NEW JERSEY
Comprehensive Cancer Control Plan 2021-2025

NJHealth
New Jersey Department of Health

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Summary

The Comprehensive Cancer Control Plan and statewide partners have guided the success in reducing the burden of cancer among all New Jersey residents and improving the quality of life of cancer survivors. This Plan builds upon previous work but also moves to strategically outline New Jersey's cancer priorities in alignment with the National Comprehensive Cancer Control Program's priority areas. This will allow for more strategic coordination among programs and partners.

Cancer is the second leading cause of death among New Jersey residents. Early detection and treatment is key in improving survival rates and quality of life. Cancer partners continue to work to improve access to screening services to all residents.

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Executive Summary

The Governor's Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey ("Task Force") was established by Executive Order #114 in 2000 under Governor Christine Todd Whitman and memorialized by Public Law 2005, Chapter 280 as of January 6, 2006. The goal of the Task Force is to reduce cancer morbidity and mortality among New Jersey residents, with a special focus on disparately impacted populations. As outlined in the Executive Order, the Task Force is comprised of the Commissioner of Health, and no more than 20 members representing the Public Health Council; the State Commission on Cancer Research; the State Minority Health Advisory Commission; the Medical Society of New Jersey; academic medical centers and universities engaged in cancer education, research, and treatment; providers of cancer treatment and services; pharmaceutical companies engaged in cancer research; community-based organizations and coalitions engaged in cancer outreach, education, and screening; and cancer survivors. The Task Force is charged with the development of the New Jersey Comprehensive Cancer Control Plan ("Plan"), a five (5) year roadmap to reducing the burden of cancer on New Jersey residents and improving the quality of life for cancer survivors. Development of this plan is supported by seven workgroups that represent seven cancer sites including: breast, cervical, colorectal, oral, lung, melanoma, and prostate. The workgroups consist of a chairperson and various members who bring robust expertise to the area of cancer control and prevention.

The Blueprint for 2021-2025

The Task Force began development of the fourth edition of the Plan utilizing best practices and a collaborative approach of bringing partners together to develop key objectives and strategic actions. Partners representing seven workgroups (Breast, Cervical, Colorectal, Lung, Melanoma, Oral, and Prostate) developed objectives and strategic actions for the priority areas. The fourth iteration of New Jersey's Plan utilizes the National Comprehensive Cancer Control Program Priorities to frame the work. This approach lays out objectives and strategic actions in the areas of: Primary Prevention, Early Detection and Treatment, and Survivorship with cross cutting priorities of Healthy Equity, Policy Systems and Environmental Change and Surveillance and Evaluation. The Plan strategically aligns with the Centers for Disease Control and Prevention's (CDC) priority areas to create efficiencies and promote effective collaboration across the cancer control spectrum.

Moving Forward

Implementation of the fourth New Jersey Comprehensive Cancer Control Plan (2021-2025) will require strategic collaboration to address the issues facing New Jersey cancer patients and their families. Addressing health equity is a major focus of the work and Plan implementation will continue with support from the New Jersey Department of Health and the coordinated efforts of its relevant programs. Implementation of the 2021-2025 Plan will also require continued intensive collaboration among the Task Force and its public and private partners. Partnerships must be optimized with a focus on mutual benefits and a coordinated approach to planning as a means to achieve the higher good of reducing the cancer burden in New Jersey.

The cornerstone of implementation will be the tracking of the objectives in the Plan through the use of the New Jersey Department of Health's New Jersey State Health Assessment Data (NJSHAD) system. Utilizing NJSHAD to track cancer objectives in real time will allow for easier access and transparency in the implementation process. The New Jersey State Cancer Registry plays a pivotal role as a data resource to document the differential cancer burden in various geographic locations and segments of the population, thus guiding delivery of effective and appropriate interventions to those in greatest need.

The value of the Plan lies in its blueprint to improve integration and coordination of cancer control activities among relevant New Jersey agencies, organizations, and individual stakeholders. This collaborative effort will reduce duplication; enhance delivery of programs at the state and community levels; and serve to foster synergy among the stakeholders to the ultimate benefit of all New Jersey residents. Together we can make a difference.

The value of the Plan lies in its blueprint to improve integration and coordination of cancer control activities among relevant New Jersey agencies, organizations, and individual stakeholders.

Acknowledgements

The work of the Task Force is supported by the New Jersey Department of Health. The Plan would not have been possible without the extraordinary generosity and vision of the many key stakeholders and partners who have assisted in its development. The process that propelled development of this document has brought together individuals and organizations whose passion is reflected in the Plan. We especially acknowledge the rich resources available within the Departmental programs that have provided invaluable assistance.

Cancer data used in this Plan were provided by the New Jersey State Cancer Registry, Cancer Epidemiology Services, New Jersey Department of Health, which is funded by the Surveillance, Epidemiology and End Results (SEER) Program of the National Cancer Institute (75N91021D00009), the National Program of Cancer Registries (NPCR), Centers for Disease Control and Prevention (5NU58DP006279), as well as the State of New Jersey and the Rutgers Cancer Institute of New Jersey. This plan aligns with the National Comprehensive Cancer Control Program's Priorities and details the direction where the State hopes to go in the next decade. The NJDOH wishes to thank Task Force members, cancer control partners, and Department staff for all of their input and work to make this plan a reality.

Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey

Anita Kinney, PhD, RN, FAAN, ***Chair***
Darrin Anderson, PhD
Elizabeth Lin Jewell, MD, MHSc
Amanda Medina-Forrester, MA, MPH
Monica Townsend, MPA
David Warshal, MD

New Jersey Cancer Plan Workgroup Chairs

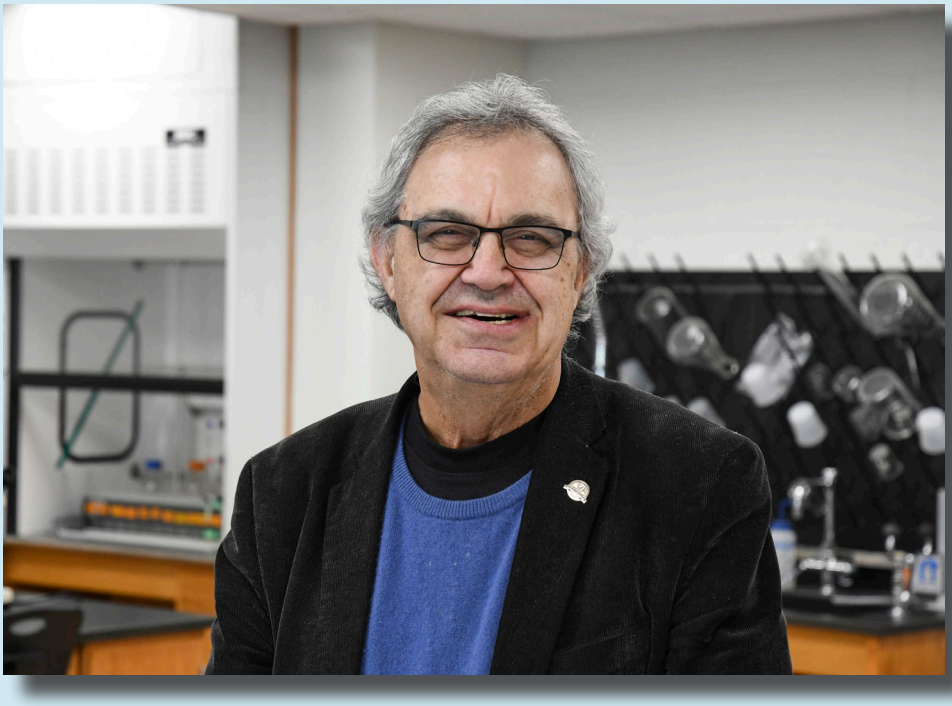
Angela Bailey, MSW, LSW
Ogori N Kalu, MD
Daniel Halevy, MD, FASN, CPC
Darwin Hayes, DDS, MHA, FAGD
Heather Jordan, MPH, CPH, MCHES
Debra Levinson, MPA
Rita Musanti, PhD, APN-BC
Lisa Rosenberry, MS, MSW, LCSW, OSW-C

In Memoriam

Jonathan Yavelow, PhD

The New Jersey Department of Health would like to acknowledge the contributions of Dr. Jonathan Yavelow to the work of cancer control and prevention in the State of New Jersey. Dr. Yavelow was a longtime member of the New Jersey Commission on Cancer Research (NJCCR) as well as a contributor to the lung cancer work detailed in this Plan. Dr. Yavelow received a bachelor's in biology from American University in 1973 and a doctorate in cell and molecular biology from the University of Southern California, Los Angeles, in 1978. He spent 38 years at Rider University.

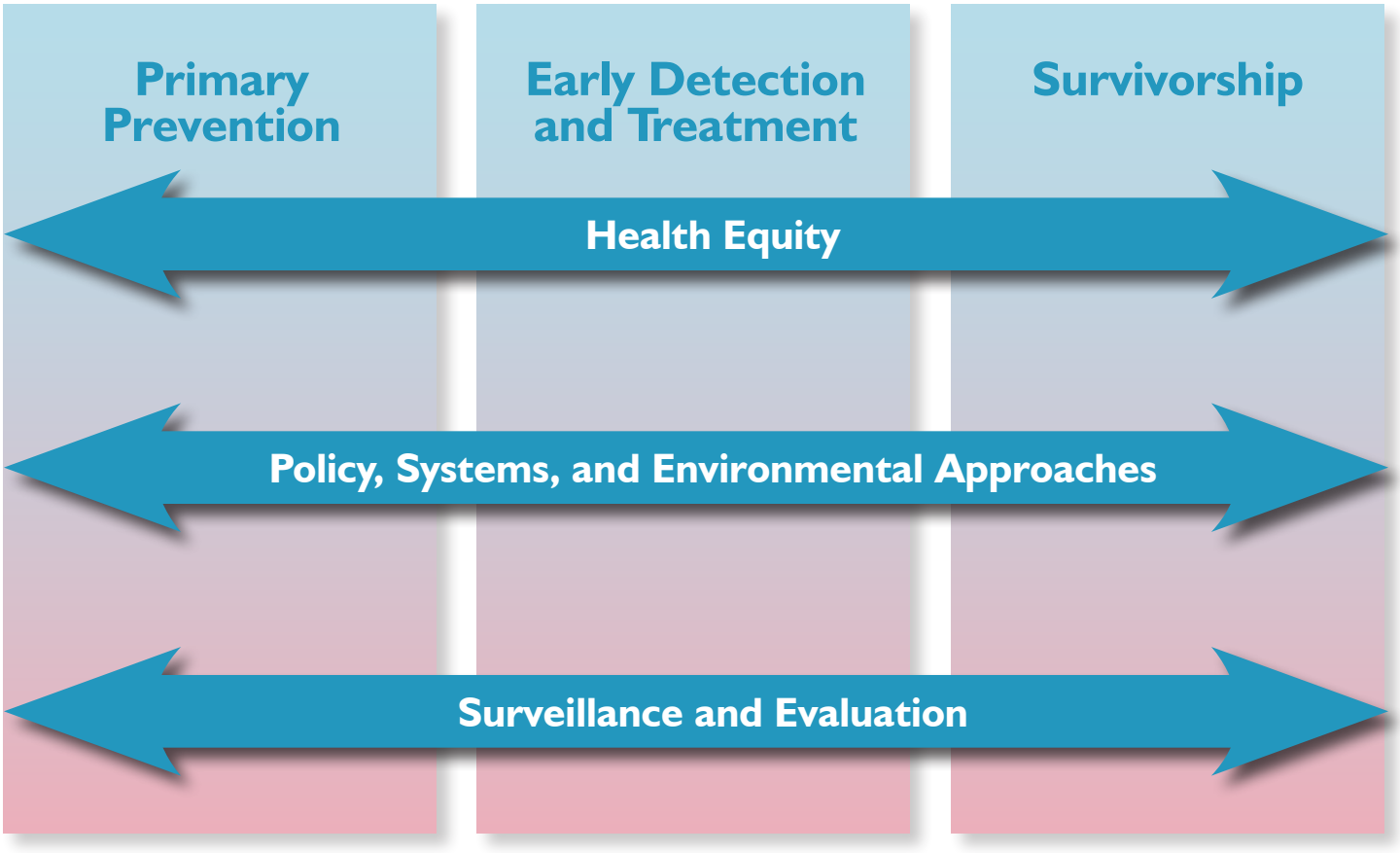
During his long career at Rider, Dr. Yavelow served as the assistant dean for the sciences, faculty director of the University's Health Studies Institute and the chair of the biology department. His contributions to the field are many and his enthusiastic support of the work and his colleagues will be missed.



INTRODUCTION

Introduction

The Task Force began development of the fourth edition of the Plan utilizing best practices and a collaborative approach of bringing partners together to develop key objectives and strategic actions. Partners representing seven workgroups (Breast, Cervical, Colorectal, Lung, Melanoma, Oral, and Prostate) developed objectives and strategic actions for the priority areas. The fourth iteration of New Jersey's Plan utilizes the The CDC's National Comprehensive Cancer Control Program Priorities to frame the work. This approach lays out objectives and strategic actions in the areas of: Primary Prevention, Early Detection and Treatment, and Survivorship with cross cutting priorities of Healthy Equity, Policy Systems and Environmental Change and Surveillance and Evaluation. The Plan strategically aligns with CDC's priority areas to create greater efficiency and effective collaboration across the cancer control spectrum. Workgroups prioritized objective to be selected for the Plan by review of historical cancer control and prevention documents. Additional objectives were created based upon their relevance to the new priority areas. All objectives are specific, measurable, achievable, relevant, time-based, inclusive and equitable (SMARTIE) and grounded in evidence. The overarching goal is for all partners to be able to utilize this plan to understand the larger vision for cancer control in New Jersey.



Primary Prevention: Primary prevention helps people choose healthy behaviors to lower their risk of getting cancer.

Early Detection and Treatment: Screening for cervical, colorectal, breast and lung cancer helps find these diseases at an early stage, when treatment works best.

Survivorship: Comprehensive cancer control programs address the needs of cancer survivors and their caregivers using: surveillance to routinely assess the needs of cancer survivors, education programs to help survivors, caregivers, and providers make informed decisions, patient navigation systems to optimize treatment and care and policies and systems changes to improve access to palliative care and other cancer resources or services.

Health Equity: Health equity is achieved when every person has the opportunity to live their healthiest life, including people in communities with a higher burden of cancer.

Policy, Systems, and Environmental Approaches: PSE approaches can make healthy living easier and provide sustainable cancer prevention and control improvements where people live, work, play, and learn.

Surveillance and Evaluation: Program evaluation drives public health decision making and identifies what works and where resources need to be invested.

The Plan strategically aligns with CDC's priority areas to create greater efficiency and effective collaboration across the cancer control spectrum.

BACKGROUND

- Demographics
- Socioeconomic Characteristics
- Cancer Burden
- Availability of Resources

Background

New Jersey (NJ) is a northeastern state with a growing population of almost nine million (United State Census Bureau, 2022). New Jersey ranks as the 11th most populous and the 3rd smallest state in the country. On average, there are about 1,196 people per every square mile in NJ; county densities range between 189.2 (Salem) and 14,973.5 (Hudson) persons per square mile. The large population concentration in the small geographic area makes New Jersey the mostly densely populated state in the nation. As the US Census Bureau reports, all New Jersey counties are urban areas, making New Jersey the most urban state in the United States.

Although all New Jersey counties are urban areas, the population is not evenly distributed. When located further away from the large metropolitan cities, the northwestern and southernmost New Jersey counties have a much lower population density where many of the municipalities are rural. New Jersey State Office of Rural Health (NJSORH) reports that over one-fifth of New Jersey municipalities (123 out of 565 municipalities) are rural (New Jersey defines rural areas in the State based on a population density of less than 500 persons per square mile), which have far-reaching implications for health outcomes. Residents in the northwestern and southern New Jersey counties where rural municipalities are located often report a shortage of mass transportation, access to health care facilities, and health care professionals as the barriers to desirable health outcomes.

Demographics

The average age of a New Jerseyan is 39.9 years, though nearly 1 out of 5 New Jerseyans is over 65 years of age and 1 out of every 4 New Jerseyans is under 18 years of age (United State Census Bureau, 2022). Similar to the United States as a whole, the population in New Jersey is aging – with the number of residents 65 years and older increasing by over 27,000 every year. Approximately half of the New Jersey population is female.

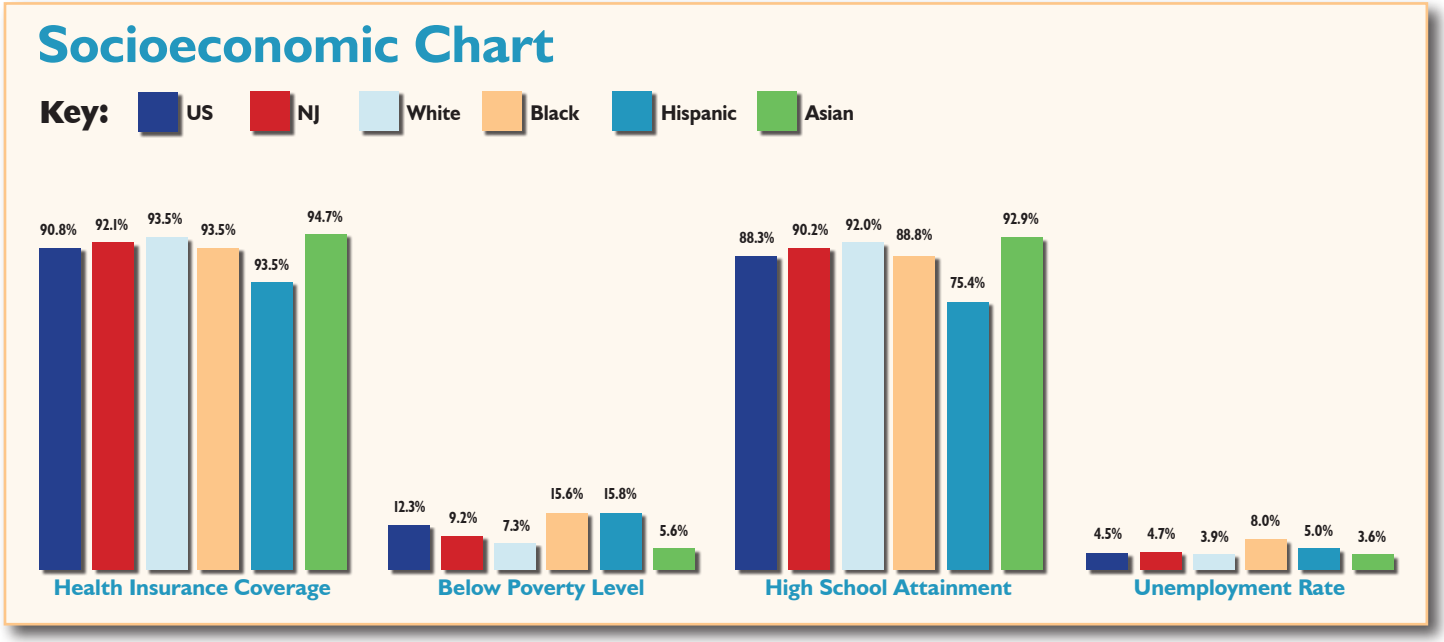
New Jersey is home to people of various races and ethnicities; it is the fourth most ethnically diverse state in the nation (US News). In 2018, 54.6% of the population was estimated to be non-Hispanic White, 20.6% Hispanic (of any race), 12.8% non-Hispanic Black, and 9.7% non-Hispanic Asian (American Community Survey 2018). In addition, 24.1% of the population was foreign-born, and 31.7% spoke a language other than English (American Community Survey 2018). NJ has high numbers of immigrants from all over the world, approximately 2 million immigrants or 23% of the population, the second largest Jewish population (after New York state), the second largest Muslim population (after Michigan), the second largest Cuban population (after Florida),

and the largest population of Peruvians in the country (American Immigration Council, 2021).

It is estimated that approximately 4% of the population identifies as lesbian, gay, bisexual, transgender, or queer (LGBTQIA+), though this estimation is met with many challenges in surveillance. The US Census Bureau estimates 22,418 same-sex couples live in New Jersey, but this number does not represent the entire LGBTQIA+ population including those who do not identify as the same sex as their partner, do not live with their partner, or do not have a partner. Cultural factors associated with race, ethnicity, religion, country of origin, and sexual orientation and gender identity can have an important impact on cancer risk factors, risk behaviors, attitudes towards disease prevention and intervention, and interactions with healthcare providers.

Socioeconomic Characteristics

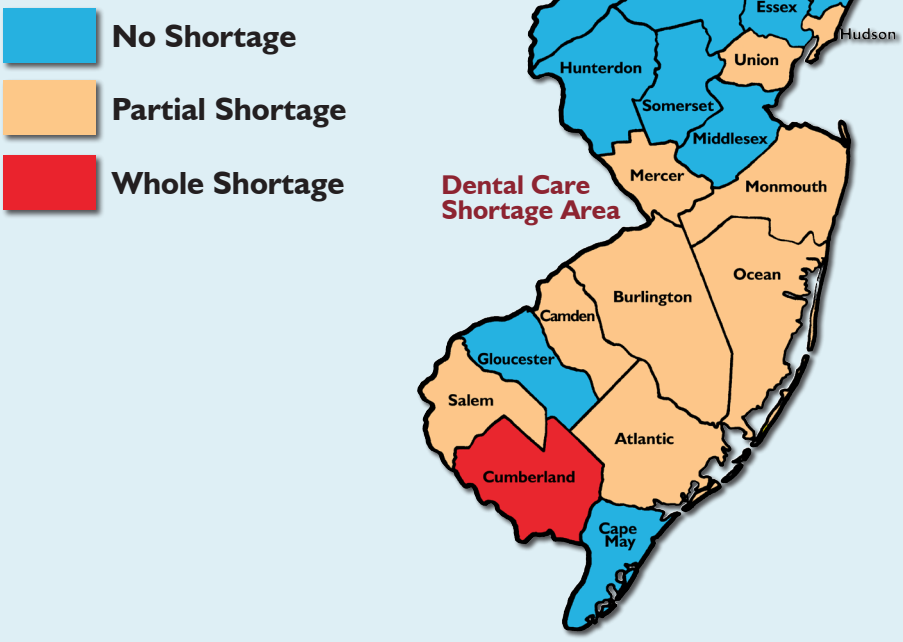
Socioeconomic characteristics such as educational attainment, income, and employment status affect the burden of cancer as well. Although the rates of educational attainment, income, and employment in New Jersey are equal to or higher than US rates, these socioeconomic characteristics are not distributed equally among all New Jerseyans. For every $1.00 among Whites in New Jersey, the per capita income is only $0.96 among Asians, $0.57 among Blacks, and $0.48 among Hispanics (American Community Survey, 2021). At least 1 out of every 10 New Jerseyans has needed to see a doctor within the past 12 months, but could not because of cost; prevalence of cost prohibitive access to care is greater among Hispanic, Black, and Asian populations (25.4%, 17.8%, 12.9%, respectively).



Background

Health insurance coverage is an important determinant of access to health care services, especially prevention and primary care. It is strongly associated with cancer screening, early detection, and treatment which consequentially impact cancer-related health outcomes including morbidity, survivorship, and mortality. The US Census Bureau Small Area Health Insurance Estimates reports that since the implementation of the Affordable Care Act in 2014, the rate of uninsured New Jerseyans has declined from 12.6% in 2014 to 8.7% in 2018; there are approximately 642,000 uninsured individuals under the age of 65 years in NJ. Rates of uninsured residents are higher than the state average in Passaic (13.5%), Hudson (12.9), Essex (11.6%) and Union (11.2%) Counties (counties that are urban and in the northern part of the state) and Cumberland (10.7%) and Atlantic (9.6%) Counties (counties that are rural and in the southern part of the state). The proportion of uninsured individuals is also higher than the state average in Mercer County (9.2%), a county that is diverse in urban, suburban, and rural municipalities and home to the state capital, Trenton. The proportion of Black and Hispanic populations that are uninsured and under 65 years are two and three times (9.2%, 18.5%) greater than the proportion of the White population that is uninsured and under 65 years (5%). Uninsured status is greater among men of all

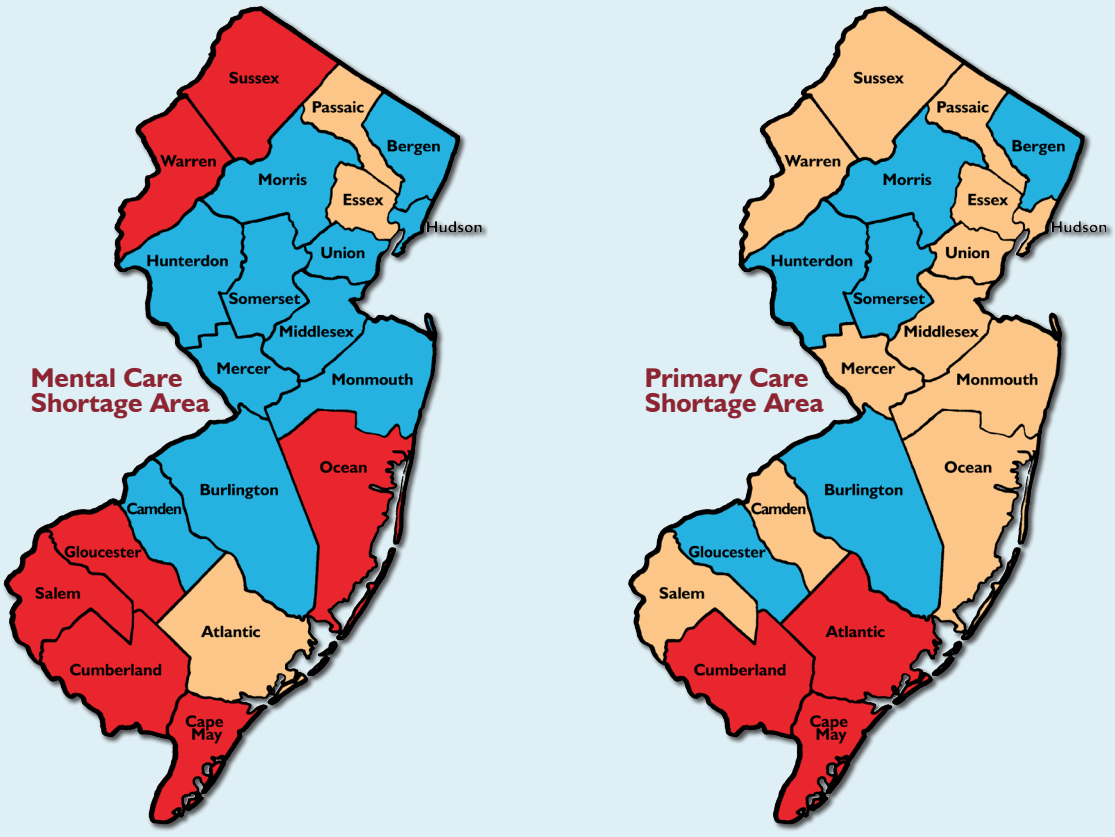
Health Professional Shortage Areas in 2019, by New Jersey county



2 Retrieved on June 1, 2020 from https://www.beckershospitalreview.com/rankings-and-ratings/primary-care-physician-supply-in-all-50-states-ranked.html

races than women. Since March of 2020, NJ FamilyCare/Medicaid has followed special rules related to the federal COVID-19 Public Health Emergency. These rules have allowed most NJ FamilyCare/Medicaid members to keep their health coverage, even if they no longer qualified – for example, if their income was too high. However, Congress recently passed legislation requiring state Medicaid programs to revert back to normal federal rules on April 1, 2023. The return to normal federal rules may result in loss of coverage for some individuals.

Access to health care, especially primary care is essential to cancer-related health outcomes and equity. The average number of primary care physicians per 100,000 people in the country is 156.7. New Jersey ranks 12th in the nation with 176.3 primary care physicians per 100,000 residents. However, as designated by the Health Resources and Services Administration (HRSA), most New Jersey counties are short of health care providers in primary care, mental health care, or dental care. The maps below, and on the previous page, show that 15 out of the 21 New Jersey counties are short of primary care providers; 10 counties are short of mental health care providers; 11 counties are short of dental care providers (Rural Health Information Hub, 2019).



3 Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration (HRSA) as having shortages of primary care, dental care or mental health providers. These shortages may be geographic-, population-, or facility-based.

4 https://www.ruralhealthinfo.org

Background

Cancer Burden

Cancer is the second leading cause of death in New Jersey, but accounts for the most years of potential life lost (premature mortality) among New Jerseyans (NJSHAD). More than 50,000 new cancer cases, 34,000 cancer hospitalizations, and 16,000 cancer deaths are reported among New Jerseyans every year (NJSHAD, United States Cancer Statistics, 2022). New Jersey ties second in the nation with West Virginia for rate of new cancer cases among residents (Kentucky ranks first); the rate of new cancer cases among New Jerseyans (482.4) is much higher than the national average (437.8) (USCS). New cancer cases can be detected and reported at four different stages: *in situ*, localized, regional, and

	New Cancer Cases*	Cancer Deaths*
Males	Prostate – 131.2 Lung and Bronchus – 60.8 Colon & Rectum – 46.9 Urinary Bladder, invasive and *in situ* – 40.2 Melanoma of the Skin – 28.9	Lung & Bronchus – 41.0 Prostate – 17.8 Colon & Rectum – 16.8 Miscellaneous – 14.9 Pancreas – 12.8
Females	Breast – 136.6 Lung & Bronchus – 51.7 *In Situ* Breast – 41.1 Colon & Rectum – 35.9 Corpus Uteri – 30.6	Lung & Bronchus – 31.1 Breast – 21.3 Colon & Rectum – 11.9 Pancreas – 10.1 Miscellaneous – 10.0

Data Source: United States Cancer Statistics 2018
*Rates are per 100,000 population

Stage 0	***In situ***	**Abnormal cells are present, but have not spread to nearby tissue**
Stage I, II, III	**Localized**	**Cancer is limited to the place where it started, with no sign that it has spread**
	Regional	**Cancer has spread to nearby lymph nodes, tissues, or organs**
Stage IV	**Distant**	**Cancer has spread to distant parts of the body**

distant. Cancer cases that are diagnosed at a late stage (regional or distant) are associated with increased morbidity and mortality. Over the last two decades though, the rates of both new cancer cases and cancer deaths have been trending down. The rate of cancer deaths in New Jersey (145.7) is lower than the national average (152.6), indicating successful early detection and treatment efforts (USCS). Early detection and the subsequent treatment of cancer at early stages are associated with increased survival and decreased morbidity and mortality. Female breast, lung and bronchus, and prostate cancers are among the top three cancer sites for the rate of both new cancer cases and cancer deaths (USCS).

Cancer burden is not evenly distributed among all New Jersey residents; both demographic and socioeconomic factors contribute to the disparities seen in reported cancer cases. New cancer cases and cancer deaths vary by age, gender, race and ethnicity, income, and residential location. Morbidity and mortality associated with cancer in New Jersey increase with increasing age, and the rate of both new cancer cases and cancer deaths are higher among New Jersey males compared to New Jersey females. Rates of both new cancer cases and cancer deaths are highest among counties in New Jersey that are more rural. The highest rates of new cancer cases are found in Burlington, Camden, Gloucester, Salem, and Cape May Counties, while the highest rates of cancer deaths are found in Camden, Gloucester, Salem, Cumberland, and Cape May Counties (NJSCR). With respect to race and ethnicity, rates of new cancer cases are highest among the White population, while the rate of cancer deaths is highest among the Black population. Black New Jerseyans are more likely to be diagnosed with cancer at a late stage than their White, Hispanic, or Asian/Pacific Islander counterparts.

Rates of New Invasive Cancer Cases by County and Race

	All Races	White	Black	Hispanic	Asian/PI
New Jersey	485.9	497.7	449.4	393.9	278.4
Atlantic	495.8	507.0	454.1	426.1	277.0
Bergen	472.4	491.5	403.7	403.7	285.0
Burlington	527.8	537.5	491.3	500.0	280.3
Camden	524.6	529.4	535.6	421.0	298.4
Cape May	564.6	561.8	511.9	496.8	**
Cumberland	512.0	523.8	472.3	409.2	288.2
Essex	462.1	468.6	435.9	407.4	305.4
Gloucester	541.6	540.5	514.6	445.0	377.1
Hudson	403.5	416.6	381.1	351.0	241.3
Hunterdon	475.1	475.5	395.4	617.9	216.3
Mercer	503.9	512.0	520.9	394.3	296.8
Middlesex	460.8	495.0	449.9	405.3	262.9
Monmouth	523.2	529.9	463.4	464.6	297.6
Morris	487.9	496.3	454.7	414.1	291.1
Ocean	521.2	518.1	465.2	484.1	270.4
Passaic	451.6	458.8	360.8	345.8	260.9
Salem	554.1	535.5	630.9	437.6	**
Somerset	463.3	481.6	435.5	429.2	281.8
Sussex	510.3	506.5	409.5	451.5	290.4
Union	453.7	453.7	428.6	390.4	298.6
Warren	506.4	504.7	434.1	476.1	357.6

Data Source: NJSCR 2013-2017 age-adjusted invasive
*Rates are per 100,000 population
**Data has been suppressed to ensure confidentiality and stability of rate estimates

Rates of Cancer Death by County and Race

	All Races	White	Black
New Jersey	151.4	155.2	170.3
Atlantic	166.5	169.6	195.1
Bergen	136.6	144.2	145.2
Burlington	164.4	167.4	170.9
Camden	172.0	173.2	190.8
Cape May	185.7	186.8	193.5
Cumberland	188.3	191.4	188.2
Essex	150.5	141.0	174.3
Gloucester	178.1	180.5	181.4
Hudson	133.7	140.9	158.6
Hunterdon	138.1	140.7	144.3
Mercer	152.3	148.7	197.6
Middlesex	142.4	158.0	147.3
Monmouth	144.7	145.7	175.2
Morris	139.2	144.3	149.7
Ocean	165.8	167.1	174.6
Passaic	147.1	152.6	146.8
Salem	200.9	199.0	218.7
Somerset	135.7	143.6	145.5
Sussex	164.7	165.8	152.2
Union	142.9	140.9	164.0
Warren	164.5	166.6	152.4

Data Source: NJSCR 2013-2017 age-adjusted mortality
*Rates are per 100,000 population
**Data not available for Hispanic or Asian/PI populations

Cancer burden is not evenly distributed among all New Jersey residents; both demographic and socioeconomic factors contribute to the disparities seen in cancer reporting. New cancer cases and cancer deaths vary by age, gender, race and ethnicity, income, and residential location.

Incidence of Late Stage* Cancer					
	All Races (includes Hispanic)	White (Non-Hispanic)	Black (includes Hispanic)	Hispanic (any race)	Asian/PI (includes Hispanic)
Breast (Female)	44.3	44.5	52.0	37.9	32.9
Cervical	3.8	3.1	5.7	5.9	2.9
Colorectal	22.8	23.6	24.7	20.7	14.7
Lung	37.9	41.6	37.5	22.9	18.6
Melanoma	2.7	3.7	0.4	0.9	**
Oral	6.8	7.5	5.5	4.7	5.1
Prostate	20.0	19.8	28.6	15.9	11.3

Data Source: NCI State Cancer Profiles
*Late Stage is defined as cases determined to be regional or distant
**Data has been suppressed to ensure confidentiality and stability of rate estimates
***Rates are per 100,000 population

Black New Jerseyans are more likely to be diagnosed with cancer at a late stage than their White, Hispanic, or Asian/Pacific Islander counterparts.

Availability of Resources

New Jersey is robust in its availability of cancer care. The Office of Cancer Control and Prevention at the New Jersey Department of Health (NJDOH) pools resources with the community and its partners to reduce cancer-related morbidity and mortality through the activities of the ten (10) Regional Chronic Disease Coalitions. Activities include policy, systems, and environmental changes, as well as outreach and navigation to services. There are 40 American College of Surgeons Commission on Cancer (CoC) accredited hospitals in New Jersey (American College of Surgeons Commission on Cancer). The CoC is dedicated to improving survival and quality of life for cancer patients through the promotion of cancer prevention, research, education, and monitoring of comprehensive quality care. NJDOH partners with 19 health systems and organizations to offer the New Jersey Cancer Education and Early Detection (NJCEED) Program in all 21 counties of New Jersey. The NJCEED Program provides free breast, cervical, colorectal, and prostate cancer screening to eligible low-income, uninsured, and underinsured New Jersey residents. NJCEED Program patients can receive care, if needed, at most of the CoC accredited hospitals in New Jersey. Cancer screening is also available for New Jersey residents regardless of their ability to pay at the 23 Federally Qualified Health Centers, in partnership with NJCEED program services. Additionally, as of June 2020, the National Institutes of Health reports 1,543 recruiting and active (not recruiting) cancer clinical trials at various health systems throughout the state.

HEALTH EQUITY

Health Equity

The CDC defines health equity as the opportunity to attain a person's full health potential without disadvantage from achieving this potential due to social position or other socially determined circumstances. Health inequities manifest in a variety of ways including length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment (Prevention, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) Health Equity, 2020). Disparities among these variables are a reflection of the interaction between socioeconomic factors, culture, diet, stress, the environment, and biology (Health, 2019). The need for cancer health equity spans New Jersey populations who face barriers due to race and ethnicity, sexual orientation and gender identity (SOGI), geography, income level, and educational attainment.

Access to adequate resources disproportionately affects vulnerable populations nationally. As indicated by the New Jersey Behavioral Risk Factor Survey (NJBRFS) in 2018, only 81.5% of Hispanics and 90.8% of Blacks had health insurance coverage compared to 95% of Whites. Data on health insurance coverage for the Asian and LGBTQIA+ populations were not collected and is currently unavailable. Even fewer minority populations (Blacks, Hispanics, and Asians) had access to at least one primary provider (NJBRFS). Data on primary provider access is also unavailable for the LGBTQIA+ population.

Current cancer screening recommendations for the LGBTQIA+ population include screening for site specific cancers, where the site-specific tissue is present in the patient. Race and ethnicity are key variables in risk assessments for cancer screening. Cancer screening rates are currently available by race, but are not available by SOGI. The NJCEED Program provides services to people who speak more than 16 different languages. The top five languages spoken (after English) in New Jersey are Spanish, Hindi, Polish, Portuguese, and Mandarin. The utilization of culturally appropriate cancer screening and treatment materials and language in the health care setting are imperative to the receptiveness among all vulnerable populations.

Cancer screening, early detection, and survivorship quality measures are collected through the NJBRFS and the New Jersey State Cancer Registry (NJSCR). The NJBRFS collects variables on race and ethnicity, SOGI (as of 2019), geography, income level, and educational attainment. The NJSCR collects variables on race and ethnicity, and geography. The NJSCR does not collect variables on SOGI, income level, or educational attainment. Surveillance of vulnerable populations is integral to quantitatively and qualitatively describe the burden of disease in these populations so they may access resources to effectively reduce disparities.

Vulnerable populations are less likely to seek cancer screening and complete cancer treatment, which results in worse health outcomes. In an article published in the Journal of Clinical Oncology, oncologist implicit racial bias was negatively associated with communication with patients, patients' reactions to interactions, and patient perceptions of recommended treatments (Louis A. Penner, 2016). Implicit bias in LGBTQIA+ cancer care has not been specifically studied. Implicit bias restricts fair access to cancer screening and treatment for all people of color, as well as sexual and gender minorities. Only nine (9) practices in New Jersey are identified as LGBTQIA+-friendly screening facilities and only two (2) facilities are identified as LGBTQIA+-friendly treatment facilities by the National LGBTQIA+ Cancer Network, the leading organization on cancer care in the LGBTQIA+ population.

POLICY, SYSTEMS, & ENVIRONMENTAL CHANGE

Policies and Laws

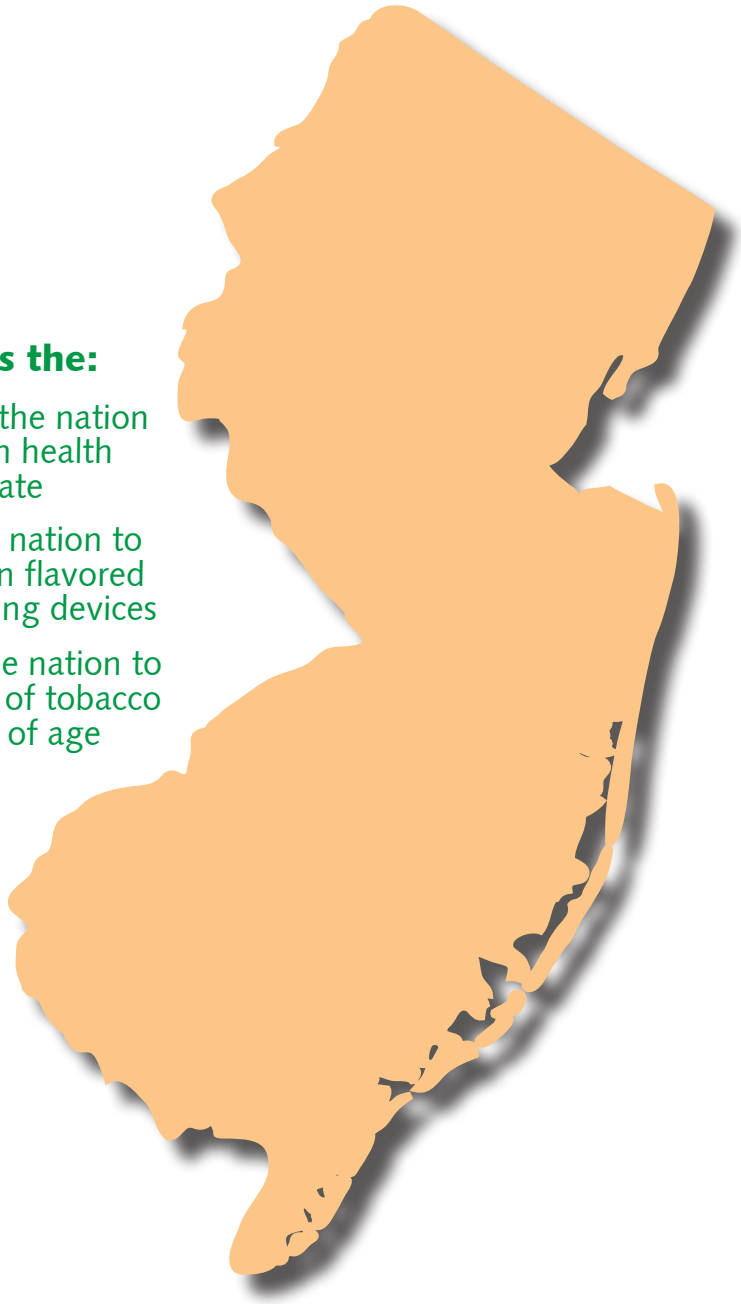
Policy, Systems, & Environmental Change

Policies & Laws

Historically, the state of New Jersey has been progressive in its policies and legislation on health for New Jersey residents. New Jersey opted to expand coverage for the treatment of breast and cervical cancers in women through the Medicaid Treatment Act of 2000. New Jersey was the third state in the nation to change the age of tobacco sale to 21 years of age and the first in the nation to permanently ban flavored electronic smoking devices. Additionally, New Jersey was the second state in the nation to create its own health insurance mandate. The health and well-being of New Jersey residents is a priority for New Jersey legislators and community organizations.

New Jersey was the:

1. Second state in the nation to create its own health insurance mandate
2. First state in the nation to permanently ban flavored electronic smoking devices
3. Third state in the nation to change the age of tobacco sale to 21 years of age



Medicaid Treatment Act of 2000

2001

As of July 27, 2001, New Jersey enacted expansion of the Medicaid Treatment Act of 2000 to provide medical assistance to women who have been screened for breast and/or cervical cancer under the National Breast and Cervical Cancer Early Detection Program and require treatment for breast and/or cervical cancer based upon criteria established by the Health Commissioner.

Smoke Free Air Act of 2006

2006

As of April 15, 2006, New Jersey's Smoke Free Air Act of 2006 ensures that workers have a safe, smoke-free workplace and that all nonsmokers can breathe smoke-free air in public places. The Smoke Free Air Act was expanded in 2019 to significantly limit smoking on beaches and in parks.

Minor Tanning Bed Ban

2013

As of October 1, 2013, minors under 17 years of age are prohibited from using commercial tanning beds in New Jersey due to evidence of melanoma risk. Minors aged 17 years and older require the presence of a parent or guardian for an initial consultation at a tanning salon.

Tobacco 21

2017

As of November 1, 2017, the legal age for purchasing tobacco products and electronic smoking devices in New Jersey is 21 years of age.

Health Insurance Mandate

2019

Beginning January 1, 2019, New Jersey requires state residents to maintain minimum essential health insurance coverage.

Palliative Care Law

2019

As of August 9, 2019, New Jersey established a state advisory council on palliative care and quality of life that requires the creation of a palliative care access initiative to make information about accessing palliative care in New Jersey more readily available to the public. A pediatric oncologist certified in palliative or hospice care is required for inclusion on the council.

Flavor Ban

2020

As of April 20, 2020, there is a permanent ban on the sale and distribution of flavored vapor products, including menthol, across the state.

SURVEILLANCE & EVALUATION

Data Sources

Surveillance & Evaluation

Data Sources

The state of New Jersey utilizes a variety of surveillance systems to provide robust data for comprehensive cancer prevention and control. The New Jersey State Health Assessment Data (NJSHAD) System provides access to public health datasets, statistics, and information on the health status of New Jersey residents. The NJSHAD interactive query system allows users to query public health datasets directly, and produce graphs, tables, and maps of the desired data.

Data from the sources on the following page will be utilized to measure progress on cancer prevention and control in New Jersey.

Data from national surveillance systems and organizations will also be utilized to monitor and track cancer prevention and control progress in New Jersey. These sources include the United States Cancer Statistics (USCS), National Cancer Institute State Cancer Profiles, National Immunization Survey (NIS), Center to Advance Palliative Care / National Palliative Care Research Center, and LGBT Cancer Network.

Data Sources	
New Jersey Behavioral Risk Factor Survey (NJBRFS)	**NJBRFS is an ongoing health survey of New Jersey residents in collaboration with CDC as a component of the national Behavior Risk Factor Surveillance System (BRFSS). It is used to monitor major behavioral risk factors and chronic conditions associated with death and disability. NJBRFS has two main parts:** 1) a required core component consisting of fixed core, rotating core, and emerging core questions, and 2) a set of optional modules. The data in NJBRFS is self-reported.
New Jersey State Cancer Registry (NJSCR)	**NJSCR is a population-based registry, mandated by state law, that collects data on all cancer cases diagnosed and/or treated in New Jersey since October 1, 1978. All health care facilities, physicians, dentists, labs, ambulatory care facilities, and other health care providers that diagnose or provide treatment for cancer patients must report cancer cases to the NJSCR.**
New Jersey Cancer Education and Early Detection Cancer Screening and Tracking System (CaST)	**The CaST System is a software application utilized for patient tracking and data management of New Jersey Cancer Education and Early Detection (NJCEED) Program patients. The NJCEED Program provides free cancer screening to low income, uninsured, and underinsured New Jersey residents. The CaST System will soon be replaced by a web-based Medical Information Tracking System, called Oxbow Med-IT.**
New Jersey Youth Tobacco Survey (NJYTS)	**The New Jersey Youth Tobacco Survey (NJYTS) is an adaptation of the National Youth Tobacco Survey (NYTS) developed by the CDC, consisting of both CDC-recommended "core" questions and "state-added questions" specific to New Jersey. The NJYTS includes questions about ever and past-30-day use of cigarettes, cigars, smokeless tobacco (SLT), pipe, hookah, snus, bidis, and electronic cigarettes (e-cigarettes), as well as questions that assess susceptibility to tobacco use, exposure to secondhand smoke, and access to tobacco.**
New Jersey Youth Risk Behavior Survey (NJYRBS)	**The New Jersey Youth Risk Behavior Survey, known as the New Jersey Student Health Survey is a survey of students' self-reported health behaviors using questions from the Youth Risk Behavior Survey developed by the CDC with additional questions selected from other sources.**

OBJECTIVES

- Primary Prevention
  - Environmental Health
  - HPV Vaccination
  - Nutrition and Fitness
  - Tobacco Use
- Early Detection and Treatment
  - All Sites
  - Breast
  - Cervical
  - Colorectal
  - Lung
  - Melanoma
  - Oral
  - Prostate
- Survivorship
- Health Equity
- Policy, Systems, and Environmental Changes
- Surveillance and Evaluation

Primary Prevention

To mitigate common risk factors for the prevention of cancer cases and ultimately cancer deaths.

Environmental Health

Many substances in the environment are well-demonstrated carcinogens, such as radiation, chemicals, and metals among others. These substances damage DNA in cells, which contributes to the development of cancer (NIH).

Vaccination

Few cancers are vaccine preventable, but currently Human Papillomavirus (HPV) and Hepatitis B vaccines are both effective in minimizing subsequent cancer cases. It is estimated that 79 million adults in the United States are infected, knowing or unknowingly, with the sexually transmitted infection, HPV. This accounts for approximately 80% of all sexually active adults. HPV types 16 and 18 specifically account for approximately 66% of all cervical cancer cases in the United States (CDC). HPV causes most cervical cancers, and some cancers of the genitals and oropharynx (USCS). The Hepatitis B vaccine prevents Hepatitis B virus (HBV); serious long-term illness with HBV can lead to liver disease or liver cancer (CDC).

Nutrition and Fitness

Nutrition and fitness are two of the few modifiable risk factors for cancer. It is estimated that 20-30% of all cancer cases could be prevented through the adaptation of a healthy lifestyle through diet, physical activity, and weight management (UPenn). Excess body fatness, defined as overweight, obesity, and weight gain, is associated with at least 13 cancers including adenocarcinoma of the esophagus; breast cancer; colon and rectum; endometrium; gallbladder; gastric cardia; kidney; liver; ovary; pancreas; thyroid; meningioma; and multiple myeloma (USCS). There is strong evidence that physical activity reduces the risk of breast cancer in postmenopausal women, endometrium cancer, and colon cancer (USCS). Drinking alcohol also increases the risk of cancers of the mouth and throat; voice box; esophagus; colon and rectum; liver; and breast (USCS).

Tobacco Use

Tobacco use is the leading preventable cause of cancer cases and cancer-related deaths. Cancers related to tobacco use make up 40% of all cancer cases in the United States (CDC). Tobacco use can cause cancer in the bladder; blood; cervix; colon and rectum; esophagus, kidney and renal pelvis; liver; lungs, bronchi and trachea; mouth and throat; pancreas; stomach; and voice box (USCS).

Environmental Health

To promote the prevention of cancer through environmental toxin mitigation for New Jerseyans in all places of residential, recreational, and workplace activity.

Environmental Health			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Reduce to zero the number of unhealthy days throughout the state, as determined by the National Ambient Air Quality Standards, attributable to carbon monoxide, coarse particulate matter (PM-10), lead, sulfur dioxide, and nitrogen dioxide.	Carbon Monoxide: 0 Particulate Matter: 0 Lead: 0 Sulfur Dioxide: 0 Nitrogen Dioxide: 2 (2018)	Carbon Monoxide: 0 Particulate Matter: 0 Lead: 0 Sulfur Dioxide: 0 Nitrogen Dioxide: 0	NJSHAD (Bureau of Air Monitoring, Department of Environmental Protection)
Increase the percentage of homes in New Jersey that have ever been tested for radon to 50%.	36.9% (2019)	50%	NJSHAD (Bureau of Environmental Radiation, Department of Environmental Protection)
Increase the percentage of homes testing equal to or greater than 4 picocuries per liter of air (pCi/L) for radon that have been mitigated to 55%.	48.5% (2019)	55%	NJSHAD (Bureau of Environmental Radiation, Department of Environmental Protection)
Increase the percentage of community water systems in compliance with all current state and federal drinking water requirements for water quality to 100% for chemical standards, 100% for radiological standards, and 100% for microbiological standards.	Chemical Standard: 99% Radiological Standard: 98% Microbiological Standard: 95% (2014)	Chemical Standard: 100% Radiological Standard: 100% Microbiological Standard: 100%	NJSHAD (Bureau of Safe Drinking Water, Department of Environmental Protection)

**Data has been suppressed to ensure confidentiality and stability of rate estimates

Strategic Actions

- Promote radon testing and mitigation in all settings, including schools
- Improve air quality through policy change that addresses air pollution
- Enforce comprehensive strategies to promote respiratory health and reduce environmental exposure in schools, including comprehensive smoke-free school policies
- Explore asbestos data surveillance and collection

Vaccination

Human Papillomavirus- and Hepatitis B-related cancers are currently the only vaccine preventable cancers. HPV vaccination can reduce the incidence of many HPV-related genital and oral cancers, while Hep B vaccination can reduce the incidence of liver cancer.

Vaccination			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Increase the proportion of male and female adolescents aged 13-17 years who have initiated (defined by ≥ 1 vaccination dose) the Human Papillomavirus (HPV) vaccination series to 80% among the total population.	NJ: 67.1% White (Non-Hispanic): 60.1% Black: ** Hispanic: 79.9% Asian: ** (2019)	NJ: 80%	National Immunization Survey
Increase the proportion of male and female adolescents aged 13-17 years who are up to date with the Human Papillomavirus (HPV) vaccination series to 80% among the total population.	NJ: 51.4% White (Non-Hispanic): 45.9% Black: ** Hispanic: 64.2% Asian: ** (2019)	NJ: 80%	National Immunization Survey
Increase the proportion of male and female adults aged 18 years and older who are up to date with the Human Papillomavirus (HPV) vaccination series to 80% among the total population.	NJ: 16.9% (Male) 18-24y: 43.4% 25-34y: 15.6% 35-44y: 3.8% 45-54y: 1.9% (2020) NJ: 31.8% (Female) 18-24y: 66.3% 25-34y: 40.6% 35-44y: 10.9% 45-54y: 6.0% (2020)	NJ: 80%	NJBRFS
Increase the proportion of infants who receive the birth dose of hepatitis B vaccine to 75% among each annual birth cohort.	NJ: 68.0% (2018)	NJ: 75%	National Immunization Survey

**Data has been suppressed to ensure confidentiality and stability of rate estimates

Strategic Actions

- Focus messaging of HPV vaccination on cancer prevention
- Educate providers on importance of vaccine recommendations as their recommendations impact vaccination uptake among the community
- Increase access to and availability of the HPV vaccination for all vaccine-eligible populations
- Support provider participation in the New Jersey Immunization Information System (NJIIS) to improve HPV vaccination surveillance

Nutrition & Fitness

To prevent new cancer cases and improve the quality of life for cancer survivors through the adoption of a healthy lifestyle, which includes a diet full of fiber through fruits and vegetables and appropriate physical activity.

Nutrition & Fitness			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Reduce the proportion of the adult population aged 20 years and older who are obese to 23.8% for the total population.	**NJ: 27.7%; White: 27.0% Black: 37.6%; Hispanic: 33.2% Asian: 10.4% (2017)**	**NJ: 23.8%**	**NJBRFS**
Reduce the proportion of high school students in grades 9-12 who are obese to 7.8% for the total population.	**NJ: 11.9%; White: 10.4% Black: 19.9%; Hispanic: 15.2% Asian: 3.4% (2019)**	**NJ: 7.8%**	**NJYRBS**
Increase the proportion of adults who meet current Federal physical activity guidelines for moderate or vigorous physical activity to 58.5% for the total population.	**NJ: 49.2%; White: 51.9% Black: 41.3%; Hispanic: 41.2% Asian: 57.0% (2017)**	**NJ: 58.5%**	**NJBRFS**
Increase the proportion of high school students in grades 9-12 who meet current Federal physical activity guidelines for moderate or vigorous physical activity to 54.8% for the total population.	**NJ: 44.5%; White: 49.9% Black: 31.3%; Hispanic: 45.9% Asian: 36.7% (2019)**	**NJ: 54.8%**	**NJYRBS**
Reduce the proportion of the population who identify as chronic heavy drinkers (>30 for women, >60 for men) to 4.0% among the total population.	**NJ: 5.4%; White: 6.9% Black: 3.5%; Hispanic: 4.0% Asian: 3.7% (2017)**	**NJ: 4.0%**	**NJBRFS**

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Strategic Actions

- Increase access to and affordability of healthy foods
- Promote shared use of public recreation space, including school playgrounds and tracks, such as through Joint Use Agreements between municipalities and school districts
- Use food service guidelines to create healthier food environments in schools that align with the 2010 Healthy Hunger-Free Kids Act
- Prevent excessive alcohol use through regulation of alcohol density; increasing of alcohol taxes; dram shop liability; maintaining limits on days of sale; maintaining limits on hours of sale; electronic screening and brief intervention (e-SBI); and enhanced enforcement of laws prohibiting sales to minors

Tobacco Use

To reduce the incidence of tobacco-related cancers through the prevention and cessation of tobacco use.

Tobacco Use			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Reduce the proportion of the population who are current smokers (any use in past 30 days) adults aged 18 years and older to 12.4% for the total population.	NJ: 14.1%; White: 15.9% Black: 15.3%; Hispanic: 13.3% Asian/PI: 6.8% (2017)	NJ: 12.4%	NJBRFS
Reduce the proportion of the population who are current e-cigarette smokers (any use in past 30 days) adults aged 18 years and older to 2.2% for the total population.	NJ: 4.4% 18-24y: 11.5% 25-34y: 8.5% 35-44y: 4.3% 55-64y: 2.7% 65+y: 0.9% (2017)	NJ: 2.2%	NJBRFS
Reduce current tobacco use (cigarettes, cigars, smokeless tobacco, bidis) by high school students grades 9-12 to 12.8% among all students.	NJ: 21.7%; White: 23.7% Black: 16.8%; Hispanic: 24.6% Asian/PI: ** (2018)	NJ: 12.8%	NJYTS
Reduce the proportion of high school students grades 9-12 who are current smokers (any use in past 30 days) to 1.5% among the total population.	NJ: 2.9%; White: 2.4% Black: 2.6%; Hispanic: 4.6% Asian/PI: ** (2018)	NJ: 1.5%	NJYTS
Reduce the proportion of high school students grades 9-12 who are current e-cigarette users (any use in past 30 days) to 12% among the total population.	NJ: 17.8%; White: 22.3% Black: 9.6%; Hispanic: 16.7% Asian/PI: 10.6% (2018)	NJ: 12%	NJYTS

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Strategic Actions

- Promote and refer New Jerseyans who use tobacco to cessation services and support (including New Jersey Quitline and Quit Center(s))
- Prevent New Jersey youth from initiating tobacco use
- Promote enforcement of and compliance with the 2006 New Jersey Smoke Free Air Act
- Promote the use of electronic health record systems for the identification and referral of tobacco users to cessation services

Early Detection & Treatment

Screening and early detection of cancer is critical for effective treatment and long-term survival in cancer patients. Effective screening tests are ones that find cancer early; reduce the chance that someone who is screened regularly will die from the cancer; and have more potential benefits than harm (NIH). Many cancer sites do not currently have an effective cancer screening test available. Per the United States Preventive Services Task Force (USPSTF, 2022), effective cancer screening tests are currently available for:

- Breast cancer - in the form of mammograms
- Cervical cancer - in the form of pap tests and human papillomavirus (HPV) co-testing
- Colorectal cancer - in the form of colonoscopies, sigmoidoscopies, and stool tests
- Lung cancer - in the form of low-dose helical computed tomography (LDCT)

All Sites

All Sites			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Increase the proportion of New Jersey adults who have a primary care provider to 90% for the total population.	NJ: 79.2%; White: 84.4%; Black: 78.6%; Hispanic: 65.3%; Asian: 76.9%; (2017)	NJ: 90%	NJBRFS
Reduce the age-adjusted incidence rate of all types of new cancer per 100,000 standard population to below the national rate.	NJ: 482.4; US: 437.8 NJ > US; (2017)	NJ < US	United States Cancer Statistics
Reduce the age-adjusted incidence rate of all invasive cancers per 100,000 standard population to 439.9 for the total population.	NJ: 485.9; White: 497.7; Black: 449.4; Hispanic: 393.9 Asian/PI: 278.4; (2013-2017)	NJ: 439.9	NJSCR
Reduce the age-adjusted mortality rate due to all cancers per 100,000 standard population to 122.8 for the total population.	NJ: 151.4; White: 155.2; Black: 170.3; Hispanic: 99.4* Asian/PI: 74.8*; (2013-2017)	NJ: 122.8	NJSCR/SEER*

Strategic Actions

- Utilize evidence-based health education practices to educate communities about the importance of early detection and treatment
- Assist New Jersey residents in establishing medical homes through the utilization of community health workers and patient navigators
- Reduce structural barriers to screening and treatment services
- Collect adequate personal and family history for appropriate cancer risk assessments
- Integrate cancer education and screening into routine clinical preventative services
- Provide culturally and linguistically tailored cancer education materials to patients
- Improve functionality of the New Jersey Health Information Network to facilitate case tracking for cancer surveillance and treatment purposes
- Support education, screening, and early detection such as the NJCEED Program and ScreenNJ
- Increase utilization of genetic testing and counseling for eligible patients

Breast

Breast			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Increase the proportion of women aged 50 to 74 years who receive a breast cancer screening based on the most recent guidelines to 87.5% for the total population.	NJ: 79.3 % White: 78.3% Black: 80.2% Hispanic: 87.9% Asian: ** (2017)	NJ: 87.5%	NJBRFS
Reduce the age-adjusted incidence rate of female breast cancer per 100,000 standard female population to below the national rate.	NJ: 138.4 US: 125.1 NJ > US (2017)	NJ < US	United States Cancer Statistics
Reduce the age-adjusted incidence rate of invasive female breast cancer per 100,000 standard female population to 122.0 for the total population.	NJ: 136.6 White: 139.5 Black: 128.2 Hispanic: 109.5 Asian/PI: 103.5 (2013-2017)	NJ: 122.0	NJSCR
Reduce the age-adjusted incidence rate of late-stage female breast cancer per 100,000 standard female population to 42.2 for the total population.	NJ: 44.3 Non-Hispanic White: 44.5 Black (includes Hispanic): 52.0 Hispanic: 37.9 Asian/PI (includes Hispanic): 32.9 (2013-2017)	NJ: 42.4	NCI State Cancer Profiles
Reduce the age-adjusted mortality rate due to female breast cancer per 100,000 standard female population to 19.2 for the total population.	NJ: 21.3 White: 20.9 Black: 29.1 Hispanic: 13.1* Asian/PI: 10.6* (2013-2017)	NJ: 19.2	NJSCR/SEER*

Strategic Actions

- Educate providers on identifying high risk populations, including patients with dense breasts
- Increase access to mobile mammography services

Cervical

Cervical			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Increase the proportion of women aged 21 to 65 years who receive a cervical cancer screening based on the most recent guidelines to 93.6% for the total population.	NJ: 81.7% White: 85.1% Black: 81.6% Hispanic: 84.0% Asian: 67.1% (2017)	NJ: 93.6%	NJBRFS
Reduce the age-adjusted incidence rate of cervical cancer per 100,000 standard female population to below the national rate.	NJ: 7.6 US: 7.5 NJ > US (2017)	NJ < US	United States Cancer Statistics
Reduce the age-adjusted incidence rate of invasive uterine cervical cancer in females per 100,000 standard female population to 7.2 for the total population.	NJ: 7.7 White: 7.7 Black: 10.1 Hispanic: 11.0 Asian/PI: 4.9 (2013-2017)	NJ: 7.2	NJSCR
Reduce the age-adjusted incidence rate of late-stage uterine cervical cancer per 100,000 standard female population to 3.5 for the total population.	NJ: 3.8 Non-Hispanic White: 3.1 Black (includes Hispanic): 5.7 Hispanic: 5.9 Asian/PI (includes Hispanic): 2.9 (2013-2017)	NJ: 3.5	NCI State Cancer Profiles
Reduce the age-adjusted mortality rate due to uterine cervical cancer per 100,000 standard female population to 1.8 for the total population.	NJ: 2.0 White: 1.9 Black: 3.5 Hispanic: 1.4* Asian/PI: 0.5* (2013-2017)	NJ: 1.8	NJSCR/SEER*

Strategic Actions

- Increase the knowledge and utilization of HPV co-testing

Colorectal

Colorectal			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Increase the proportion of adults aged 50 to 75 years who receive a colorectal cancer screening based on the most recent guidelines to 80% for the total population.	NJ: 67.5% White: 69.1% Black: 68.9% Hispanic: 59.9% Asian: 65.3% (2017)	NJ: 80%	NJBRFS
Reduce the age-adjusted incidence rate of colorectal cancer per 100,000 standard population to below the national rate.	NJ: 39.4 US: 36.8 NJ > US (2017)	NJ < US	United States Cancer Statistics
Reduce the age-adjusted incidence rate of invasive colorectal cancer per 100,000 standard population to 36.7 for the total population.	NJ: 40.8 White: 41.0 Black: 43.3 Hispanic: 37.0 Asian/PI: 26.4 (2013-2017)	NJ: 36.7	NJSCR
Reduce the age-adjusted incidence rate of late-stage colorectal cancer per 100,000 standard population to 20.5 for the total population.	NJ: 22.8 Non-Hispanic White: 23.6 Black (includes Hispanic): 24.7 Hispanic: 20.7 Asian/PI (includes Hispanic): 14.7 (2013-2017)	NJ: 20.5	NCI State Cancer Profiles
Reduce the age-adjusted mortality rate due to colorectal cancer per 100,000 standard population to 12.9 for the total population.	NJ: 14.1 White: 14.2 Black: 17.0 Hispanic: 10.1* Asian/PI: 6.9* (2013-2017)	NJ: 12.9	NJSCR/SEER*

Strategic Actions

- Encourage the utilization of the most appropriate colorectal screening test (stool test [FOBT/FIT], sigmoidoscopy, or colonoscopy) for each individual patient
- Educate providers on new USPSTF colorectal cancer screening guidelines

Lung

Lung			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Increase the proportion of adults aged 55 to 80 years with a history of smoking who receive a lung cancer screening based on the most recent guidelines.	Baseline for NJ: 21.9% White: ** Black: ** Hispanic: ** Asian: ** (2020)	23.0%	NJBRFS
Reduce the age-adjusted incidence rate of invasive lung and bronchus cancer per 100,000 standard population to 49.8 for the total population.	NJ: 55.3 White: 58.2 Black: 51.8 Hispanic: 32.6 Asian/PI: 25.9 (2013-2017)	NJ: 49.8	NJSCR
Reduce the age-adjusted incidence rate of late-stage lung and bronchus cancer per 100,000 standard population to 34.1 for the total population.	NJ: 37.9 Non-Hispanic White: 41.6 Black (includes Hispanic): 37.5 Hispanic: 22.9 Asian/PI (includes Hispanic): 18.6 (2013-2017)	NJ: 34.1	NCI State Cancer Profiles
Reduce the age-adjusted mortality rate due to lung and bronchus cancer per 100,000 standard population to 31.7 for the total population.	NJ: 35.2 White: 36.9 Black: 36.1 Hispanic: ** Asian: ** (2013-2017)	NJ: 31.7	NJSCR

**Data has been suppressed to ensure confidentiality and stability of rate estimates

Strategic Actions

- Direct New Jersey residents to cessation services (including New Jersey Quitline and Quit Center(s))
- Integrate lung cancer screening into routine preventative services for eligible patients
- Educate providers on new USPSTF lung cancer screening guidelines
- Increase provider utilization of informed decision-making for lung cancer screening

Melanoma

Melanoma			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Reduce the proportion of adults aged 18 years and older who report sunburn to 16.0% among the total population.	NJ: 17.8% White: 26.6% Black: 5.0% Hispanic: 11.4% Asian: 10.2% (2015)	NJ: 16.0%	NJBRFS
Reduce the age-adjusted incidence rate of melanomas of the skin per 100,000 standard population to below the national rate.	NJ: 22.9 US: 22.7 NJ > US (2017)	NJ < US	United States Cancer Statistics
Reduce the age-adjusted incidence rate of invasive melanoma of the skin per 100,000 standard population to 20.0 for the total population.	NJ: 22.2 White: 26.6 Black: 1.1 Hispanic: 4.1 Asian/PI: 1.0 (2013-2017)	NJ: 20.0	NJSCR
Reduce the age-adjusted incidence rate of late-stage melanoma of the skin per 100,000 standard population to 2.5 for the total population.	NJ: 2.7 Non-Hispanic White: 3.7 Black (includes Hispanic): 0.4 Hispanic: 0.9 Asian/PI (includes Hispanic): ** (2013-2017)	NJ: 2.5	NCI State Cancer Profiles
Reduce the age-adjusted mortality rate due to melanoma of the skin per 100,000 standard population to 1.9 for the total population.	NJ: 2.2 White: 2.7 Black: 0.2 Hispanic: 0.7 Asian/PI: ** (2013-2017)	NJ: 1.9	NJSCR/SEER

**Data has been suppressed to ensure confidentiality and stability of rate estimates

Strategic Actions

- Emphasize the importance of reducing UVA and UVB radiation exposure
- Emphasize the importance of compliance with the Minor Tanning Bed Ban of 2013
- Provide sun safety education in schools, recreational, and tourism settings to include: sun avoidance between 10a-4p; wearing sunglasses and sun-protective clothing such as hats; seeking shade; and utilization of sunscreen

Oral

Oral			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Increase the proportion of New Jersey adults who have visited a dentist within the last year to 90% for the total population.	NJ: 73.1% White: 78.4% Black: 66.5% Hispanic: 61.8% Asian: 70.4% (2016)	NJ: 90%	NJBRFS
Reduce the age-adjusted incidence rate of cancer of the oral cavity and pharynx per 100,000 standard population to below the national rate.	NJ: 11.7 US: 11.7 NJ = US (2017)	NJ < US	United States Cancer Statistics
Reduce the age-adjusted incidence rate of invasive cancer of the oral cavity and pharynx per 100,000 standard population to 10.0 for the total population.	NJ: 11.1 White: 11.5 Black: 8.1 Hispanic: 7.8 Asian/PI: 8.9 (2013-2017)	NJ: 10.0	NJSCR
Reduce the age-adjusted incidence rate of late-stage cancer of the oral cavity and pharynx per 100,000 standard population to 6.2 for the total population.	NJ: 6.8 Non-Hispanic White: 7.5 Black (includes Hispanic): 5.5 Hispanic: 4.7 Asian/PI (includes Hispanic): 5.1 (2013-2017)	NJ: 6.2	NCI State Cancer Profiles
Reduce the age-adjusted mortality rate due to cancer of the oral cavity and pharynx per 100,000 standard population to 1.8 for the total population.	NJ: 2.0 White: 2.0 Black: 2.2 Hispanic: ** Asian/PI: ** (2013-2017)	NJ: 1.8	NJSCR

**Data has been suppressed to ensure confidentiality and stability of rate estimates

Strategic Actions

- Increase access to dental care for New Jersey residents
- Educate dental and medical providers on the primary prevention and early detection of oral and oropharyngeal cancer
- Determine and utilize a statewide screening measure for surveillance of oral cancer

Prostate

Prostate			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Increase the proportion of men aged 40 and over who have discussed the advantages and disadvantages of the prostate-specific antigen (PSA) test to screen for prostate cancer with their health care provider to 26.3% for the total population.	NJ: 23.9% White: 22.9% Black: 34.7% Hispanic: 22.7% Asian: 21.4% (2015)	NJ: 26.3%	NJBRFS
Reduce the age-adjusted incidence rate of prostate cancer per 100,000 standard male population to below the national rate.	NJ: 139.6 US: 106.5 NJ > US (2017)	NJ < US	United States Cancer Statistics
Reduce the age-adjusted incidence rate of invasive prostate cancer per 100,000 standard male population to 118.1 for the total population.	NJ: 131.2 White: 120.5 Black: 187.1 Hispanic: 121.7 Asian/PI: 61.9 (2013-2017)	NJ: 118.1	NJSCR
Reduce the age-adjusted incidence rate of late-stage prostate cancer per 100,000 standard male population to 18.0 for the total population.	NJ: 20.0 Non-Hispanic White: 19.8 Black (includes Hispanic): 28.6 Hispanic: 15.9 Asian/PI (includes Hispanic): 11.3 (2013-2017)	NJ: 18.0	NCI State Cancer Profiles
Reduce the age-adjusted mortality rate due to prostate cancer per 100,000 standard male population to 15.4 for the total population.	NJ: 17.8 White: 16.3 Black: 38.9 Hispanic: ** Asian/PI: ** (2013-2017)	NJ: 15.4	NJSCR

**Data has been suppressed to ensure confidentiality and stability of rate estimates

Strategic Actions

- Increase provider utilization of informed decision-making for prostate cancer screening
- Emphasize the importance of a risk assessment as part of informed decision-making and the decision to screen for prostate cancer

Survivorship

Cancer survivorship begins at the time of cancer diagnosis and spans the patient's lifetime. As a result of cancer diagnosis and treatment, survivors face challenges with their physical, mental, and emotional well-being. To improve the quality of life for cancer survivors throughout all stages of cancer survivorship, it is necessary to take a holistic approach to care and care management.

Survivorship			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Increase the proportion of cancer survivors who report physical activity or exercise (including running, calisthenics, golf, gardening, or walking) beyond work-related activity.	84.5% (2020)	93.0%	NJBRFS
Reduce the proportion of cancer survivors who report current tobacco use (cigarettes, cigars, smokeless tobacco, bidis).	16.5% (2020)	14.9%	NJBRFS
Increase the proportion of cancer survivors who receive majority of their health care from a primary care provider.*	61.7% (2020)	67.9%	NJBRFS Cancer Survivorship module (CSRVDOC1)
Increase the proportion of cancer survivors who report having health insurance that paid for all or part of their cancer treatment.*	94.0% (2020)	100%	NJBRFS Cancer Survivorship module (CSRVINSR)
Reduce the proportion of cancer survivors who report physical pain caused by cancer or cancer treatment.	18.2% (2020)	16.4%	NJBRFS Cancer Survivorship module (CSRVPAIN)

*Objectives only asked of those cancer survivors who have completed treatment.

Survivorship (continued)			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Reduce the proportion of cancer survivors whose pain is currently not under control.	** (2020)	TBD	NJBRFS Cancer Survivorship module (CSRVCTL1)
Increase availability of Cancer Thriving and Surviving Program throughout all 21 counties in New Jersey.	11 (2020)	21	NJDHS
Increase the 5-year relative survival rate among cancer survivors.	All sites: 70.3 (M), 68.7 (F) Breast: 89.7 (F) Cervical: 67.2 (F) Colorectal: 62.8 (M), 65.3 (F) Lung: 18.1 (M), 25.4 (F) Melanoma: 91.0 (M), 94.3 (F) Oral: 64.7 (M), 67.4 (F) Prostate: 99.8 (M) (2008-2012)	All sites: 77.3 (M), 75.6 (F) Breast: 98.7 (F) Cervical: 73.9 (F) Colorectal: 69.1 (M), 71.8 (F) Lung: 19.9 (M), 27.9 (F) Melanoma: 100.0 (M/F) Oral: 71.2 (M), 74.1 (F) Prostate: 100.0 (M)	NJSCR
Increase the palliative care report card grade for New Jersey.	91.8 (2019)	100	Center to Advance Palliative Care / National Palliative Care Research Center

**Data has been suppressed to ensure confidentiality and stability of rate estimates
M=Male, F=Female

Strategic Actions

- Implement shared decision making among cancer patients and health care providers
- Increase the utilization of survivorship care plans among cancer survivors
- Increase participation in cancer survivorship programs
- Create a centralized database of statewide support groups for cancer survivors and caretakers; listing locations available in multiple languages

Health Equity

Access to and delivery of cancer care is not equally distributed among all New Jersey subpopulations. To improve health outcomes and quality of life among all New Jerseyans, the system that provides cancer services must adequately address the needs and challenges of each population appropriately. Equitable cancer care including education, screening, early detection, and treatment are necessary for cancer health equity.

Health Equity			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Increase the proportion of New Jersey adults who have health insurance coverage to 100.0% for the total population.	NJ: 91.3% White: 95.0% Black: 90.8% Hispanic: 81.5% Asian/PI: ** (2017)	TBD	NJBRFS
Increase the participation of New Jersey residents in clinical trials to reflect the demographics of cancer burden.	TBD	TBD	National Institutes of Health
Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis to 74.6% for the total population.	NJ: 70.2% White: 70.3% Black: 64.1% Hispanic: 70.4% Asian/PI: 73.3% (2018)	NJ: 74.6%	NJSCR
Increase the number of clients (male and female) who have never or rarely been screened utilizing the New Jersey Cancer Education and Early Detection Program for cancer screening.	9,765 (2019)	10,742	CaST System
Increase the number of cancer screening and treatment facilities in New Jersey known to be culturally competent in delivering health services to LGBTQ individuals.	Screening: 9 Treatment: 2 (2020)	Screening: 11 Treatment: 4	LGBT Cancer Network

**Data has been suppressed to ensure confidentiality and stability of rate estimates

Strategic Actions

- Conduct cultural competency and implicit bias training for providers
- Provide cancer screening in the community to vulnerable populations
- Improve collection and reporting of cancer screening rates among the LGBTQ population
- Increase education about clinical trial availability and safety among populations that are traditionally underrepresented in clinical trials

Policy, Systems, and Environmental (PSE) Approaches modify the environment to make healthy choices practical and available to all community members. PSE approaches can make healthy living easier and provide sustainable cancer prevention and control improvements where people live, work, play, and learn.

Policy, Systems, & Environmental Approaches

Policy, Systems, & Environmental Approaches
Objective
Ensure oncology representatives are included in the Palliative Care Law state advisory council on palliative care and quality of life.
Make cancer screening convenient, such as by providing benefit time for cancer screening.
Collect data on sexual orientation and gender identity.
Ensure primary care, family practice, pediatric, FQHC, and school-based clinics enter immunizations..
Expand dental coverage among New Jersey residents.
Expand categorical eligibility for Medicaid patients diagnosed with colorectal or prostate cancer similar to the Breast and Cervical Cancer Prevention and Treatment Act.

Surveillance & Evaluation

Surveillance and evaluation are integral to public health decision making through the collection and monitoring of data surrounding chronic diseases and their risk factors.

Surveillance & Evaluation			
Objective	**Baseline**	**Target (2030)**	**Data Source**
Report adult HPV vaccination compliance on the New Jersey State Heath Assessment Data System.	Not currently available	Available	NJSHAD
Report annual updates on progress for the New Jersey Comprehensive Cancer Control Plan objectives in a public facing system.	Not currently available	Available	NJSHAD
Increase the number of providers that report immunization records to the New Jersey Immunization Information System (NJIIS).	2,046	4,456	NJIIS
Report sexual orientation and gender identity variables in public surveillance systems.	Not currently available	Available	NJSHAD
Report cancer mortality data for Hispanic and Asian/Pacific Islander populations in the New Jersey Cancer Registry public surveillance system.	Not currently available	Available	NJSCR (Cancer-rates.info/nj/)
Report early stage cancer incidence in public surveillance systems.	Not currently available	Available	NJSCR (Cancer-rates.info/nj/)

Strategic Actions

- Integrate objectives of the New Jersey Comprehensive Cancer Control Plan into NJSHAD to facilitate up to date tracking
- Identify and review data sources for oral health surveillance among youth
- Explore the feasibility of reporting zip code- and/or municipality-level data in public surveillance systems
- Review additional data surveillance systems for use in monitoring and evaluating cancer control and prevention objectives

The Comprehensive Cancer Control Plan and statewide partners have guided our success in reducing the burden of cancer among all New Jersey residents and improving the quality of life of cancer survivors.

RESOURCES

- Office of Cancer Control & Prevention (OCCP)
- New Jersey Cancer Education & Early Detection (NJCEED)
- Cancer Specialty Centers
- Clinical Trial Resources
- National LGBT Cancer Network

Resources

The Office of Cancer Control and Prevention

Region 1 – Sussex-Warren Regional Chronic Disease Coalition
sussex.nj.us/cn/webpage.cfm?tpid=12272

Region 2 – Essex Passaic Wellness Coalition
epwcnj.org/

Region 3 – Bergen-Hudson Chronic Disease Coalition
co.bergen.nj.us/health-promotion/chronic-disease-coalition

Region 4 – Morris-Somerset Regional Chronic Disease Coalition
co.somerset.nj.us/government/public-health-safety/health-department/regional-chronic-disease-and-cancer-coalition

Region 5 – Hunterdon-Mercer County Regional Chronic Disease Coalition
hunterdonregionalcancercenter.org/why-choose-us/prevention-early-detection/hunterdon-and-mercer-county-regional-chronic-disease-coalition/

Region 6 – Chronic Disease Coalition of Middlesex and Union Counties
middlesexcountynj.gov/Government/Departments/PSH/Pages/Regional-Chronic-Disease-Coalition.aspx#:~:text=Regional%20Chronic%20Disease%20Coalition%20of%20Middlesex%20and%20Union%20Counties,-Page%20Content&text=%E2%80%9CThe%20Regional%20Chronic%20Disease%20Coalition,for%20the%20prevention%20of%20disease.%E2%80%9D

Region 7 – Ocean-Monmouth Health Alliance

Region 8 – Burlington and Camden County Regional Chronic Disease Coalition
bccrcdc.org/

Region 9 – Cape Atlantic Coalition for Health
capeatlanticcoalition.org/

Region 10 – Region 10 (Gloucester, Salem, Cumberland) Cancer and Chronic Disease Coalition
region10ccdc.org/

New Jersey State Cancer Registry

The NJSCR is a population-based registry, mandated by state law, that collects data on all cancer cases diagnosed and/or treated in New Jersey since October 1, 1978. It is a member of the NAACCR, the CDC/NPCR, and NCI/SEER.

NJSCR Reports and Data Briefs

state.nj.us/health/ces/reports.shtml
state.nj.us/health/ces/briefs.shtml

New Jersey Commission on Cancer Research

nj.gov/health/ces/cancer-researchers/njccr/

The New Jersey Commission on Cancer Research (NJCCR) promotes significant and original research in New Jersey into the causes, prevention, treatment, and palliation of cancer and serves as a resource to providers and consumers of cancer services.

Cancer Thriving and Surviving (CTS)

state.nj.us/humanservices/doas/home/tchagencies.html

The Cancer Thriving and Surviving (CTS) program is for individuals who have completed cancer treatments and/or their caregivers presented in a workshop format. The workshop meets for 2.5 hours once a week for six weeks. CTS topics include:

- Techniques to deal with problems such as frustration, fatigue, pain, isolation, poor sleep, and living with uncertainty;
- Exercises for regaining and maintaining flexibility and endurance;
- Making decisions about treatment and complementary therapies;
- Communicating effectively with family, friends, and health professionals;
- Nutrition; and
- Setting priorities.

ScreenNJ

screennj.org/

ScreenNJ partners with the Rutgers Cancer Institute of New Jersey, the New Jersey Department of Health, and various healthcare and community organizations throughout New Jersey to increase screening for colorectal and lung cancer, reduce cancer mortality rates, reduce disparities, and educate New Jersey residents about the importance of cancer screening, early detection, and prevention.

Partners

screennj.org/partners/

New Jersey Cancer Plan Contributors

Oral Health Workgroup

Kim Attanasi, MS, PhD
Silvia Camelo
Mahnaz Fatahzadeh, DMD, MS
Lorraine Hubbard, BS
Maureen Kuhn

Melanoma Workgroup

Arnold Baskies, MD
Sheri Cognetti
Ashley Decker, MD
Margaret Drozd MSN, RN, APRN-BC
Lea Kimmelman, MPH, CHES
Peg Knight, RN, MEd
Elizabeth A. Quigley, MD
Marcia M. Sass, ScD

Lung Cancer Workgroup

Victoria Buhl, MPH, CHES
Stasia S. Burger MS, CTR
Emily Carey
Viviana De Los Angeles
Brian Giancola, BS
Daniel Guinee
Jatesha Madden-Wilson, LPN
Meg McQuarrie
Donald Noblett, NCTTP
Sharon Sam
Uta Steinhauser, MPH
Pamela Valera, PhD

Contributors continued on page 63

Resources

The New Jersey Cancer Education and Early Detection (NJCEED) Program

Atlantic County

Shore Medical Center
shoremedicalcenter.org/screening-uninsured

Bergen County

Bergen County Department of Health Services
co.bergen.nj.us/public-health-nursing/cancer-education-and-early-detection-ceed

Burlington County

Virtua Health
virtua.org/services/cancer-treatment/njceed-at-virtua

Camden County

Cooper University Hospital
cooperhealth.org/services/md-anderson-cancer-center-cooper/cancer-outreach-education-and-screening

Cape May County

Cape May County Department of Health
capemaycountynj.gov/834/Cancer-Education-Early-Detection-Program

Cumberland & Salem Counties

Inspira Medical Center Vineland
inspirahealthnetwork.org/services-treatments/cancer-care/cancer-screenings/nj-cancer-education-and-early-detection-njceed

Essex County

St Michael's Medical Center
smmcnj.com/our-services/cancer-center/in-the-pink-program/

Rutgers University Medical School
njms.rutgers.edu/departments/medicine/divisions/gmed/gmedclinical.php

Gloucester County

Inspira Medical Center Mullica Hill
inspirahealthnetwork.org/services-treatments/cancer-care/cancer-screenings/nj-cancer-education-and-early-detection-njceed

Hudson & Union Counties

Hoboken Family Planning

Hunterdon County

Hunterdon Regional Cancer Center
hunterdonregionalcancercenter.org/why-choose-us/prevention-early-detection/njceed-cancer-screening-program/

Mercer County
Trenton Health Team
trentonhealthteam.org/projects/njceed/

Middlesex County
Middlesex County Office of Health Services
middlesexcountynj.gov/government/departments/psh/pages/ceed.aspx

Monmouth & Ocean Counties
Visiting Nurse Association of Central Jersey

Morris County
Morristown Medical Center
atlantichealth.org/conditions-treatments/cancer-care/cancer-support-services/cancer-screening-early-detection.html

Passaic County
St Joseph's Hospital and Medical Center
stjosephshealth.org/clinical-focuses/cancer-services/item/1543-ceed

Somerset County
Zufall Health Center
zufallhealth.org/services/medical-services/cancer-screening/

Sussex County
Sussex County Department of Environmental and Public Health Services
sussex.nj.us/cn/webpage.cfm?tpid=14618

Warren County
NORWESCAP
norwescap.org/what-we-do/health-and-nutrition/health-connections/

American College of Surgeons Commission on Cancer

facs.org/quality-programs/cancer/coc

Each American College of Surgeons Commission on Cancer (CoC) accredited program is designated a specific category based on the type of facility, program structure, services provided, and the number of cases accessioned each year. There are six different types of CoC programs in New Jersey, spanning 40 facilities: Community Cancer Program; Comprehensive Community Cancer Program; Integrated Network Cancer Program; Academic Comprehensive Cancer Program; NCI-Designated Comprehensive Cancer Center Program; and Veterans Affairs Cancer Program.

New Jersey Cancer Plan Contributors, *continued*

Colorectal Cancer Workgroup

Bill Bullock
Maureen M Cianci, RN, BSN
Natasha Coleman, MPH
Terry Harrison, RN, MSN
Lisa Little
Jatesha Madden-Wilson, LPN
Jackie Miller MSN, RN, OCN
Ana Natale-Pereira
Lovely Randle
Daniel Rosenblum, PhD
Tobi Rudoltz
Carolyn Thompson, MA
Margaret Vellotti
Christine Winn

Cervical Cancer Workgroup

Amanda Tanay
Angelica Stokes
Aretha Hill-Forte
Debbie Delesantro
Diana Robinson
Gendzyl Dalton
Jatesha Madden-Wilson, LPN
Jenna Sistad
Jillian Travilla
Karen D'Alonzo
Kate Di Paola
Kelly Kohler
Marta Sujdak
Mildred Mendez
Michele DeDea
Raven Gates
Rula Btoush
Rhiannon Shelton, MPH

Contributors continued on page 65

United States Preventative Services Task Force

uspreventiveservicestaskforce.org/uspstf/

Cancer Screening Recommendations		
	Population	**Recommendation**
Breast	**Women aged 50-74 years**	**The USPSTF recommends biennial screening mammography for women aged 50-74 years.** **The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years.**
Cervical	**Women aged 21-65 years**	**The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21-29 years.** **For women aged 30-65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).**
Colorectal	**Adults aged 45-75 years**	**The USPSTF recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.** **The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history.**
Lung	**Adults aged 50-80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years**	**The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50-80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.** **Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.**
Prostate	**Men aged 55-69 years**	**For men aged 55-69 years, the decision to undergo periodic prostate-specific antigen (PSA)-based screening for prostate cancer should be an individual one.**

As per CDC:

Screening for ovarian, pancreatic, prostate, testicular, and thyroid cancers has not been shown to reduce deaths from those cancers. The USPSTF found insufficient evidence to assess the balance of benefits and harms of screening for bladder cancer and oral cancer in adults without symptoms, and of visual skin examination by a doctor to screen for skin cancer in adults.

Community Cancer Program

The facility accessions more than 100 but fewer than 500 newly diagnosed cancer cases each year and provides a full range of diagnostic and treatment services, but referral for a portion of diagnosis or treatment may occur. The facility participates in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or referring patients for enrollment at another facility or through a physician's office. Participation in the training of resident physicians is optional.

Cape Regional Medical Center
CarePoint Health – Bayonne Medical Center
CarePoint Health – Christ Hospital
Inspira Medical Center Mullica Hill
Jersey City Medical Center
Shore Medical Center
Trinitas Regional Medical Center

Comprehensive Community Cancer Program

The facility accessions 500 or more newly diagnosed cancer cases each year. The facility provides a full range of diagnostic and treatment services either on-site or by referral. The facility participates in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or by referring patients for enrollment at another facility or through a physician's office. Participation in the training of resident physicians is optional.

Atlanticare Regional Medical Center
Capital Health Medical Center – Hopewell
CentraState Healthcare System
Chilton Medical Center
Community Medical Center
Englewood Hospital & Medical Center
Hackensack UMC Mountainside
Holy Name Medical Center
Hunterdon Medical Center
Inspira Medical Center Vineland
JFK Medical Center
Penn Medicine Princeton Medical Center
Robert Wood Johnson University Hospital Hamilton
Robert Wood Johnson University Hospital Somerset
Saint Clare's Hospital – Denville
The Valley Hospital
Virtua Health Cancer Program

New Jersey Cancer Plan Contributors, *continued*

Prostate Cancer Workgroup

Amie Fairman
Richard Ward
Barbara Dick

Breast Cancer Workgroup

Bonnie Petrauskas, MBA
Sarah Krug, MS
Susan Crandall, BSN
Jill Patel, MPH, CHES

New Jersey State Cancer Registry

Lisa E. Paddock, MPH, PhD
Heather Stabinsky, MS.Ed, CTR
Antoinette Stroup, PhD, MS

NCI-Designated Comprehensive Cancer Center Program

The facility secures a National Cancer Institute (NCI) peer-reviewed Cancer Center Support Grant and is designated a Comprehensive Cancer Center by the NCI. A full range of diagnostic and treatment services and staff physicians are available. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.

Robert Wood Johnson University Hospital

Academic Comprehensive Cancer Program

The facility participates in postgraduate medical education in at least four program areas, including internal medicine and general surgery. The facility accessions more than 500 newly diagnosed cancer cases each year, and it offers the full range of diagnostic and treatment services either on-site or by referral. The facility participates in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or by referring patients for enrollment at another facility or through a physician's office.

Cooper University Hospital
Hackensack University Medical Center
Jefferson Health – Sidney Kimmel Cancer Center
Monmouth Medical Center
Morristown Medical Center
Newark Beth Israel Medical Center
Overlook Medical Center
Saint Barnabas Medical Center
Saint Peter's University Hospital
St Joseph's Regional Medical Center
University Hospital

Integrated Network Cancer Program

The organization owns, operates, leases, or is part of a joint venture with multiple facilities providing integrated cancer care and offers comprehensive services. At least one facility in the category is a hospital and must be a CoC-accredited cancer program. Generally, INCP's are characterized by a unified cancer committee, standardized registry operations with a uniform data repository, and coordinated service locations and practitioners. Each entity meets performance expectations for the quality measures under the umbrella of the integrated program. The INCP participates in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or by referring patients for enrollment at another facility or through a physician's office. Participation in the training of resident physicians is optional, and there is no minimum caseload requirement for this category.

Hackettstown Medical Center
Meridian Health System
Newton Medical Center

Veterans Affairs Cancer Program

The facility provides care to military veterans and offers the full range of diagnostic and treatment services either on-site or by referral, preferably to CoC-accredited cancer program(s). The facility participates in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or by referring patients for enrollment at another facility or through a physician's office. Participation in the training of resident physicians is optional. There is no minimum caseload requirement for this category.

VA New Jersey Health Care System

National Cancer Institute (NCI)-Designated Cancer Center

The NCI Cancer Centers Program was created as part of the National Cancer Act of 1971 to bolster cancer research efforts in the nation. Centers around the country are recognized for meeting rigorous standards for transdisciplinary, state-of-the-art research that's focused on developing new and better approaches to preventing, diagnosing, and treating cancer. There are 71 NCI-Designated Cancer Centers, located among 36 states and the District of Columbia, that are funded to deliver cutting-edge cancer treatments to patients. Of the 71 institutions:

- 13 are Cancer Centers, recognized for their scientific leadership, resources, and the depth and breadth of their research in basic, clinical, and/or prevention, cancer control, and population science.
- 51 are Comprehensive Cancer Centers, also recognized for their leadership and resources, in addition to demonstrating an added depth and breadth of research, as well as substantial transdisciplinary research that bridges these scientific areas.
- 7 are Basic Laboratory Cancer Centers that are primarily focused on laboratory research and often conduct preclinical translation while working collaboratively with other institutions to apply these laboratory findings to new and better treatments.

Rutgers Cancer Institute of New Jersey is the state's *only* NCI-Designated Comprehensive Cancer Center.

cinj.org/

Resources

Federally Qualified Health Centers

The Federally Qualified Health Centers (FQHCs) offer high quality healthcare regardless of the ability to pay. Uninsured patients are charged fees based on their income level using a sliding fee scale. The FQHCs offer primary care services, including cancer screening.

Atlantic County

healthapps.state.nj.us/fhs/cphc/cphcList.aspx

- AtlantiCare Health Services
- Southern Jersey Family Medical Centers

Bergen County

healthapps.state.nj.us/fhs/cphc/cphcList.aspx

- North Hudson Community Action Corporation Health Center

Burlington County

healthapps.state.nj.us/fhs/cphc/cphcList.aspx

- Southern Jersey Family Medical Centers

Camden County

healthapps.state.nj.us/fhs/cphc/cphcList.aspx

- CAMcare Health Corporation
- Osborn Family Medical Health Center
- Project H.O.P.E.

Cape May County

healthapps.state.nj.us/fhs/cphc/cphcList.aspx

- CompleteCare Health Network

Cumberland County

healthapps.state.nj.us/fhs/cphc/cphcList.aspx

- CompleteCare Health Network

Essex County

healthapps.state.nj.us/fhs/cphc/cphcList.aspx

- Jewish Renaissance Medical Center
- Newark Community Health Centers
- Newark Department of Health and Community Wellness
- Rutgers – Nursing Faculty Practice
- Saint James Health, Inc
- Zufall Health Center

Gloucester County

healthapps.state.nj.us/fhs/cphc/cphcList.aspx

- CAMcare Health Corporation
- CompleteCare Health Network

Hudson County

healthapps.state.nj.us/fhs/cphc/cphcList.aspx

- Horizon Health Center
- Metropolitan Family Health Network
- North Hudson Community Action Corporation Health Center

Hunterdon County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- Zufall Health Center

Mercer County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- Henry J Austin Health Center

Middlesex County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- Eric B Chandler Health Center
- Jewish Renaissance Foundation Community Health Center
- Jewish Renaissance Medical Center
- Rutgers – Nursing Faculty Practice

Monmouth County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- Monmouth Family Health Center
- Ocean Health Initiatives
- Visiting Nurse Association of Central Jersey

Morris County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- Zufall Health Center

Ocean County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- Lakewood Resource and Referral Center – CHEMED
- Ocean Health Initiatives

Passaic County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- North Hudson Community Action Corporation Health Center
- Paterson Community Health Center

Salem County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- Southern Jersey Family Medical Centers

Somerset County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- Zufall Health Center

Sussex County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- Zufall Health Center

Union County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- Neighborhood Health Services Corporation

Warren County
healthapps.state.nj.us/fhs/cphc/cphcList.aspx
- Zufall Health Center

Resources

Local Health Departments

state.nj.us/health/lh/documents/LocalHealthDirectory.pdf

Office of Tobacco Control

Quit Centers

tobaccofreenj.com/quit-smoking

Atlantic County

Atlantic Prevention Resources Quit Center, (609) 804-QUIT
quitcenter@atlprev.org

Cape May County

Cape May County Quit Center at Cape Assist, (609) 522-5960
quitcenter@capeassist.org

Cumberland County

Inspira Quit Center, (856) 641-8633
quitcenter@ihn.org

Essex County

RWJBH IFPR Quit Center – Essex, (833) 795-7848
quitcenter@rwjbh.org

Hudson County

Hackensack Meridian Health Quit Center – Hudson, (551) 996-1632
quitcenter@hmhn.org

Mercer County

RWJBH IFPR Quit Center – Mercer, (833) 795-7848
quitcenter@rwjbh.org

Middlesex County

RWJBH IFPR Quit Center – Middlesex, (833) 795-7848
quitcenter@rwjbh.org

Monmouth County

RWJBH IFPR Quit Center – Monmouth, (833) 795-7848
quitcenter@rwjbh.org

Ocean County

RWJBH IFPR Quit Center – Ocean, (833) 795-7848
quitcenter@rwjbh.org

Passaic County

Hackensack Meridian Health Quit Center – Passaic, (551) 996-1632
quitcenter@hmhn.org

Salem County

Inspira Quit Center, (856) 641-8633
quitcenter@ihn.org

Union County

RWJBH IFPR Quit Center – Union, (833) 795-7848
quitcenter@rwjbh.org

CancerCare

cancercare.org/
800-813-HOPE

CancerCare is the leading national organization providing free, professional support services and information to help people manage the emotional, practical, and financial challenges of cancer. CancerCare's services include case management; counseling and support groups over the phone, online, and in-person; educational workshops; publications; and financial and co-payment assistance.

The Community Guide to Preventive Services (The Community Guide)

thecommunityguide.org

The Community Guide is a collection of evidence-based finding of the Community Preventive Services Task Force, used to help select interventions to improve health and prevent disease within communities from the local- to state-level. The Community Guide uses a science-based approach to determine whether an intervention works and is cost-effective; helps identify and select interventions for behavior change, disease prevention, and environmental change; identify where evidence is insufficient, and more research is needed; and complements decision support tools such as Healthy People and the Guide to Clinical Preventive Services.

National LGBT Cancer Network

cancer-network.org/
(212) 675-2633
info@cancer-network.org

The National LGBT Cancer Network is a 501c3 non-profit organization that works to improve the lives of LGBT cancer survivors and those at risk through education of the LGBT community; training of health care providers; and advocating for LGBT survivors.

The National LGBT Cancer Network has identified screening and treatment facilities that are committed to offering safe, affordable, welcoming care to all LGBT people.

Screening Providers
cancer-network.org/screening-providers/?state=nj#state_selector

Treatment Providers
cancer-network.org/out-and-surviving/?state=nj#state_selector

Resources

Publicly Available Data and Surveillance Resources

New Jersey State Health Assessment Data (NJSHAD)

The New Jersey Department of Health's SHAD System provides access to public health datasets, statistics, and information on the health status of New Jerseyans. New Jersey Behavioral Risk Factor Survey (NJBRFS) data is one of the queryable datasets in NJSHAD.

doh.state.nj.us/doh-shad/

New Jersey State Cancer Registry (NJSCR)

The NJSCR publishes cancer incidence and mortality data available by geography, cancer site, year, sex, and race/ethnicity.

cancer-rates.info/nj/

National Cancer Institute (NCI) State Cancer Profiles

NCI State Cancer Profiles characterizes cancer burden in a standardized manner to motivate action, integrate surveillance into cancer control planning, characterize areas and demographic groups, and expose health disparities. The focus is on cancer sites with evidence based control interventions.

statecancerprofiles.cancer.gov/

National Immunization Survey (NIS)

NIS are conducted annual and used to obtain national, state, and selected local area estimates of vaccination coverage rates for children 19-35 months (NIS-Child) and for U.S. adolescents 13-17 years (NIS-Teen). Interactive versions of the data are available through ChildVaxView and TeenVaxView.

ChildVaxView
cdc.gov/vaccines/imz-managers/coverage/childvaxview/interactive-reports/index.html

TeenVaxView
cdc.gov/vaccines/imz-managers/coverage/teenvaxview/data-reports/index.html

United States Cancer Statistics (USCS)

The USCS are the official federal cancer statistics, which include registry data from The Centers for Disease Control and Prevention's (CDC) National Program of Cancer Registries (NPCR) and the National Cancer Institute's (NCI) Surveillance, Epidemiology, and End Results (SEER) Program, as well as mortality data from CDC's National Center for Health Statistics. Information is provided on newly diagnosed cancer cases and cancer deaths for the whole United States population.

gis.cdc.gov/Cancer/USCS/#/AtAGlance/

NEW JERSEY

Comprehensive Cancer Control Plan 2021-2025

NJHealth
New Jersey Department of Health

C2840