer screening based on most recent guidelines

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- Increase the proportion of adults who receive a colorectal screening based on the most recent guidelines
- Increase the proportion of women aged 40 years and older who have received a breast cancer screening based on the most recent guidelines.

Objectives New to Healthy People 2010

- (Developmental) Increase the proportion of cancer survivors who reported physical-health related quality of life similar to the general population.
- Decrease incidence of invasive colorectal cancer
- Decrease incidence of invasive uterine cervical cancer

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- Decrease incidence of late-stage disease breast cancer
- Increase the proportion of men who have discussed with their health provider whether or not to have a prostate-specific antigen (PSA) test to screen for prostate cancer

Progress has been made during the almost 40 years since the passage of the National Cancer Act in 1971; the age adjusted death rate from cancer declined 1% per year between 1990 and 2002. Each successive year has seen continued improvements.

The ACS published a midpoint analysis of progress toward its goal of reducing cancer deaths by 50% over the 25 year period from 1990-2015. If trends over the first 12 years continue, the projection is for a 23% reduction.

Cancer Statistics in South Carolina

- Our focus on cancer reflects the disproportionate burden that cancer imposes on the people of South Carolina in terms of incidence, mortality, morbidity and quality of life
- South Carolina ranks in the **top ten states** in cancer mortality for prostate, cervical, oral/pharyngeal, pancreatic, esophageal and multiple myeloma

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State demographics also reflect an underserved, largely rural population with a high percentage (30%) of African Americans experiencing significant disparities in access to care, life expectancy and cancer death.

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Examples of these cancer disparity gaps include:

- The incidence of squamous cell esophageal cancer in South Carolina is 10 times higher in African Americans than Caucasians
- African American women in South Carolina are about 60% more likely than Caucasian women to die of breast cancer once it is diagnosed – the **largest such disparity in the U.S.**

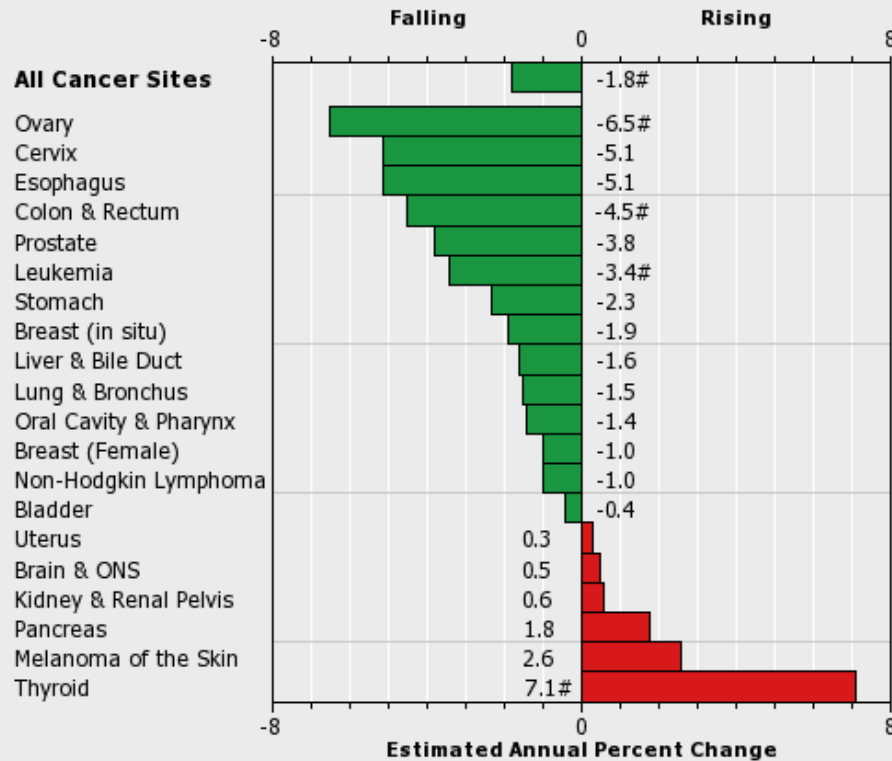
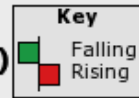
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- African American men in South Carolina are nearly 80% more likely to get prostate cancer and 2.5 times more likely to die of the disease than Caucasian men – this is about 50% higher than national rates.

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- More than 22,000 new cases of cancer are diagnosed in South Carolina every year
- Despite progress in early detection, risk reduction and prevention, more than 9,000 South Carolinians die of cancer each year

5-Year Rate Changes - Incidence South Carolina, 2002-2006 All Ages, Both Sexes, All Races (incl Hisp)



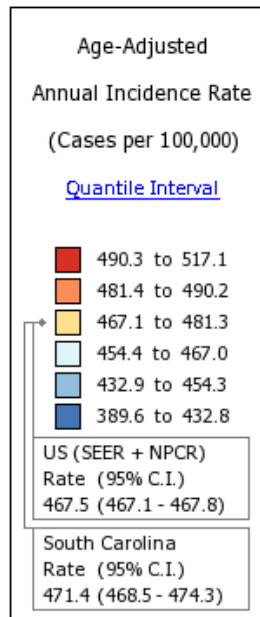
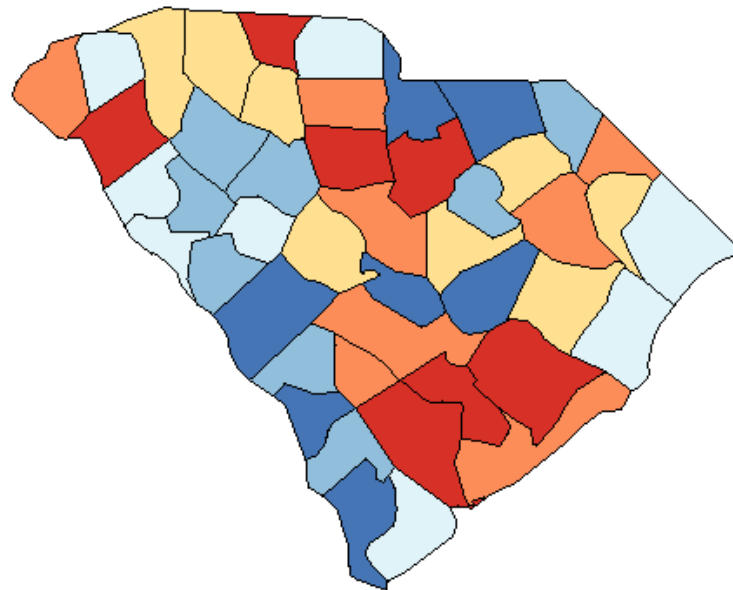
Created by statecancerprofiles.cancer.gov on 03/08/2010 8:20 am.

Source: Incidence data provided by the National Program of Cancer Registries (NPCR). EAPCs calculated by the National Cancer Institute using SEER*Stat. Rates are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ..., 80-84, 85+). Rates are for invasive cancer only (except for bladder cancer which is invasive and in situ) or unless otherwise specified. Population counts for denominators are based on Census populations as modified by NCI.

Please note that the data comes from different sources. Due to different years of data availability, most of the trends are AAPCs based on APCs but some are EAPCs calculated in SEER*Stat. Please refer to the source for each graph for additional information.

- The annual percent change is significantly different from zero ($p < 0.05$).

Incidence Rates[†] for South Carolina, 2002 - 2006
All Cancer Sites
All Races (includes Hispanic), Both Sexes, All Ages



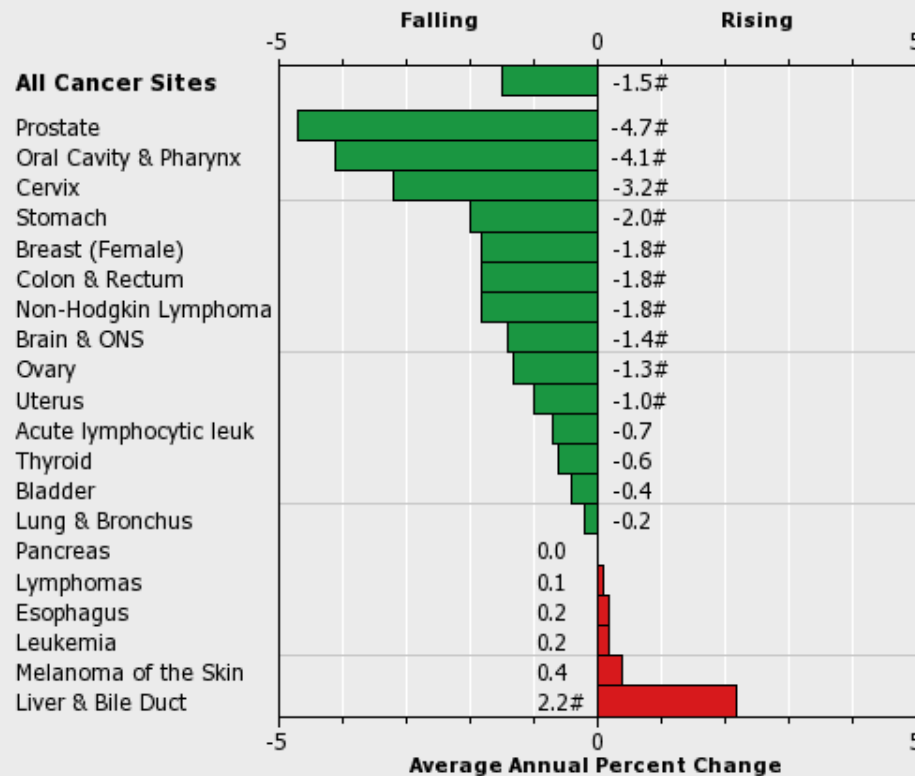
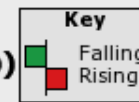
Created by statecancerprofiles.cancer.gov on 03/06/2010 12:27 pm.

State Cancer Registries may provide more current or more local data.

Data presented on the State Cancer Profiles Web Site may differ from statistics reported by the State Cancer Registries (for more information).

[†] Incidence rates (cases per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... , 80-84, 85+). Rates are for invasive cancer only (except for bladder which is invasive and in situ) or unless otherwise specified. Rates calculated using SEER*Stat. Population counts for denominators are based on Census populations as modified by NCI. The US populations included with the data release have been adjusted for the population shifts due to hurricanes Katrina and Rita for 62 counties and parishes in Alabama, Mississippi, Louisiana, and Texas (See US Population Data - 1969-2006 for more information.)

5-Year Rate Changes - Mortality South Carolina, 2002-2006 All Ages, Both Sexes, All Races (incl Hisp)



Created by statecancerprofiles.cancer.gov on 03/08/2010 8:21 am.

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 (deaths per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ..., 80-84, 85+). Population counts for denominators are based on Census populations as modified by NCI.

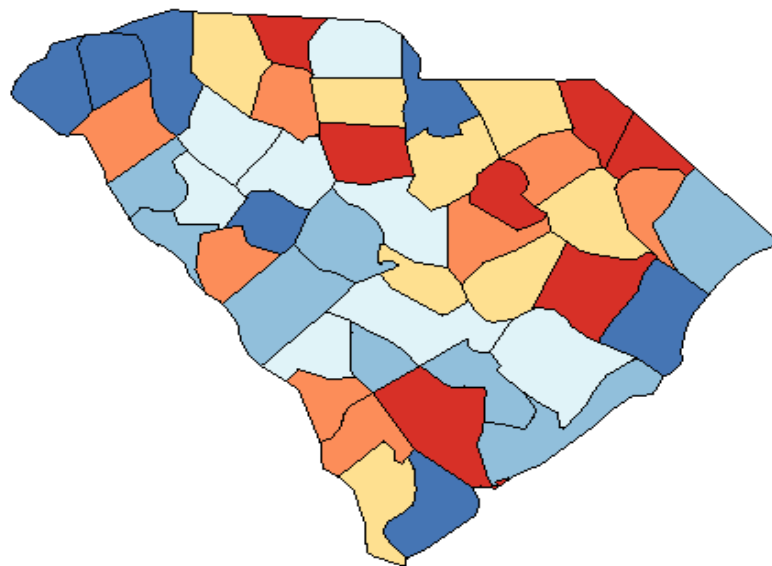
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- The annual percent change is significantly different from zero ($p < 0.05$).

Age-Adjusted Death Rates for South Carolina, 2002 - 2006

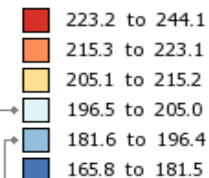
All Cancer Sites

All Races (includes Hispanic), Both Sexes, All Ages



Age-Adjusted
Annual Death Rate
(Deaths per 100,000)

[Quantile Interval](#)



United States
Rate (95% C.I.)
186.9 (186.7 - 187.1)

South Carolina
Rate (95% C.I.)
197.7 (195.8 - 199.6)

Healthy People 2010
Goal 03-01
159.9

Created by statecancerprofiles.cancer.gov on 03/06/2010 12:26 pm.

State Cancer Registries may provide more current or more local data.

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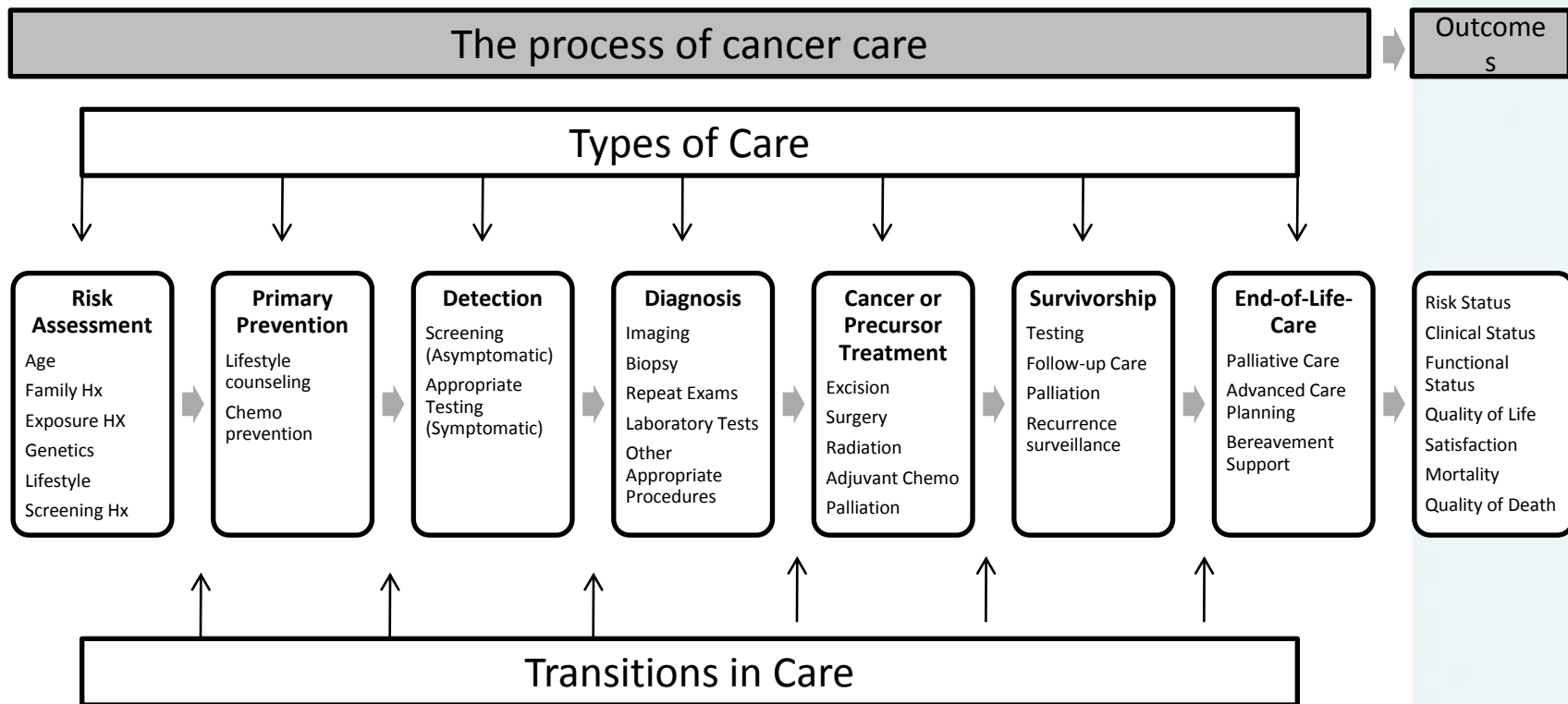
Source: Death data provided by the National Vital Statistics System public use data file. Death rates calculated by the National Cancer Institute using SEER*Stat. Death rates (deaths per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... , 80-84, 85+). 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. The US populations included with the data release have been adjusted for the population shifts due to hurricanes Katrina and Rita for 62 counties and parishes in Alabama, Mississippi, Louisiana, and Texas (See US Population Data - 1969-2006 for more information.)

Healthy People 2010 Goal 03-01 : Reduce the overall cancer death rate to 159.9.

Healthy People 2010 Objectives provided by the Centers for Disease Control and Prevention.

In South Carolina we must work together.
All of us – from our divergent
backgrounds – including grassroots,
volunteers, public health and social
scientists, primary care to specialty
providers...

COLLABORATION is the KEY



People become patients and enter an entirely new world of specialty care that is foreign and complicated by the number and type of providers needed to create their plan of care.

Staging studies, assessments of body parts and systems, and definitive therapies including surgery, radiation chemotherapy, and immunotherapy.

- The question is then, how do we create the interface between primary and oncology specialty care?
- How do we evaluate the challenges and opportunities in the development of effective and collaborative relationships between primary and specialty care partnerships?
- How do we incorporate primary prevention, early detection and access concerns into this evolving modeling?

The 2005 Institute of Medicine report entitled 'From a Cancer Patient to Cancer Survivor: Lost in Transition'

A major focus in this important report emphasizes the role of effective **communication between providers** so that we are clear about the process of care and their role within the care paradigm.

A second important focus is the awareness that functional, medical and psychosocial consequences of cancer and treatment must be acknowledged between all providers.

Collaboration is the cornerstone of the solution to this multifaceted challenge:

- continuity between providers
- management of preventive care as well as co morbid conditions affecting treatments and survival
- supportive care during and post acute treatment

First, the role of the primary care relationship can not be overstated:

- primary care involvement during pre-diagnosis, role in continuity and symptom management, long term follow up
- inclusion in active treatment planning necessary

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- management of co-morbid conditions by primary care physicians improves both care and outcomes especially important in the aging (35 and over?) cancer patient population
- important source of information regarding patient's medical, social, functional history

Supportive care includes the informational, physical and emotional, spiritual and economic needs of patients. This must be a collaboration among various caregivers with a history of personal relationships, community support and primary care.

Collaboration along the continuum
has the potential to improve the
patient's ability to receive a
satisfying end result of met vs.
unmet needs

- ‘Sharing of care’ models have greatest potential to serve current and future populations of patients across the spectrum of interactions
- Inclusion of case management, nurse practitioners, social work, counselors, oncology nutritionists, navigation models and fully inclusive of primary care partners.



Live so that when
you are gone it
will have mattered.