2022 – 2027 ILLINOIS COMPREHENSIVE CANCER CONTROL PLAN: PROGRESS REPORT

06/16/2025

INTRODUCTION

Cancer is a term used for diseases in which abnormal cells divide uncontrollably, invade other tissues, and spread to parts of the body through the blood and lymph systems. This report provides an important update to the cancer priority areas in Illinois. Collaboration efforts between stakeholders and partners are encouraged and appreciated so that the state can meet the goals and objectives that were laid out in the 2022-2027 Illinois Comprehensive Cancer Control Plan, which is available at https://dph.illinois.gov/topics-services/diseases-and-conditions/cancer/2022-2027-illinois-comprehensive-cancer-control-plan.html. The state has met some of the goals and objectives; however, several goals and objectives still need addressed. This report will include the incidence and mortality rates for the top priority cancers – female breast, cervical, colorectal, lung, prostate, and skin.

We hope this report provides valuable information that can be utilized to continue work on cancer prevention, screening, diagnosis, treatment, and survivorship efforts across Illinois.

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Goals And Objectives

This section includes the goals and objectives for each of the three priority areas: prevention, screening and early detection, and diagnosis, treatment, and survivorship.

The goals reflect overarching changes we want to see in Illinois.

The objectives are measurable accomplishments necessary to meet the goal. The objectives were made to be specific, measurable, attainable, realistic, and timely (SMART) to facilitate the assessment of progress made towards meeting these objectives over the remainder of the five years (2022-2027).

Data sources used for the objectives are listed in parentheses after each objective and are publicly available so anyone can track Illinois's progress towards meeting these objectives.

The status indicates our progress to date.

Met	The current value meets or exceeds the target.
Improved	The current value has improved compared to the baseline but has not yet met the target.
No change	The current value has not changed.
Worsened	The current value is further from the target and baseline.

It is important to continue or increase the efforts on all goals and objectives.

Prevention

Prevention is stopping cancer before it starts. This includes promoting healthy living habits amongst adults and youth to reduce the risk of cancer occurring from a poor diet, drinking alcohol, and inadequate physical activity.

Goal 1. Increase healthy living habits among youth and adults.	Baseline	Target (2027)	Current	Status
Objective 1: Decrease the percentage of high school students who did not eat vegetables from 7.9% to 7.1% by 2027 (YRBSS).	7.9% (2019)	7.1%	8.5% (2023)	Worsened
Objective 2: Decrease the percentage of high school students who drank a sugar-sweetened soda one or more times per day from 13.7% to 12.3% by 2027 (YRBSS).	13.7% (2019)	12.3%	13.0% (2023)	Improved
Objective 3: Decrease the percentage of high school students who are obese (a body mass index of 30 or greater) from 15.2% to 13.7% by 2027 (YRBSS).	15.2% (2019)	13.7%	13.5% (2023)	Met
Objective 4: Increase the percentage of adults who eat one vegetable per day from 76.6% to 84.3% by 2027 (BRFSS).	76.6% (2019)	84.3%	83.4% (2021)	Improved
Objective 5: Decrease the percentage of adults who are overweight (a body mass index between 25.0 and 30) or obese from 65.7% to 59.1% by 2027 (BRFSS).	65.7% (2019)	59.1%	71.0% (2023)	Worsened
Objective 6: Decrease the percentage of adults binge drinking alcohol from 19.9% to 17.9% by 2027 (BRFSS). Binge drinking for men is having five or more drinks, and for women, it is having four or more drinks on one occasion.	19.9% (2019)	17.9%	18.1% (2023)	Improved
Objective 7: Increase the percentage of adults ages 18-64 with health insurance coverage from 84.4% to 92.8% by 2027 (BRFSS).	84.4% (2019)	92.8%	93.4% (2023)	Met
Objective 8: Increase the percentage of adults who visited a doctor in the past year from 76.5% to 84.2% by 2027 (BRFSS).	76.5% (2019)	84.2%	79.4% (2023)	Improved

Resources

CDC BRFSS at https://www.cdc.gov/brfss/brfssprevalence/index.html
CDC YRBSS at https://yrbs-explorer.services.cdc.gov/#/

Goal 2. Reduce exposure to environmental carcinogens.	Baseline	Target (2027)	Current	Status
Objective 1: Decrease the amount of particulate matter the general public is exposed to from 9.5 microns to 8.3 microns in micrograms per cubic meter by 2027.	9.5 (2019)	8.3	9.8 (2020-2022)	Worsened
Objective 2: Increase the number of Illinois schools tested for radon from 89 to 200 per year by 2027 (IEMA School testing program for radon with the American Lung Association).	89 (2019)	200	8 (2022)	Worsened
Objective 3: Reduce the percentage of tested classrooms with a ≥ 4.0 pCi/L measurement for radon from 9.7% to 8.7% by 2027 (IEMA School Testing Program for radon with the American Lung Association).	9.7% (2019)	8.7%	6.2% (2022)	Met
Objective 4: Reduce the percentage of tested schools with one classroom with a ≥ 4.0 pCi/L measurement for radon from 65.6% to 59.0% by 2027 (IEMA School Testing Program for radon with the American Lung Association).	65.5% (2019)	59.0%	62.5% (2022)	Improved

Resources

Objective 1: https://www.americashealthrankings.org/explore/annual/measure/air/state/IL
Objectives 2, 3, and 4: https://www.isbe.net/Documents/Report-Radon-Test-Results-Il-Public-Schools.pdf

In the state code Section 10-20.48 and 34-18.39 of the School Code, the Illinois State Board of Education (ISBE) requires school districts that have performed testing to report the results. Note, this state code does **not** require testing (the code recommends it), but if a school tests, they are required to submit the results. The 2022 report of schools that reported their radon test results is available at https://www.isbe.net/Documents/Report-Radon-Test-Results-Il-Public-Schools.pdf.

Goal 3. Prevent tobacco-related lung cancers among youth and adults.	Baseline	Target (2027)	Current	Status
Objective 1: Decrease the percentage of high school students who currently smoke cigarettes or used electronic vapor products in the last 30 days from 20.9% to 18.8% by 2027 (YRBSS).	20.9% (2019)	18.8%	16.1% (2023)	Met
Objective 2: Decrease the percentage of high school students who currently use smokeless tobacco in the last 30 days from 4.1% to 3.7% by 2027 (YRBSS).	4.1% (2019)	3.7%	1.9% (2023)	Met
Objective 3: Decrease the percentage of adults who are current smokers from 14.5% to 13.1% by 2027 (BRFSS). *Healthy People 2030 Target: 5.0%*	14.5% (2019)	13.1%	10.8% (2023)	Met
Objective 4: Decrease the percentage of adults who currently use smokeless tobacco from 2.7% to 2.4% by 2027 (BRFSS).	2.7% (2019)	2.4%	2.5% (2023)	Improved
Objective 5: Increase the number of adults using the Illinois Tobacco Quitline from 2,202 to 2,459 callers for FY22 and 5% annually thereafter (Illinois Tobacco Quitline FY20).	2,202 (FY20)	2,459	6,926 (FY23)	Met

Resources

CDC BRFSS at https://www.cdc.gov/brfss/brfssprevalence/index.html
CDC YRBSS at https://yrbs-explorer.services.cdc.gov/#/

Goal 4. Prevent HPV-related cancers.	Baseline	Target (2027)	Current	Status
Objective 1: Increase the percentage of female adolescents ages 13-17 who have at least received one dose of the HPV vaccine from 72.1% to 79.3% by 2027 (TeenVaxView).	72.1% (2019)	79.3%	84.5% (2023)	Met
Objective 2: Increase the percentage of male adolescents ages 13-17 who have at least received one dose of the HPV vaccine from 71.3% to 78.4% by 2027 (TeenVaxView).	71.3% (2019)	78.4%	76.9% (2023)	Improved
Objective 3: Increase the percentage of female adolescents ages 13-17 who are up to date on the HPV vaccine from 55.2% to 60.7% by 2027 (TeenVaxView). *Healthy People 2030 Target: 80%*	55.2% (2019)	60.7%	74.3% (2023)	Met
Objective 4: Increase the percentage of male adolescents ages 13-17 who are up to date on the HPV vaccine from 54.5% to 60% by 2027 (TeenVaxView). *Healthy People 2030 Target: 80%*	54.5% (2019)	60.0%	64.2% (2023)	Met

Resources

CDC TeenVaxView at https://www.cdc.gov/teenvaxview/interactive/index.html

Goal 5. Promote awareness of hereditary cancers and use of genetic counseling.	Baseline	Target (2027)	Current	Status
Objective 1: Promote two resources annually to patients on hereditary cancer risks and cancer genetic counseling services.	0	2	26 (as of 05/14/2025)	Met
Objective 2: Promote two resources annually to providers on hereditary cancer risks, such as breast, ovarian, and colorectal cancers.	0	2	29 (as of 05/14/2025)	Met
Objective 3: Increase the number of certified genetic counselors in Illinois by 10% from 77 to 85 by 2027	77 (2021)	85	107 (2024)	Met

Resources

https://findageneticcounselor.nsgc.org/In-Person-FindaGC?reload=timezone.

Screening and Early Detection

Screening and early detection are screening for cancer in its earliest stage when treatment works best.

Goal 1: Increase cancer screening.	Baseline	Target (2027)	Current	Status
Objective 1: Increase lung cancer screening among adults 50-80 years of age (American Lung Association).	6.3% (2019)	6.9%	6.3% (2021)	No change
Objective 2: Increase colorectal cancer screening among adults 45-75 years of age (State Cancer Profiles).	66.7% (2018)	73.4%	65.5% (2022)	Worsened
Objective 3: Increase breast cancer screening among females 40 years and older (State Cancer Profiles).	73.1% (2018)	80.4%	65.9% (2022)	Worsened
Objective 4: Increase prostate cancer screening among Hispanic males 50-69 years of age (BRFSS).	17.3% (2018)	19.0%	20.9% (2020)	Met
Objective 4.1: Increase prostate cancer screening among Black non-Hispanic males 50-69 years of age (BRFSS).	29.4% (2018)	32.3%	25.9% (2020)	Worsened
Objective 5: Increase cervical cancer screening among females 21-65 years of age (State Cancer Profiles).	69.1% (2018)	76.0%	72.1% (2022)	Improved

Resources

CDC State Cancer Profiles at https://statecancerprofiles.cancer.gov/

CDC BRFSS at https://www.cdc.gov/brfss/brfssprevalence/index.html

Goal 2: Reduce late-stage cancer diagnosis.	Baseline	Target (2027)	Current	Status
Objective 1: Reduce late-stage lung and bronchus cancer diagnosis among adults 50 years of age and older (State Cancer Profiles).	45.4 per 100,000 (2013-2017)	40.9	38.4 (2017-2021)	Met
Objective 2: Reduce late-stage colorectal cancer diagnosis among all adults (State Cancer Profiles).	24.1 per 100,000 (2013-2017)	21.7	23.8 (2017-2021)	Improved
Objective 3: Reduce late-stage breast cancer diagnosis among females of all ages (State Cancer Profiles).	45.6 per 100,000 (2013-2017)	41.0	44.5 (2017-2021)	Improved
Objective 4: Reduce late-stage prostate cancer diagnosis among males ages 50 years and older (State Cancer Profiles).	24.0 per 100,000 (2013-2017)	21.6	28.1 (2017-2021)	Worsened
Objective 5: Reduce late-stage cervical cancer diagnosis among females 21-65 years of age (State Cancer Profiles).	3.8 per 100,000 (2013-2017)	3.4	3.6 (2017-2021)	Improved

Resources

CDC State Cancer Profiles at https://statecancerprofiles.cancer.gov/

Goal 3: Reduce cancer mortality rates.	Baseline	Target (2027)	Current	Status
Objective 1: Reduce lung and bronchus cancer mortality rates among adults 50-80 years of age (State Cancer Profiles 2018-2022).	41.1 per 100,000 (2014-2018)	38.5	34.4 (2018-2022)	Met
Objective 2: Reduce colon and rectum cancer mortality rates among adults 50-75 years of age (State Cancer Profiles 2018-2022).	14.7 per 100,000 (2014-2018)	13.0	13.5 (2018-2022)	Improved
Objective 3: Reduce the breast cancer mortality rate among females 45 years and older (State Cancer Profiles 2018-2022).	21.0 per 100,000 (2014-2018)	20.1	20.2 (2018-2022)	Improved

Objective 4: Reduce the prostate cancer mortality rate among males 45 years and older (State Cancer Profiles 2018-2022).	20.0 per 100,000 (2014-2018)	19.0	19.0 (2018-2022)	Met
Objective 5: Reduce the cervical cancer mortality rate among females 21-65 years of age (State Cancer Profiles 2018-2022).	2.3 per 100,000 (2014-2018)	2.2	2.1 (2018-2022)	Met

Resources

CDC State Cancer Profiles at https://statecancerprofiles.cancer.gov/

Diagnosis, Treatment, and Survivorship

Diagnosis, treatment, and survivorship include providing support and services to cancer patients, survivors, and their caregivers to address social, emotional, and financial challenges they may face to increase quality of life. Promoting awareness and access to different supports and services includes navigation, ongoing care coordination, genetic counseling, and telehealth or outreach programs.

Goal 1. Promote awareness and access to navigation services, including financial and care navigation, to reduce disparities in cancer health outcomes.	**Baseline**	**Target (2027)**	**Current**	**Status**
Objective 1: Promote four educational opportunities for patient navigators per year. Measure: Distribution of patient navigator educational opportunities per year.	0	4 per year	35 (as of 05/14/2025)	Met
Objective 2: Develop a resource document of supportive services. Measure: Completion and distribution of the resource document.	0	1 per year	24 (as of 05/14/2025)	Met

Goal 2. Increase the diagnosis of high-risk patients with familial or genetic risk factors.	**Baseline**	**Target (2027)**	**Current**	**Status**
Objective 1: Improve awareness of guidelines for surveillance, diagnosis, and appropriate treatment based on tumor characteristics (i.e., Lynch syndrome). Measure: Compare the percentage of Microsatellite Unstable (MSI-H) cancers reported to the National Cancer Database before and after providing resources.	0	0	No data for measure	No data for measure
Objective 2: Increase referrals to genetic testing. Measure: Survey genetic counselors about referral patterns before and after resources are provided.	0	0	No data for measure	No data for measure

Goal 3. Increase awareness of ongoing care coordination for monitoring, follow-up, and recurrence screening.	**Baseline**	**Target (2027)**	**Current**	**Status**
Objective 1: Promote awareness among health care providers of guidelines for surveillance and follow-up. Measure: Promote guidelines to four organizations with health care providers per year.	0	4 per year	183 organizations (as of 05/14/2025)	Met
Objective 2: Promote existing resources to share with associations to educate providers on navigation elements. Measure: Identify five associations each year to distribute materials to their constituency (25 total over five years).	0	25 (5 per year)	183 organizations (as of 05/14/2025)	Met
Objective 3: Increase patient and provider awareness of survivorship care coordination and guidelines by directing patients and providers to survivorship resources (use QR code). Measure: Distribute materials to at least five patient advocacy organizations per year.	0	5 per year	183 organizations (as of 05/14/2025)	Met

Goal 4. Raise awareness of the need for increased quality of life for enhanced recovery and survivorship, and available resources.	Baseline	Target (2027)	Current	Status
Objective 1: Decrease the percentage of days (8-30 days) where cancer patients' and survivors' mental health was not good from 9.7% to 8.7% by 2027 (BRFSS).	9.7% (2019)	8.7%	8.7% (2019)	Met
Objective 2: Decrease the percentage of days (8-30 days) cancer patients and survivors were kept from doing their usual activities due to their health from 15.4% to 13.9% by 2027 (BRFSS).	15.4% (2019)	13.9%	10.0% (2019)	Met
Objective 3: Decrease the percentage of cancer patients and survivors who are overweight or obese from 11.3% to 10.2% by 2027 (BRFSS).	11.3% (2019)	10.2%	6.7% (2019)	Met
Objective 4: Decrease the percentage of cancer patients and survivors who binge drink alcohol from 4.8% to 4.3% by 2027 (BRFSS).	4.8% (2019)	4.3%	3.0% (2019)	Met
Objective 5: Promote clinical trials to current cancer patients. Measure: Promote clinical trials in two educational documents each year (newsletter, brochure, flyer, etc.).	0	2 per year	52 (as of 05/14/2025)	Met
Objective 6: Increase the number of Illinois providers certified in hospice and palliative medicine from 207 to 228 by 2027.	207 (2022)	228	212 (2025)	Improved

Resources

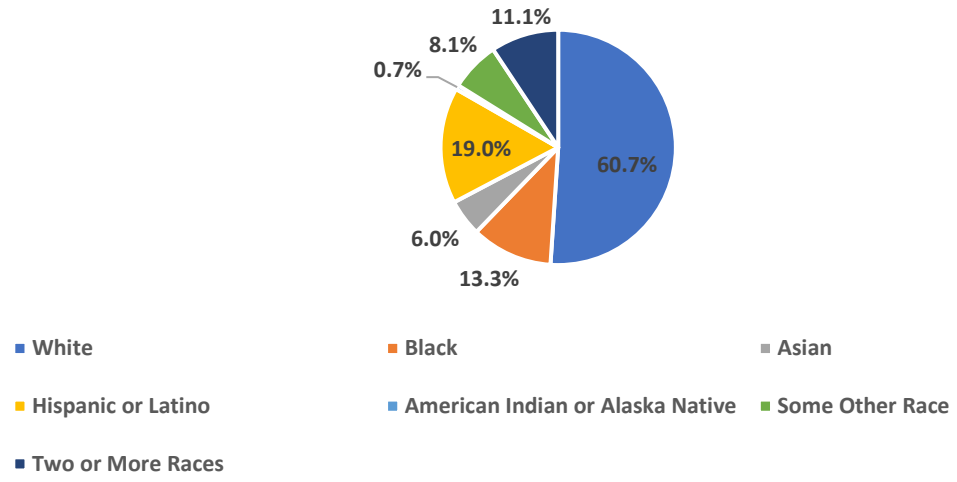
Illinois Behavioral Risk Factor Surveillance System (BRFSS) at http://www.idph.state.il.us/brfss/statedata.asp
Health Grades at https://www.healthgrades.com/specialty-directory

Goal 5. Support the availability of telehealth and outreach programs.	Baseline	Target (2027)	Current	Status
Objective 1: Promote continued availability of telehealth for patients. Measure: Further research needs to be done for data sources that collect this information in Illinois.	0	0	No data source	No data source
Objective 2: Promote educating patients on how to utilize telehealth platforms and other technology. Measure: Availability of curriculum or training resources for clinic staff and CBOs to support patient use of telehealth platforms. Organizations assess the patient's ability to access the internet from home.	0	0	No data source	No data source

Demographics

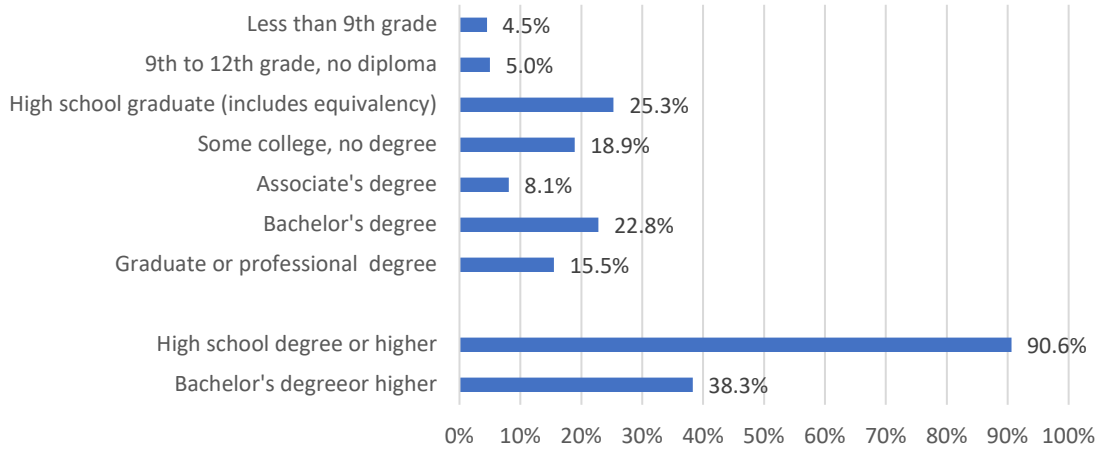
According to U.S. Census Bureau data, the population estimate for Illinois in 2023 was 12,549,689. Figure 1 demonstrates the Illinois population by race: 60.7% White, 13.3% Black, 6.0% Asian, 19.0% Hispanic or Latino, and 0.7% American Indian and Alaska Native.[1] Hispanics may be of any race.

Figure 1. Illinois Population Estimate, by Race and Ethnicity (2023 U.S. Census).



According to U.S. census data, in 2023, 90.6% of Illinois residents 25 years of age or older had graduated from high school. Figure 2 shows the percentage of the population by educational attainment.[2]

Figure 2. Educational Attainment in Illinois: Persons 25 Years and Older (2023 U.S. Census).



[1] U.S. Census Bureau. (2022). *QuickFacts; Illinois*. Retrieved from https://www.census.gov/quickfacts/fact/table/US,IL/PST045219.

[2] U.S. Census Bureau. (2022). *American Community Survey: Data Profiles*. Retrieved from https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/.

According to the U.S. census data in 2023, 21.5% of the Illinois population is under 18 years of age, and 78.5% is 18 years of age or older, as shown in Figure 3.[3]

Figure 3. Percent of Illinois Population Under and Over 18 Years (2023 U.S. Census).

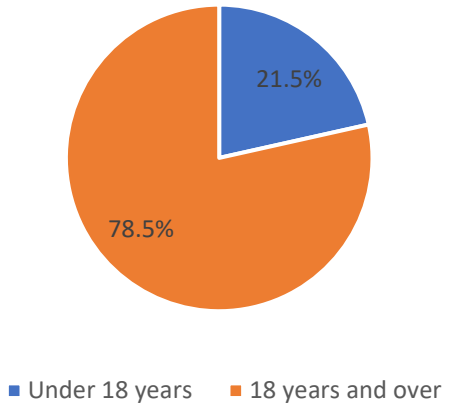
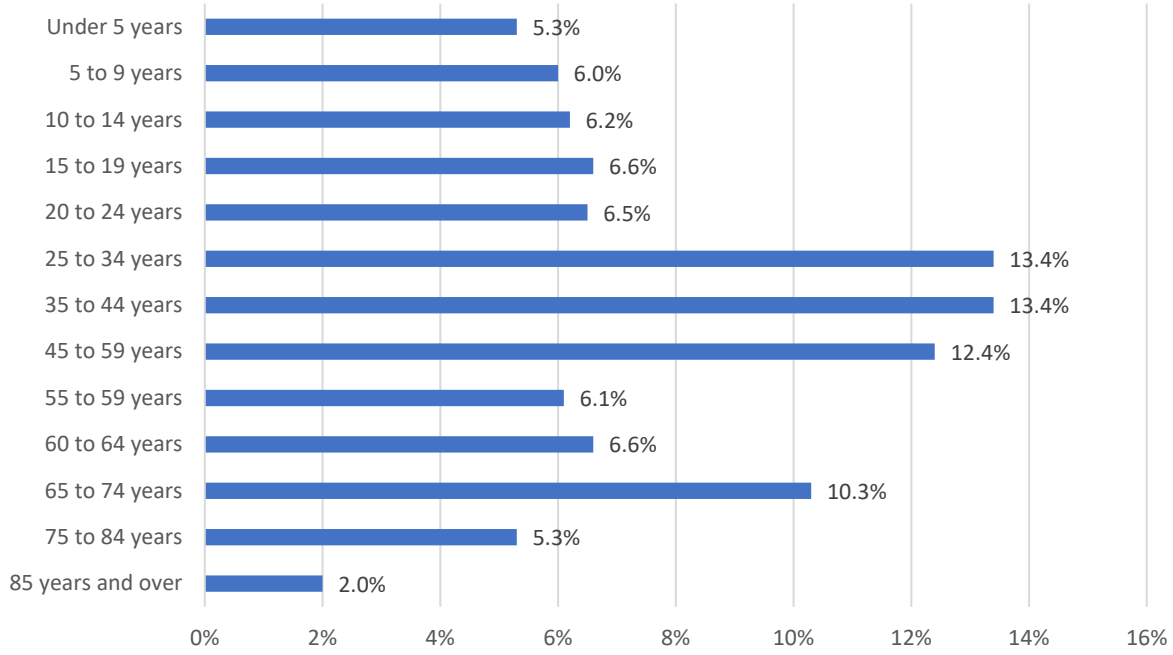


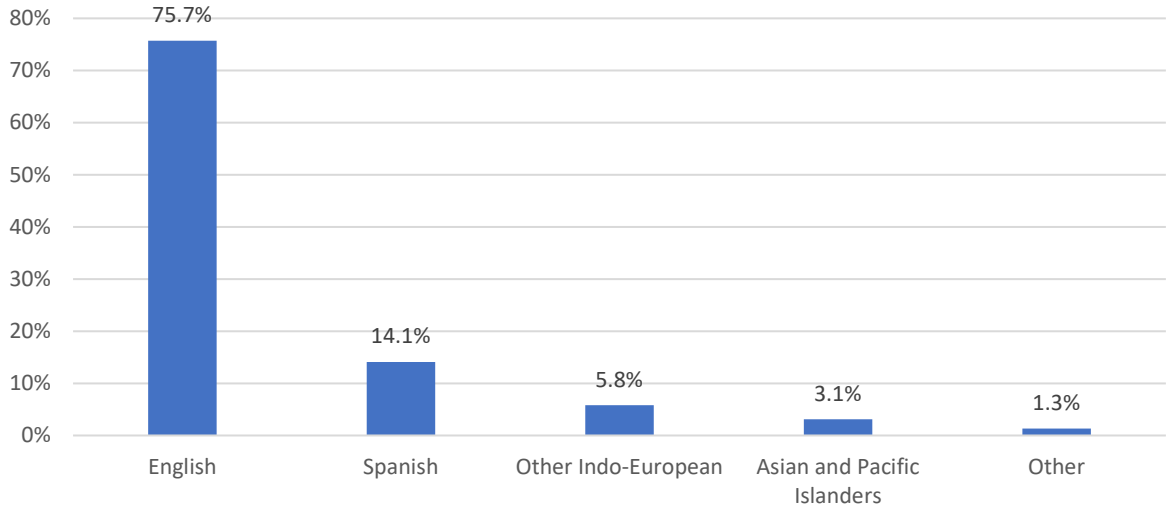
Figure 4. Illinois Population Estimate, by Age Group (2023 U.S. Census).



[3] U.S. Census Bureau. (2022). *American Community Survey: Data Profiles*. Retrieved from https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/.

In 2023, 75.7% of Illinois residents reported English as the language spoken at home. Other languages spoken at home include 14.1% Spanish, 5.8% other Indo-European, 3.1% Asian and Pacific Islanders, and 1.3% other languages.[4] See Figure 5.

Figure 5. Illinois Population Estimates, by Languages Spoken at Home (2023 U.S. Census).

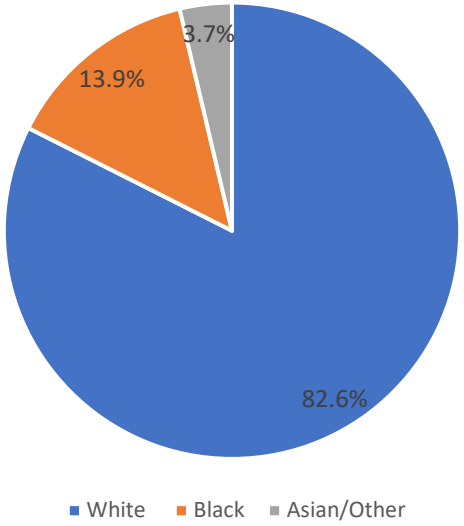


[4] U.S. Census Bureau. (2022). *American Community Survey: Data Profiles*. Retrieved from https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/.

Cancer Incidence

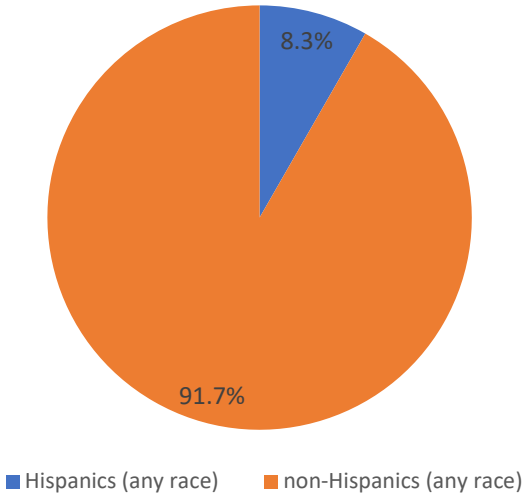
A total of 2,181,256 cases of invasive cancer among Illinois residents were reported to the Illinois State Cancer Registry (ISCR) from 1986 through 2021, including 72,622 new cases reported in 2021.[5] The overall race distribution for cases in 2021, as shown in Figure 6, was 82.6% White, 13.9% Black, and 3.7% Asian/other races. All the following data came from the ISCR.

Figure 6. Cancer Incidence among Illinois Residents by Race (1986-2021 ISCR).



For the ethnicity/race categories, a total of 2,002,325 cases of invasive cancer among Illinois residents were reported to ISCR from 1990 through 2021. Figure 7 shows the ethnicity/race distribution for cases diagnosed in 2021 of 8.3% Hispanics (any race) and 91.7% non-Hispanics (any race); among non-Hispanic cases, non-Hispanic Whites accounted for 85.4% and non-Hispanic Blacks 14.6%.

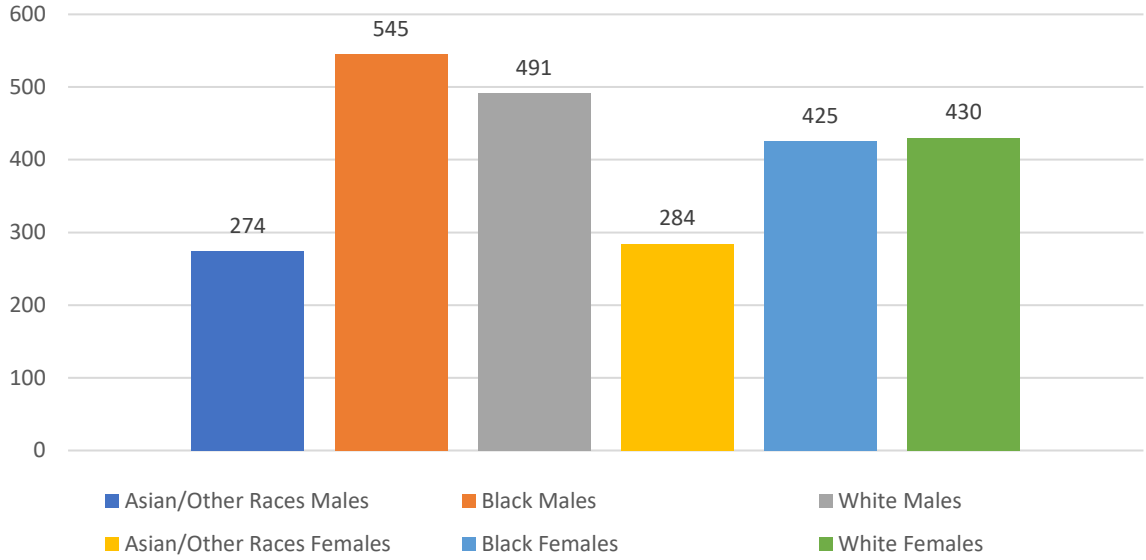
Figure 7. Cancer Incidence by Ethnicity (2021 ISCR).



[5] Roy S, Garner K, Koch L, Fornoff J. Illinois State Cancer Incidence Review and Update, 1986-2021. Epidemiologic Report Series 24:03. Springfield, Ill.: Illinois Department of Public Health, June 2024.

In 2021, Black males continued to have the highest overall age-adjusted invasive cancer incidence rates of all major race/gender groups, as shown in Figure 8. In general, males and females of Asian/other races in Illinois had substantially lower cancer incidence rates than their White or Black counterparts.

Figure 8. Overall Age-Adjusted Cancer Incidence per 100,000 Population (2021 ISCR).



Breast cancer was the most diagnosed cancer among Illinois females, accounting for 30.5% of 36,030 invasive cancer diagnoses in women during 2021. The predominance of breast cancer among females persists for all primary race and ethnicity groups.

The incidence of female breast cancer diagnosed in the in-situ stage increased steadily for every race and ethnicity between 1986 and 2000, with an annual percent increase of 8.1%, but slowed between 2000 and 2003 to -1.7%. The average annual percent change was an increase of 3.63% for all races.

For Illinois males, prostate cancer was the most frequently diagnosed invasive cancer, accounting for 26.4% of 36,592 new cancer diagnoses in men during 2021. Black males had the highest prostate cancer incidence rates among all race groups, approximately 51.7% and 92.7% higher than those observed for White and Asian/other race males in 2021.

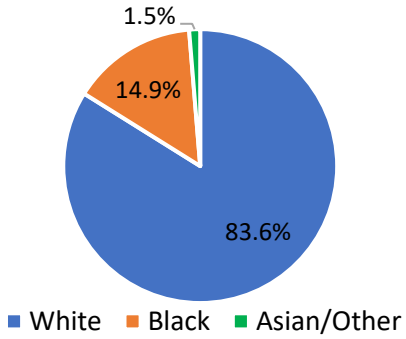
The incidence of male prostate cancer had an 18.7% annual increase between 1989 and 1992. The rate then decreased by 4.9% before plateauing between 1995 and 2008. From 2008 to 2013, the annual percent change for prostate cancer incidence showed a 7.7% decrease on average. After 2013, the trend again flattened out through 2021. Similar trends were seen across 1986-2021 in both White and Black men.

A total of 20,812 new cases of cancer were diagnosed during 1986-2021 among Illinois children aged 0 to 19 years. The three most common diagnostic sites for childhood cancer in Illinois were, in descending order, leukemia, central nervous system, and lymphoma.

Cancer Mortality

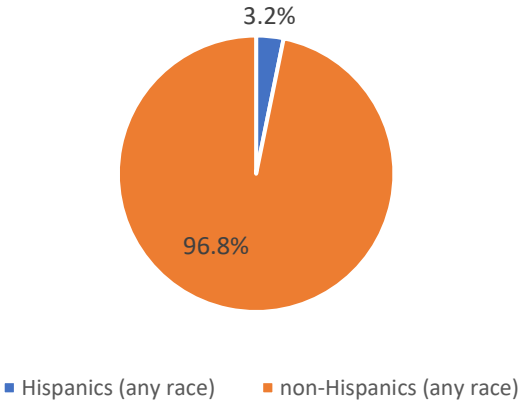
According to the ISCR, from 1986 through 2021, 876,400 Illinois residents died from cancer.[6] Figure 9 demonstrates that the race distribution for these deaths was 83.6% among Whites, 14.9% in the Black population, and the remainder occurring among the Asian/other race population group (1.5%).

Figure 9. Cancer Mortality by Race (1986-2021 ISCR).



From 1990 through 2021, 782,769 Illinois residents died from cancer, as shown in Figure 10. The distribution for these deaths was 3.2% Hispanic (any race) and 96.8% non-Hispanic (any race). Among non-Hispanic deaths, 80.0% were non-Hispanic Whites and 14.8% were non-Hispanic Blacks.

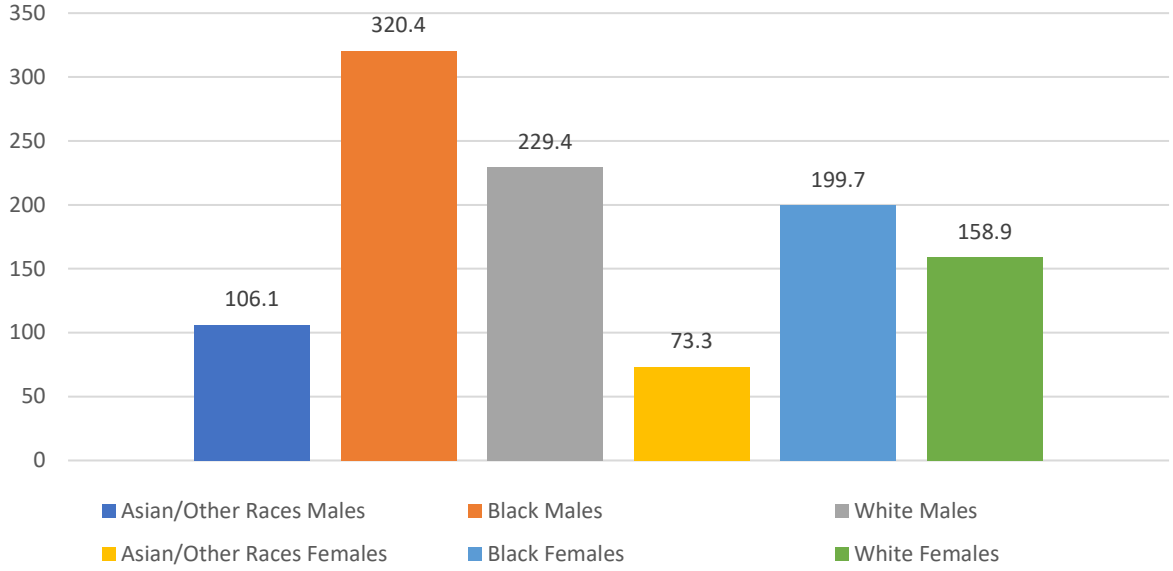
Figure 10. Cancer Mortality by Ethnicity (1990-2017 ISCR).



Black males had the highest overall age-adjusted mortality rates from cancer during the 1986-2021 period, about 33% higher than the rate for White males and three times the rate for males identified as Asian or other races (Figure 11). Similarly, Illinois' cancer mortality rates for Black females exceeded those for White females by about 23% and were 2.7 times greater than those observed among females identified as Asian or other races in Illinois. Non-Hispanic males and females (any race) had mortality rates that were 1.8 times that of their Hispanic (any race) counterparts.

[6] Roy S, Garner K, Koch L, Fornoff J. Illinois Cancer Mortality Review and Update, 1986-2021. Epidemiologic Report Series 24:04. Springfield, Ill.: Illinois Department of Public Health, June 2024.

Figure 11. Overall Age-Adjusted Cancer Mortality per 100,000 Population (1986-2017 ISCR).



Based on age-adjusted cancer mortality rates, covering 1986-2021, lung cancer remains the leading cause of death from cancer for both Illinois males and females, followed by prostate cancer for males and breast cancer for females. The third leading cause of cancer death is from cancers of the colon and rectum for both males and females.

From 1986 through 2021, among males of all races, over one-third of all cancer deaths were from cancer of the lung and bronchus (30.0%), 10.5% from prostate cancer, and 10.3% from cancer of the colon and rectum. These three cancers accounted for a little over half of all cancer deaths (50.8%).

From 1986 through 2021, 23.3% of all cancer deaths among females of all races were due to cancer of the lung and bronchus, 16.2% due to cancer of the breast, and 10.7% due to cancer of the colon and rectum. These three cancers made up 50.2% of all cancer deaths in females.

Priority Cancers

The Illinois priority cancers include female breast, cervical, colorectal, lung, prostate, and skin cancer. These cancers were identified based on the opportunity for prevention and early detection. In addition to the priority cancers, information is provided on the 13 cancer types that are most common for late-stage diagnosis.

Breast Cancer

In Illinois in 2021, there were 11,098 new cases, including 117 males and 10,981 females. [7] The incidence rate for breast cancer was 138.2 per 100,000 females and 1.7 per 100,000 males. In Illinois in 2022, 1,676 people died from breast cancer. Male breast cancer is a rare form that develops in breast tissue. It is often found in older males. The graphs are for female breast cancer only.

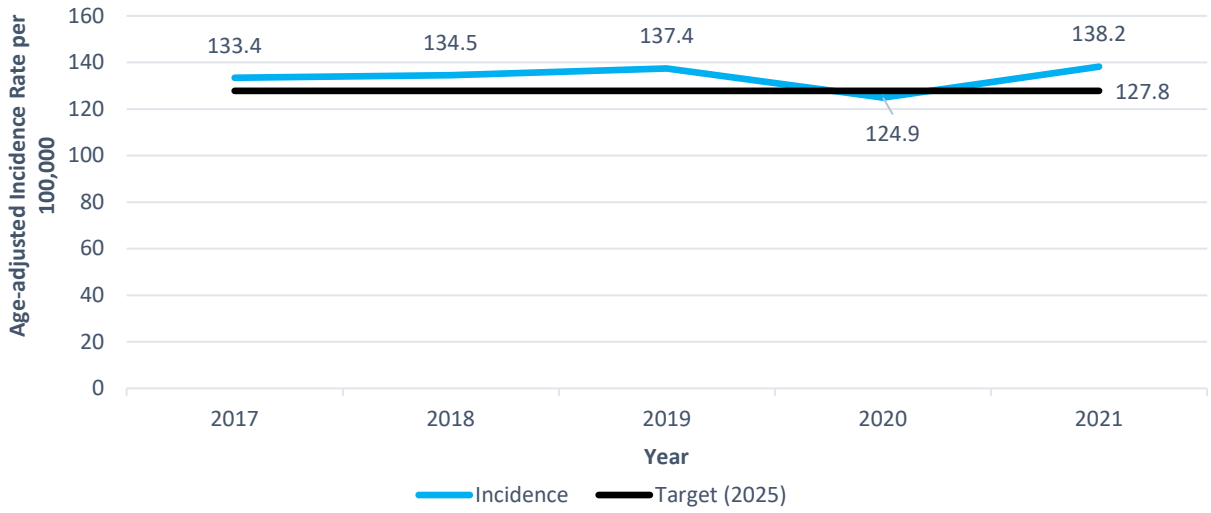
The risk factors for breast cancer are:

- Being a woman
- Older age
- Having a family history of breast cancer or those with inherited changes (mutations) in their BRCA1 or BRCA2 genes
- Taking hormone therapy medications that include estrogen and progesterone
- Taking certain birth control pills
- Giving birth to a first child after age 30 or having never been pregnant
- Drinking alcohol
- Klinefelter syndrome

The United States Preventive Services Task Force (USPSTF) recommends that all women get screened for breast cancer every other year, starting at age 40.

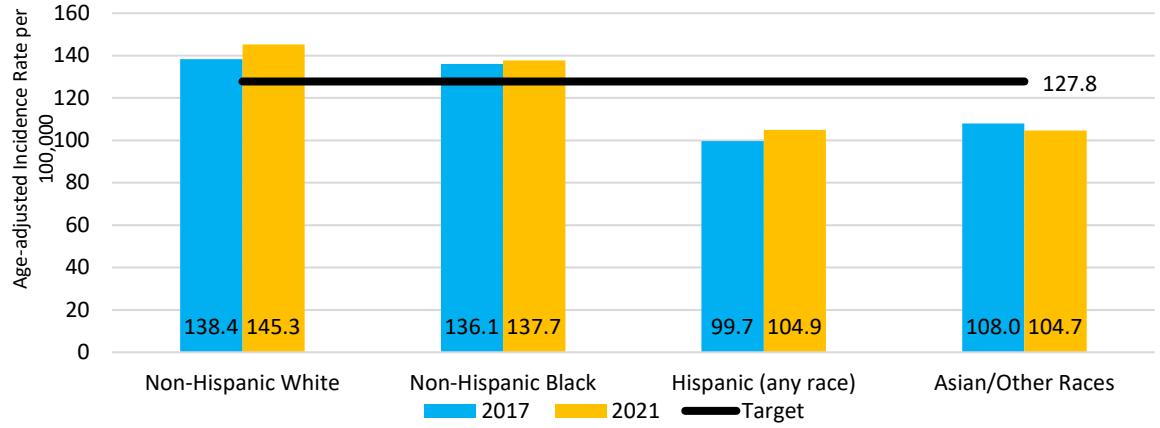
Incidence Rates

Figure 12. Breast cancer incidence rates, females, 2017-2021, Illinois, and 2025 target.



[7] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2024.

Figure 13. Breast cancer incidence rates by race/ethnicity, females, 2017 and 2021, Illinois. The target for the incidence rate is for all incidence rates to be below 127.8 per 100,000.



Mortality Rates

Figure 14. Breast cancer mortality rates, females, 2017-2021, Illinois, with 2025 target and 2030 Healthy People 2030 goal.

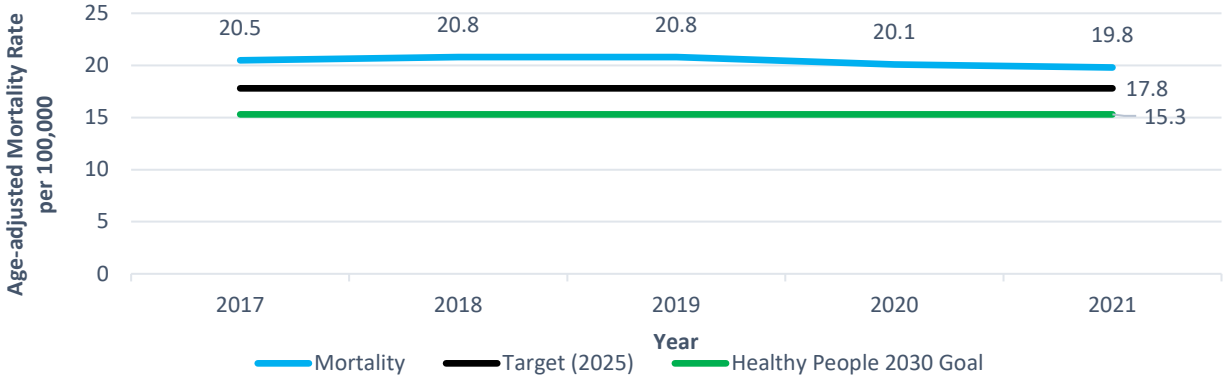
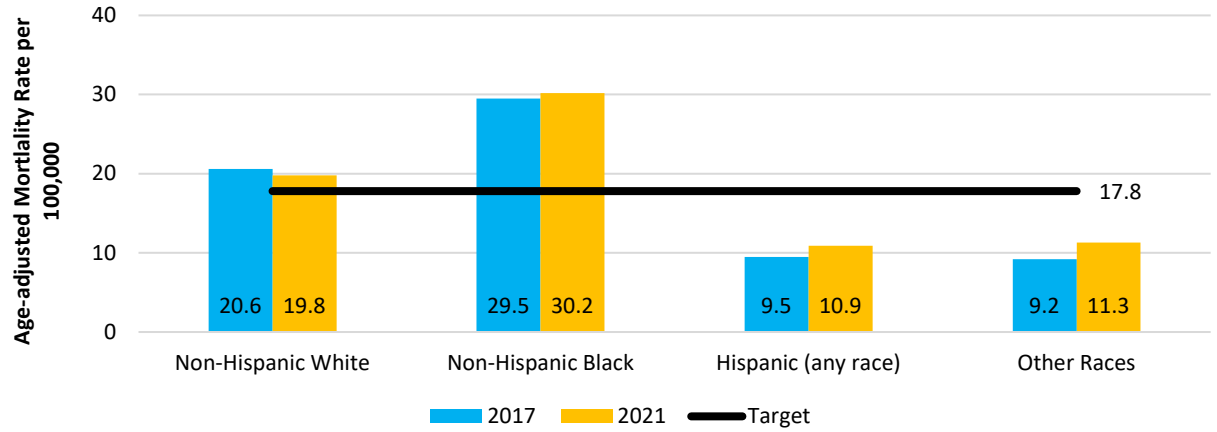


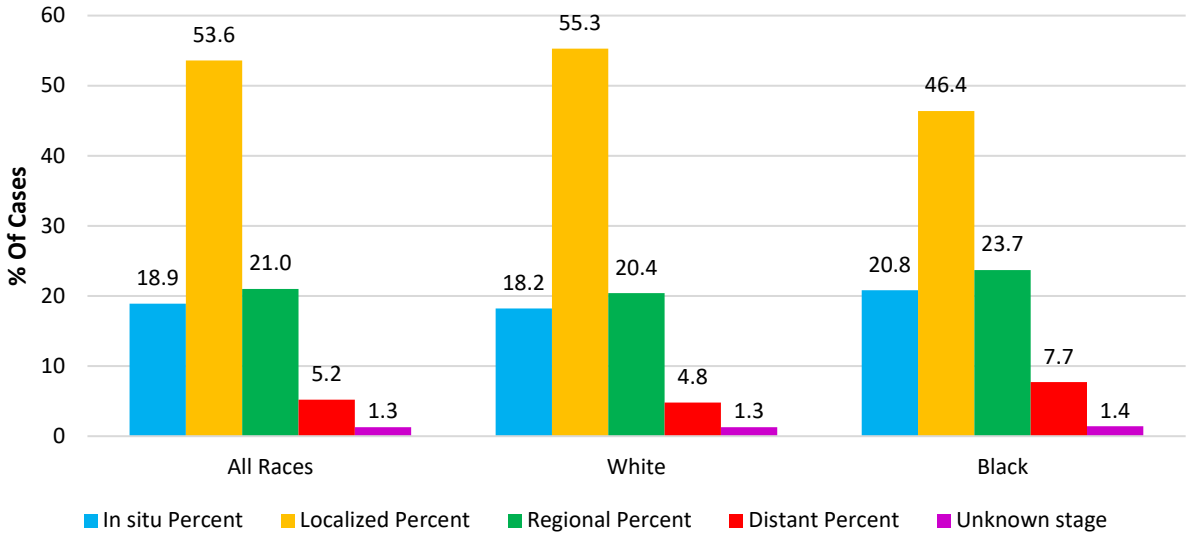
Figure 15. Breast cancer mortality rates by race/ethnicity, females, 2017 and 2021, Illinois. The target for the mortality rate is 17.8 per 100,000.



Stage at Diagnosis

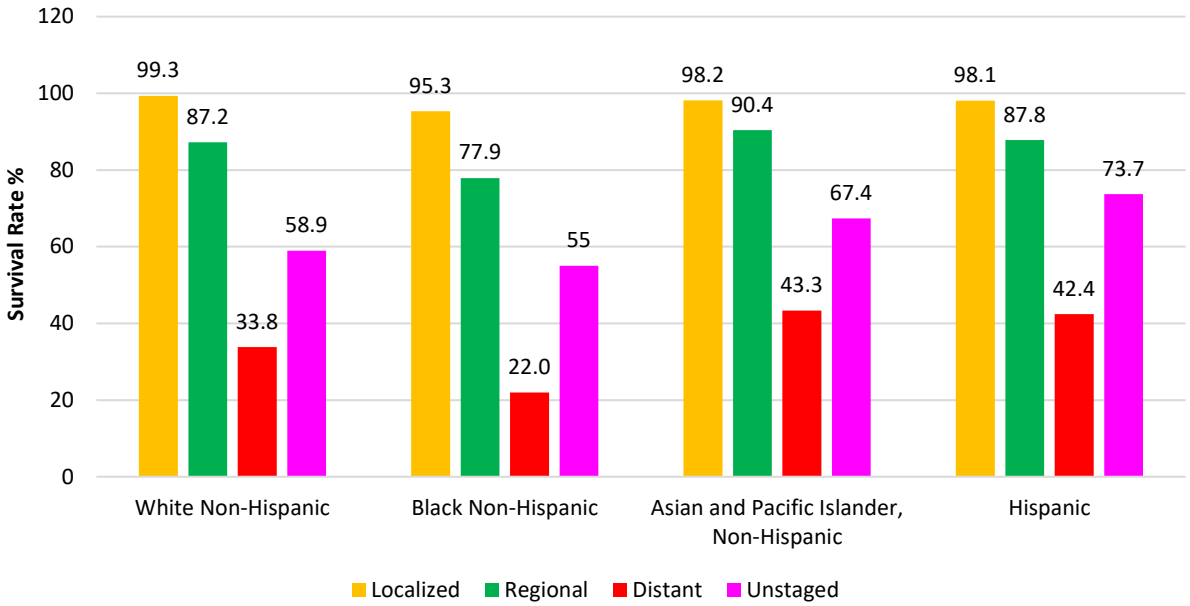
The following charts (Figures 16 and 17) show the distribution of new female breast cancer diagnoses by stage. The summary stage characterizes invasive cancers as localized, regional, or distant. Localized cancer is confined to the primary site, regional cancer has spread directly beyond the primary site (regional extension) or to regional lymph nodes, and distant cancer has spread to other organs (distant extension) or remote lymph nodes. Some cancers are unstaged, or the stage is unknown or unspecified.

Figure 16. Female breast cancer cases by stage at diagnosis and race/ethnicity, 2017-2021, Illinois.



Five-year Relative Survival Rate

Figure 17. Female breast cancer five-year relative survival rate (%) by stage, all ages, 2014-2020, Illinois.



Cervical Cancer

In Illinois, in 2022, there were 482 females diagnosed with cervical cancer.[8] The incidence rate for cervical cancer was 7.0 per 100,000 females. In Illinois, in 2022, 159 females died from cervical cancer.

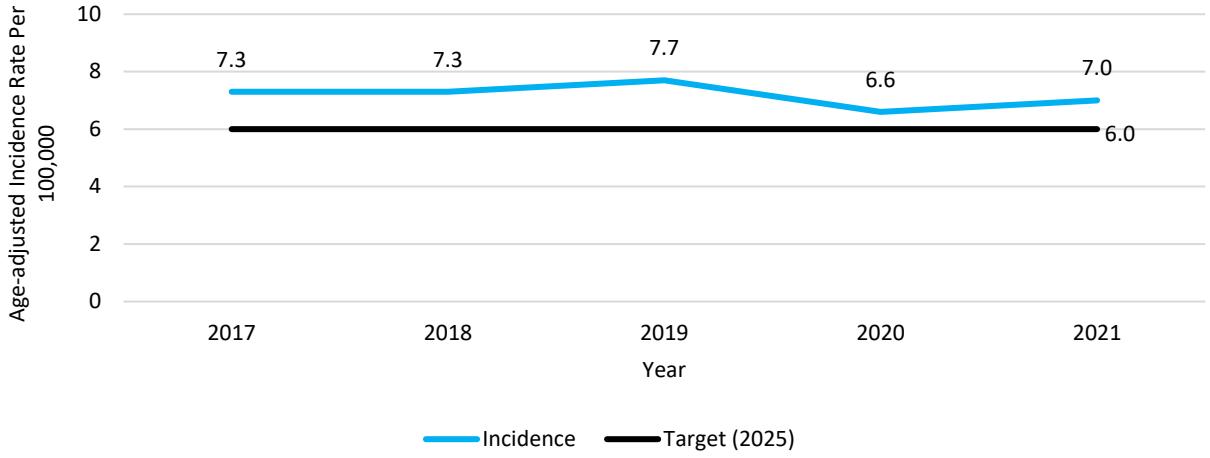
The risk factors for cervical cancer are:

- Having an HPV infection.
- Having other sexually transmitted infections, such as HIV, chlamydia, gonorrhea, or syphilis.
- Having a weakened immune system.
- Tobacco smoking.
- Using birth control pills for five or more years.
- Having given birth to three or more children.

The United States Preventive Services Task Force (USPSTF) recommends that women aged 21 to 65 years be screened for cervical cancer. For women aged 21 to 29 years, the USPSTF recommends screening for cervical cancer every three years with cervical cytology. For women aged 30 to 65 years, the USPSTF recommends screening every three years with cervical cytology alone, every five years with high-risk human papillomavirus (hrHPV) testing alone, or every five years with hrHPV testing in combination with cytology (cotesting).

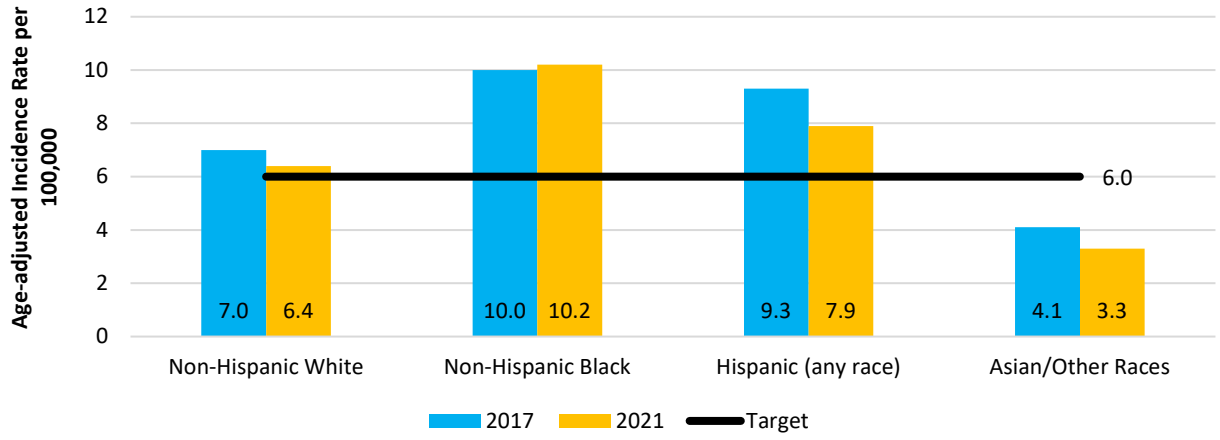
Incidence Rates

Figure 18. Cervical cancer incidence rates, females, 2017-2021, Illinois, and 2025 target.



[8] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2024.

Figure 19. Cervical cancer incidence rates by race/ethnicity, 2017 and 2021, Illinois. The target incidence rate is 6.0 per 100,000.



Mortality Rates

Figure 20. Cervical cancer mortality rates, females, 2017-2021, Illinois, and 2025 target.

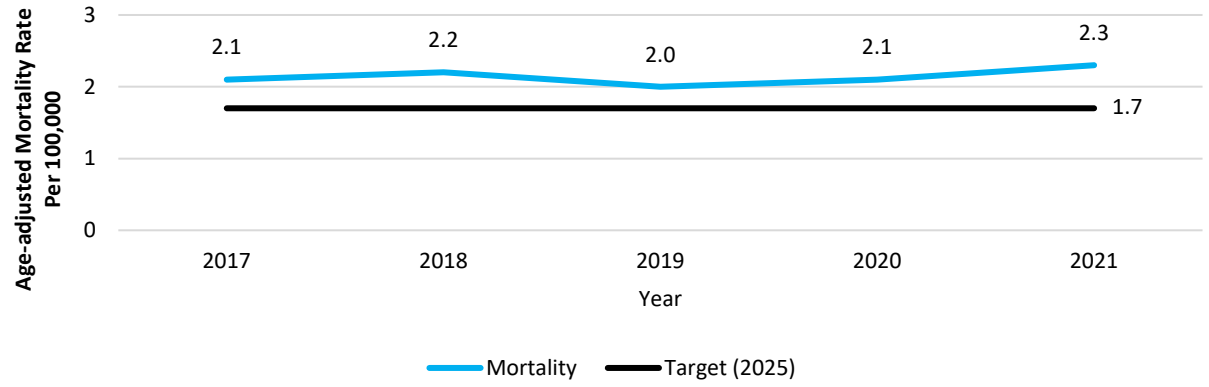
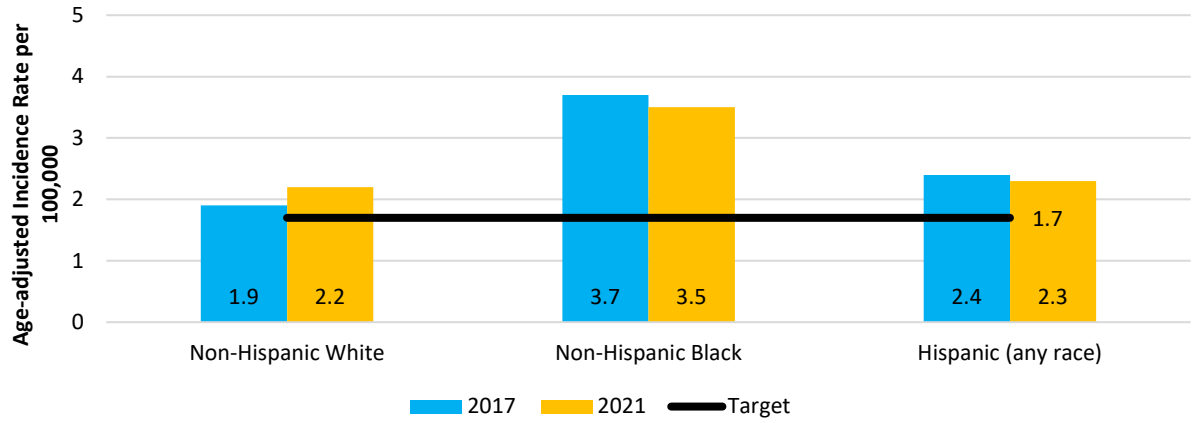


Figure 21. Cervical cancer mortality rates by race/ethnicity, 2017 and 2021, Illinois. Mortality data for Asian/other races are suppressed due to insufficient counts. The target rate is 1.7 per 100,000.



Colorectal Cancer

Colorectal cancer is the second-leading cause of cancer deaths in the U.S. and in Illinois among men and women combined. In Illinois in 2021, 5,878 people (2,732 females and 3,146 males) were diagnosed with colorectal cancer.[9] The incidence rate was 33.0 per 100,000 females and 44.2 per 100,000 males. During 2021, 2,116 people (1,123 males and 993 females) died from colorectal cancer.

The risk factors for colorectal cancer are:

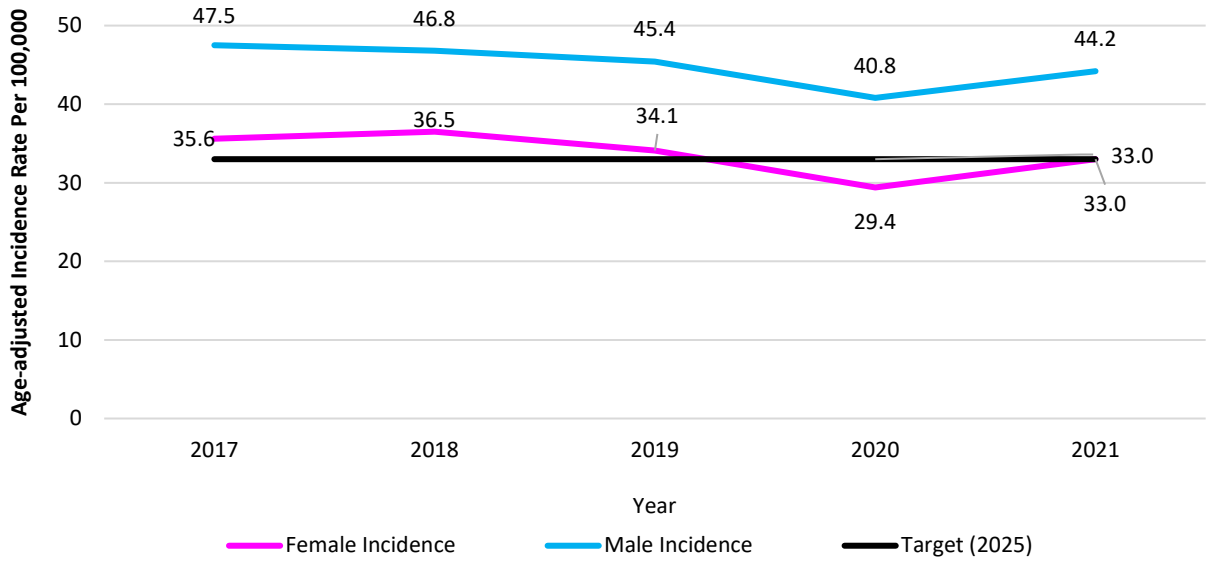
- Poor diet
- Lack of physical activity
- Overweight or obese
- Alcohol or tobacco use
- Family history of colorectal cancer
- Personal history of colorectal cancer, polyps, or bowel disease

Currently, the USPSTF recommends that people aged 45 to 75 years be screened for colorectal cancer. Screening tests for colorectal cancer include a fecal occult blood test, sigmoidoscopy, colonoscopy, or a DNA stool test. Individuals should speak with their doctor about:

- When to begin screening.
- Which test to use.
- How often to get tested.

Incidence Rates

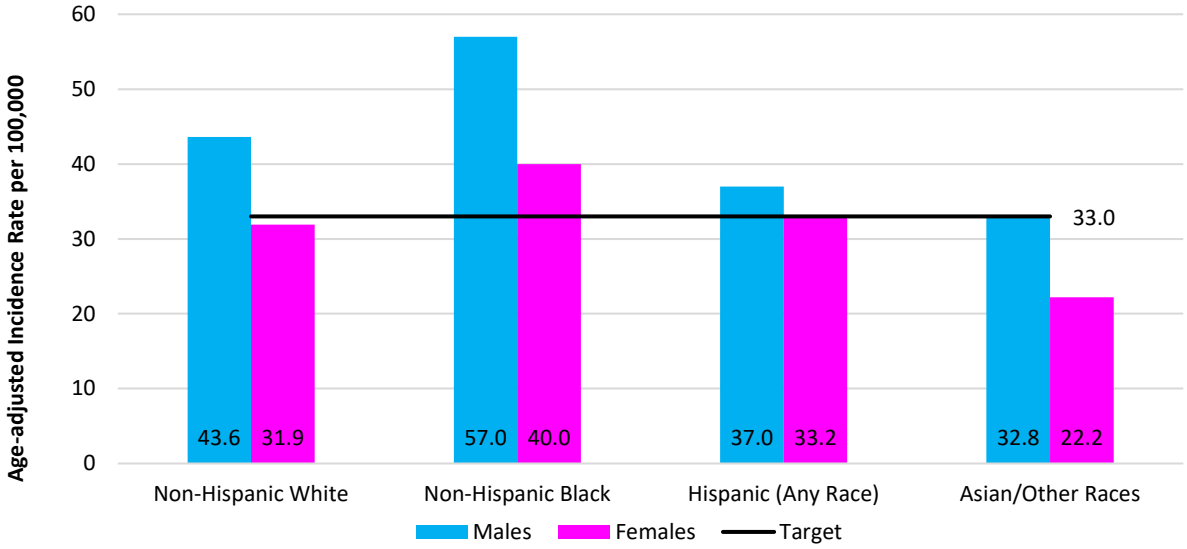
Figure 22. Colorectal cancer incidence rates by sex, 2017-2021, Illinois, and 2025 target.



[9] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2024.

Incidence Rates

Figure 23. Colorectal cancer incidence rate by race/ethnicity, and sex, 2021, Illinois. The target rate is 33.0 per 100,000.



Mortality Rates

Figure 24. Colorectal cancer mortality rates by sex, 2017-2021, Illinois, and 2025 target.

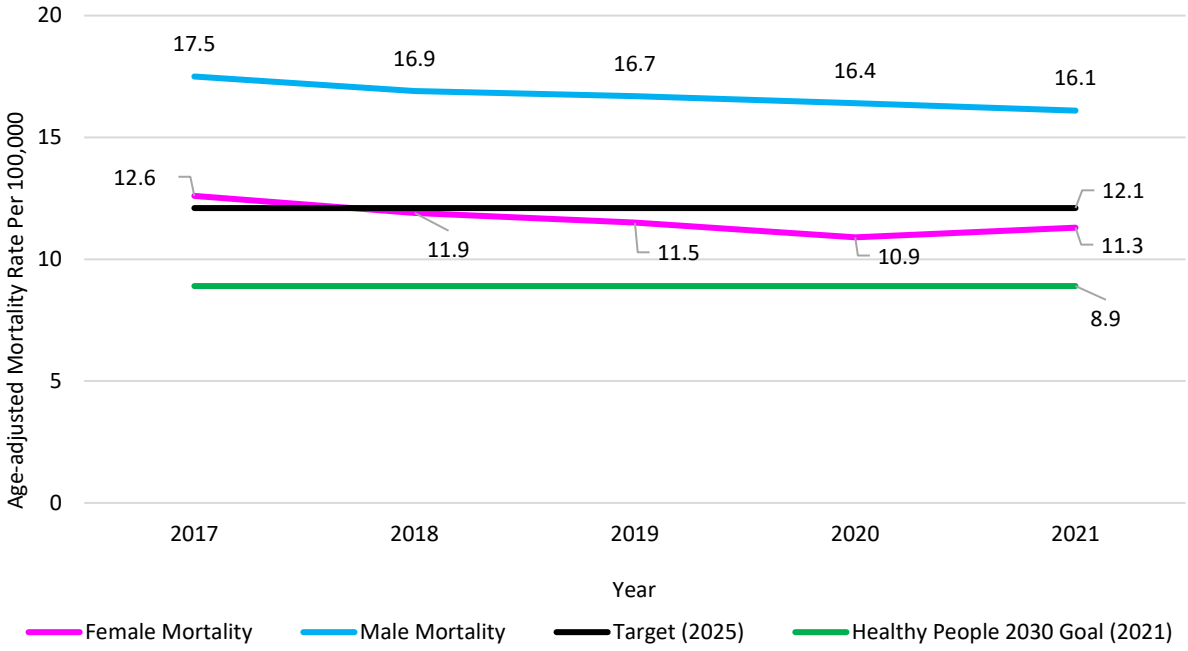
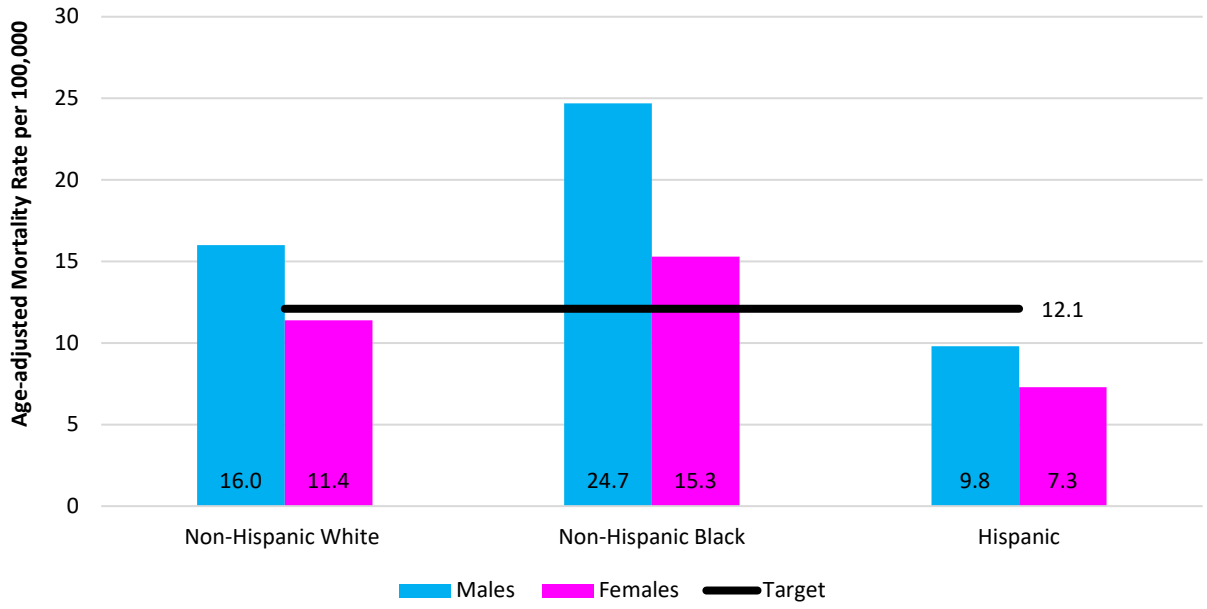


Figure 25. Colorectal cancer mortality rates by race/ethnicity, and sex, 2021, Illinois. Mortality data for Asian/other races are suppressed due to insufficient counts. The target rate is 12.1 per 100,000.



Lung Cancer

Lung cancer is the leading cause of cancer death and is the third most common cancer in the state. In Illinois in 2021, there were 9,167 new cases of lung cancer.[10] The incidence rate for lung cancer was 51.8 per 100,000 females and 61.6 per 100,000 males. In Illinois in 2021, 5,440 people died from lung cancer, including 2,797 males and 2,643 females.

The risk factors for lung cancer are:

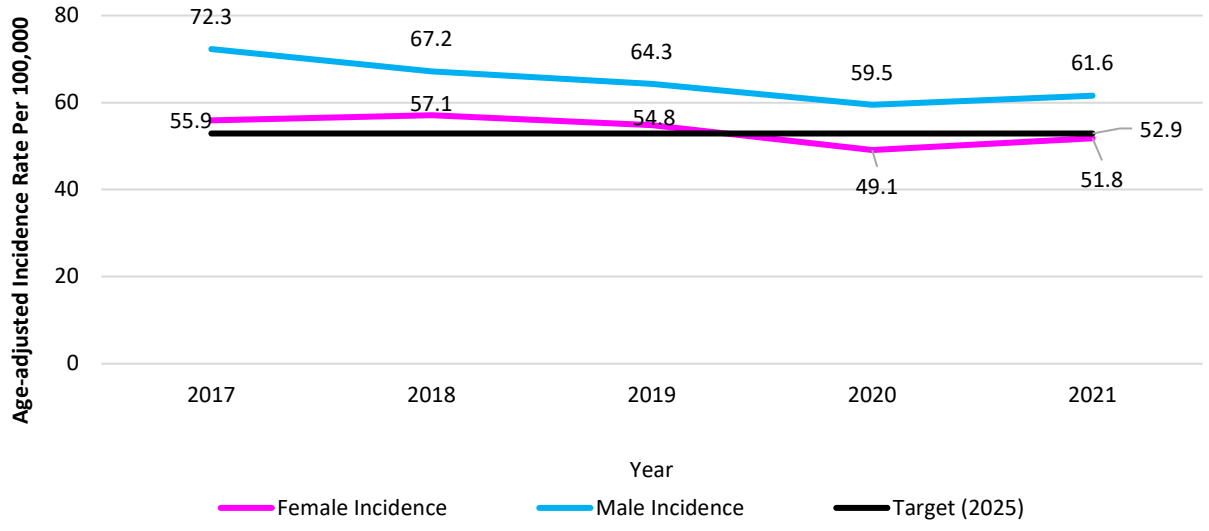
- Smoking.
- Breathing in secondhand smoke from another person's cigarette, pipe, or cigar.
- Exposure to radon (a naturally occurring gas from rocks and dirt that can get trapped in houses and buildings).
- Workplace exposure to other substances, such as asbestos, arsenic, diesel exhaust, and some forms of silica and chromium.
- A personal or family history of lung cancer.
- Previous radiation therapy to the chest.

The USPSTF recommends annual screening in adults aged 50 to 80 who have a 20-pack-year smoking history and currently smoke or have quit within the past 15 years. The USPSTF recommends that yearly lung cancer screening stop when the person being screened:

- Turns 81 years old, or
- has not smoked in 15 or more years, or
- develops a health problem that makes them unwilling or unable to have surgery if lung cancer is found.

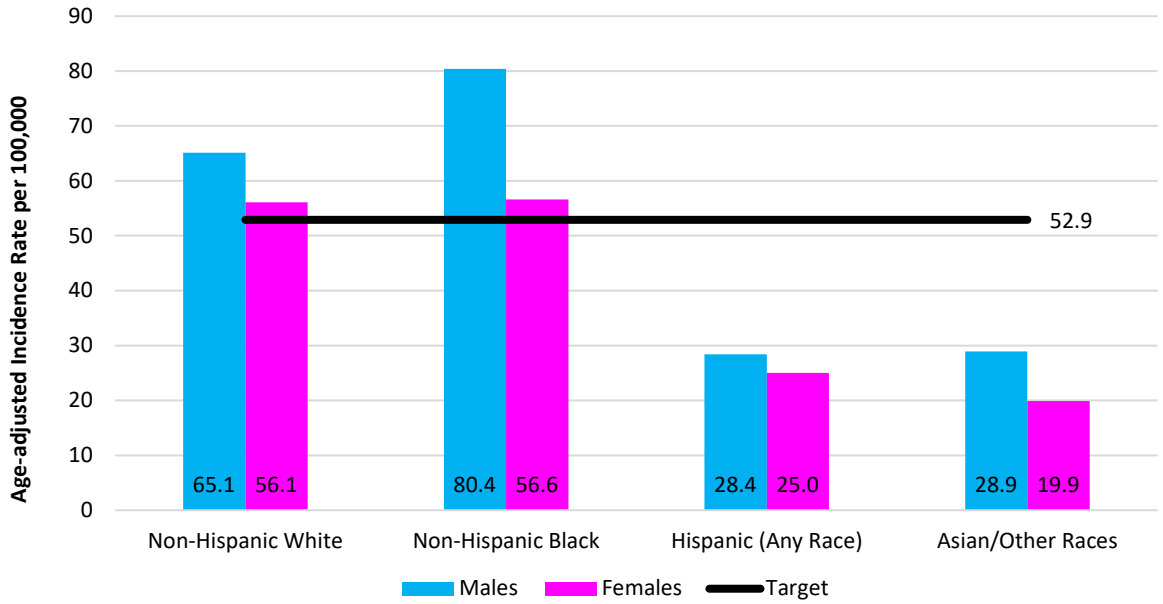
Incidence Rates

Figure 26. Lung cancer incidence rates by sex, 2017-2021, Illinois, and 2025 target.



[10] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2024.

Figure 27. Lung cancer incidence rates by race/ethnicity, and sex, 2021, Illinois. The target rate is 52.9 per 100,000.



Mortality Rates

Figure 28. Lung cancer mortality rates by sex, 2017-2021, Illinois, and 2025 target.

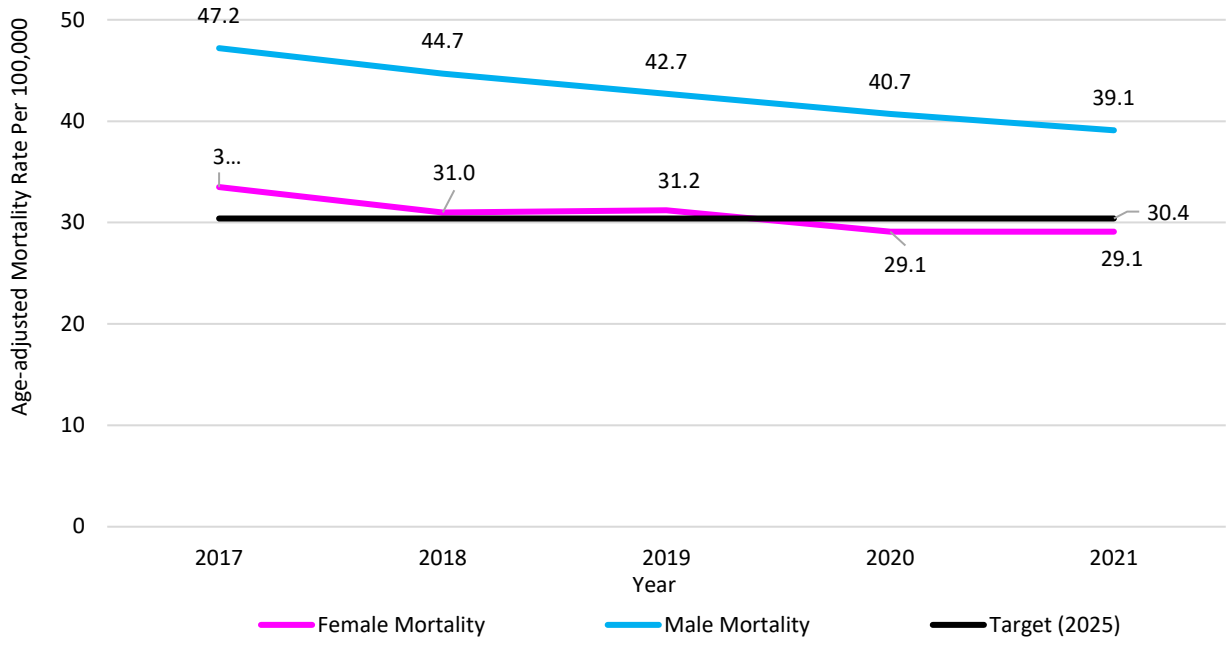
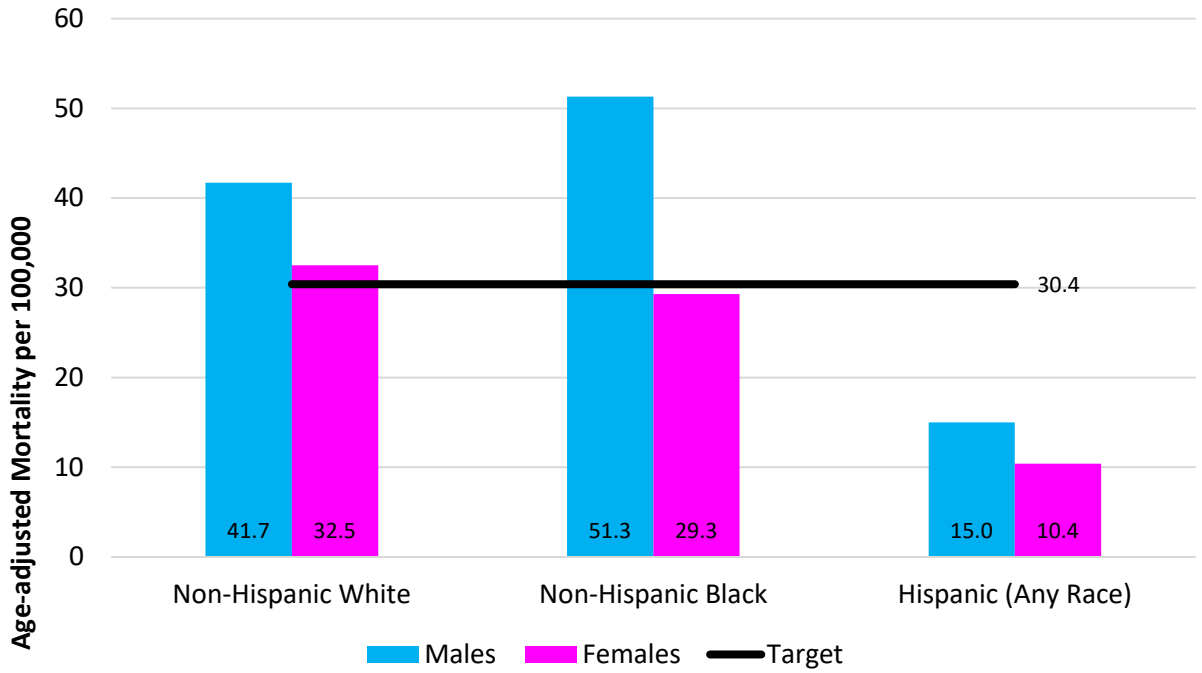


Figure 29. Lung cancer mortality rates by race/ethnicity, and sex, 2021, Illinois. Mortality data for Asian/other races are suppressed due to insufficient counts. The target rate is 30.4 per 100,000.



Prostate Cancer

Prostate cancer is the most common cancer and the second leading cause of death for males. In Illinois in 2021, there were 9,667 new cases of prostate cancer.[11] In Illinois in 2022, 1,262 men died of prostate cancer.

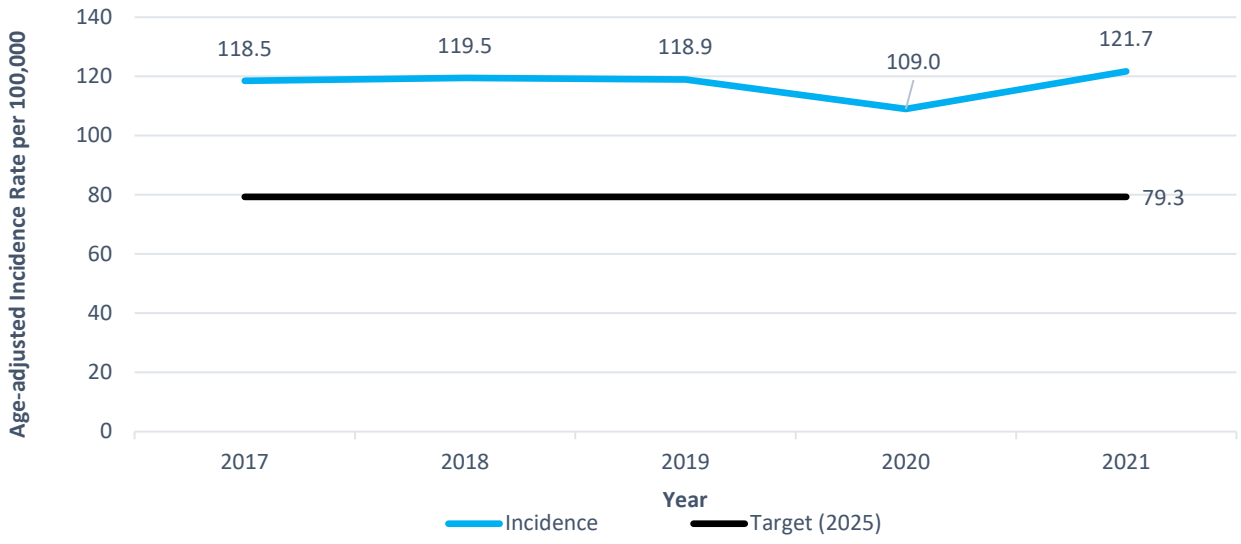
Risk factors for prostate cancer are:

- Older age
- Race
- Family history
- Obesity

The United States Preventive Services Task Force recommends prostate cancer screening for men aged 55 to 69; however, the choice to undergo prostate cancer screening should be an individual one. Prostate cancer can be identified using a prostate-specific antigen (PSA) blood test, digital rectal exam (DRE), or a prostate biopsy. Men who are 70 and older should not be screened for prostate cancer routinely. Organizations like the American Urological Association and the American Cancer Society may have different recommendations.

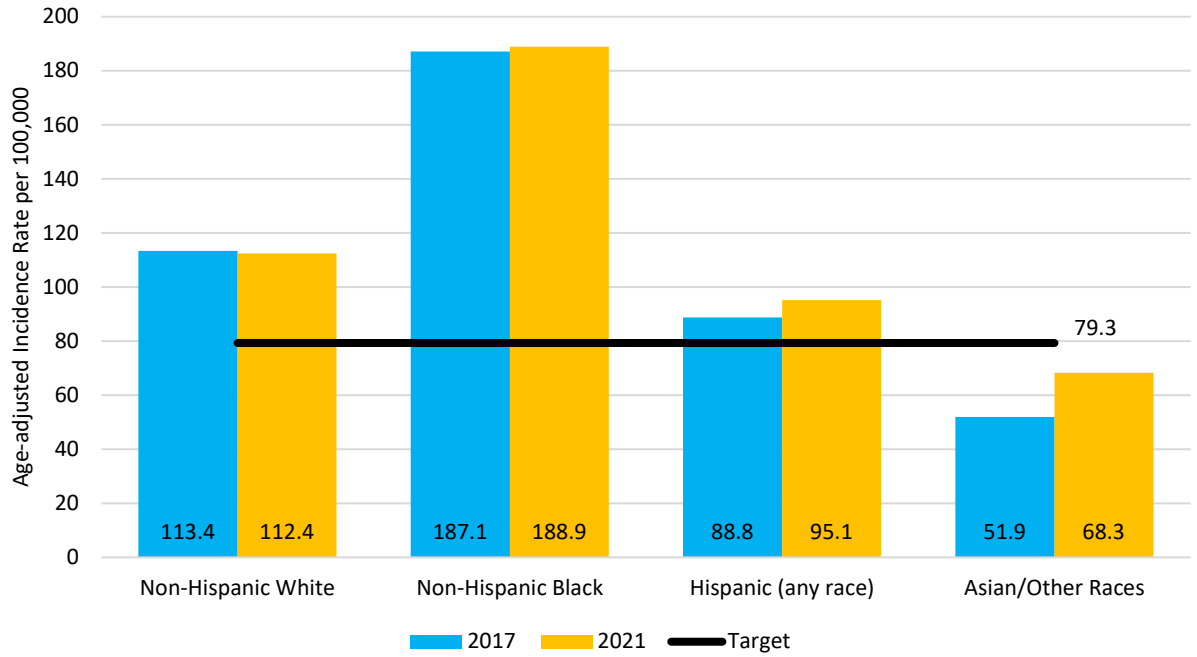
Incidence Rates

Figure 30. Prostate cancer incidence rates, 2017-2021, Illinois, and 2025 target.



[11] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2024.

Figure 31. Prostate cancer incidence rates by race/ethnicity, 2017 and 2021, Illinois. The target rate is 79.3 per 100,000.



Mortality Rates

Figure 32. Prostate cancer mortality rates, 2017-2021, Illinois, with 2025 target and Healthy People 2030 goal.

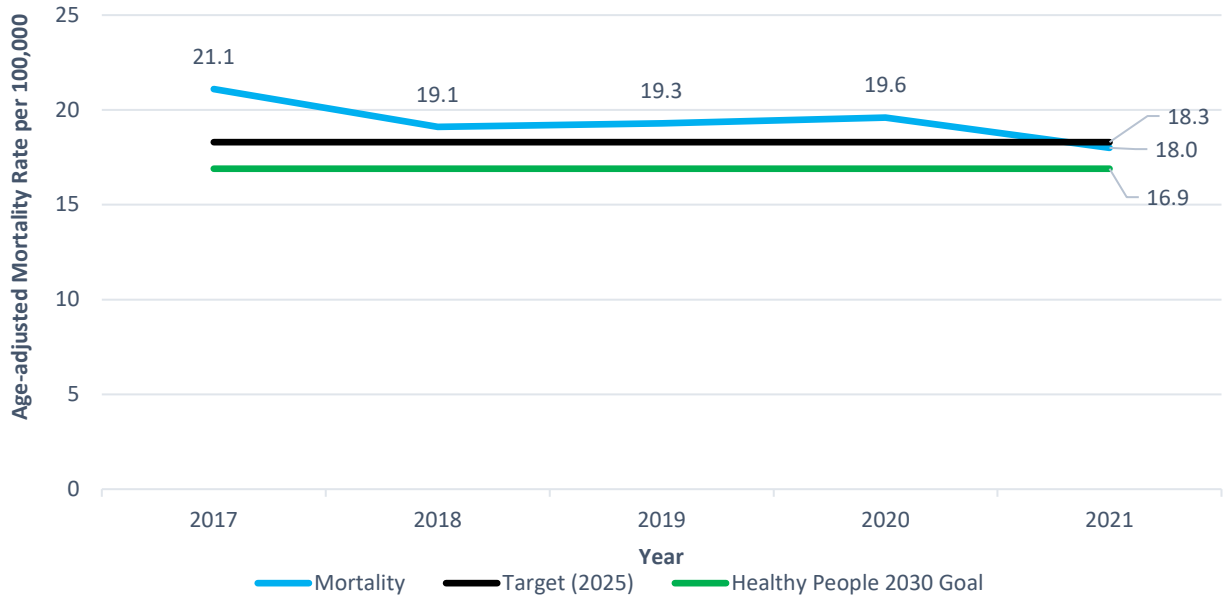
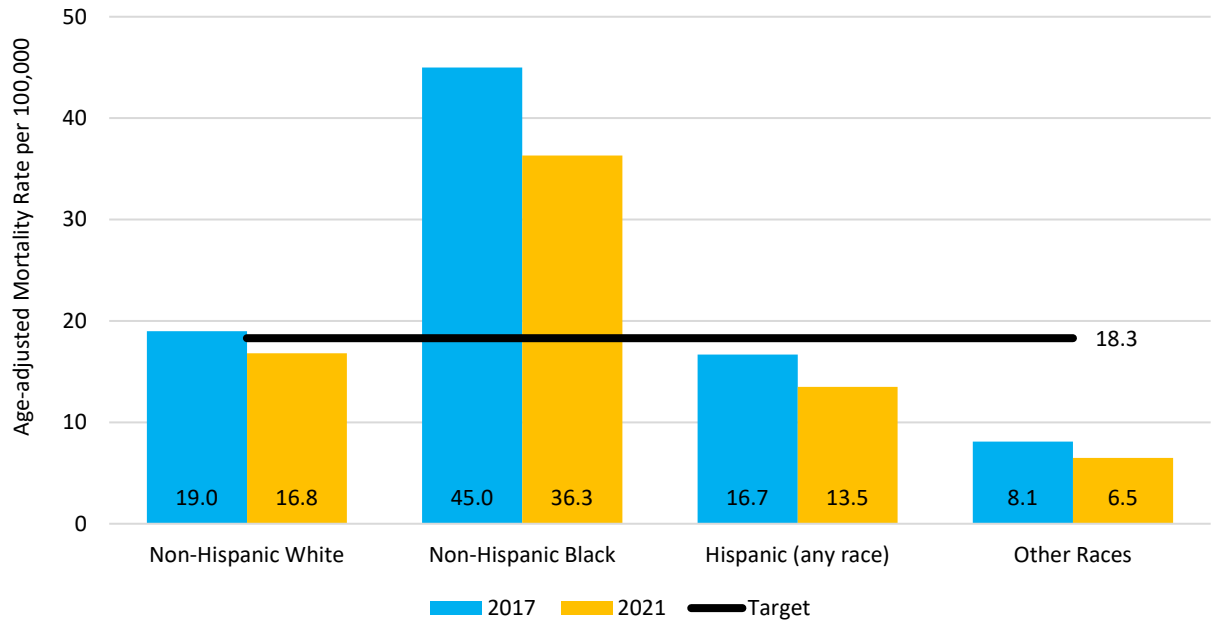


Figure 33. Prostate cancer mortality rates by race/ethnicity, 2017 and 2021, Illinois. The target rate is 18.3 per 100,000.



Skin Cancer

Skin cancer is the most common form of cancer in the United States.[12] Skin cancers are divided into nonmelanoma and melanoma of the skin. Nonmelanoma skin cancer includes basal cell and squamous cell carcinoma, the most common forms of skin cancer. Both are considered highly treatable. Melanomas of the skin are less common but more likely to spread to other parts of the body if left untreated, making them more serious forms of skin cancer.

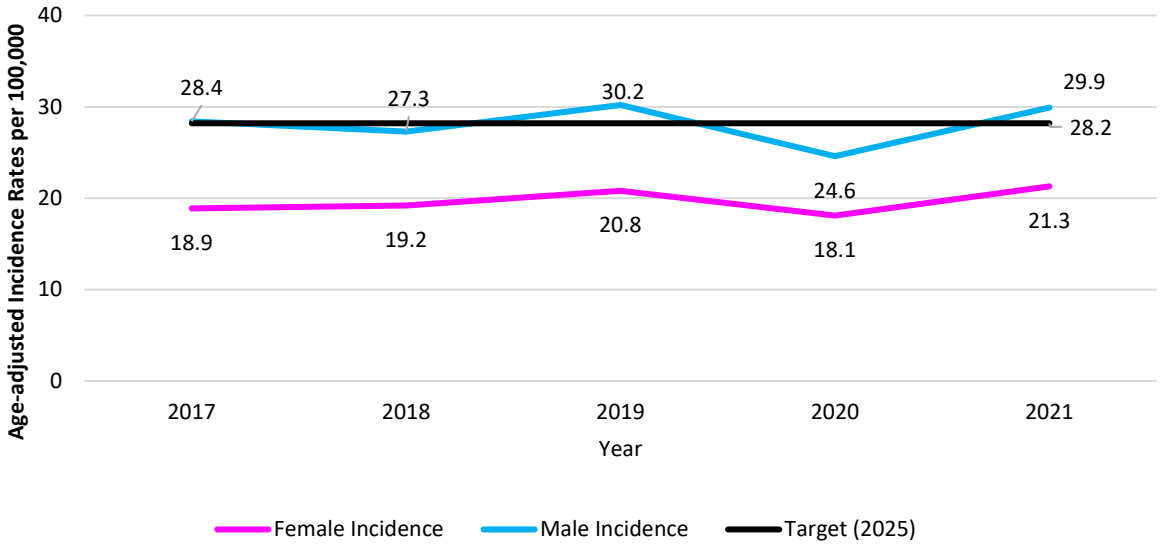
The risk factors for melanoma and skin cancer are:

- Exposure to ultraviolet (UV) radiation from natural or artificial sunlight
- Fair complexion
- Older age
- Exposure to arsenic
- Radiation treatment
- Weakened immune system

The USPSTF does not recommend routine skin cancer screening (total body examination) for individuals without a history of skin cancer or suspicious moles.

Incidence Rates

Figure 34. Melanoma cancer incidence rates by sex, 2017-2021, Illinois, and 2025 target.



[12] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2024.

Figure 36. Melanoma cancer incidence rates by race and sex, 2021, Illinois. The target rate is 28.2 per 100,000.

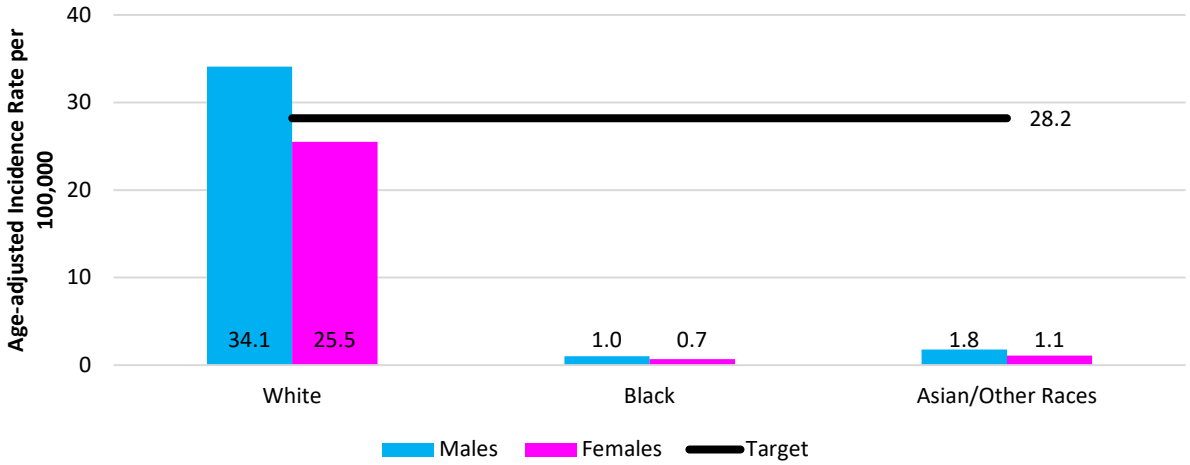
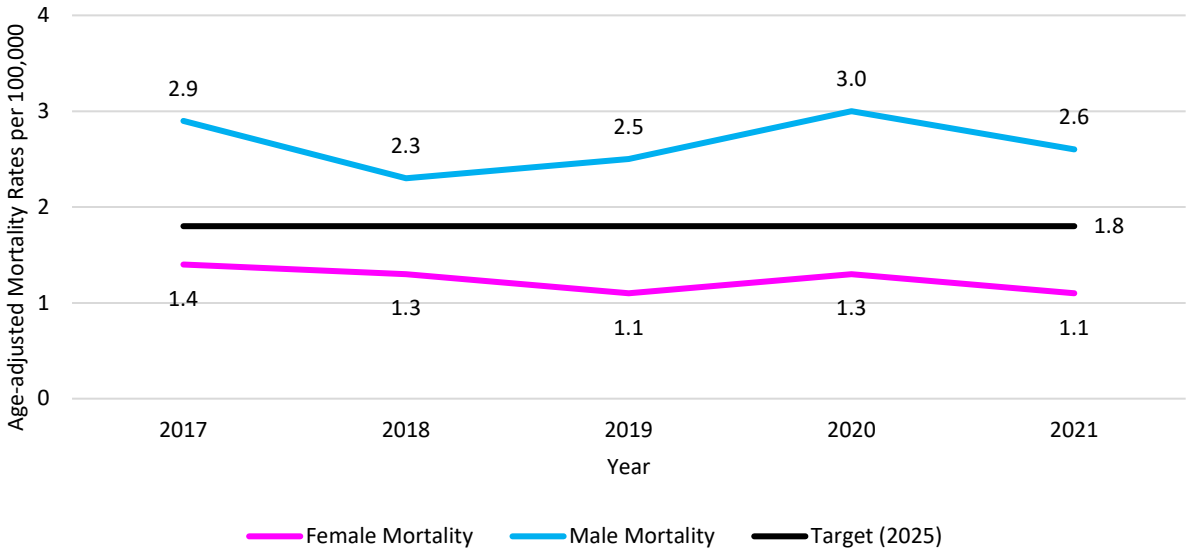


Figure 35. Melanoma cancer mortality rates by sex, 2017-2021, Illinois, and 2025 target. The mortality rates by race and sex are suppressed due to insufficient data.



All Other Cancers – Late-Stage Diagnosis

Late-stage diagnosis is a term used to describe cancer that is far along in its growth and has spread to the lymph nodes or other places in the body. Table 1 describes the risk factors for other cancer types, outside of the priority cancers previously described, that are most common for late-stage diagnosis.

Table 1. Late-Stage Cancer Types Risk Factors.

Cancer Type	Risk Factors
Bladder[13]	• Family history of bladder cancer • Genetic disorders • Smoking • Exposure to chemicals, such as processing paint, dye, metal, and petroleum products • Taking certain kinds of chemotherapy drugs • Drinking well water contaminated with arsenic • Chronic urinary tract infections
Brain[14]	• No one known cause • Some brain cancers can be linked to family history, radiation exposure, and a weakened immune system • Genetic disorders
Esophagus[15]	• Age • Smoking • Drinking alcohol • Gastroesophageal reflux disease (GERD) • Barrett's esophagus • HPV
Kidney and Renal Pelvis[16]	• Smoking • High blood pressure • Taking certain pain medicine for a long period • Having a long-lasting infection with hepatitis C • Having kidney stones • Having the sickle cell trait • Being exposed to trichloroethylene
Leukemia[17]	• Smoking • Family history of leukemia • Previous cancer treatment • Exposure to certain chemicals • Genetic disorders

[13] Centers for Disease Control and Prevention. (2023). *Bladder Cancer.* Retrieved from https://www.cdc.gov/bladdercancer/about/index.html.
[14] American Cancer Society. (2021). *Brain and Spinal Cord Tumors in Adults.* Retrieved from https://www.cancer.org/cancer/brain-spinal-cord-tumors-adults.
[15] American Cancer Society. (2021). *Esophagus Cancer*. Retrieved from https://www.cancer.org/cancer/esophagus-cancer.
[16] Centers for Disease Control and Prevention. (2023). *Kidney Cancer*. Retrieved from https://www.cdc.gov/kidney-cancer/about/index.html.
[17] Mayo Clinic. (2024). *Leukemia.* Retrieved from https://www.mayoclinic.org/diseases-conditions/leukemia/symptoms-causes/syc-20374373.

Cancer Type	Risk Factors
Liver[18]	• Hepatitis B or C • Smoking • Drinking alcohol • Having cirrhosis • Having nonalcoholic fatty liver disease • Diabetes • Having hemochromatosis
Non-Hodgkin Lymphoma[19]	• Family history • Radiation exposure • Exposure to certain drugs and chemicals • Having a weakened immune system • Autoimmune disease
Oral Cavity and Pharynx[20]	• Tobacco use • Drinking alcohol • HPV • Ultraviolet (UV) light • Weakened immune system
Ovarian[21]	• Middle-aged or older • Family history or gene mutations • Personal history of breast, uterine, or colorectal cancer • Genetic mutation of BRCA1 or BRCA2 or one associated with Lynch syndrome • Having endometriosis • Eastern European or Ashkenazi Jewish background • Never have given birth
Pancreas[22]	• Smoking • Obesity • Diabetes • Chronic pancreatitis • Exposure to certain chemicals • Family history
Stomach[23]	• *H. pylori* infection • Smoking • Drinking alcohol • Previous stomach surgery • Being overweight or obese • Genetic disorders

[18] Centers for Disease Control and Prevention. (2024). *Liver Cancer*. Retrieved from https://www.cdc.gov/cancer/liver/index.html.
[19] American Cancer Society. (2021). *Non-Hodgkin Lymphoma.* Retrieved from https://www.cancer.org/cancer/non-hodgkin-lymphoma.html.
[20] American Cancer Society. (2021). *Oral Cavity and Oropharyngeal Cancer.* Retrieved from https://www.cancer.org/cancer/oral-cavity-and-oropharyngeal-cancer.
[21] Centers for Disease Control and Prevention. (2024). *Ovarian Cancer.* Retrieved from https://www.cdc.gov/ovarian-cancer/.
[22] American Cancer Society. (2021). *Pancreatic Cancer.* Retrieved from https://www.cancer.org/cancer/pancreatic-cancer.
[23] American Cancer Society. (2021). *Stomach Cancer.* Retrieved from https://www.cancer.org/cancer/stomach-cancer.

Cancer Type	Risk Factors
Thyroid[24]	• Family history • Radiation exposure • Excessive iodine in your diet • Inherited genetic conditions
Uterus[25]	• Older than 50 years of age • Taken estrogen by itself (without progesterone) • Had trouble getting pregnant • Had fewer than five periods in a year before starting menopause • Taken tamoxifen • Family history of uterine, colon, or ovarian cancer • Obesity

Table 2 highlights the incidence rate, mortality rate, and incidence rate for late-stage diagnoses per 100,000 population for the 13 cancer types known for late-stage diagnosis.[26]

Table 2. Late-Stage Cancer Diagnosis Incidence and Mortality.

Cancer Type	Incidence Rate per 100,000 (Illinois) 2017-2021	Mortality Rate per 100,000 (Illinois) 2018-2022	Incidence Rate – Late Stage per 100,000 (Illinois) 2017-2021
Bladder	19.5	4.0	2.7
Brain	6.1	4.2	0.8
Esophagus	4.9	4.0	3.4
Kidney and Renal Pelvis	18.1	3.5	5.4
Leukemia	13.8	6.0	13.1
Liver	8.1	6.4	3.3
Non-Hodgkin Lymphoma	18.9	5.0	12.7
Oral Cavity and Pharynx	12.1	2.7	7.9
Ovarian	10.3	5.9	7.0
Pancreas	14.3	11.7	10.6
Stomach	7.0	2.8	4.0
Thyroid	12.9	0.5	4.4
Uterus	30.6	5.9	8.2

[24] American Cancer Society. (2024). *Thyroid Cancer.* Retrieved from https://www.cancer.org/cancer/thyroid-cancer.
[25] Centers for Disease Control and Prevention. (2024). Retrieved from https://www.cdc.gov/uterine-cancer/.
[26] NCI. (n.d.). *State Cancer Profiles*. Retrieved from https://statecancerprofiles.cancer.gov/quick-profiles/index.php?statename=illinois

Strategies

Cancer Screening Change Packages

The Cancer Screening Change Packages are intended to support the delivery of cancer screening services that have received A or B recommendations from the United States Preventive Services Task Force (USPSTF).[27]

Cancer screening services may be improved by implementing change concepts, change ideas, and relevant tools and resources.

- Change concepts are "general notions that are useful for developing more specific strategies for changing a process."
- Change ideas are "actionable, specific ideas or strategies" for changing a process. These change packages include evidence-based and practice-based change ideas.
- Each change idea is linked to tools and resources that can be used or adapted to improve cancer screening.

The following six focus areas organize the change concepts, change ideas, and tools and resources in the Cancer Screening Change Packages:

- Follow-up and referral
  - Promote and support regular screening per USPSTF recommendations.
  - Ensure timely referral for diagnostic testing, treatment, and other appropriate next steps, such as genetic testing, when screening tests are abnormal.
- Screening policies, procedures, and practices within health facilities
  - Assess the status of cancer screening.
  - Make cancer screening a priority.
  - Reduce structural barriers.
  - Use data to identify patients due for screening and opportunities to improve cancer screening rates within a clinical setting or system.
- Capacity building for providers and staff
  - Increase knowledge and skills.
  - Improve cancer screening practices.
  - Monitor and report on screening performance.
- Community-clinical linkages
  - Engage community members and organizations to support screening efforts.
  - Reduce structural barriers to screening in the community.
  - Implement bi-directional outreach and referral between the community and clinical organizations.
- Individual and community awareness
  - Inform and educate the public about cancer, risk factors, and screening practices to increase awareness about and demand for cancer screening services.
- Social determinants of health
  - Inform and educate about the non-medical factors that influence health outcomes.

[27] Centers for Disease Control and Prevention. (n.d). Retrieved from https://www.cdc.gov/cancer/dcpc/resources/change-packages/pdf/change-packages-overview-508.pdf.

Evidence-Based Intervention Planning Guides

Evidence-Based Intervention Planning Guides provide tips to help clinic staff and those providing technical assistance to them implement evidence-based interventions to increase screening for breast, cervical, and colorectal cancer.[28] The following list provides information on several interventions.

Client (Patient) Reminder Planning Guide

- This evidence-based intervention is a message telling patients they are due for cancer screening.
- For more information: https://www.cdc.gov/cancer/php/ebi-planning-guides/client-reminder-planning-guide.html

Reducing Structural Barriers Planning Guide

- This intervention makes it easier for people to get cancer screenings.
- For more information: https://www.cdc.gov/cancer/php/ebi-planning-guides/reducing-structural-barriers-planning-guide.html

Provider Reminder Planning Guide

- This intervention tells doctors that a patient is due or overdue for a cancer screening test.
- For more information: https://www.cdc.gov/cancer/php/ebi-planning-guides/provider-reminder-planning-guide.html

Provider Assessment and Feedback Planning Guide

- This intervention assesses doctors' performance in delivering or offering cancer screening.
- For more information: https://www.cdc.gov/cancer/php/ebi-planning-guides/provider-assessment-and-feedback-planning-guide.html

Patient Navigation Services

The Community Preventive Services Task Force (CPSTF) recommends patient navigation services to increase breast cancer screening by mammography among historically disadvantaged racial and ethnic populations and people with lower incomes.[29] Patient navigation services are also recommended for cervical cancer and colorectal cancer.

Patient navigation services are expected to advance health equity when implemented among these populations, who often have lower screening rates. With timely and appropriate follow-up care and treatment, patient navigation services may improve health for these groups.

For more information: https://www.thecommunityguide.org/findings/cancer-screening-patient-navigation-services-to-increase-breast-cancer-screening.html

[28] Centers for Disease Control and Prevention (2024). Evidence-Based Intervention Planning Guides. Retrieved from https://www.cdc.gov/cancer/php/ebi-planning-guides/index.html#:~:text=The%20four%20Evidence-Based%20Intervention%20Planning%20Guides%20provide%20tips,increase%20screening%20for%20breast%2C%20cervical%2C%20and%20colorectal%20cancer

[29] Guide to Community Preventive Services (May 31, 2023). Cancer. https://thecommunityguide.org/topics/cancer.html.

Interventions Engaging Community Health Workers

The CPSTF recommends interventions that engage community health workers to increase screening for breast cancer by mammography, as well as for cervical and colorectal cancers. Evidence shows these interventions increase cancer screening rates when community health workers deliver them independently or as part of an implementation team.

Interventions that engage community health workers to increase cancer screening are typically implemented in underserved communities to improve health and can enhance health equity.

For more information: https://www.thecommunityguide.org/findings/cancer-screening-interventions-engaging-community-health-workers-breast-cancer.html

Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices

The American Cancer Society National Colorectal Cancer Roundtable offers a guide for steps to increase colorectal cancer screening rates.[30] This guide offers a step-by-step process, incorporating evidence-based, expert-endorsed strategies to enhance colorectal cancer screening rates in primary care practices. The guide is available at https://nccrt.org/resource/steps-for-increasing-crc-screening-rates-2022/.

Overall Strategies to Increase Cancer Screening Rates

Patients unable to schedule appointments or who do not understand the health care system are less likely to be screened for cancer. The CDC states that interventions removing barriers for patients have increased breast cancer screenings by 18% and colorectal cancer screenings by 37%.[31]

The Community Preventive Services Task Force recommends several interventions for health care providers to increase screening for breast, cervical, and colorectal cancers. Combining two or more strategies may increase community demand for cancer screening. Clinics should consider incorporating strategies into their daily workflow to ensure they are long-lasting and applicable to different cancer programs.

Here are some strategies to make screening easier for patients.

Transportation

- Partner with local organizations that already provide transportation services.
- Provide options where available, including local transit systems, bus passes, gas cards, or taxi or ride-sharing services to appointments.

[30] American Cancer Society National Colorectal Cancer Roundtable (2025). Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices. https://nccrt.org/resource/steps-for-increasing-crc-screening-rates-2022/.

[31] Centers for Disease Control and Prevention (2024). Reducing Structural Barriers. Retrieved from https://www.cdc.gov/cancer/php/interventions/reducing-structural-barriers.html.

Locations

- Offer screening at worksites or mobile mammography vans, and neighborhood pick-up locations for stool samples.
- Develop new partnerships and identify any additional resources that may be needed.

Paperwork

- Remove or reduce unnecessary and confusing forms and help patients set up appointments.
- Offer translation services and patient navigators.
- Share translation staff with other clinic programs or using language interpreting telephone services.

Flexible hours

- Open clinics earlier and close later, and offer appointments during lunch hours or on weekends.
- Assign staff to assist patients in identifying and overcoming barriers to cancer screening.

Identify community needs

- Engage with community members who require screening and collaborate with local organizations.
- Use data to determine if a specific intervention is needed.

Pilot project

- Start with a small change that doesn't need a lot of resources.
- Record any changes in cancer screening rates and make changes as needed.
- Track costs to estimate the amount of money needed for larger changes.

Conclusion

The progress report update for the 2022-2027 Illinois Comprehensive Cancer Control Plan indicates that Illinois is making progress toward its goals and objectives. Still, Illinoisans are continuing to experience disparities across the cancer continuum. These disparities result from multilevel determinants of health, including fundamental factors, like policies and social conditions; intermediate factors, including physical and social contexts; and proximate factors, such as individual demographics and risk factors. Undoubtedly, eliminating cancer disparities in Illinois will be a challenge. However, Illinois has abundant resources and assets to address this challenge, as well as a dedicated group of stakeholders who continue to work and advocate for the health of Illinoisans.

Organizations, health systems, community groups, employers, and Illinoisans must review the progress report update and assess how to incorporate the goals, objectives, and strategies within their organizations or groups to help reduce cancer incidence in Illinois.

With the assistance of stakeholders, we will increase awareness of and access to cancer education, screening, treatment, and long-term survivorship care for Illinoisans, regardless of geography, financial status, insurance coverage, or any other characteristic.

Through continued collaborations, we will strengthen the fight against cancer, decrease death and suffering from cancer, and enrich the lives of the people of Illinois.