



Comprehensive Cancer Control Update

Centers for Disease Control and Prevention (CDC) Site Visit

Annette Gardner, CDC program consultant, is scheduled to visit Indiana, July 16-17. As part of her site visit, Ms. Gardner will attend the Indiana Cancer Consortium (ICC) Steering Committee meeting. She will also meet with various other consortium partners during her two-day stay.

Indiana Cancer Control Plan (ICCP)

Per the request of the ICC Steering Committee, a subcommittee was developed to establish recommendations for the process of revising the ICCP. An initial subcommittee meeting was held on Wednesday, June 25. The group decided further research was needed prior to making any decisions. After reviewing CDC guidance documents and other states' cancer control plans, the subcommittee reconvened on Wednesday, July 9. Recommendations for ICCP revisions will be made at July's steering committee meeting.

National Comprehensive Cancer Control Program (NCCCP)

Tom Rich, Wayne Fischer, and Keylee Wright represented the ICC at the NCCCP Directors' Business Meeting in Atlanta, May 13-15. The three-day meeting focused on evidence based practice, updating cancer control plans, expanding partnerships, and program evaluation.

In addition, the ICC was one of just 32 programs selected to display a poster at this year's business meeting. The purpose of the poster session was to share promising practices or successful strategies for Comprehensive Cancer Control. The ICC poster was entitled, Results from the 2007 Restructuring of the Indiana Cancer Consortium.

Action Team Updates

Clinical Trials Action Team

The clinical trials action team is currently developing a grassroots strategy to engage communities across Indiana. In May, the team designed a fact sheet to educate the public on the basics of clinical trials and clinical trial insurance coverage. The action team is in the process of obtaining other fact sheets to further educate the community on various issues, such as underserved populations, patient participation, and why cancer patients enroll in clinical trials. If you would like to participate on the clinical trials action team, please contact Nikki Davis at nicdavis@isdh.in.gov or 317-234-2887.

The next clinical trials action team meeting will be held on Thursday, July 24, at 3 p.m. (EDT) at the Indiana University, School of Nursing, room 338.

Primary Prevention Action Team

The primary prevention action team is focused on encouraging primary care practitioners to incorporate educational resources in their practice to promote prevention and early detection of cancer. The group is currently working to identify valuable resources for breast cancer, cervical cancer, prostate cancer, colorectal cancer, skin cancer, lung cancer, and healthy lifestyles to distribute to primary care providers across the state. Their goal is to begin reaching primary care providers by the fall of 2008. If you are interested in joining in these efforts, please contact Nikki Davis at nicdavis@isdh.in.gov or 317-234-2887.

The next meeting for the primary prevention action team is on Wednesday, August 6, at 4 p.m. (EDT) via conference call.

The Indiana Comprehensive Cancer Control Program (ICCCP) has a new prostate cancer coordinator, Deirdre George Davis.
Phone: 317-234-2883
Email: deirdavis@isdh.in.gov

Congratulations to Jennifer Taylor who gave birth to a healthy baby girl, Parker Ada Taylor, on June 11. In addition, Jennifer accepted a position with the American Academy of Osteopathy. The ICCCP staff wishes Jennifer the best of luck in her future endeavors.

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Smoking and Smoking Cessation in Relation to Mortality in Women

Context: Smoking is associated with an increased risk of total and cause-specific death, but the rate of mortality risk reduction after quitting compared with continuing to smoke is uncertain. There is inadequate or insufficient evidence to suggest the presence or absence of a causal relationship between smoking and ovarian cancer and colorectal cancer.

Objective: To assess the relationship between cigarette smoking and smoking cessation on total and cause-specific mortality in women

Design, setting, and participants: Prospective observational study of 104,519 female participants in the Nurses' Health Study with follow-up from 1980 to 2004

Main outcome measure: Hazard ratios (HR) for total mortality, further categorized into vascular and respiratory diseases, lung cancer, other cancers, and other causes

Results: A total of 12,483 deaths occurred in this cohort; 4,485 (35.9 percent) among never smokers, 3,602 (28.9 percent) among current smokers, and 4,396 (35.2 percent) among past smokers. Compared with never smokers, current smokers had an increased risk of total mortality (HR, 2.81; 95 percent confidence interval [CI], 2.68-2.95) and all major cause-specific mortality. The HR for cancers classified by the 2004 surgeon general's report to be smoking-related was 7.25 (95 percent CI, 6.43-8.18) and 1.58 (95 percent CI, 1.45-1.73) for other cancers. Compared with never smokers, the HR for colorectal cancer was 1.63 (95 percent CI, 1.29-2.05) for current smokers and 1.23 (95 percent CI, 1.02-1.49) for former smokers. A significant association was not observed for ovarian cancer. Significant trends were observed for earlier age at initiation of smoking for total mortality ($P=.003$), respiratory disease mortality ($P=.001$), and all smoking-related cancer mortality ($P=.001$). The excess risk for all-cause mortality decreases to the level of a never smoker 20 years after quitting, with different time frames for risk reduction observed across outcomes. Approximately 64 percent of deaths among current smokers and 28 percent of deaths among former smokers were attributable to cigarette smoking.

Conclusions: Most of the excess risk of vascular mortality, due to smoking in women, may be eliminated rapidly upon cessation and within 20 years for lung diseases. Postponing the age of smoking initiation reduces the risk of respiratory disease, lung cancer, and other smoking-related cancer deaths, but has little effect on other cause-specific mortality. These findings suggest that smoking is associated with an increased risk of colorectal cancer mortality, but not ovarian cancer mortality.

To view this article in full, please read: The Journal of the American Medical Association
JAMA. 2008;299(17):2037-2047 www.jama.com



Program Spotlight



Prevention Clinic and Resource Center

The Fort Wayne African American Cancer Alliance Incorporated (FWAACA) has partnered with several health care organizations in the Fort Wayne area to initiate the Prevention Clinic and Resource Center, an innovative project that provides free or low-cost health screenings to uninsured and underinsured local residents every third Wednesday.

The mission of the Prevention Clinic and Resource Center is to encourage wellness to the medically underserved by working collaboratively with health care organiza-

tions to provide free or low-cost health screenings and education for many preventable diseases.

The Prevention Clinic and Resource Center provides screenings for blood pressure, cholesterol, depression, drug and alcohol abuse, glucose, HIV/AIDS, breast cancer, oral exams, and prostate cancer. The FWAACA is currently seeking collaboration for clinical breast exams, digital rectal exams, and hearing and vision screenings. The Prevention Clinic and Resource Center provides

education to those they serve about cancer, dental care, diabetes, heart disease, HIV/AIDS, obesity, stroke, and smoking cessation.

This project is funded in part by a federal grant through the Indiana University School of Medicine, but the services are largely in-kind donations from participating organizations.

For more information, call the Fort Wayne African American Cancer Alliance at 260-745-1600.

Save the Date

ICC Fall Meeting *Evidence Based Practice*

Monday, October 20, 2008
Clarian North Learning Center
11700 N. Meridian St.
Carmel, IN 46032

As it becomes available, more information will be posted on the ICC Web site.

Improving Participation of Minorities in Clinical Trials

The Chronic Disease Prevention and Control Research Center at Baylor College of Medicine and the Intercultural Cancer Council in Houston are conducting a four-year (2005-2009) research project that addresses problems and solutions related to improving participation of minority and underserved patients in oncology and asthma clinical trials. The four-year study is funded by Genentech, Inc.

To maximize the impact of this effort, the study has two arms, coupling research on strategies to improve health care policy together with conducting actual field research.

The policy research arm focuses on health policy and patient advocacy affecting clinical trial recruitment efforts in the targeted populations. The end products will be both a consensus document outlining health policy priorities and also educational materials

for advocacy to improve national policy affecting minority recruitment to clinical trials.

The field research demonstration arm addresses barriers and facilitators to clinical trial recruitment and retention in the targeted populations, including methods and educational materials for outreach to researchers, referring physicians, patients, and the general public. In this arm, demonstration research is being aimed at increasing minority accrual to oncology and asthma clinical trials.

Overall, accrual rates of minority and medically underserved patients to oncology and asthma clinical trials are much lower than necessary to be representative of these groups. Conversely, women and minority subjects often withdraw from studies to a disproportionate degree. However, little is known about the factors af-

fecting retention or attrition of minorities.

Without adequate minority representation, researchers can neither assess differential effects among groups nor ensure generalizability of trial results. Barriers to clinical trial participation by minority and underserved populations include simple lack of information and culturally appropriate educational materials, socioeconomic and cultural factors, as well as mistrust of the medical research establishment. For many Asians and Hispanics, limited English proficiency additionally hampers access, not only to clinical trials, but also to preventive and medical services in general.

For more information, please contact the Chronic Disease Prevention and Control Research Center at 713-798-4614 or edict@bcm.edu.



The need: Excess body weight in youth is a major predictor of early onset type II diabetes mellitus and obesity throughout the life span. According to the CDC, 12 to 22 percent of preadolescent American youth are overweight. In addition to a diet high in fat and calories, lack of physical activity has been linked to the concern about weight increases in children. Although most states mandate physical education (PE) and most elementary school youth participate in some form of PE, many schools are reducing PE requirements because of higher priorities for academics.

The program: Youth Fit For Life is a 12-week, after-school physical activity program for children aged five to 12 years. The program is administered by trained, after-school counselors with little or no PE delivery experience. Children are prescreened through a parent/guardian consent form for any basic medical conditions that might prohibit physical activity. Program sessions are held in either a school multipurpose room or recreation area with a child-to-counselor ratio of 15:1. Children are grouped by age, and the after-school counselors keep session attendance records.

Youth Fit For Life meets three times per week for 45 minutes. Sessions include physical resistance training and cardiovascular exercise in the form of noncompetitive activities and cooperative games. A nutrition and health education component is provided for each session, centered on a weekly theme. Once a week, there is an interactive behavioral life skills (goal-setting, social support, and positive self-talk) training presented in a conversational group format. A workbook (Goals for My Body in 5 Easy Steps, A Youth Fit For Life Activity Workbook, 2006) is provided to each child. Some of the workbook activities require tasks to be continued outside of the program sessions. Trained assessors support the after-school counselors by periodically supervising activities and evaluating instruction.

Time required: The time required to implement Youth Fit For Life includes:

- a six-hour training course for after-school counselors and assessors with PE or exercise science experience,
- a two-hour additional training for quality assurance audits (administered five times during the 12-week program),
- a two-hour additional training for the data analyst who handles the quality assurance audit data, and
- three, 45-minute, after-school sessions a week for 12 weeks, for each child enrolled in the program.

Intended audience: The program is intended for children aged five to 12 years.

Suitable settings: Youth Fit For Life is suitable in any after-school care setting, such as the YMCA, schools, churches, and camps.

Required resources:

- Youth Fit For Life training manual
- nutrition/health information packet
- Goals For My Body in 5 Easy Steps activity workbook
- supplemental physical education information sheet
- quality assessment form
- poster samples as visual aids

A complete in-house training program is provided for about \$10,000. This includes training of the after-school counselors (with a designated supervisor for the counselors) to provide direct delivery of the Youth Fit For Life program with additional specialized training of two to four assessors (with prior PE experience or exercise science background) and an identified program administrator for each site.

The study: A pre/post control study design compared the effects of two 12-week, after-school care physical activity programs--the 2003 and 2005 Youth Fit for Life--with an unstructured activity control group in 165 children aged nine to 12 years. Each program met three times per week after school for 45 minutes per session across 12 weeks. The study measured the reported number of days with "voluntary" (not programmed or school PE) physical activity that made one "breathe harder than usual". The study also measured physical self-concept and exercise barriers self-efficacy. Exercise barriers self-efficacy included social, personal, and environmental reasons for not exercising or participating in moderate-to-vigorous physical activity.

The results:

- Reported days of voluntary physical activity increased from week one (M=2.39) to week 12 (M=3.24) in the 2003 Youth Fit For Life (p<.001) children. In the 2005 Youth Fit For Life group, the children reported an increase in voluntary physical activity from week one (M=2.18) to week 12 (M=3.42) (p<.001). This represents a significant increase (p<.05) from the 2003 study. Reported days of voluntary physical activity at week 12 by children in the control group did not differ from week one.
- Reported increases in voluntary physical activity across the 12-week, Youth Fit For Life program were associated with increases in physical self-concept scores (p<.05) and with decreases in exercise barriers self-efficacy .
- Physical self-concept improved significantly from week one (M=34.22) to week 12 (M=35.38) in the 2005 Youth Fit For Life group only (p<.05).
- Exercise barriers self-efficacy improved significantly from week one (M=27.92) to week 12 (M=29.80) in the 2005 Youth Fit For Life group only (p<.001).
- The amount of improvements in exercise barriers self-efficacy and physical self-concept were, together, associated with the amount of increases in voluntary physical activity for both the 2003 (p<.01) and 2005 (p<.05) Youth Fit For Life groups.

More information can be found at the National Cancer Institute Research Tested Interventions Programs.

http://rtips.cancer.gov/rtips/rtips_details.do?programid=92&topicid=2&co=N&cg=

Prostate Cancer Initiative

In February and March, the Indiana Prostate Cancer Initiative sponsored six mini-grant events to disseminate accurate and up-to-date information about the effects of prostate cancer on the community. These events targeted African-American men, over the age of 40 years, in Marion and surrounding counties. Each event featured an educational presentation on informed decision making and concluded with a question-and-answer session. Free screening opportunities were also available. All events proved to be successful.

For more information, please contact Deirdre George Davis at deirdavis@isdh.in.gov or 317-234-2883.

Treanda Approved for Chronic Lymphocytic Leukemia

After receiving priority review last September, Treanda (bendamustine) gained approval on March 20, 2008 from the Food and Drug Administration (FDA) for treatment of chronic lymphocytic leukemia (CLL). An estimated 15,000 new cases of CLL, a slowly progressing blood and bone marrow disease, will be diagnosed this year.

In an international study of 301 patients with untreated CLL, those who received Treanda had better clinical outcomes compared with patients treated with chlorambucil, an FDA-approved CLL chemotherapy. Specifically, Treanda

patients had a significantly higher overall response rate (59 percent compared to 26 percent with chlorambucil). Patients who received Treanda also had a higher complete response rate than those treated with chlorambucil (eight percent versus less than one percent), which means that after treatment with Treanda, some patients had no signs of disease in their blood.

Importantly, Treanda patients also had a significantly longer progression-free survival (18 months versus six months), meaning the disease did not get worse for a significant period of time. The response to Treanda lasted longer than chloram-

bucil (19 months versus seven months). The most common adverse events in the trial were myelo-suppression (lowering of blood counts), fever, nausea and vomiting.

This past December, Treanda was submitted for approval as treatment for slow-growing, non-Hodgkin's lymphoma that's progressed during or following treatment with Rituxan (rituximab) or a Rituxan-containing regimen. A decision is expected by late 2008.

For more information, visit
www.cephalon.com

Action Teams and 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 action teams or committees, please contact us at admin@indianacancer.org.

Clinical Trials Action Team

Co-chairs: Susan Haithcox and Amy Kwass

This action team's goal is to advocate for legislation that will increase insurance coverage for the standard care of cancer patients enrolled in clinical trials.

Primary Prevention Action Team

Co-chairs: Doug Schwartzentruber and Erin Wyatt

This action team's goal is to encourage primary care practitioners to incorporate cancer prevention resources into practice to promote prevention and early detection of cancer.

Advocacy Committee

Co-chair: Jerry King

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

Data Committee

Co-chair: Elizabeth Hamilton-Byrd and Greg Steele

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

Co-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.

Quality of Life Coordinating Committee

Co-chairs: Jane Berby-Todd and Harriet O'Connor

The quality of life coordinating committee is working to improve the understanding of pain management and breast cancer survivorship.



“Chemo-brain” in the News

Many survivors who have previously received or are currently undergoing chemotherapy report experiencing cognitive changes, often referred to as “chemo-brain.” These changes include difficulty with short-term memory, multi-tasking, new learning, reading comprehension, and working with numbers, as well as a decrease in concentration ability. For many years, this was attributed by physicians and researchers to depression or anxiety over the diagnosis and treatment of cancer. More recently, researchers have begun to study and document what survivors have been saying all along; cognitive changes after chemotherapy are real. Although we are not yet able to pinpoint whether only certain chemotherapy drugs are responsible for these cognitive changes, it seems certain that the effects are cumulative. That is, those who receive more chemotherapy tend to experience greater deficits. Studies have found that cognitive ability can improve over time in some survivors, but deficits are still present in many survivors, even years after treatment.

Two studies recently presented at the annual meeting of the American Academy of Neurology prompted health news reports to claim that “chemo-brain” may be a myth. These reports fly in the face of millions of survivors’ accounts and numerous research studies (one that was presented at the same meeting).

The two abstract presentations addressed in the recent news were both small in size (30 women and 17 women, respectively) and evaluated breast cancer patients in areas of memory, anxiety, depression, and quality of life. Both studies found that cognitive function was impaired when compared with control patients even prior to beginning therapy for their cancer, suggesting that anxiety over diagnosis and treatment decisions may play a role. One study found that one’s mental “speed of detection” declined significantly after therapy, and 10 percent of the women had developed cognitive impairment. The second study found poorer performance on memory and “speed of information processing” testing when comparing women with a new diagnosis to those who were at least one year post treatment. While these studies found differences pre-treatment, one did not evaluate function after therapy while the second stated in the conclusion that a rate of 10 percent for cognitive impairment one month after treatment was “infrequent”.

Unfortunately, much of the research that has been done regarding “chemo-brain” evaluated small numbers of patients. Studying this issue is particularly difficult given the extensive variety of treatments and combinations of therapies used to treat different cancer diagnoses. On top of these differences, patients have varying levels of anxiety, depression and support when it comes to dealing with the diagnosis, treatment decisions and post-therapy issues. So, while patients have reported this phenomenon since the 1970’s, it is only recently that physicians and researchers have begun to acknowledge the effect of therapy on cognition. This attention has led to the formation of a multidisciplinary “International Cognition and Cancer Task Force”, which aims to address issues facing cognitive research in cancer survivors.

While this side effect has been unofficially named “chemo-brain”, researchers have found that chemotherapy is not the only culprit. Radiation therapy (particularly involving the brain), biologic therapies, and hormone therapies have also been implicated. Other health problems and the cancer itself may also contribute, and as the above studies

noted, the anxiety of diagnosis likely plays a role as well. Many experts have proposed renaming this phenomenon, given the various possible causes, but that change has not yet occurred.

Studies have reported “chemo-brain” in anywhere from 15 to 50 percent or more of survivors who had received chemotherapy. Deficits may include impairments in attention, concentration, memory (visual and verbal), and processing speed. These may resolve over time, but in some survivors can persist for years after therapy. This may affect a survivor’s ability to perform his/her job or manage family responsibilities. Some studies have seen declines in cognitive function, while others have not, and it is uncertain if these inconsistencies are due to various therapies or the numerous study designs and methods used to test for changes in function. Studies using radiologic imaging have shown differences in the brain functioning of survivors when compared to control groups, even in patients who perform well on cognitive function tests, providing some “evidence” that differences do exist. No mechanism for how cognitive decline develops has been clearly identified, and research is also needed in this area.

What does all of this mean for the survivor struggling to manage daily tasks? Researchers have begun evaluating “treatments” for the condition, and while there are no interventions that have been proven in studies, there are a few that can help a survivor cope while research continues.

Some medications are being studied as potential treatments for cognitive changes, but there is not yet enough data to support their use. Some of the agents being studied include methylphenidate (Ritalin), modafinil (a medication approved to treat narcolepsy), various antidepressants, herbal therapies, and certain amino acids. Cognitive rehabilitation programs are structured programs utilizing exercise, tasks that use memory, and puzzles to “rehabilitate” one’s mind. These programs are typically used for people with brain injuries, but therapists have tailored programs for cancer survivors. Bookstores and websites offer memory training, which may be helpful to survivors. Puzzles using numbers may help “exercise” the brain. Fatigue can enhance cognitive problems, so avoiding fatigue by getting enough sleep, incorporating exercise into daily life, and eating a healthy diet may be helpful.

It is important to remember that some very treatable problems can result in cognitive difficulties, such as thyroid dysfunction, depression and anxiety, so it is important to exclude or treat these diagnoses. Hypothyroidism (low thyroid hormone levels) is a common issue for survivors and can make one feel “fuzzy” or “out of it.” This is easily treatable with supplemental thyroid hormone. Survivors who may be depressed or experiencing anxiety would benefit from consulting with a psychiatrist or psychologist experienced in working with cancer patients or survivors.

Research will continue regarding this issue, but in the meantime, survivors will need to incorporate their own solutions to make life a bit easier.

By: Carolyn Vachani, RN, MSN, AOCN

The Abramson Cancer Center of the University of Pennsylvania

For more information, please visit: <http://www.oncolink.org/resources/article.cfm?c=3&s=38&ss=230&id=970>

Help Wanted

Cervical Cancer Outreach Project

Outreach Workers Needed!

The primary goal of the ICC’s cervical cancer outreach project, Take Control, is to increase cervical cancer awareness and screening among underserved and uninsured Latina and African-American women in Marion County. Currently, the project is focusing its efforts toward program development by tailoring existing evidence based programs to meet the project’s goals and objectives. Take Control is looking for part-time outreach workers who will be responsible for working with the community on this project. Outreach workers will work to increase cervical cancer education, awareness, and screenings in underserved communities in Marion County. Outreach workers will participate in community education and community events and assist with event planning and coordination of community activities.

Job duties include:

- talk with women about the importance of cervical cancer screenings,
- participate in community education and community events,
- assist in planning community events, and
- work closely with community organizations regarding the importance of cervical cancer screenings.

Qualifications include:

- experience in community outreach,
- experience in public speaking,
- bi-lingual in English and Spanish preferred, and
- community service experience preferred.

Fun work environment and flexible hours!

If you are interested in participating on the ICC Cervical Cancer Task Force or are aware of possible candidates for these positions, please contact Jacquelyn Peelle at Jacquelyn.Peelle@cancer.org.

Upcoming Health Awareness

July	UV Safety Awareness Month	
September	Prostate Cancer Awareness Month Childhood Cancer Month Leukemia and Lymphoma Awareness Month Ovarian Cancer Awareness Month Fruit and Veggies - More Matters Month	
October	National Breast Cancer Awareness Month Healthy Lung Month	October 17, 2008—National Mammography Day
November	Lung Cancer Awareness Month National Hospice Palliative Care Month Pancreatic Cancer Awareness Month	November 20, 2008—Great American Smokeout

ICC Event Calendar

ICC meetings for the action teams and coordinating committees are now posted on the ICC Web site. Please visit www.indianacancer.org for the most up-to-date calendar information.

ICC Member Events



Saturday, July 12, 2008
8 a.m.

INDIANA WAR MEMORIAL
431 N. MERIDIAN ST.
INDIANAPOLIS, IN 46204

Run and walk on July 12 in the fight against prostate cancer, a disease that affects one out of every six men in the United States. Unite 2 Fight : Race Against Prostate Cancer consists of a 5K run, a 5K walk, and a one-mile family walk in downtown Indianapolis. Organized by Little Red Door Cancer Agency and the Indiana Cancer Research Foundation, this event will support each groups' efforts to reach the underserved men in our community and to find a cure for prostate cancer.

Race Day Events

Free PSA blood tests: 7:30 - 9:30 a.m.

Prostate cancer survivor picture: 7:30 a.m.

5K competitive run: 8 a.m.

5K non-competitive run/walk: 8 a.m.

Rev. Charles Williams family-fun walk

awards ceremony: 9:15 a.m.

For more information or to register, please visit <http://>

www.raceagainstprostatecancer.org.

Summary: Given pervasive physical inactivity, rising obesity rates and environmental degradation, encouraging “mode shift” - getting people out of their cars and instead using walking, biking, and public transportation as legitimate means of getting to work, school, and retail and business centers—is one primary prevention strategy. The audience will gain insight into evidence based, short and long-term planning and implementation activities which will lead to balanced transportation for Hoosiers.

For more information, please visit: www.healthbydesignonline.org.

ICC Membership

The ICC is composed of public, private, and voluntary organizations. ICC membership is open to all organizations interested in cancer prevention, early detection, treatment, promoting quality of life, accessing cancer and 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, member organizations make a commitment to collaborate together to implement specific strategies identified in the Indiana Cancer Control Plan.

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 form. 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.