

Florida Cancer Plan 2003–2006

*to work together to minimize the occurrence and impact of cancer,
and to improve health and quality of life among persons of all ages
with cancer in Florida*





Dear Colleague:

“You have cancer.” This year alone, more than 90,000 Floridians will hear this from their physician. In fact, cancer is the second leading cause of death in Florida, killing over 38,000 people in 2001.

The Florida Cancer Control and Research Advisory Council and the Florida Department of Health, Bureau of Chronic Disease Prevention, are pleased to present the Florida Cancer Plan – 2003. This plan is a direct culmination of many dedicated professionals’ efforts whose broad spectrum of expertise and experience provides a comprehensive view on Florida’s cancer burden. The plan provides a blueprint for a course of action by identifying relevant cancer data, outlining the state’s goals and strategies, and linking partners to better address areas of need. We hope that this plan will serve as a guide to better understand cancer in Florida and the focus as we work to reduce the cancer burden in the state.

This plan was developed through concerted efforts of many public and private organizations, and individuals to whom we would like to express our appreciation and gratitude for their contributions of time and effort to produce the Florida Cancer Plan 2003.

The Florida Department of Health and the Florida Cancer Control and Research Advisory Council are committed to promoting the health and safety of all Florida citizens and their communities, and we appreciate your interest in Florida’s efforts to reduce the burden of cancer in Florida. We invite you to learn more about our efforts and encourage you to participate at the local collaborative level.

Sincerely,

A handwritten signature in black ink, appearing to read "John O. Agwunobi", written over a horizontal line.

John O. Agwunobi, M.D., M.B.A.
Secretary
Florida Department of Health

A handwritten signature in black ink, appearing to read "JoBeth Speyer", written in a cursive style.

JoBeth Speyer, M.S.W.
Chairperson
Cancer Control & Research Advisory Council



Acknowledgements

The Florida Department of Health, Comprehensive Cancer Control Program, and the Florida Cancer Control and Research Advisory Council would like to thank and acknowledge the hard work and dedication of the following people who served a vital role in the development of the **Florida Cancer Plan 2003**. Without their contributions, the completion of this document would not have been possible.

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Steering Committee Members

Florida Comprehensive Cancer Control Initiative Staff

National Cancer Institute Staff and

Regional Collaborative Members





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Mission, Vision and Prioritized Goals

mission

The mission of the statewide cancer collaborative is to reduce the burden of cancer in Florida on individuals, families and communities by improving communication, coordination and collaboration among public and private organizations at local, regional and state levels. The synergy of our combined efforts will contribute to decreasing cancer-related mortality, morbidity and disparities statewide, enhancing quality of life for persons with cancer, and increasing:

- **Accessibility, appropriateness and effectiveness** of programs and services for prevention, early detection, treatment and palliative care as well as survivorship;
- **Adoption** of recommended policies and best practices; and
- **Availability** of data, evaluation and research findings and other needed resources.

vision

The **vision** is to **work together** to **minimize** the occurrence and impact of **cancer** and to improve health and quality of life among persons of all ages with cancer in Florida.

The **three-year (2003–2006) prioritized goals** are:

three-year goals

Goal 1: Make state-of-the-art clinical services for cancer screening, diagnosis and treatment **more accessible** and **affordable** throughout Florida.

Goal 2: Increase the percentage of Floridians who are **screened** appropriately for cancer per recommended guidelines.

Goal 3: Increase prompt, accurate diagnosis of cancer and appropriate referral to treatment.

Goal 4: Increase behaviors associated with **primary prevention** of cancer among Floridians of all ages.

Goal 5: Increase communication and **collaboration** among public and private cancer control stakeholders statewide.

Goal 6: Improve quality, continuity and appropriateness of care for all Floridians with cancer.

Goal 7: Reduce disparities in Florida's cancer burden.

Goal 8: Enhance quality of life for Floridians with cancer and their families and friends.

Goal 9: Improve social and **public policies** that advance cancer prevention and control.

Goal 10: Increase public and **private funding** for cancer programs and services in Florida.

Goal 11: Increase the availability of statewide and community-specific data for surveillance, planning and evaluating progress toward improving cancer outcomes and decreasing disparities.

Goal 12: Advance cancer research in Florida.

Introduction

cancer plan 2003- 2006

The Florida Department of Health, in collaboration with the Florida Cancer Control and Research Advisory Council (C-CRAB <sic>) and the efforts of various, dedicated statewide partners, is proud to present the **Florida Cancer Plan 2003–2006**. The Florida Cancer Plan 2003–2006 is the ninth adaptation since its inception in 1980 and continues to build upon the strong foundation of reducing cancer mortality and morbidity in Florida through prevention, early detection and access to state-of-the-art treatment. The intent of this document is to present the 2003–2006 strategic plan including goals, strategies, and projected activities for 2003–2004. Also included in this document is a description of the burden of cancer in Florida overall and for priority cancers.

A **motivating force** behind the creation of this document is the **Florida Cancer Control and Research Advisory Council**. The Florida Legislature created this body in 1979 (Chapter 240.5121, Florida Statutes). In conjunction with the C-CRAB's efforts, a steering committee, composed of several members of C-CRAB, regional cancer control collaborative members, staff from several cancer treatment centers, and other interested experts, has been formed and will serve as a steering committee to the larger C-CRAB body. **The Steering Committee** will direct efforts to fostering linkages between the **Florida Cancer Plan 2003–2006** and the four regional plans for the state, which were developed by the **Florida Comprehensive Cancer Control Initiative (FCCCI)**. The regional plans identify a more specific scope on regional cancer data and the necessary goals and activities to address their burden.

Methods

database usage

Throughout this report, a number of **databases** were utilized to present **data on various cancers**. These databases include:

Mortality Data

Data on mortality were **compiled** and **tabulated** by the Florida Department of Health, **Bureau of Vital Statistics**. Age-adjusted death rates for 1990–2001 were calculated using the year 2000 standard million population (US population).

Hospital Discharge Data

Hospital discharge rates and **charges** were compiled using an **administrative database** of all Florida hospital discharges (with the exception of government hospitals). This database is managed by the Florida Agency for Health Care Administration (AHCA). These data represent all hospital discharges; therefore, a single resident may have multiple discharges. Daily hospital charges are expressed in constant dollars (C\$) in order to eliminate the effects of inflation.

Florida Cancer Data System

The University of Miami, under a contract with the **Department of Health**, operates and houses the **Statewide Cancer Registry Program** via the **Florida Cancer Data System (FCDS)**, Florida's statewide population-based cancer registry. FCDS has been collecting incidence data since 1981.

Risk Factors

The prevalence of **behavioral risk factors** and **use of preventive services** are estimated using data from the **Florida Behavioral Risk Factor Surveillance System (BRFSS)**. The BRFSS is a national, monthly telephone survey that is conducted in Florida by the Florida Department of Health in cooperation with the Centers for Disease Control and Prevention and collects health information from randomly selected, non-institutionalized Florida adults aged 18 years and older.

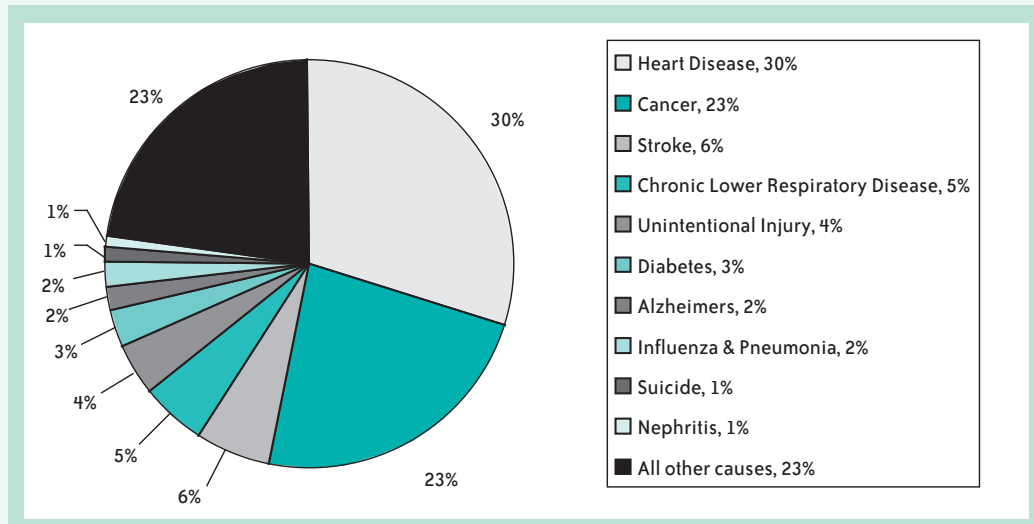
risks

The prevalence of **youth tobacco use** was estimated from the **Florida Youth Tobacco Survey (FYTS)**. The FYTS is a survey of **Florida public middle** (grades 6–8) and **high** (grades 9-12) **school students** in classrooms and schools that were **randomly selected** using a **two-stage cluster design**. The FYTS is conducted by the **Florida Department of Health** in cooperation with the **Florida Department of Education** and was administered in 1998-2002.

Burden of Cancer in Florida

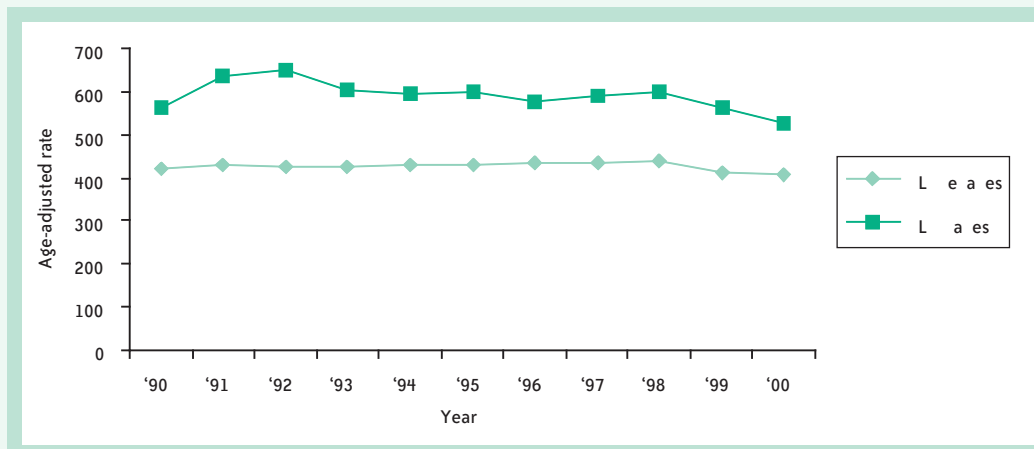
Cancer is the **second leading cause of death** in the United States and Florida. In 2001 in Florida, 38,835 people died from cancer. Nearly one out of every four deaths (23.2%) in Florida was due to cancer (see Figure 1).

Figure 1. Leading causes of death, Florida, 2001, Vital Statistics



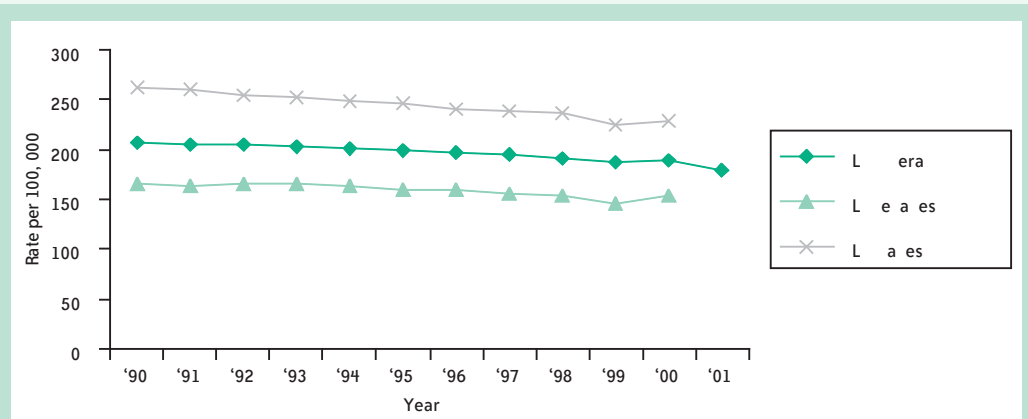
In Florida in 2000, over **90,000 new cases of cancer** were diagnosed. The overall age-adjusted incidence of cancer is higher for men than for women. Between 1990 and 2000, the overall age-adjusted incidence for both genders increased, then decreased below the level observed in 1990 (see Figure 2). The lifetime probability of developing cancer is now estimated at 1 in 3.

Figure 2. Age-adjusted incidence of cancer, 1990–2000, by year and gender, 2002 Florida Annual Cancer Report, Florida Cancer Data System



Age-adjusted cancer mortality rates have slowly **decreased** between 1990 and 2001 — about 13% in Florida (see Figure 3). Overall mortality rates are higher for men than for women.

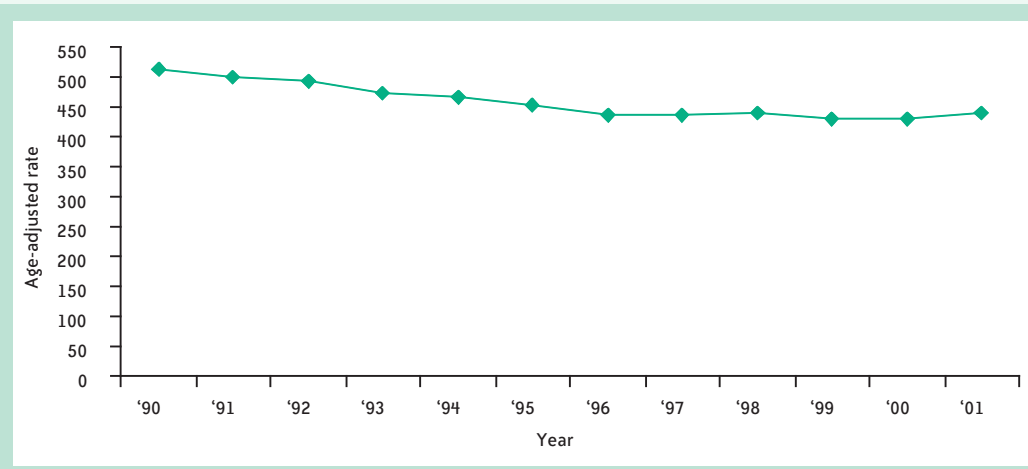
Figure 3. Age-adjusted(1) mortality rates for cancer, 1990–2001, by year, Florida Vital Statistics, Florida Cancer Data System



1. Age-adjusted to the 2000 standard million

As a group, **the myriad of diseases** that comprise “**cancer**” are not only the second leading cause of death — **second to cardiovascular disease** — but also the second leading cause of hospitalization — again, second to cardiovascular disease. In Florida, **cancer-related hospitalization days decreased substantially** from approximately 761,000 in 1990 to approximately 601,000 in 2001. The price tag for cancer-related hospitalizations increased in the same time span from \$2.3 billion (C\$) to \$2.6 billion. The average cost per day increased from \$3,198 (C\$) per day in 1990 to \$5,224 per day in 2001. Age-adjusted hospital discharge rates for cancer have decreased over the time period 1990-2001 (see Figure 4).

Figure 4. Age-adjusted hospital discharge rates for cancer, 1990–2001, by year, Florida Agency for Health Care Administration Hospital Discharge Data



Plan Development

three-year plan

In **May 2002, 44 cancer control stakeholders**, including members of C-CRAB, met to participate in the development of a **strategic plan for statewide comprehensive cancer control**. Through a number of meetings and conference calls, a **three-year plan (7/03–6/06)**, including a **mission, vision, prioritized goals, and strategies**, was developed. In addition, existing activities for each strategy were identified along with suggested activities for July 2003 through June 2004. The next steps are to reach consensus on activities for the first year of the plan and to establish an **infrastructure for plan implementation, monitoring and evaluation**.

short-, medium-, and long- term plans

The group was able to identify some priority areas that currently have existing activities, and other areas where new activities have been suggested. These priority areas were not meant to exclude any other opportunities for impact, and additional priority areas may be identified as the plan unfolds. For every strategy, a proposed lead agency, potential intervention partners and a fiscal year in which to begin implementation are indicated.

A **Steering Committee** met to discuss the next steps in **implementing short-, medium-, and long-term plans** to make decision makers and Florida's citizens aware of the Florida Cancer Plan 2003–2006 and their role in implementation. The primary approach to implementation will be through the creation and support of **goal-focused groups** that will consist of a broad array of additional stakeholders from around the state. Appendix 3 lists the follow-up Steering Committee attendees.

The **cancer partners** are aware that this is a **beginning point**, and are prepared for the challenging work ahead; thus, this one document cannot encapsulate all of the work that is being done or is planned. Since this is a **working document**, as new challenges, tools and strategies emerge, they may be incorporated. In addition, the partners listed in the plan as proposed lead or as proposed partners are not an exclusive listing, but a **beginning point**. Any and all individuals or agencies that share an interest may become an active participant in the reduction of cancer in Florida through the established **regional cancer collaboratives** and/or **the goal-focused groups**. For more information on your regional collaborative and how to become involved, please contact the **Florida Department of Health, Comprehensive Cancer Control Program** at **850/245-4330** or visit the Florida Comprehensive Cancer Control Initiative website at **www.fccci.med.miami.edu**.

The **twelve, three-year** (2003–2006) **goals** outline the **priority areas, strategies, proposed leads, and partners**, in addition to the existing and suggested activities. Although there may be areas in which a proposed lead has not been identified, the goal remains critical to the document and requires further attention.

12 goals

- Goal 1:** **Make state-of-the-art clinical services** for cancer screening, diagnosis and treatment **more accessible** and **affordable** throughout Florida.
- Goal 2:** **Increase the percentage** of Floridians who are **screened** appropriately for cancer per recommended guidelines.
- Goal 3:** **Increase prompt, accurate diagnosis** of cancer and appropriate referral to treatment.
- Goal 4:** **Increase behaviors** associated with **primary prevention** of cancer among Floridians of all ages.
- Goal 5:** **Increase communication** and **collaboration** among public and private cancer control stakeholders statewide.
- Goal 6:** **Improve quality**, continuity and appropriateness of care for all Floridians with cancer.
- Goal 7:** **Reduce disparities** in Florida's cancer burden.
- Goal 8:** **Enhance quality of life** for Floridians with cancer and their families and friends.
- Goal 9:** **Improve social** and **public policies** that advance cancer prevention and control.

goal 1

Goal 10: Increase public and private funding for cancer programs and services in Florida.

Goal 11: Increase the availability of statewide and community-specific data for surveillance, planning and evaluating progress toward improving cancer outcomes and decreasing disparities.

Goal 12: Advance cancer research in Florida

Goal 1: Make state-of-the-art clinical services for cancer screening, diagnosis and treatment more accessible and affordable throughout Florida.

Priority areas:

- Breast cancer
- Colorectal cancer
- Lung cancer
- Prostate cancer
- Skin cancer
- Gynecologic cancers
- Cancers in children

Strategies:

1A: Design, implement and evaluate a campaign to raise public awareness of referral resources.

Proposed lead: Department of Health (DOH)

Proposed partners: American Cancer Society (ACS), National Cancer Institute (NCI), Cancer Information Service (CIS), American College of Surgeons Commission on Cancer (ACOSCO), Association of Community Cancer Centers (ACCC)

Timeframe: 03/04–05/06

Existing activities:

1A1: Update the ACS patient services database for Florida.

Identified lead: ACS, Florida Division

1A2: Publicize the CIS in Florida as a source of referrals to national organizations.

Identified lead: CIS

1A3: Inform Floridians about referral resources during time periods officially designated for cancer awareness.

Identified lead: DOH

1A4: Disseminate the results statewide of the ACS grant to improve transportation for cancer patients.

Identified lead: ACS

Suggested new activities:

1A5: Assess current referral resources.

Proposed lead: Not specified

1A6: Bring agencies together to reduce service overlap.

Proposed lead: Not specified

1A7: Undertake a gap analysis of referral resources.

Proposed lead: Not specified

1A8: Plan to make a comprehensive, current directory of referral resources available statewide.

Proposed lead: Not specified

1A9: Explore the feasibility of promoting the use of school-based sun safety education.

Proposed lead: Richard David Kann Melanoma Foundation

Proposed partner: American Skin Association

1A10: Place sun safety posters in airports, seaports and schools.

Proposed lead: Richard David Kann Melanoma Foundation

1B: Strengthen the education on cancer related topics for health care professionals.

Proposed lead: Florida medical and nursing schools

Proposed partners: Florida Medical Association (FMA), Florida Osteopathic Medical Association (FOMA), Florida Nurses Association (FNA)

Timeframe: 03/04–05/06

Existing activities: None identified

Suggested new activities:

1B1: Identify existing professional school education and continuing education activities.

Proposed leads/partners: Universities, professional schools, CIS

1B2: Explore the feasibility of developing cancer prevention and control curricula for Florida medical and nursing schools.

Proposed leads/partners: University of Miami, University of Florida, University of South Florida, Florida State University

1C: Organize, implement and evaluate an advocacy initiative for improving transportation to healthcare for those in need.

Proposed lead: Metropolitan Planning Organization

Proposed partners: Department of Transportation, ACS, Council on Aging, local groups providing transportation

Timeframe: 05/06

1D: Develop and promote uniform cancer screening guidelines based upon existing national guidelines.

Proposed lead: C-CRAB

Proposed partners: FMA, ACS, NCI

Timeframe: 03/04–05/06

Existing activities: None identified

goal 2

Suggested new activities:

1D1: Identify existing cancer screening guidelines from national public and private sector organizations.

Proposed lead: FMA

Proposed partners: ACS, NCI, Florida Breast and Cervical Cancer Program (BCCP)

1D2: Develop and maintain a list of existing cancer guidelines and make them available to the public on the Internet and in document format.

Proposed lead: DOH

1D3: Develop a feasible approach for monitoring professional and public compliance with existing screening guidelines.

Proposed lead: Not identified

Goal 2: Increase the percentage of Floridians who are screened appropriately for cancer per recommended guidelines.

Priority areas:

- Colorectal cancer screening
- Breast cancer screening
- Screening for gynecologic cancers
- Prostate cancer screening
- Skin cancer screening

Strategies:

2A: Develop collaborations on cancer screenings among non-profit organizations.

Proposed lead: ACS

Proposed partner: BCCP

Timeframe: 03/04–05/06

Existing activities: None identified

Suggested new activities:

2A1: Identify and promote public screenings available at Florida hospitals through program requirements for the American College of Surgeons Commission on Cancer.

Proposed lead: None identified

2A2: Explore the feasibility of making cancer screening available through county health departments.

Proposed lead: DOH

2A3: Explore the feasibility of improving reimbursement for screening.

Proposed lead: Agency for Health Care Administration (AHCA)

2A4: Collaborate in pursuit of increased funding for screening.

Proposed lead: None identified

2A5: Explore the feasibility of making tax rebates available for physicians and healthcare facilities that document appropriate screening practices.

Proposed lead: None identified

2A6: Explore the feasibility of limiting malpractice exposure for screening.

Proposed lead: None identified.

2A7: Explore the feasibility of improving reimbursement for screening.

Proposed lead: None identified

2B: Develop, implement and evaluate public education consistent with established screening guidelines.

Proposed lead: ACS

Proposed partners: CIS, DOH, BCCP

Timeframe: 03/04–05/06

Existing activities:

2B1: Coordinate public education with national and state observances for cancer awareness.

Identified leads: DOH, ACS

2B2: Continue to educate the public about established screening guidelines.

Identified lead: CIS

Suggested new activities:

2B3: Make information about evidence-based cancer screening guidelines available on the Internet.

Proposed lead: None identified

2C: Develop, implement and evaluate professional education.

Proposed lead: Area Health Education Centers (AHECs)

Timeframe: 04/05–05/06

2D: Plan, conduct and evaluate outreach to graduates and post-graduates.

Proposed leads: Florida schools of medicine

Proposed partners: Florida schools of nursing, health technical schools

Timeframe: 04/05–05/06

2E: Plan, implement and evaluate grassroots services.

Proposed lead: ACS

Proposed partner: Intercultural Cancer Council (ICC)

Timeframe: 03/04–05/06

Existing activities: None identified

goal 3

Suggested new activities:

2E1: Identify and publicize low-cost transportation to healthcare facilities for those in economical need, where available.

Proposed lead: None identified

2E2: Explore the potential to extend faith-based assistance programs to include meeting the needs of local cancer patients.

Proposed lead: Council of Churches

Goal 3: Increase prompt, accurate diagnosis of cancer and appropriate referral to treatment.

Priority areas:

- Breast Cancer
- Cervical cancer
- Colorectal cancer
- Skin cancer
- Cancers in children

Strategies:

3A: Organize, implement and evaluate an advocacy initiative for increasing health insurance coverage for cancer screening and treatment.

Proposed lead: Insurance Commissioner

Proposed partners: Legislature, FMA, Florida Hospital Association (FHA), American Association of Retired Persons (AARP), Florida Dialogue on Cancer (FDOC)

Timeframe: 03/04–05/06

3B: Organize, implement and evaluate an advocacy initiative to improve and ensure access to diagnosis and treatment.

Proposed lead: DOH

Proposed partners: Legislature, FMA, FOMA, FHA, Florida Society of Clinical Oncology (FLASCO)

Timeframe: 03/04–05/06

Existing activities: None identified

Suggested new activities:

3B1: Assess the applicability of, and compliance with the ombudsman law.

Proposed lead: None identified

3C: Organize, implement and evaluate an advocacy initiative in support of site-specific case managers/coordinators.

Proposed lead: FHA

Proposed partners: Oncology Nursing Society (ONS), Florida Society of Oncology Social Workers (FSOSW), case manager organization

Timeframe: 04/05–05/06

3D: Identify data available to assess cancer-related needs, gaps and disparities.

Proposed lead: DOH

Proposed partner: Florida Cancer Data System (FCDS)

Timeframe: 03/04–05/06

Existing activities: None identified

Suggested new activities:

3D1: Survey leading state cancer data programs to determine needs and opportunities for upgrading cancer data.

Proposed lead: None identified

3D2: Share data about cancer gaps, needs and disparities with regional collaboratives, county health departments and other community health leaders.

Proposed lead: None identified

goal 4

Goal 4: Increase healthy behaviors associated with primary prevention of cancer among Floridians of all ages.

Priority areas:

- Avoidance of tobacco use
- Nutrition and physical activity
- Sun protection
- Avoidance of environmental carcinogens
- Screenings

Strategies:

4A: Monitor priority areas through the Behavioral Risk Factor Surveillance System (BRFSS).

Proposed lead: DOH Bureau of Epidemiology

Proposed partners: FCCCI, Centers for Disease Control and Prevention (CDC)

Timeframe: 04/05–05/06

4B: Develop, implement and evaluate comprehensive school health education programs that address priority areas.

Proposed lead: Department of Education (DOE)

Proposed partners: Local school boards, Florida Regional Cancer Collaboratives

Timeframe: 03/04–05/06

Existing activities: None identified

Suggested new activities:

4B1: Explore the feasibility of adopting Australian curricula (available on the Internet) that teach school children of all ages about skin protection.

Proposed lead: Not identified

4B2: Explore the feasibility of creating a Florida Comprehensive Assessment Test (FCAT) requirement related to school-based cancer prevention.

Proposed lead: Not identified

4C: Develop, implement and evaluate corporate wellness initiatives that address priority areas.

Proposed leads: Florida corporations (e.g., pharmaceutical companies, health insurance companies)

Proposed partners: Wellness Councils of America, health insurance companies, chambers of commerce

Timeframe: 04/05–05/06

4D: Design, implement and evaluate community health services that address priority areas.

Proposed leads: State- and locally-funded health centers

Proposed partners: Faith-based organizations, community hospitals, local civic clubs, intervention centers

Timeframe: 04/05–05/06

4E: Design, implement and evaluate multi-media communications that address priority areas.

Proposed lead: TBD

Timeframe: 05/05–05/06

goal 5

Goal 5: Increase communication and collaboration among public and private cancer control stakeholders statewide.

Priority areas:

All cancers

Strategies:

5A: Apply technology to increase communications.

Proposed lead: CIS

Proposed partners: ACS, DOH, FCCCI

Timeframe: 04/05–05/06

5B: Design, implement and evaluate methods for increasing face-to-face interaction to enhance capacity building.

Proposed lead: DOH

Proposed partners: Regional Cancer Control Collaboratives

Timeframe: 03/04–05/06

5C: Develop synergy among the statewide initiative, Regional Cancer Control Collaboratives and other stakeholders.

Proposed lead: DOH

Proposed partners: C-CRAB, Regional Cancer Control Collaboratives, universities, FDOC, other cancer stakeholders

Timeframe: 03/04–05/06

5D: Coordinate strategic plan monitoring and evaluation statewide.

Proposed lead: DOH

Timeframe: 03/04–05/06

goal 6

Goal 6: Improve quality, continuity and appropriateness of care for all Floridians with cancer.

Priority areas:

All cancers

Strategies:

6A: Develop, implement and evaluate interventions to improve communications between cancer care professionals and primary healthcare professionals.

Proposed leads: Medical schools and nursing schools

Proposed partners: Health professional associations

Timeframe: 03/04–05/06

6B: Develop, implement and evaluate interventions to improve communications between healthcare providers and the public (e.g., telemedicine, interactive websites, e-mail).

Proposed lead: Medical schools

Proposed partners: Health professional associations, voluntary health organizations, consumer advocacy organizations, media

Timeframe: 04/05–05/06

Suggestions for future activities:

- Offer CME programs on cancer control at medical conferences (proposed lead: state and county medical associations)
- Promote the use of web-based clinical practice guidelines by physicians and the public
- Explore the feasibility of promoting the use of “Healing Conversations,” a CD program that teaches physicians and nurses how to talk to cancer patients

goal 7

Goal 7: Reduce disparities in Florida’s cancer burden.

Priority areas:

- Breast cancer (e.g., mortality among African-American women)
- Cervical cancer (e.g., mortality among African-American women)
- Colorectal cancer (e.g., mortality among African-American adults)
- Lung cancer (e.g., mortality among African-American men)
- Prostate cancer (e.g., mortality among African-American men)

Strategies:

7A: Develop, implement and evaluate an intervention to improve data collection, analysis and dissemination related to racial, ethnic, socioeconomic and geographic disparities.

Proposed lead: DOH

Proposed partners: FCDS, AHCA, CDC, Florida Medical Quarterly Assurance, Inc. (FMQAI)

Timeframe: 03/04–05/06

Existing activities:

7A1: Fund Racial and Ethnic Health Disparity contracts with local community-based organizations for cancer education, screening, referral, treatment, and education regarding clinical trials.

Identified lead: DOH

Suggested new activities:

7A2: Identify all available data sources.

Proposed lead: FAMU

Proposed partners: FCDS, DOH, FCCCI

7A3: Analyze data to determine priority needs.

Proposed lead: FAMU

7A4: Plan, implement and evaluate a comprehensive educational program.

Proposed leads: FAMU, AHEC

7A5: Develop a Florida Minority Health Report.

Proposed lead: FAMU

7B: Organize, implement and evaluate an advocacy initiative to strengthen policies and improve access for populations experiencing disparities.

Proposed lead: C-CRAB

Proposed partners: ACS, AHCA, (FMQAI), research hospitals, university-based cancer centers

Timeframe: 05/05–05/06

7C: Educate high-risk populations on prevention, early diagnosis, treatment, and rehabilitation.

Proposed lead: DOH

Proposed partners: Department of Elder Affairs (DOEA), advocacy groups

Timeframe: 04/05–5/06

7D: Build on existing efforts to educate healthcare providers to improve cultural competencies.

Proposed lead: AHEC

Proposed partners: FMA, FHA

Timeframe: 03/04–05/06

Existing activities: None identified

Suggested new activities:

7D1: Assess and address deficiencies in cultural diversity education in professional training.

Proposed lead: None identified

goal 8

Goal 8: Enhance quality of life for Floridians with cancer and their families and friends.

Priority areas:

All cancers

Strategies:

8A: Make information and resources accessible to patients and families.

Proposed lead: Florida cancer centers and hospitals

Proposed partners: State and county medical societies, ACS, CIS

Timeframe: 03/04–05/06

Existing activities: None identified

Suggested new activities:

8A1: Expand and enhance the ACS online resource directory (e.g., make more comprehensive, offer a print version, translate into languages other than English).

Proposed lead: ACS

8A2: Make patient information about cancer control and available resources more widely available to the public.

Proposed lead: None identified

8A3: Develop a resource book of treatment information and instructions for cancer patients.

Proposed lead: None identified

8B: Organize, implement and evaluate an advocacy initiative to increase funding for palliative and end-of-life care.

Proposed lead: State hospice association

Proposed partners: State and county medical societies, insurance companies, third-party payers

Timeframe: 04/05–05/06

8C: Provide training with continuing medical education credits for physicians, nurses and medical and nursing students regarding quality-of-life issues affecting persons with cancer.

Proposed leads: Florida medical schools

Proposed partners: State and county medical societies' continuing medical education programs

Timeframe: 04/05–05/06

8D: Organize, implement and evaluate an advocacy initiative supporting legislation for medical privacy and non-discrimination for cancer survivors.

Proposed lead: ACS

Proposed partners: Other cancer organizations

Timeframe: 04/05–05/06

goal 9

Goal 9: Improve social and public policies that advance cancer prevention and control.

Priority areas:

All cancers

Strategies:

9A: Coordinate the development of policy priorities among cancer organizations.

Proposed lead: ACS

Proposed partners: DOH, DOE, C-CRAB

Timeframe: 03/04–05/06

9B: Raise awareness of legislators and other decision-makers of the need to have cancer-related issues on their agenda.

Proposed lead: ACS

Proposed partners: C-CRAB, Regional Cancer Control Collaboratives

Timeframe: 04/05–05/06

No activities suggested

9C: Build a network of grassroots advocates.

Proposed lead: ACS

Proposed partners: FCCCI, C-CRAB, Regional Cancer Control Collaboratives

Timeframe: 03/04–05/06

9D: Design, implement and evaluate media advocacy for cancer-related social and public policies.

Proposed lead: University of South Florida College of Public Health (social marketing)

Timeframe: 04/04–05/06

9E: Monitor policies protecting the privacy of genetic information of individuals.

Proposed leads: University-based cancer centers

Proposed partners: Other universities

Timeframe: 03/04–05/06

goal 10

Goal 10: Increase public and private funding for cancer programs and services in Florida.

Priority areas:

All cancers

Strategies:

10A: Identify unmet needs for programs and services.

Proposed lead: ACS

Proposed partners: CIS, FCDS, FDOC, Regional Cancer Control Collaboratives, Florida Association of Pediatric Tumor Programs (FAPTP)

Timeframe: 03/04–05/06

10B: Identify best practices for cancer related programs.

Proposed lead: CDC via DOH

Timeframe: 03/04–05/06

10C: Seek public and private funding opportunities to evaluate and continue demonstration projects that apply best practices in areas of need.

Proposed lead: DOH

Proposed partners: ACS, FDOC

Timeframe: 04/05–05/06

goal 11

Goal 11: Increase the availability of statewide and community-specific data for surveillance, planning and evaluating progress toward improving cancer outcomes and decreasing disparities.

Priority areas:

All cancers

Strategies:

11A: Assess data needs.

Proposed lead: DOH Bureau of Epidemiology

Timeframe: 03/04–05/06

Existing activities: None identified

Suggested new activity:

11A1: Survey other states regarding their data resources and availability.

Proposed lead: DOH

11B: Facilitate the sharing and coordination of data sets among partners.

Proposed lead: DOH

Proposed partners: AHCA, CDC, FMQAI, FCDS, CIS, FCCCI, FAPTP

Timeframe: 03/04–05/06

Existing activities: None identified

Suggested new activities:

11B1: Increase support for the FCDS.

Proposed lead: None identified

11B2: Create a centralized cancer database that includes incidence, mortality and stage data as well as health insurance, demographic and Medicare data, etc.

Proposed lead: FCDS

11B3: Make the centralized cancer database easily accessible and user-friendly to facilitate utilization and sharing of data.

Proposed lead: None identified

11C: Continue to inform stakeholders about the cancer burden through the dissemination of a comprehensive Florida Annual Cancer Report.

Proposed lead: ACS

Proposed partners: Research hospitals

Timeframe: 03/04–05/06

Existing activity:

11C1: Disseminate a comprehensive Florida Annual Cancer Report in 2004.

Proposed leads: DOH, C-CRAB

Suggested new activities:

No new activities suggested for 03/04

11D: Model and promote the use of data in program planning.

Proposed lead: DOH

Proposed partners: FCCCI, cancer organizations

Timeframe: 04/05–05/06

Goal 12: Advance cancer research in Florida.

Priority areas:

All cancers

Strategies:

12A: Organize, implement and evaluate an advocacy initiative to mandate coverage by third-party payers of the routine costs of care associated with clinical trials.

Proposed lead: ACS

Proposed partners: Other cancer advocacy organizations

Timeframe: 04/05–05/06

12B: Disseminate cancer research findings and implications for practice.

Proposed lead: H. Lee Moffitt Cancer Center & Research Institute

Timeframe: 04/05–05/06

12C: Publicize Internet sources that list current clinical trials (e.g., National Cancer Institute, www.cancer.gov; National Library of Medicine, www.clinicaltrials.gov; Food and Drug Administration, www.FDA.gov/oashi/cancer/trials.html; Pharmaceutical Research and Manufacturers of America, www.phrma.org).

Proposed lead: DOH

Timeframe: 04/05–05/06

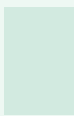
12D: Encourage and quantify enrollment of Floridians in clinical trials.

Proposed lead: CIS

Proposed partner: FDOC

Timeframe: 03/04–05/06

goal 12



Existing activities: None identified

Suggested new activities:

12D1: Assess the implementation of new American College of Surgeons standards for cancer programs mandating that every patient must be informed about available clinical trials as of January 2004.

Proposed lead: None identified

12D2: Explore the designation of Florida as a Cancer Prevention State with a focus on clinical trials for disparity groups.

Proposed lead: None identified

12E: Bring more clinical trials to Florida.

Proposed lead: FDOC

Timeframe: 03/04–05/06

Existing activities: None identified

Suggested new activities:

12E1: Partner with BioFlorida to connect with biotechnology industry organizations for the purpose of identifying opportunities for patients and physicians to participate in clinical trials with industry (e.g., biotechnology and pharmaceutical companies).

Proposed lead: None identified

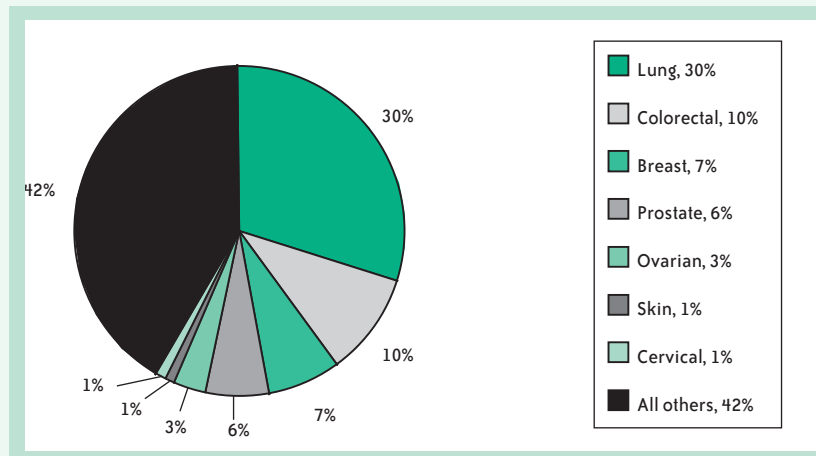
12E2: Advocate for state funding dedicated to bringing more clinical trials to Florida.

Proposed lead: None identified

Cancer in Florida

The strategic plan identifies a number of **priority cancers**. They include: breast cancer, colorectal cancer, lung cancer, prostate cancer, skin cancer, gynecologic cancers and childhood cancers (see Figure 5). The burden of cancer in Florida will be described in terms of **gender and race/ethnicity** and includes trends and hospital charges. In addition, risk factors for cancer such as **smoking, physical activity, and nutrition** will be discussed.

Figure 5. Selected cancer deaths as a percentage of all cancers, Florida, 2001, Vital Statistics



Lung cancer is the primary cause of cancer death in men and women

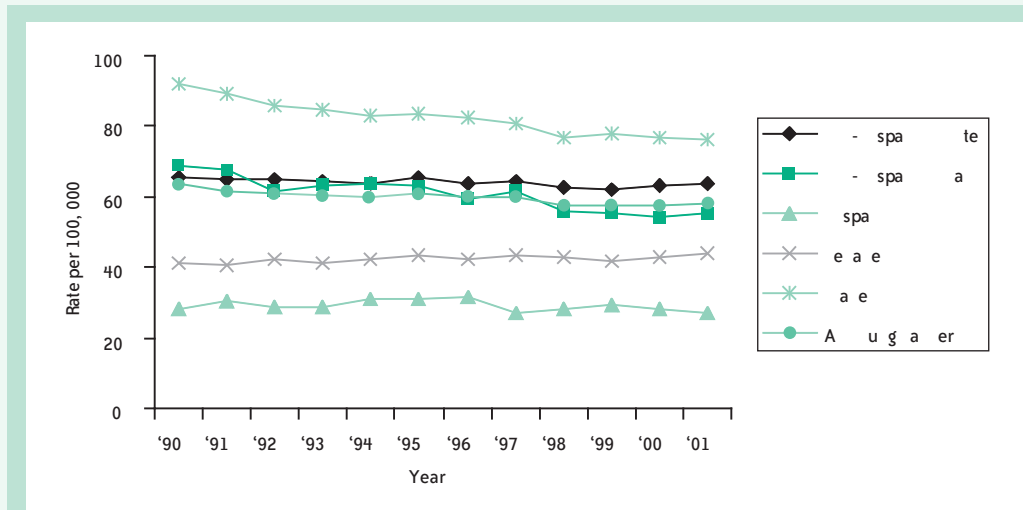
Lung Cancer

November is Lung Cancer Awareness Month

Lung cancer is the primary cause of cancer **death** for both **men** and **women**. According to the **American Cancer Society**, more people die of lung cancer than of colon, breast and prostate cancers combined. In Florida, age-adjusted mortality rates for lung cancer are about three times higher than those for breast, prostate and colorectal cancer.

Age-adjusted lung cancer mortality rates vary greatly by sex and race/ethnicity. Figure 6 shows that age-adjusted mortality rates among men were about twice the rates observed for women throughout the 1990s. This gap, however, narrowed during the decade due to a 17% decline in age-adjusted lung cancer mortality rates among men. Rates did not change for non-Hispanic whites and Hispanics, but did decrease by 20% among non-Hispanic blacks.

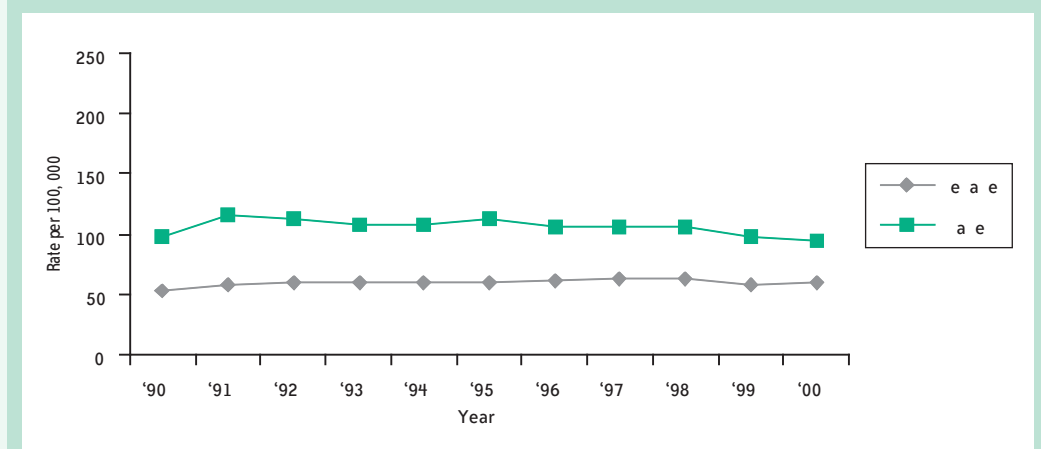
Figure 6. Age-adjusted(1) mortality rates for lung cancer, 1990–2001, by year, sex and race/ethnicity, Florida Vital Statistics



1. Age-adjusted to the 2000 standard million

Lung cancer is the most commonly diagnosed cancer for men and women. In 2000, approximately 15,000 cases of lung cancer were diagnosed. Men have a much higher incidence than women with 94.0 new cases per 100,000 men compared to 59.3 new cases per 100,000 women. Age-adjusted incidence has remained relatively stable from 1990-2000 (see Figure 7).

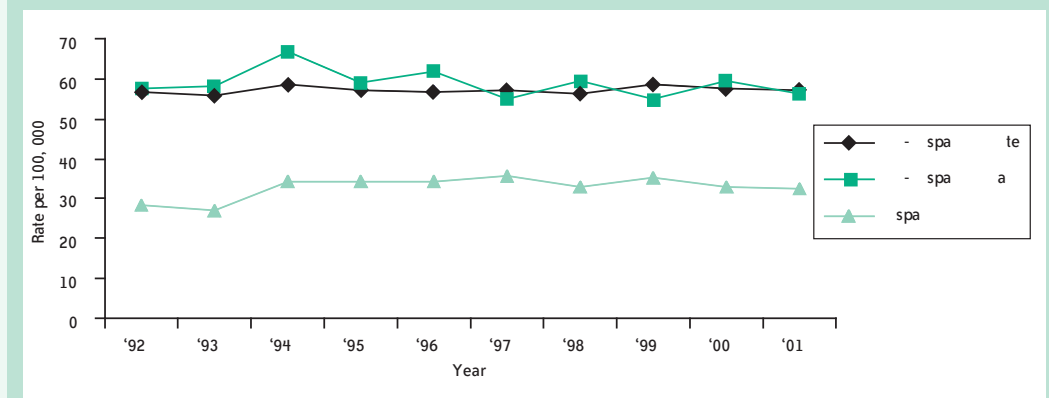
Figure 7. Age-adjusted(1) incidence rates for lung cancer, 1990–2000, by year and sex, Florida Cancer Data System



1. Age-adjusted to the 2000 standard million

Age-adjusted hospital discharge rates for lung cancer for non-Hispanic whites were similar to rates for non-Hispanic blacks, but were higher than the rates for Hispanics (see Figure 8). Whereas lung cancer hospital discharge rates were mostly stable among non-Hispanic whites and non-Hispanic blacks, these rates increased among Hispanics between 1992 and 2001. From 1992–2001, daily hospitalization charges increased from \$3,065 (C\$) in 1990 to \$4,288 in 2001.

Figure 8. Age-adjusted(1) hospital discharge rates for lung cancer, 1992–2001, by year and race/ethnicity(2), Florida Agency for Health Care Administration Hospital Discharge Data



1. Age-adjusted to the 2000 standard million

2. Race/ethnicity information not available in data prior to 1992

According to the American Cancer Society, **risk factors** include **cigarette smoking**, which accounts for 90% of all lung cancers, **cigar and pipe use, environmental tobacco smoke, radon, asbestos, pollution, lung disease**, and a personal history of lung cancer. Women who smoke increase their chance of dying from lung cancer by nearly 12 times; men increase by 22 times. Exposure to environmental tobacco smoke causes an estimated 3,000 lung cancer deaths among American adults each year. Non-smoking spouses of smokers have a 30% greater risk of developing lung cancer than do spouses of nonsmokers. Children of parents who smoke are more likely to have childhood asthma, bronchitis, and chronic ear infections.

Common signs and symptoms associated with lung cancer include:

- A **cough** that does not go away;
- **Chest** pain;
- **Coughing** up blood;
- Shortness of **breath**; and
- Recurring **bronchitis** or **pneumonia**.

When lung cancer spreads to distant organs, it may cause symptoms that do not seem to be at all related to the lungs. Anyone experiencing these signs or symptoms should consult a physician immediately:

- Bone **pain** or **fractures**;
- **Weakness** or **numbness** of the arms or legs, dizziness;
- **Yellow** coloring of the **skin** and **eyes** (jaundice);
- **Masses** near the surface of the body, caused by cancer spreading to the skin or to lymph nodes; and
- **Bleeding** or blood clots.

Lung cancer is almost entirely preventable by eliminating cigarette use and exposure to environmental tobacco smoke. The best way to prevent lung cancer is to never start or to quit smoking. Stopping smoking at any age lowers the risk of lung cancer. After five years of living smoke-free, risk of lung cancer decreases. There is no evidence that smoking low tar cigarettes reduces the risk of lung cancer.

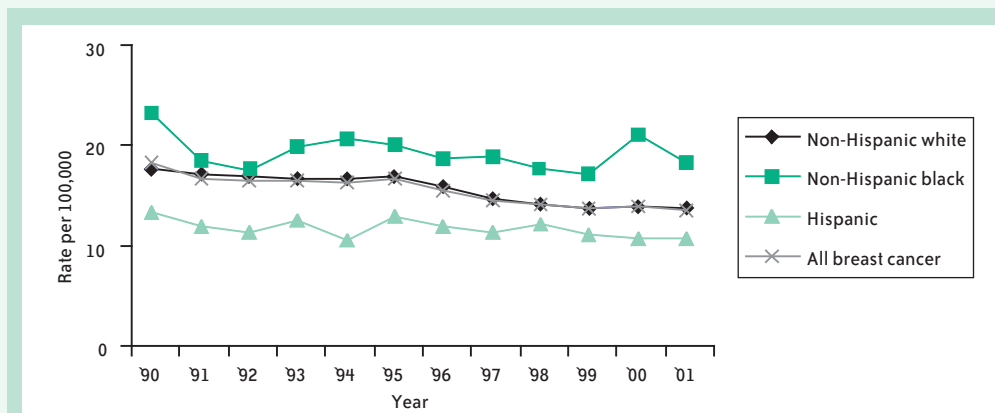
Breast cancer is the most commonly diagnosed cancer among Florida women.

Figure 9. Age-adjusted(1) mortality rates for breast cancer, 1990–2001, by year and race/ethnicity, Florida Vital Statistics

Breast Cancer

October is Breast Cancer Awareness Month

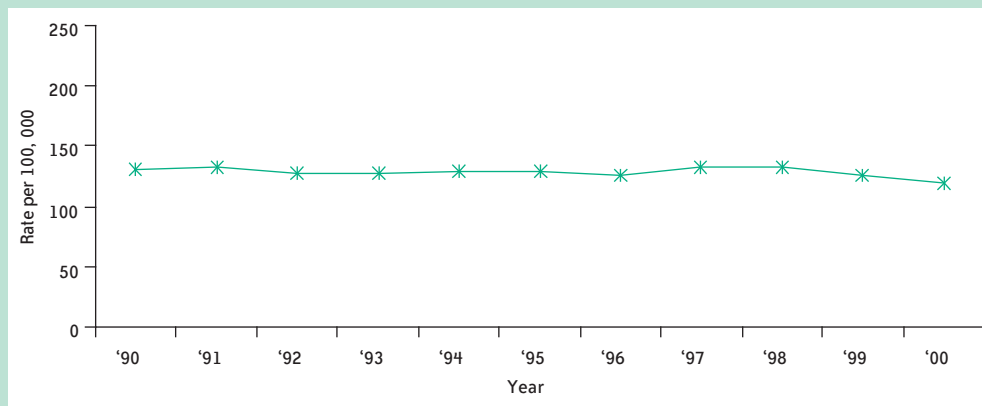
Breast cancer is **predominantly a disease** among **women**. A very small number of men are diagnosed with breast cancer each year, but this number does not significantly change the overall breast cancer incidence or mortality rates. Breast cancer is the **second leading cause of cancer deaths among women**, killing 2,544 women in Florida in 2001. Figure 9 shows the age-adjusted breast cancer mortality rates by year and race/ethnicity. Overall, breast cancer mortality rates have decreased by nearly one quarter between 1990 and 2001. Rates among non-Hispanic white women were typically higher than Hispanic women and lower than non-Hispanic black women. Between 1990 and 2001, Hispanic women had the lowest age-adjusted mortality rates.



1. Age-adjusted to the 2000 standard million

Breast cancer is the most commonly diagnosed cancer among Florida women. In 2000, approximately 12,000 new cases of breast cancer were diagnosed. Age-adjusted incidence has remained relatively stable from 1990–2000 (see Figure 10).

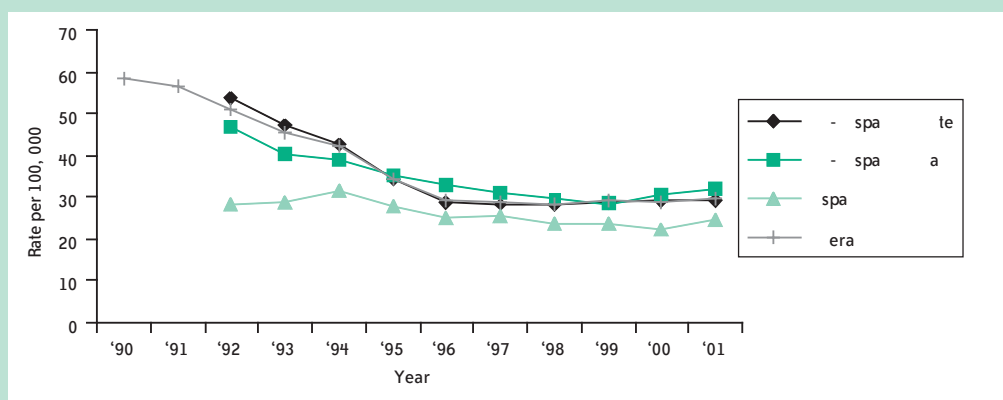
Figure 10. Age-adjusted(1) incidence rates for breast cancer, 1990–2000, Florida Cancer Data System



1. Age-adjusted to the 2000 standard million

Age-adjusted hospital discharge rates for breast cancer decreased from 1990 to 2001 (see Figure 11). Declines were steeper among non-Hispanic white women and non-Hispanic black women compared to Hispanics. Non-Hispanic white and non-Hispanic black women had higher age-adjusted discharge rates than Hispanics. During this same time period, daily hospitalization charges increased from \$3,804 (C\$) to \$8,999.

Figure 11. Age-adjusted(1) hospital discharge rates for breast cancer, 1990–2001, by year and race/ethnicity(2), Florida Agency for Health Care Administration Hospital Discharge Data



1. Age-adjusted to the 2000 standard million

2. Race/ethnicity information not available in data prior to 1992

The following are **symptoms of breast cancer**; however, having these symptoms does not mean that cancer is present. They could indicate a benign condition.

- **Lump or thickening** in or near the breast or underarm area;
- **Nipple pain**, redness or discharge (other than breast milk); and
- **Breast skin** appears dimpled or pitted.

Early breast cancer usually does not cause pain.

There are **many different varieties of breast cancer**. Some are fast-growing and unpredictable, where others are slow and steady. Some are stimulated by estrogen in your body; some result from an oncogene (a cancer gene). A physician will plan treatment based on the special characteristics of the specific breast cancer.

The exact causes of breast cancer are not known.

After affected tissues are removed, the cancer is staged. Staging is a classification that implies which treatment is best and also the prognosis for recovery. Staging in breast cancer is based on the size of the tumor, which parts of the breast are involved, how many and which lymph nodes are affected, and whether the cancer has metastasized to another part of the body. Cancers may be referred to as invasive if they have spread to other tissues. Those that do not spread to other tissues are called noninvasive. Carcinoma in situ is a noninvasive cancer.

Breast cancer is staged from 0 to IV.

- **Stage 0** is noninvasive breast cancer; that is, carcinoma in situ with no affected lymph nodes or metastasis.
- **Stage I** is breast cancer that is less than three quarters of an inch in diameter and has not spread from the breast.
- **Stage II** is breast cancer that is fairly small in size but has spread to lymph nodes in the armpit or cancer that is somewhat larger but has not spread to the lymph nodes.
- **Stage III** is breast cancer of a larger size (greater than 2 inches in diameter), with greater lymph node involvement, or of the inflammatory type.
- **Stage IV** is metastatic breast cancer: a tumor of any size or type that has metastasized to another part of the body.

Treatment of breast cancer depends on many factors including stage, type of breast cancer, tumor grade, size and location of the tumor, proliferative capacity of the tumor, hormone receptor status, woman's age, menopausal status, and specific gene amplification. There are currently four different types of commonly used treatments for patients with breast cancer. These include surgery, radiation therapy, chemotherapy, and hormone therapy.

The **exact causes of breast cancer** are **not known**; however, studies show that the risk of breast cancer increases as a woman gets older. The following are conditions that increase a women's chance of getting breast cancer:

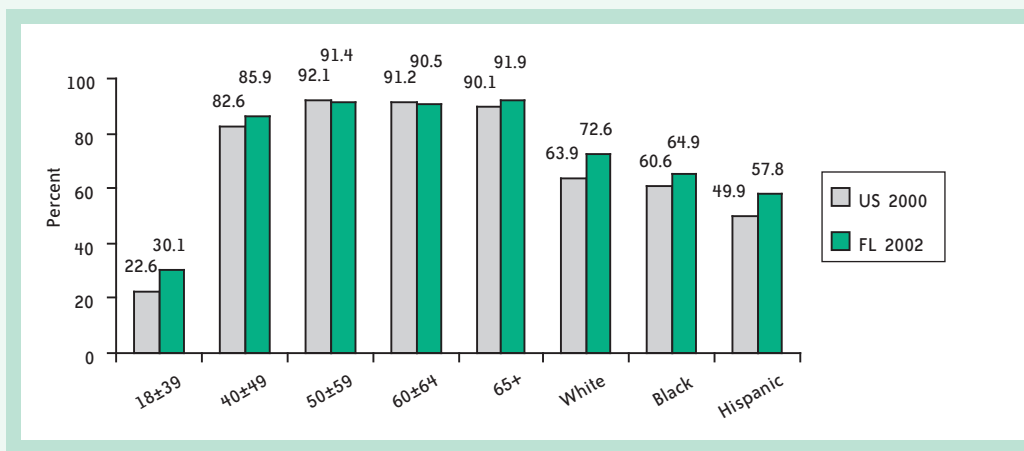
- Personal history of breast cancer;
- Family history;
- Certain breast changes;
- Genetic alterations;
- Estrogen;
- Late childbearing;
- Breast density;
- Radiation therapy; and
- Alcohol use.

Getting regular breast cancer screening tests is the best way to **lower** the **risk** of dying from breast cancer. By finding the disease early, before any symptoms arise, these tests greatly improve the chances of successful treatment. Clinical breast exams are physical examinations done by physicians, nurse practitioners, or other trained medical staff, who examine the breasts with the pads of their fingertips to check for lumps or thickening. The American Cancer Society (ACS) recommends that women have a mammogram annually beginning at age 40. Among Florida women aged 40 and older, 37.2% did not have a mammogram within the past two years in 1990. In 2002,

this percent had dropped by 65% to 12.8%. During the last half of the 1990s and into the 21st century, the prevalence of women aged 40 and older who did not have a mammogram in the past two years was below the prevalence observed for the U.S.

Mammography is not uniformly distributed across race/ethnic groups. Figure 12 shows the prevalence of having a mammogram among U.S. and Florida women aged 18 and older in 2000 (US) and 2002 (FL). As expected, the prevalence of having a mammogram is significantly lower among women aged 18–39 years possibly because of ACS recommendations. However, the prevalence of ever having a mammogram is significantly lower among Hispanic women compared to white and black women in the U.S. In Florida, black and Hispanic women have significantly lower prevalences of ever having a mammogram compared to their white counterparts.

Figure 12. Percent of Florida and US women age 18 years and older who have ever had a mammogram, by age and race/ethnicity, BRFSS 2000 and 2002



Among Florida men in 2000, prostate cancer was the most commonly diagnosed cancer.

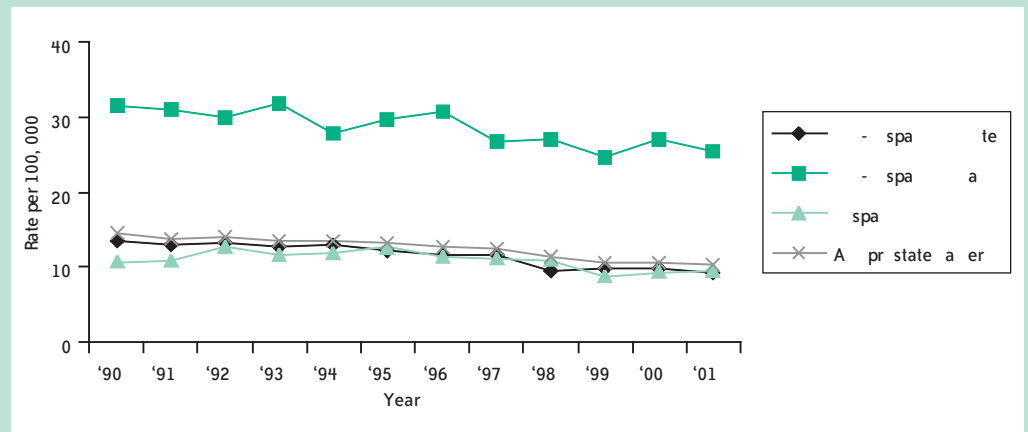
Prostate Cancer

September is Prostate Cancer Awareness Month

Cancer of the prostate, a common form of cancer, is a disease in which cancer cells are found in the prostate. The prostate is a walnut-sized gland around the urethra below the bladder. The prostate and other glands secrete fluids that make up semen. The urethra is a tube that carries urine out of the body through the penis.

Prostate cancer is the second leading cause of cancer death among men, killing 2,197 men in Florida in 2001. Prostate cancer age-adjusted mortality rates decreased by 30% between 1990 and 2001 (see Figure 13). Mortality rates among non-Hispanic black men were 70% to 80% higher than rates among non-Hispanic white men and Hispanic men. Rates among non-Hispanic white men, non-Hispanic black men and Hispanic men dropped 32%, 19% and 9%, respectively, during the decade.

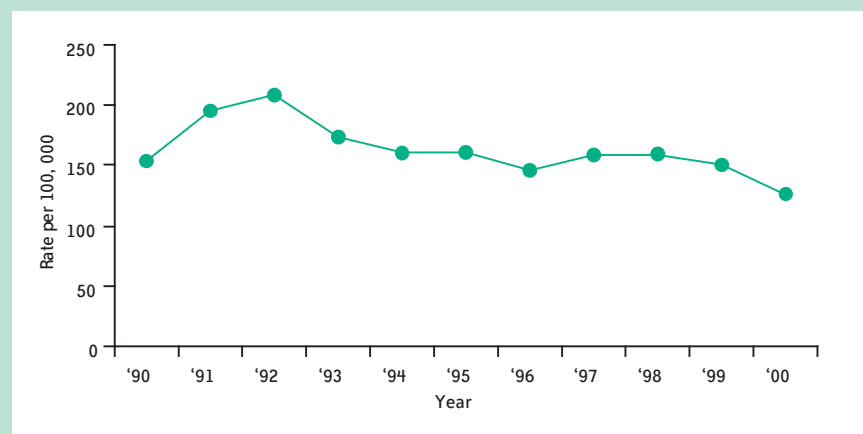
Figure 13. Age-adjusted(1) mortality rates for prostate cancer, 1990–2001, by year and race/ethnicity, Florida Vital Statistics



1. Age-adjusted to the 2000 standard million

Among Florida men in 2000, prostate cancer was the most commonly diagnosed cancer accounting for one in every four cancer diagnoses. In 2000, almost 12,000 new cases were diagnosed. Prostate cancer incidence is higher than breast cancer incidence. There is no clear trend in prostate cancer incidence from 1990–2000.

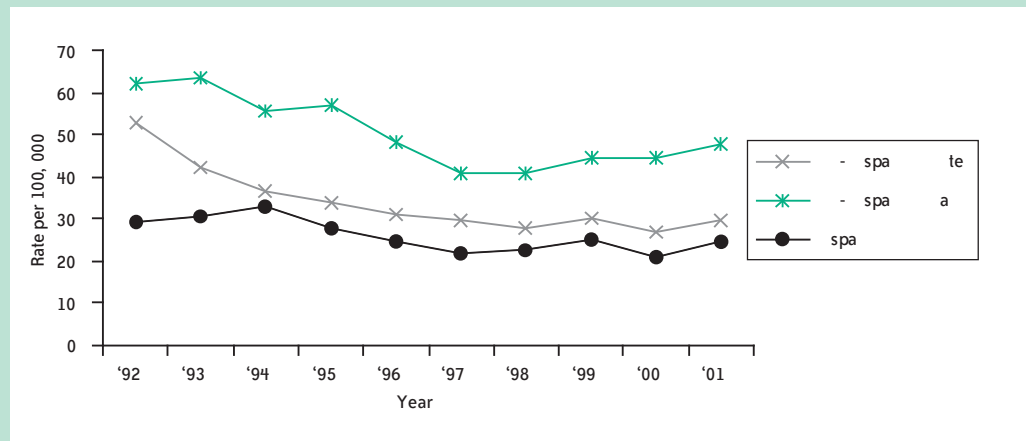
Figure 14. Age-adjusted(1) incidence rates for prostate cancer, 1990–2000, by year, Florida Cancer Data System



1. Age-adjusted to the 2000 standard million

Hospital discharge rates decreased from 1992–2001. Discharge rate declines were steeper among non-Hispanic white and non-Hispanic black men compared to Hispanic men. Non-Hispanic black men had higher discharge rates compared to Hispanic and non-Hispanic white men. From 1990–2001, hospital charges increased more than 2.5 times from \$2,994 (C\$) in 1990 to \$7,550 in 2001.

Figure 15. Age-adjusted(1) hospital discharge rates for prostate cancer, 1992–1999, by year and race/ethnicity(2), Florida Agency for Health Care Administration Hospital Discharge Data



1. Age-adjusted to the 2000 standard million
 2. Race/ethnicity information not available in data prior to 1992

Symptoms associated with prostate cancer may include:

- **Frequent urination** or difficulty urinating;
- **Pain or burning** sensation when urinating;
- **Blood** in urine or semen;
- **Difficulty** in having an erection;
- **Pain or stiffness** in the lower back, hips, or thighs; and
- **Pain** during ejaculation.

If cancer is found in the prostate, the doctor will need to determine the stage or extent, of the disease. Many cancers are categorized in stages that indicate whether the cancer has spread and, if so, what parts of the body are affected. Eighty-three percent of all prostate cancers are discovered in the local/regional stages of the disease, and the relative survival rate for these patients is 100%. The following are the main features of each stage:

- **Stage I or Stage A** – The cancer cannot be felt during a rectal exam. It may be found by accident when surgery is done for another reason, usually for BPH (benign prostatic hyperplasia). There is no evidence that the cancer has spread outside the prostate.
- **Stage II or Stage B** – The tumor involves more tissue within the prostate, it can be felt during a rectal exam, or it is found with a biopsy that is done because of a high prostate-specific antigen (PSA) level. There is no evidence that the cancer has spread outside the prostate.
- **Stage III or Stage C** – The cancer has spread outside the prostate to nearby tissues.
- **Stage IV or Stage D** – The cancer has spread to lymph nodes or to other parts of the body.

Treatment of prostate cancer depends on the size of the tumor, location, tumor grade, extent of the tumor, and the general health of the patient. Options for the patient include:

- **Awareness** and regular examinations to ensure the cancer does not spread.
- **Cancer drugs** and hormone replacement therapy to lower levels of testosterone in the body.
- **External-beam radiation** therapy may be used to destroy the cancer cells in the body. Seed implant therapy implants radioactive seeds in the prostate to destroy cancer cells.
- **Cryosurgery** kills cancer cells by freezing the prostate. This technique needs further evaluation for effectiveness.

- As a last resort, **surgery** to remove the prostate gland in cases where the individual is in otherwise good health and is expected to live at least ten more years.

Risk factors associated with prostate cancer include:

- Increasing **age**;
- **Family history** of prostate cancer;
- **Race**; and
- **Diet** and dietary factors.

Prostate cancer can be detected by a digital rectal examination (DRE) and the Prostate Specific Andigen (PSA) blood test. Transrectal ultrasound and biopsies may be needed to determine the cause for an elevated PSA or to confirm a diagnosis of prostate cancer. Guidelines for routine screening of healthy men vary. The U.S. Preventative Health Task Force indicates that there is insufficient evidence to recommend for or against DRE as an effective screening test for prostate cancer in asymptomatic men, and that routine use of PSA testing as part of the periodic health examination is not recommended.

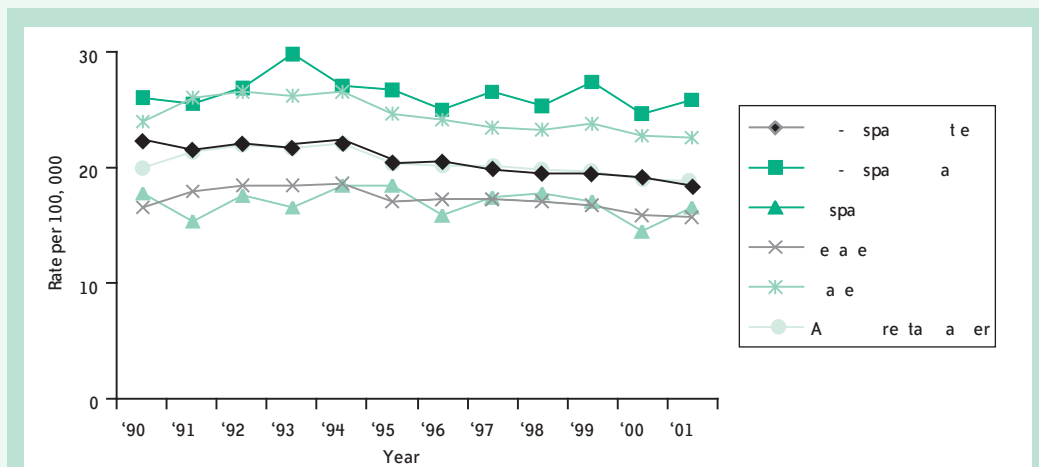
Colorectal Cancer

March is Colorectal Cancer Awareness Month

Colorectal cancer (commonly referred to as **colon cancer**) begins in the digestive tract. This cancer develops in the lining of the organs either in one of the four sections of the colon or the rectum. Colorectal cancer is the third leading cause of cancer deaths among both sexes in Florida, killing 1,982 men and 1,854 women in 2001. Figure 16 shows the age-adjusted mortality rates for colorectal cancer by sex and race/ethnicity. Overall, age-adjusted colorectal cancer mortality rates were stable from 1990-1994 and then began to decline slowly. The slow decline was driven by declines among non-Hispanic whites. Colorectal cancer mortality rates were consistently about 40% higher among men compared to women. Hispanics had the lowest mortality rates compared to non-Hispanic whites and non-Hispanic blacks.

Colorectal cancer is the **third** leading cause of cancer deaths in Florida.

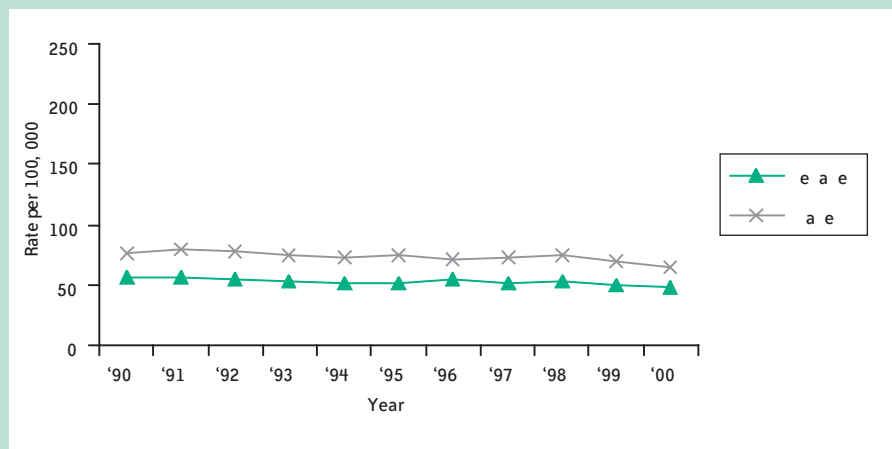
Figure 16. Age-adjusted(1) mortality rates for colorectal cancer, 1990–2001, by year, sex and race/ethnicity, Florida Vital Statistics



1. Age-adjusted to the 2000 standard million

Colorectal cancer is the **third** most diagnosed cancer in both men and women in Florida. In 2000, slightly more cases were diagnosed among men (6,098) than among women (5,837). Age-adjusted incidence rates for colorectal cancer are higher for men than for women (see Figure 17). Rates have dropped modestly since 1990.

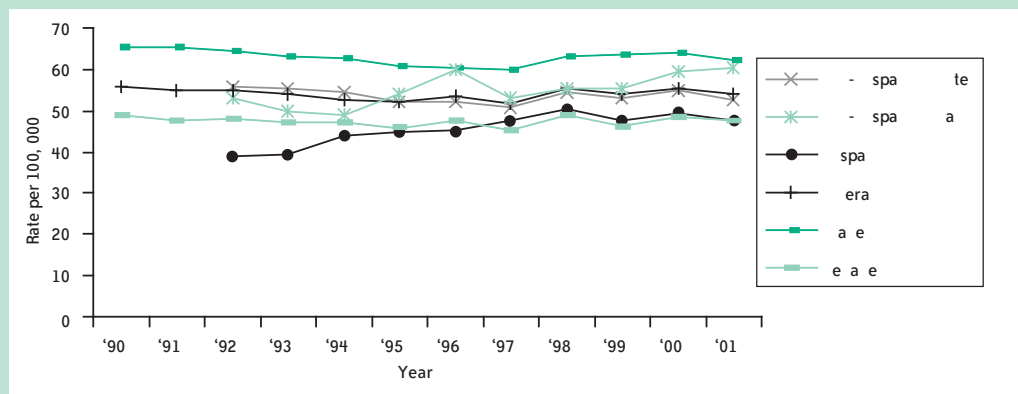
Figure 17. Age-adjusted(1) incidence rates for colorectal cancer, 1990–2000, by year and gender, Florida Cancer Data System



1. Age-adjusted to the 2000 standard million

Age-adjusted hospital discharge rates for colorectal cancer were stable from 1990 to 2001 (see Figure 18). Rates were stable for non-Hispanic whites and increased modestly for non-Hispanic blacks and Hispanics. Rates for men were higher than those for women. Age-adjusted hospital discharge rates for both men and women were stable. During this same time, daily hospitalization charges increased from \$3,124 (C\$) to \$4,355.

Figure 18. Age-adjusted(1) hospital discharge rates for colorectal cancer, 1990–2001, by year, gender and race/ethnicity(2), Florida Agency for Health Care Administration Hospital Discharge Data



1. Age-adjusted to the 2000 standard million

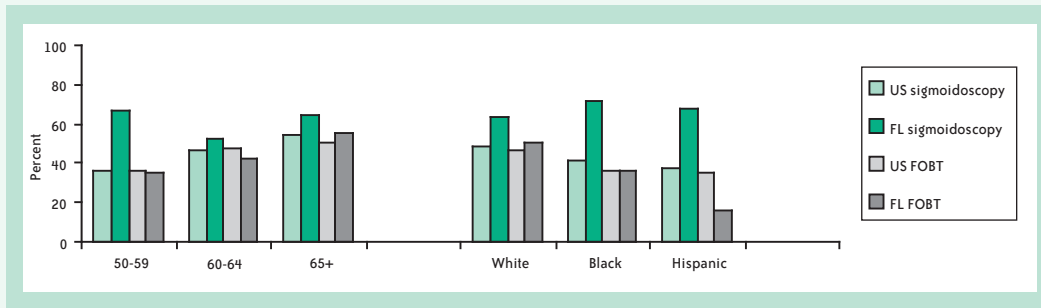
2. Race/ethnicity information not available in data prior to 1992

Those at risk for developing colorectal cancer are individuals with the following risk factors:

- **Increasing age;**
- **Personal history**—Those with a history of inflammatory bowel disease, a personal or family history of colorectal cancer or colorectal polyps; and
- **Diet**—Associated with high-fat diet, obesity and alcohol consumption.

The ACS recommends that men and women have a sigmoidoscopy every five years and a fecal occult blood test (FOBT) annually beginning at age 50. Compared to the use of mammography and pap smears, the use of sigmoidoscopy and FOBT is much lower. Figure 19 shows the prevalence of sigmoidoscopy and FOBT test use by age group. Florida has much higher use of sigmoidoscopy than does the U.S. In Florida, approximately 60% of adults aged 50 years and older have had a sigmoidoscopy. Approximately 50% of adults aged 50 years and older have had a FOBT. Utilization of sigmoidoscopy and FOBT also varies by race/ethnicity. The prevalence of ever having a FOBT is significantly lower among blacks and Hispanics aged 50 years and older compared to whites.

Figure 19. Percent of Florida and US adults aged 50 years and older who have ever had a sigmoidoscopy and percent who have ever had a FOBT, by age and race/ethnicity, BRFSS 2002 (FL) and 2001 (US)



With a diagnosis of colorectal cancer, it is important to identify the stage of the cancer in order to plan an appropriate treatment. Depending on the stage and the health of the patient, there are many treatments that may be used or combined. For cancers that have not spread, surgery is the most common treatment. Other treatments include chemotherapy, radiation therapy, and biological therapy. There are two systems for staging colorectal cancer. The first system uses the following categories with a further numerical breakdown: (T) to describe the extent of the primary tumor, (N) for the absence or presence of metastasis to nearby lymph nodes, and (M) for the absence or presence of distant metastasis. The second system uses Roman numerals 0 through IV. The stages for colorectal cancer by Roman numeral are:

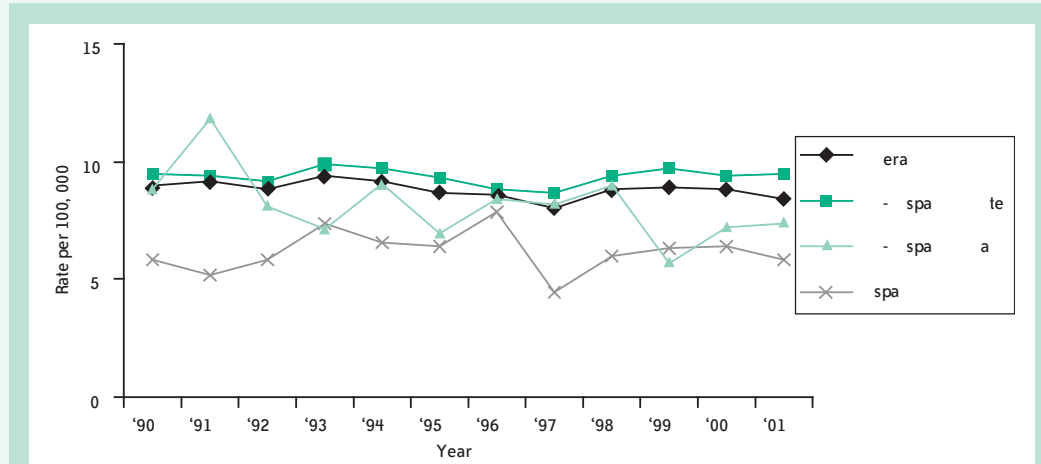
- Stage 0** – Earliest stage, in which the tumor has not grown beyond the mucosa of the colon or rectum. This stage is also known as carcinoma in situ or intramucosal carcinoma.
- Stage I** – Cancer has grown beyond the mucosa.
- Stage II** – Cancer has grown or spread beyond the colon or rectum wall but has not reached the lymph nodes.
- Stage III** – Cancer has grown and spread to the lymph nodes.
- Stage IV** – Cancer has grown and spread to other parts of the body. Colorectal cancer tends to spread to the liver and/or lungs.

Ovarian Cancer

September is Ovarian Awareness Month

Ovarian cancer is caused by a malignant tumor that begins in the ovaries. Cancers that metastasize from other areas of the body to the ovary are not considered ovarian cancer. The most common type of ovarian cancer is epithelial carcinoma, which begins on the surface of the ovary. Ovarian cancer is the fifth leading cause of cancer deaths among women killing 972 women in Florida in 2001. Figure 20

Figure 20. Age-adjusted(1) mortality rates for ovarian cancer, by year and race/ethnicity, 1990–2001, Florida Vital Statistics, CDC WONDER

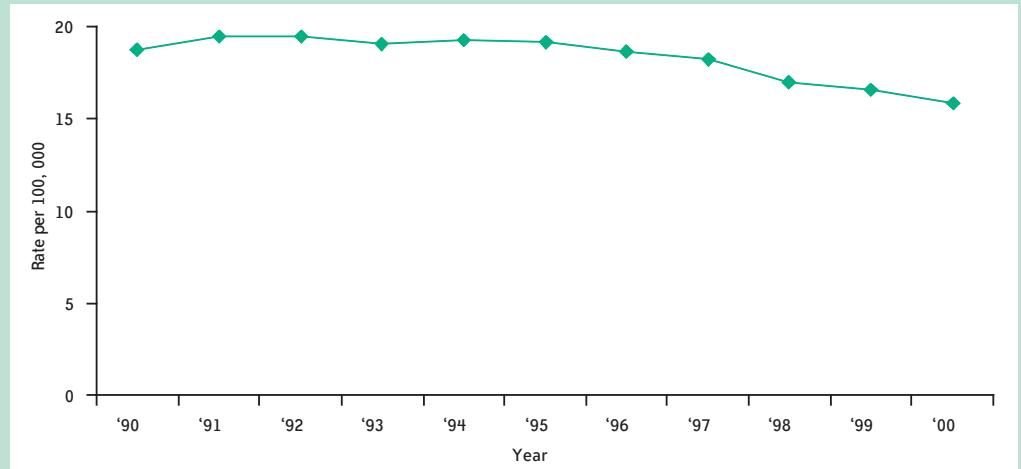


1. Age-adjusted to the 2000 standard million

shows the age-adjusted mortality rates for ovarian cancer overall and by race/ethnicity. Rates are highest for non-Hispanic whites.

Ovarian cancer is the fourth most diagnosed cancer in women. In 2000, there were 1,605 women diagnosed with ovarian cancer. Among women diagnosed with ovarian cancer, 58% were diagnosed at a late stage. Age-adjusted incidence rates have decreased slightly from 1990–2000 (see Figure 21).

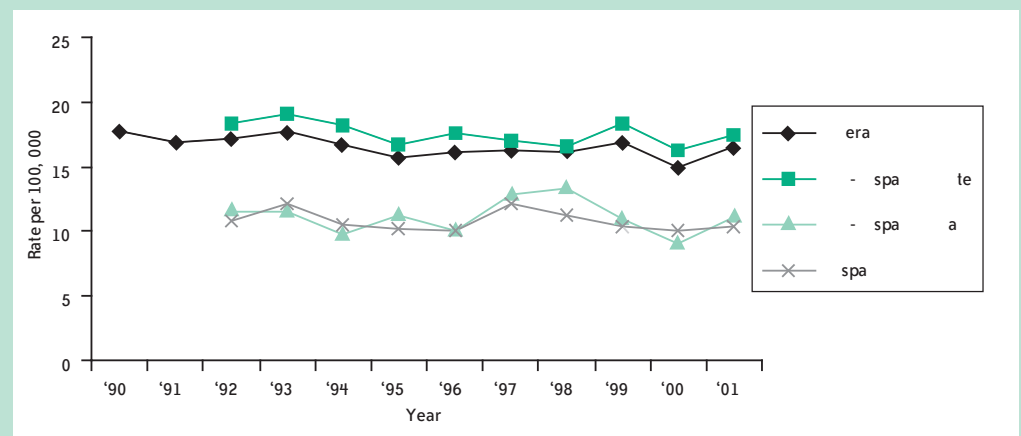
Figure 21. Age-adjusted(1) incidence rates for ovarian cancer, 1990–2000, Florida Cancer Data System



1. Age-adjusted to the 2000 standard million

Age-adjusted hospital discharge rates for ovarian cancer have remained relatively stable from 1990–2001 (see Figure 22). During this same time, daily hospitalization charges increased from \$3,257 (C\$) to \$4,588.

Figure 22. Age-adjusted(1) hospital discharge rates for ovarian cancer, by year and race/ethnicity(2), 1990–2001, Florida Agency for Health Care Administration Hospital Discharge Data



1. Age-adjusted to the 2000 standard million

2. Race/ethnicity information not available in data prior to 1992

Early detection and treatment is key.

Ovarian cancer has four stages which identify how far the tumor has spread from the ovary. The survival rate for a woman at stage I is 90 to 95% while the survival rate for a women at stage IV is significantly lower. Thus, early detection and treatment is key. However, ovarian cancer is difficult to detect since it often does not show any obvious signs or symptoms until it is in an advanced stage.

Risk factors that may contribute to the chance of developing ovarian cancer include:

- **Family** history;
- **Age**;
- **Never had children**; and
- Personal **history**.

Screening for cervical cancer may include a pelvic exam and a Pap test.

An ovarian cancer diagnosis may result from a physical exam or by a diagnostic test such as a pelvic exam, ultrasound, CA-125 assay, lower gastro-intestinal series or barium enema, CT scan, or biopsy. There are a number of factors to be considered when identifying the best treatment such as the stage of the disease and the general health of the woman. The usual initial treatment is surgery to remove the ovaries, fallopian tubes, uterus and the cervix. Chemotherapy or radiation therapy may be used after surgery to kill remaining cancer cells in the body.

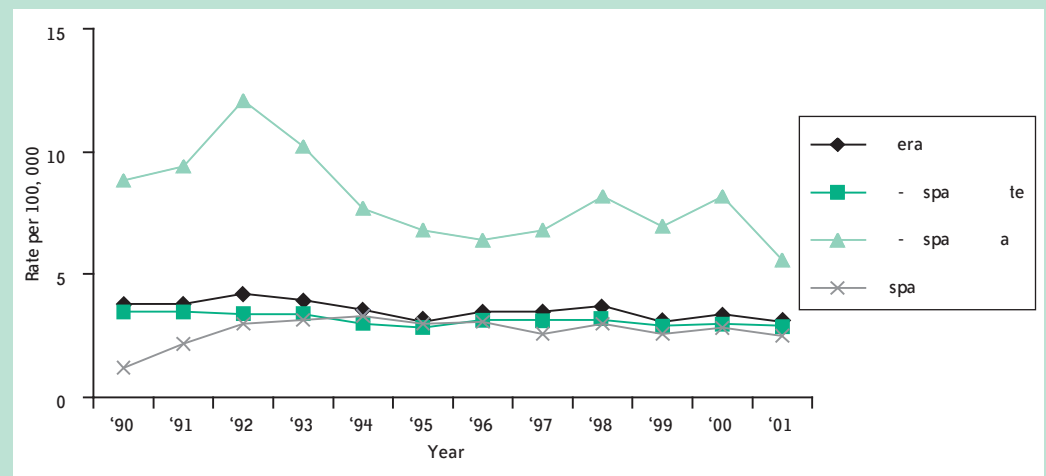
Cervical Cancer

January is Cervical Cancer Awareness month.

Cervical cancer is cancer of the cervix. This particular cancer does not develop suddenly but more gradually; normal cervical cells develop precancerous changes that turn into cancer. Doctors use different terms to refer to precancerous changes including cervical intraepithelial neoplasia (CIN), squamous intraepithelial lesion (SIL), and dysplasia.

Age-adjusted mortality rates are two to three times higher for non-Hispanic blacks than for non-Hispanic whites or Hispanics (see Figure 23). Rates for non-Hispanic blacks have generally decreased since 1990. Rates for Hispanics increased and then decreased modestly since 1990.

Figure 23. Age-adjusted(1) mortality rates for cervical cancer, by year and race/ethnicity, 1990–2001, Florida Vital Statistics, CDC WONDER



1. Age-adjusted to the 2000 standard million

In 2000, 928 women in Florida were diagnosed with cervical cancer. Age-adjusted incidence rates for cervical cancer have declined modestly since 1990 (see Figure 24).

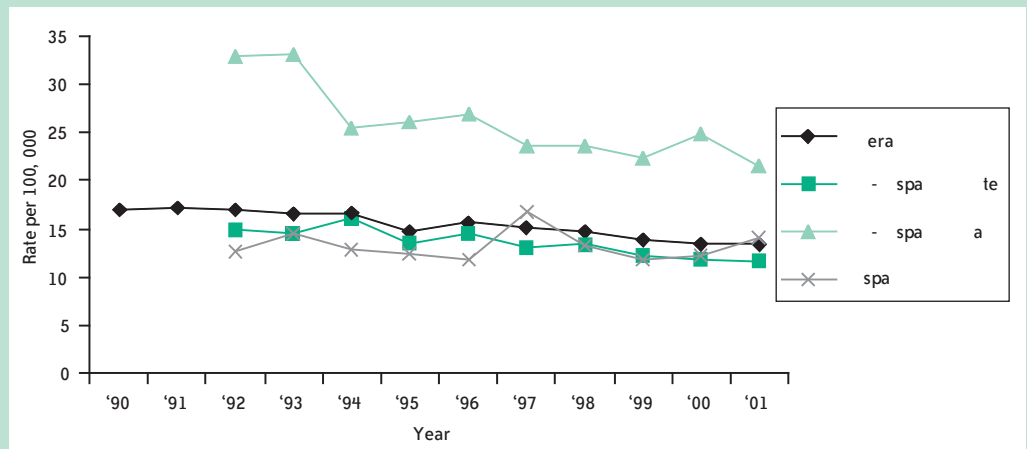
Figure 24. Age-adjusted(1) incidence rates for cervical cancer, 1990–2000, Florida Cancer Data System



1. Age-adjusted to the 2000 standard million

Age-adjusted hospital discharge rates for cervical cancer have **decreased** slightly overall and have decreased significantly for non-Hispanic blacks (see Figure 25). Rates for non-Hispanic blacks are over twice those for non-Hispanic whites and Hispanics. During this same period, daily hospital charges increased from \$3,188 (C\$) to \$5,159.

Figure 25. Age-adjusted(1) hospital discharge rates for cervical cancer, by year and race/ethnicity(2), 1990–2001, Florida Agency for Health Care Administration Hospital Discharge Data



1. Age-adjusted to the 2000 standard million
 2. Race/ethnicity information not available in data prior to 1992

Cervical cancer is preventable and curable if it is detected early. There are generally no symptoms or pain associated with cervical cancer. Some women may experience abnormal bleeding or discharge.

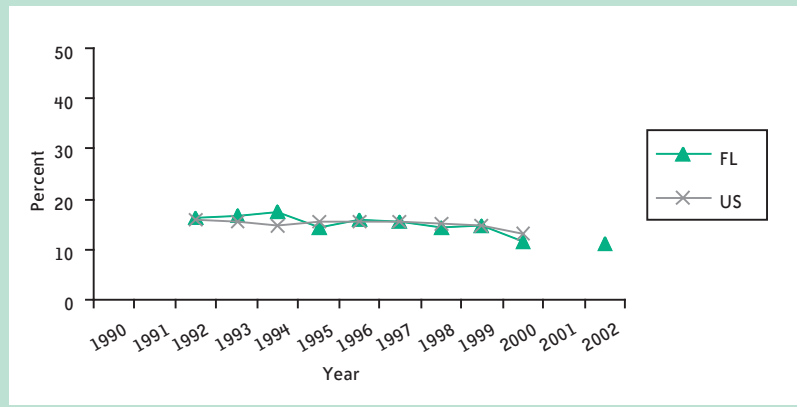
Risk factors associated with cervical cancer include:

- **Failure** to receive a regular **Pap test** screening;
- **Contracting** human **papillomavirus (HPV)** infection from a sexual encounter where there is skin to skin contact, regardless if a condom is used. HPV infection does not always produce warts or other symptoms, so a person may be infected with and pass on HPV without knowing it.

Screening for cervical cancer may include a **pelvic exam** and a **Pap test**. If the Pap test shows abnormal cells the doctor may offer another test, a colposcopy to further investigate the cervix. The type of treatment for precancerous lesions of the cervix depends whether the lesion is low or high grade, whether the woman wants children, the woman’s age, and the woman’s general health. Some techniques to treat cervical cancer include cryosurgery, cauterization, laser surgery, by loop electrosurgical excision procedure (LOOP), radiation therapy, chemotherapy, or biological therapy.

The American Cancer Society (ACS) recommends that women have a Pap smear annually beginning at age 18. Among women aged 18 and older in the US (2000) and in Florida (2002), greater than 90% have had a pap smear and the distribution is uniform across race/ethnic groups: white, black and Hispanic. About 15% of women aged 18 years and older did not have a pap smear in the past three years and this did not change significantly in the 1990s (see Figure 26).

Figure 26. Percent of Florida and US women aged 18 years and older who have not had a pap smear in the past three years, by year, BRFSS 1990–2002



The major culprit for skin cancer is exposure to the sun's ultraviolet (UV) rays.

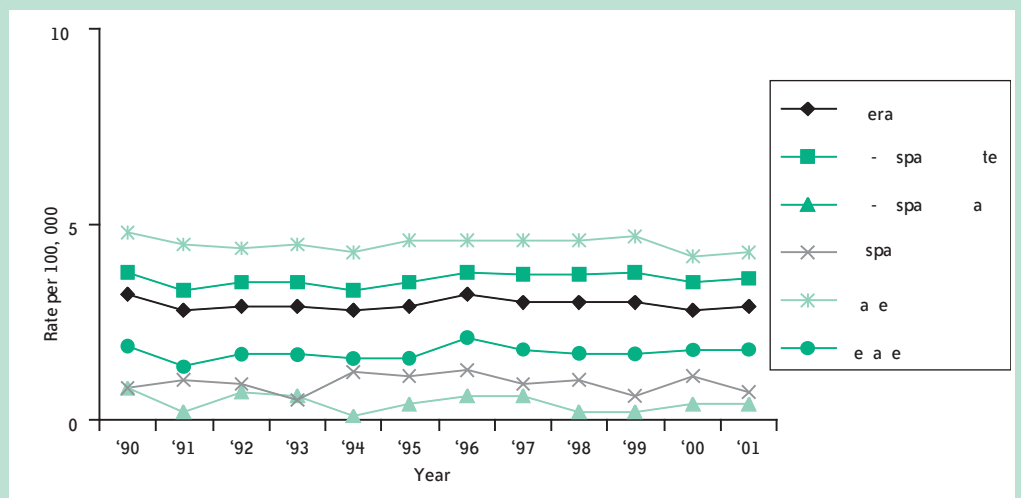
Skin Cancer

May is Skin Cancer Awareness Month

Skin cancer is the most common form of cancer. There are two major groups: non-melanoma skin cancer and melanoma skin cancer. Malignant melanoma, the most serious form of skin cancer, is the most rapidly increasing form of cancer in the United States. Melanoma is more common than any non-skin cancer among people between 25 and 29 years old.

Skin cancer, although not as deadly as the other cancers, killed 368 men and 188 women in Florida in 2001. Age-adjusted mortality rates have been stable from 1990–2001 (see Figure 27). Age-adjusted mortality rates for men are more than twice those observed for women.

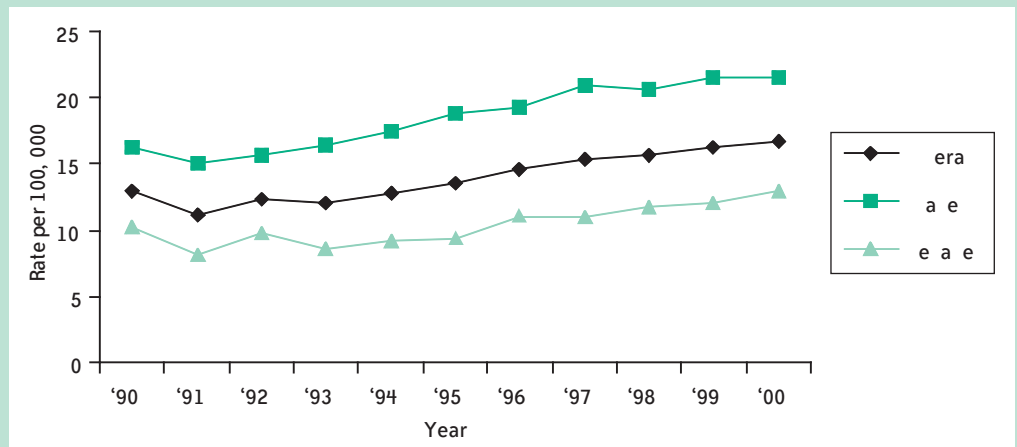
Figure 27. Age-adjusted(1) mortality rates for skin cancer, by year, gender and race/ethnicity, 1990–2001, Florida Vital Statistics, CDC WONDER



1. Age-adjusted to the 2000 standard million

In Florida, skin cancer is the sixth most common cancer diagnosed in women and the fifth most common cancer diagnosed in men. In 2000, approximately 1,200 new cases were diagnosed in women and approximately 1,800 new cases were diagnosed in men. Age-adjusted incidence rates for melanoma, the most serious form of skin cancer, have been increasing (see Figure 28).

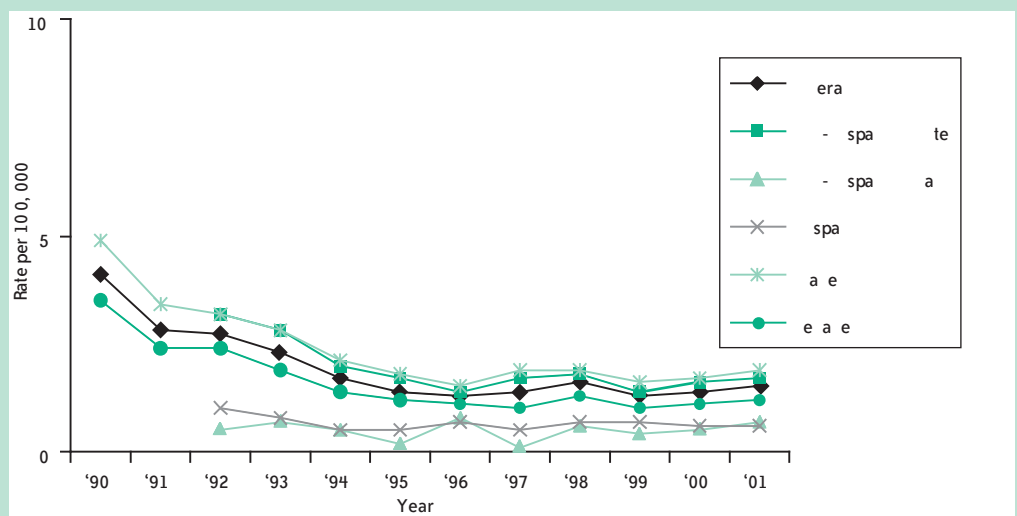
Figure 28. Age-adjusted(1) incidence rates for melanoma, by year and gender, 1990–2000, Florida Cancer Data System



1. Age-adjusted to the 2000 standard million

Age-adjusted hospital discharge rates for skin cancer have decreased from 1990–2001 (see Figure 29). Discharge rates for males are higher than those for females and discharge rates are higher for non-Hispanic whites compared to non-Hispanic blacks and Hispanics. From 1990–2001, daily hospital charges have increased from \$4,190 (C\$) to \$7,475.

Figure 29. Age-adjusted(1) hospital discharge rates for skin cancer, by year, gender and race/ethnicity(2), 1990–2001, Florida Agency for Health Care Administration Hospital Discharge Data



1. Age-adjusted to the 2000 standard million

2. Race/ethnicity information not available in data prior to 1992

The major culprit for skin cancer is exposure to the **sun's ultraviolet (UV) rays**. Skin cancer is preventable by utilizing effective sun measures consistently such as seeking shade or avoiding the sun during 10 am to 3 pm even on cloudy days, wearing hats and sunglasses, and frequently applying sun lotion with a sun protection factor (SPF) of at least fifteen.

Often, the first sign of melanoma is a change in the size, shape, color, or feel of an existing mole. Individuals should carefully examine all moles and birthmarks, looking for signs by remembering the **ABCs** of possible melanoma:

- **A**symmetry;
- **B**order irregularity;
- **C**olor variation;

The most prevalent type of cancer was acute lymphocytic leukemia at 21% of all cancer diagnoses.

- Diameter greater than a pencil eraser; and
- Enlargement.

Skin cancer treatment may include one of the following or a combination thereof: surgery, chemotherapy, biological therapy, or radiation therapy. The rule remains the same, early detection is beneficial in that it may either prevent the development of cancer or detect the disease at an early, more treatable stage.

Childhood Cancers

Although most cancers occur among adults, children also develop cancer. It is the chief cause of death by disease in children between the ages of 1 and 14 years.

Cancers in children are different from the major cancers in adults. It is often more difficult to recognize. When children are first diagnosed, they often have a more advanced stage of cancer. While most adult cancers result from lifestyle factors, the causes of most cancers in children are not known. The most common adult cancers are lung, breast, colon, prostate and pancreas, whereas cancers in children are usually leukemia, brain, bone, lymph and tumors of the muscles, kidneys, and nervous system.

Parents should be alert to any **unusual symptoms** that persist and see that their children have regular well-child check-ups. These symptoms include: an unusual mass or swelling; unexplained paleness and/or loss of energy; sudden tendency to bruise; persistent, localized pain or limping; prolonged unexplained fever or illness; frequent headaches often with vomiting; sudden eye or vision changes; and excessive, rapid weight loss.

The majority of adults with cancer are treated in their local community by their family physicians, surgeons, and other cancer specialists. Children are usually diagnosed and treated by a multidisciplinary team with expertise in the management of children with cancer. Such teams are usually located at major children's hospitals, university medical centers and cancer centers.

Based on data from the Florida Association of Pediatric Tumor Programs, Inc., in 2001, there were 677 new cases of cancer among children ages birth to 19 years. The most prevalent type of cancer was acute lymphocytic leukemia at 21% of all cancer diagnoses. A diagnosis of brain tumor was second at 16.8%. The ratio of solid tumors to leukemia was 2:1. Five-year survival for all diagnoses improved from 64% for patients diagnosed in 1980–1984 to 75% for patients diagnosed in 1995–2001, an increase of 11%.

Table 1 Diagnosis of patients at registration, Florida Association of Pediatric Tumor Programs, Inc., Pediatric Hematology/Oncology Program 2001–2002 Annual Report

CATEGORY OF DIAGNOSES	# BY CATEGORY	% OF DIAGNOSES
BONE CANCER	50	7.4
SOFT TISSUE	33	4.9
BRAIN	114	16.8
HODGKIN'S DISEASE	39	5.8
NON-HODGKIN'S DISEASE	45	6.6
ACUTE LYMPHOCYTIC LEUKEMIA	142	21
ACUTE NON-LYMPHOCYTIC LEUKEMIA	73	10.8
NEUROBLASTOMA	56	8.3
OTHER (Wilms Tumor, Retinoblastoma, Cancers of the Endocrine System)	124	18.3
TOTAL	677	100

In the State of Florida, **Children's Medical Services (CMS)**, the **State's Title V program** for children (birth to 21 years) with special health-care needs, provides a family-centered, comprehensive and coordinated statewide managed system of care that links community-based healthcare with multidisciplinary regional and tertiary pediatric care. The CMS Pediatric Hematology/Oncology Program is a regionalized program that was initiated in 1988 and is authorized by section 385.206, Florida Statutes.

CMS contracts with hematology/oncology centers throughout the state to provide care for children diagnosed with a hematological or oncological disorder. The centers meet standards developed by CMS and are members of the Children's Oncology Group (COG), a National Cancer Institute-supported clinical trials cooperative group devoted exclusively to childhood and adolescent cancer research. To be a member of COG, institutions must meet stringent competence, commitment and compliance criteria. There are currently ten CMS-designated centers providing comprehensive, multidisciplinary childhood cancer treatment services.

Tobacco use is the leading preventable cause of premature death.

Risk Factors

A number of different cancers have **common risk factors**, in particular, **smoking, physical inactivity, and poor nutrition**. From the Behavioral Risk Factor Surveillance System, the prevalence of these risk factors in the adult population can be estimated.

Tobacco Use

Tobacco use is the leading preventable cause of premature death. Use of tobacco increases the risk of cancers (lung, oral, esophageal, laryngeal), cardiovascular disease (coronary heart disease, stroke), and chronic lower respiratory disease (emphysema, chronic bronchitis, chronic airway obstruction). Although cigarette smoking has decreased greatly in the U. S. since the mid-1960s, the downward trend has flattened in the 1990s and into the 21st century among people of both sexes and from all race/ethnic groups. Between 1995 and 1999, cigarette smoking caused more than 440,000 deaths each year, or about 20% of the total U. S. annual mortality. Of these annual deaths, approximately 148,000 resulted from cardiovascular disease, 156,000 from cancers, 98,000 from respiratory diseases and 3,000 from environmental tobacco smoke (ETS)-induced lung cancer. In addition, it has been estimated that approximately 35,000 ischemic heart disease deaths in the U. S. are caused by ETS. Among U. S. adults in 2000, current cigarette smoking was reported by 24.1% of non-Hispanic whites, 18.6% of Hispanics and 23.2% of non-Hispanic blacks.

Among Florida adults, current cigarette use declined between 1986 and 1993 from 28.8% to 21.4% (see Figure 30). Since 1993, however, current smoking among adults has remained stable. In 2002, 23.3% of non-Hispanic white, 17.5% of non-Hispanic black and 19.3% of Hispanic adults currently smoked cigarettes. Another 30.1%, 10.8% and 17.7%, respectively, were former smokers and 46.6%, 71.7% and 63.0%, respectively, never smoked cigarettes.

Figure 30. Prevalence of Florida adults who are current cigarette smokers, by year, Florida BRFSS, 1986–2002



Tobacco use is not limited to adults. In 1998, the first administration of the Florida Youth Tobacco Survey, 18.5% of middle and 27.4% of Florida public high school students currently smoked cigarettes. In 2002, the prevalence of current cigarette use dropped to 9.2% among middle and 17.8% among high school students.

Among Florida **middle school (grades 6–8)** students in 1998, current smoking prevalence was 22% among non-Hispanic whites, 9.5% among non-Hispanic blacks and 16.8% among Hispanics. In 2002, these rates declined to 11.4%, 4.3% and 8.2%, respectively. Among Florida high school students (grades 9–12), current smoking prevalence in 1998 was 34.8% among non-Hispanic whites, 9.8% among non-Hispanic blacks and 24.8% among Hispanics. These rates were 23.5%, 6.2% and 16.3%, respectively, in 2002.

In Florida in 2001, there were a total of 162,122 deaths among those aged 35 years and older. Of these deaths, 30,570 or 18.9% were attributable to smoking.



Physical Inactivity

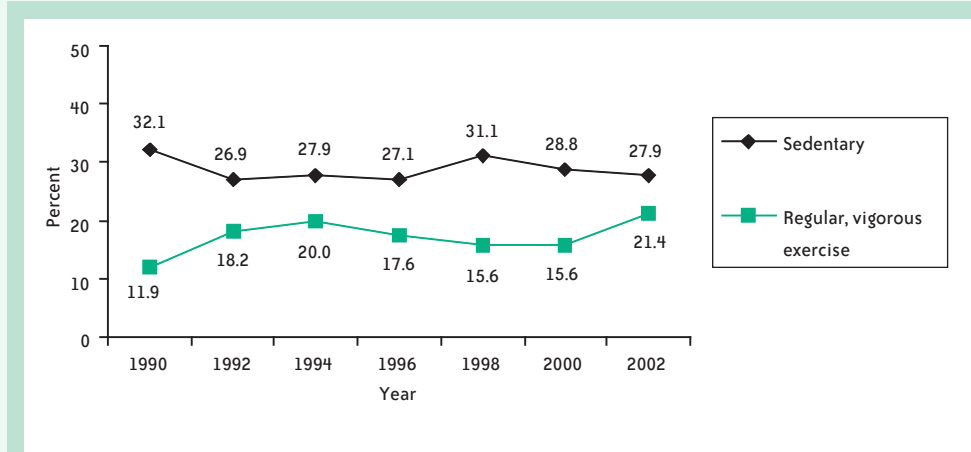
Regular physical activity reduces the risk of dying prior to reaching average life expectancy, dying from heart disease, developing diabetes, developing high blood pressure, and developing colon cancer. Regular physical activity also reduces feelings of depression and anxiety, aids in weight control, helps maintain healthy bones, muscles and joints, and aids older adults in becoming stronger, thus, preventing injuries. Nationwide, more than 60% of adults do not achieve the recommended amount of regular physical activity. In fact, 25% of all US adults are not active at all.

Nationally, inactivity increases with age and is more common among women than men and among those with lower income and less education than among those with higher income or education. Nearly half of young people aged 12–21 are not vigorously active on a regular basis and physical activ-

ity declines dramatically with age. In 1997, 72% of female and 57% of male US high school students reported not participating in physical education classes in school.

In Florida between 1990 and 2002, approximately 28–30% of adults did not participate in any leisure time physical activities. In addition, for a majority of 1990–2002, less than one in five adults participated in regular, vigorous exercise (see Figure 31).

Figure 31. Prevalence of Florida adults who are sedentary and who participate in regular, vigorous exercise, by year, Florida BRFSS 1990–2002



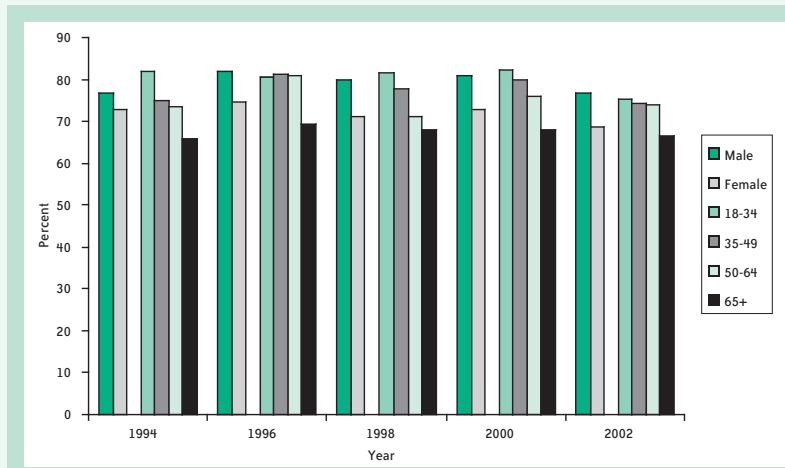
Nutrition

Among the large majority of Americans who do not smoke, **unhealthy diet** and **poor exercise patterns** are the **major cause of death and disability**. Diets rich in fruits, vegetables and whole grains are associated with reduced risk of cancer, cardiovascular disease, overweight and obesity, diabetes, and death prior to reaching life expectancy.

Poor nutrition touches all ages. Among U. S. adults in 2000, 76.8% of Hispanics, 78.7% of blacks and 76.6% of whites reported eating fewer than five servings of fruits and vegetables per day. Among U. S. high school students in 2001, 79.8% of whites, 75.5% of blacks and 76.8% of Hispanics reported eating fewer than five servings of fruits and vegetables per day.

In Florida, over three-fourths of all adults did not eat the recommended number of servings of fruits and vegetables per day (see Figure 32). Fruit and vegetable consumption was first measured by the BRFSS in 1994. Men have a higher prevalence of inadequate fruit and vegetable consumption compared to women, and adequate vegetable consumption increases with increasing age.

Figure 32. Prevalence of Florida adults who did not consume the recommended number of servings of fruits and vegetables, by year and sex, Florida BRFSS 1994–2002



Survivorship

In addressing the burden of cancer in Florida, we cannot overlook the integral component of cancer survivorship for Floridians. According to the National Cancer Institute, "Globally, there are an estimated 22.4 million people living with a history of cancer and approximately 9 million cancer survivors in the United States."

With today's medical advancements, cancer patients are living longer with cancer; however, issues regarding palliative care have not kept this same rigorous stride. Although a specific course of action has not been delineated for the State of Florida, the Florida Cancer Plan 2003–2006 does identify several goals, specifically goal eight concentrating on enhancing quality of life for Floridians with cancer and their families and friends. We will continue to strive to coordinate our efforts in addressing issues raised for patients and their families.

Healthy People 2010

The **Healthy People 2010 objectives** addressed by the **Comprehensive Cancer Control Program** are:

- 3–1:** Reduce the overall cancer death rate to 159.9 deaths per 100,000 population. (State target: 172.09. Baseline: 188.99 in 2000; Source: Community Health Assessment Resource Tool Set (CHARTS))
- 3–2:** Reduce the lung cancer death rate to 44.9 deaths per 100,000 population. (State target: 51.79. Baseline: 56.46 in 2000; Source: CHARTS)
- 3–5:** Reduce the colorectal cancer death rate to 13.9 deaths per 100,000 population. (State target: 15.52. Baseline: 18.44 in 2000; Source: CHARTS)
- 3–7:** Reduce the prostate cancer death rate to 28.8 deaths per 100,000 population. (State target: 9.25. Baseline: 10.28 in 2000; Source: CHARTS)
- 3–8:** Reduce the melanoma cancer death rate to 2.5 deaths per 100,000 population. (State target: 2.49. Baseline: 2.77 in 2000; Source: CHARTS)

The **Healthy People 2010 objectives** addressed by the **Breast and Cervical Cancer Program** are:

- 3-3:** Reduce the breast cancer death rate to 22.3 deaths per 100,000 population. (State target: 10.8. Baseline: 13.4 in 2000; Source: CHARTS)
- 3-4:** Reduce the death rate from cancer of the uterine cervix to 2.0 deaths per 100,000 population. (State target: 1.4. Baseline: 1.7 in 2000; Source: CHARTS)

Meeting the Objectives

The Florida Department of Health's Comprehensive Cancer Control Program is in its third year of funding, and second year of a new five-year cycle, with the purpose of developing a comprehensive cancer strategic action plan for the state. The plan will address eight main types of cancer – prostate, colorectal, skin, lung, ovarian, breast, cervical, and children's cancers. Each Healthy People 2010 objective will be addressed in the strategic plan. Once strategies are developed, implementation activities will be put into place to reduce the age-adjusted death rates of prostate, colorectal, skin, lung, ovarian, breast, cervical and children's cancers.

With today's
medical
advancements,
cancer patients
are living longer
with cancer.

The program objectives are:

1. **Assess and address the cancer** burden by organizing the revision of the state cancer plan, and ensuring that all objectives are implemented by a key stakeholder to ensure accountability and full integration of the plan.
2. **Utilize data** for comprehensive cancer control planning that promotes collaboration and coordination among state cancer data and surveillance systems to enhance program components and to support evaluation efforts.
3. **Mobilize** support for **comprehensive cancer planning** activities by assessing and building support among public and private entities.
4. **Build (enhance) partnerships** and support among existing state level coalitions such as the Cancer Control and Research Advisory Council, American Cancer Society, and Florida Comprehensive Cancer Control Initiative to ensure broad-based representation and a comprehensive cancer focus are maintained or augmented.
5. **Enhance** department infrastructure and leadership development.
6. **Conduct an evaluation** to determine the full integration and diffusion of comprehensive cancer control.
7. **Implement public and professional educational campaigns** to create awareness and leadership development around comprehensive cancer prevention and control issues, as well as coordinate with the CDC on education and training issues.

Genetics

According to the Centers for Disease Control and Prevention (CDC), **chronic diseases are the leading cause of death in America**, responsible for 70% of all deaths costing citizens and the government \$325 billion annually. In 2001 in Florida, five out of the top ten leading causes of death were chronic diseases accounting for 68% of all deaths. Genetic research has begun to uncover genetic links to various chronic diseases and risk factors for chronic disease.

The Florida Department of Health has **integrated genetics** into a number of programs, primarily in Children’s Medical Services (CMS), environmental health, maternal and child health, and family health services. These programs partner with each other and other department service areas such as vital statistics, and the Bureau of Epidemiology, to provide genetic services. Most recently, the department participated with national and state genetic stakeholders, in Florida, to focus on integrating genetic research into public health practice and primary care.

CMS, Florida’s program for children with special health care needs, manages the department’s Genetics and Infant Screening Program. Chapter 383.14 of the Florida Statutes provides legislative authority for the Genetics and Infant Screening Program. The program presently screens all newborns for galactosemia, hypothyroidism, sickle cell disease, phenylketonuria (PKU), and congenital adrenal hyperplasia. This is done in coordination with hospitals, birthing facilities, and endocrine metabolic, genetic and hematology referral centers. The department’s state laboratory performs the infant screening tests and reports the results to the CMS Program, birthing facility, and physician of record. Statistics and all presumptive abnormal results are reported to the CMS office in Tallahassee to assure proper confirmation and treatment and to maintain an ongoing consolidated registry of affected infants.

Since 1973, the CMS program has received funds from the **Florida Legislature** to provide **genetic services to children**, birth to age 21, at-risk for, or with, a genetic disorder. CMS collaborates with the

We ... in Florida, focus on integrating genetic research into public health practice and primary care.

National Newborn Screening/Genetics Resource Center in Austin, Texas, the John T. MacDonald Foundation, Center for Medical Genetics at the University of Miami, and the three universities in Florida under contract with CMS to provide genetic services. Services funded through the genetics program contracts include initial and follow-up genetic evaluation and diagnosis, genetic counseling, lab studies required for confirmation of genetic disorders, within available funding, patient consultations in hospitals and clinics, dietary evaluation and counseling for treatment of PKU or galactocemia, and laboratory studies to confirm metabolic screening disorders, at no cost to parents/caregivers.

Each year, **CMS conducts workshops** in the state, which include content on genetics and its relationship to cancer, that have proven to be extremely beneficial in providing current education, capacity building and resource sharing among statewide healthcare professionals. To date, CMS reports attendance of 750 healthcare professionals.

The **Bureau of Epidemiology**, among other services, **provides chronic disease epidemiological services** including cancer case reporting, managing the state cancer registry, and managing the Behavioral Risk Factor Surveillance System (BRFSS) survey and the Pregnancy Risk Assessment Monitoring System (PRAMS). The state has the ability to add genetics questions to the BRFSS. Epidemiology and surveillance are integral in assessing the impact of genetics on the health communities. The chronic disease epidemiology staff currently provide support to the various Bureau of Chronic Disease Prevention (BCDP) programs including cardiovascular health, diabetes, obesity, coordinated school health, and cancer.

The **Bureau of Chronic Disease Prevention (BCDP)** recently applied for a **genetics grant** from the **Centers for Disease Control and Prevention**. Although the grant was approved, no funding was available for implementation. The BCDP will continue to apply for funds for this program, as the genetics program in the BCDP would align with the goal of the Florida Genetics Program. When funded, the genetics program will initially integrate genomics into chronic disease programs, before undertaking a widespread department integration. The programs in the BCDP have a history of working together to achieve common goals. The programs include Heart Disease and Stroke Prevention, Diabetes Prevention and Control, Arthritis Prevention and Control, 5 A Day for Better Health, Physical Activity Promotion, Comprehensive Cancer Control, Employee Wellness, Obesity Prevention, and Chronic Disease Promotion and Education Projects.

Although family history and genetics play a role in many chronic diseases, the bureau programs have been focused on primary and secondary prevention of modifiable risk factors. The Comprehensive Cancer Control Program plans to integrate genetics as part the goals in the Florida Cancer Plan.

Cancer Partners

Florida Department of Health, Comprehensive Cancer Control Program

The Comprehensive Cancer Control Program, housed in the Bureau of Chronic Disease Prevention, is funded through a cooperative agreement with the Centers for Disease Control and Prevention. The program focuses on prostate, ovarian, skin, colorectal, and lung cancers. The main objective of the cooperative agreement is to reduce the cancer burden through a collaborative effort with public and private partners throughout Florida. This is accomplished by working with the existing governor-appointed C-CRAB. The program has utilized data provided by the **Florida Cancer Data System (FCDS)** to prepare this report and will continue to partner with them on future cancer reports and program materials. Staff collaborate with the CDC on various media projects promoting **healthy lifestyles** and **cancer reduction**,

and provide the administration and management of **Closing the Gap - Reducing Racial and Ethnic Health Disparities** funding allocated to counties and community groups. Other responsibilities include working toward developing guidelines and policies pertaining to county health department activities, especially surrounding the colorectal cancer indicator. The program networks with other programs to coordinate activities for overlapping risk factors such as smoking, poor diet and lack of physical activity.

Florida Department of Health, Breast and Cervical Cancer Program

Established in 1994, the **Florida Breast and Cervical Cancer Early Detection Program** is a breast and cervical cancer screening program that provides reduced-cost or free mammograms, clinical breast exams and Pap smears to **low-income, uninsured women** between the ages of 50 and 64. The program is funded by the CDC as part of the National Breast and Cervical Cancer Early Detection Program serving 50 states, 14 Indian Tribes, and seven territories. The program has 16 lead sites that ensure statewide access to services.

Services provided by the Breast and Cervical Cancer Program include:

- Breast and cervical **cancer screening exams** (mammograms, Pap smears and clinical breast exams) for uninsured and underinsured women 50 to 64 years of age, at or below 200% of poverty;
- **Diagnostic exams** provided as necessary;
- **Case management** provided to all clients; and
- **Outreach**, public education and professional education.

Treatment for eligible women may be paid by Medicaid. Data is collected and utilized to assess the program's effectiveness and quality.

Florida Cancer Data System

Under a contract with the Florida Department of Health, the University of Miami operates the **Statewide Cancer Registry Program** via the **Florida Cancer Data System (FCDS)**. The University of Miami retrieves cancer data from the 208 state-licensed hospitals' case reports, and abstracts, edits, and compiles the data into appropriate files within the FCDS for analysis by the department. A major program goal has been to provide cancer incidence information for public and professional education. Increased analysis and the dissemination of cancer data to decision makers has been achieved through the continued enhancement of the state's analytical capabilities. This has been achieved by the following activities: the continued production of high-quality annual reports, including a series of specialty monographs and newsletters; increasing the potential of data usage via the FCDS web query-based system; faster and more comprehensive responses to cluster investigation; and encouraging collaborations between the FCDS Registry and the university community as well as other registries and cancer-focused institutions.

Cancer Control Research Advisory Council (C-CRAB)

C-CRAB is housed within the **H. Lee Moffitt Cancer Center and Research Institute, Inc.** The Florida Cancer Control and Research Act, s. 381.3712, of the Florida State Statutes, created the Council in 1979. The Council consists of 35 members including the chairperson. All members must be residents of the state. All members except those appointed by the Speaker of the House of Representatives and the President of the Senate, must be appointed by the Governor. At least one of the members appointed by the Governor must be 60 years of age or older. The remainder of the membership is comprised of a representative from each of the following:

Each year, the
Council
approves a
program for
cancer control
and research
known as the
**Florida Cancer
Plan.**

- Agency for Health Care Administration
- American Cancer Society
- American College of Surgeons
- Association of Community Cancer Centers
- Cancer Information Service
- College of Medicine at the University of Florida
- College of Medicine at the University of South Florida
- Florida Agricultural and Mechanical University – Institute of Public Health
- College of Public Health at the University of South Florida
- Florida Association of Pediatric Tumor Programs, Inc.
- Florida Department of Education
- Florida Department of Health
- Florida Dental Association
- Florida Hospital Association
- Florida Medical Association
- Florida Nurses Association
- Florida Obstetric and Gynecologic Society
- Florida Osteopathic Medical Association
- Florida Radiological Society
- Florida Society of Clinical Oncology
- Florida Society of Oncology Social Workers
- Florida Society of Pathologists
- Florida Tumor Registrars Association
- H. Lee Moffitt Cancer Center and Research Institute
- NOVA Southeastern College of Osteopathic Medicine
- School of Medicine at the University of Miami
- Statutory teaching hospital affiliated with a community-based cancer center
- Sylvester Comprehensive Cancer Center at the University of Miami
- University of Florida, Shands Cancer Center

Three members must be representatives of the **general public** acting as **consumer advocates**. One member must be a member of the House of Representatives appointed by the Speaker of the House and one member must be a member of the Senate appointed by the President of the Senate. Of the members of the Council appointed by the Governor, at least 10 must be individuals who are minority persons as defined by s. 288.703(3).

Each year, the Council approves a program for cancer control and research known as the **Florida Cancer Plan**. This Plan is designed to be consistent with the State Health Plan and integrated and coordinated with existing programs in the state. The Council formulates and recommends to the Secretary of the Florida Department of Health, a plan for the care and treatment of persons suffering from cancer and suggests the establishment of standard requirements for the organization, equipment, and conduct of cancer units or departments in hospitals and clinics in the state. The Council may recommend to the Secretary, the designation of cancer units following a survey of the needs and facilities for treatment of cancer in the various localities throughout the state. The Secretary shall also consider the Florida Cancer Plan in developing departmental priorities, funding priorities and medical standards. The Council is responsible for including in the Florida Cancer Plan recommendations for the coordina-

tion and integration of medical, nursing, paramedical, lay, and other plans concerned with cancer control and research. Committees are formed by the Council to review the following areas that have been established as entities for actions:

1. Cancer plan evaluation: tumor registry, data retrieval systems, and epidemiology of cancer in the state and its relation to other areas
2. Cancer prevention
3. Cancer detection
4. Cancer patient management: treatment, rehabilitation, terminal care, and other patient-oriented activities
5. Cancer education: lay and professional
6. Unproven methods of cancer therapy: quackery and unorthodox therapies
7. Investigator-initiated project research

In order to implement, in whole or in part, the Florida Cancer Plan, the Council recommends to the Secretary of the Florida Department of Health, the awarding of grants and contracts to qualified profit or nonprofit associations or governmental agencies in order to plan, establish, or conduct programs in cancer control or prevention, cancer education and training, and cancer research.

Florida Comprehensive Cancer Control Initiative (FCCCI)

The **Florida Comprehensive Cancer Control Initiative (FCCCI)** was established in October 2000 through a cooperative agreement between the CDC and the University of Miami-Sylvester Comprehensive Cancer Center. Florida was the first state to receive a federal line item appropriation for comprehensive cancer control; the funding was incorporated into CDC's Comprehensive Cancer Control Program. FCCCI established four Regional Cancer Control Collaboratives that encompass the entire state of Florida. Each collaborative participated in a strategic planning process that resulted in four regional cancer plans with goals, objectives, and strategies in three areas: education, service delivery/access to care, and policy. The plans are on the FCCCI web site -- <http://fccci.med.miami.edu>. In this regional planning process, FCCCI brought together more than 100 organizations - state and local, large and small, public and private, lay and professional - in a model collaborative approach to improve cancer control efforts both regionally and statewide. The regional plans, and representatives from regional collaboratives, were part of developing the Florida Cancer Plan, and will also be part of the state implementation process.

In June 2003, when CDC funding ended, FCCCI became part of the University of Miami Sylvester Comprehensive Cancer Center. It has four functions: (1) to continue to support the Southeast Regional Collaborative, (2) to help develop community-based cancer control research in South Florida, with particular focus on reducing cancer disparities, (3) to maintain contact with the three other regional collaboratives, and (4) to participate in state cancer control activities.

All four of the Regional Collaboratives continue to work to implement their respective regional cancer plans. In the Southwest Region, the H. Lee Moffitt Cancer Center & Research Institute is the lead agency; in the Northeast Region, it is the M.D. Anderson Cancer Center Orlando. The Northwest Region is supported by a collaborative effort between Florida Agricultural & Mechanical University's College of Pharmacy, Florida State University's Center for Health Equity, and the Cancer Information Service Partnership Program.

Office of Minority Health

In July 2000, the **Patient Protection Act**, also known as **Reducing Racial and Ethnic Health Disparities: Closing the Gap Act**, was signed into law. The “Closing the Gap” grant program was created to improve the health outcomes of Florida’s racial and ethnic populations through community-based projects. The Act provides funding for such projects within Florida counties and Front Porch Florida Communities with the intent to: 1) eliminate health disparities by stimulating the development of community-based and neighborhood-based projects to improve health outcomes of racial and ethnic populations, and 2) foster the development of a broad-based participation by public and private entities, and faith-based organizations. The Act targets six priority health areas — Adult and Child Immunizations, Cancer, Cardiovascular Disease, Diabetes, HIV/AIDS, and Maternal and Infant Mortality in which racial and ethnic groups currently experience serious disparities in access to care and health concerns.

The Department’s **Office of Equal Opportunity and Minority Health**, in a collaborative effort with Family Health Services, Bureau of Chronic Disease Prevention, Bureau of Family and Community Health, Bureau of Immunizations; and the Bureau of HIV/AIDS, **administers** the **49** grant programs. The availability of funds appropriated by the Legislature is publicized through a grant announcement and application process. Any person, entity, or organization within a single county may apply for a “Closing the Gap” grant. Projects funded through the grant program provide prevention, intervention and education services that include screenings and referrals. The grant program has provided funding for cancer prevention and education services to reach select counties through three projects for early detection and referral of individuals with cancer into services.

Florida Dialogue on Cancer

The Florida Dialogue on Cancer (FDOC), established in 2002, is a **public/private collaboration**, on a statewide basis, among the state’s major health organizations, universities, patient advocate groups, and state and local government entities to create systemic change in an effort to reduce the rates of cancer incidence and mortality and minimize the impact of cancer for all Floridians. The FDOC partners speak with one voice regarding the expansion of the state's capacity to reduce cancer incidence and mortality, improve the quality of life and minimize the impact of cancer for all Floridians. The FDOC supports the goals of the state cancer plan, specifically, those that contribute to tripling the numbers of National Cancer Institute comprehensive cancer centers, establishing a statewide clinical trials network and creating a shared services program in bioinformatics and other cutting-edge research. The Florida Senate and House of Representatives has recognized the FDOC as the entity positioned to lead this initiative to systemically win Florida’s fight against cancer. The FDOC is positioned to work collaboratively with all partners to provide greater cancer care to all Floridians.

American Cancer Society

Dedicated to eliminating cancer through research, advocacy, education and service, the American Cancer Society’s mission is closely aligned with the goals of the newly-approved Florida Cancer Plan 2003–2006. The Florida Division of the American Cancer Society has provided help for the development of the regional cancer plans. The volunteers and staff of the American Cancer Society, representing the world’s largest voluntary, community-based health agency, will continue to support the goals of the plan and will work on the achievement of specific goals within the Florida Cancer Plan 2003-2006. The American Cancer Society salutes this collaborative endeavor to enhance early detection, prevention and services for cancer patients and potential cancer patients in the state of Florida.

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Cancer Information Service (CIS)

The Coastal Cancer Information Service is a program of the **National Cancer Institute (NCI)**, the Nation's lead agency for cancer research. As a resource for information and education about cancer, the CIS is a leader in helping people, particularly those who are medically underserved, become active participants in their own health care by providing the latest information on cancer in understandable language. Located at the Sylvester Comprehensive Cancer Center at the University of Miami, the Coastal CIS serves Florida, Puerto Rico, and the U.S. Virgin Islands.

For over 25 years, the **Cancer Information Service** has provided the latest and most **accurate cancer information** to patients and families, the public, and health professionals, and has worked in the cancer control arena by means of its Partnership Program and Research component. The CIS has several access points for the public and partners including the **1-800-4-CANCER** telephone line and the website at <http://www.cancer.gov>.

The CIS is committed to working with the Department of Health and the other partners in the process of achieving the goals set forth in the Florida Cancer Plan 2003–2006.

Florida Association of Pediatric Tumor Programs, Inc. (FAPTP)

FAPTP is an integral part of a coordinated network of physicians and other medical personnel who care for children with cancer and blood disorders in the State of Florida. FAPTP was established in 1973 with the mission of ensuring improved care for children with cancer and blood disorders.

In 1981, Senate Bill 308 designated FAPTP to oversee and maintain data for the State of Florida's Children's Medical Services' (CMS) hematology/oncology program. Since then, FAPTP has:

- **Developed** and continues to **maintain** the only statewide pediatric cancer registry.
- Assured the existence of a **coordinated network** of physicians and other medical personnel who care for children with cancer and blood disorders.
- **Ensured**, through **evaluation** and **consultation**, that state-of-the-art care is available for Florida's children. This infrastructure makes it possible to compete for federal funding from the National Cancer Institute through the Florida Pediatric Community Clinical Oncology Program (CCOP) that supports the care of 37 percent of the children diagnosed with cancer in Florida.

In keeping with its mission, the Florida Association of Pediatric Tumor Programs, Inc., provides many scientific and educational opportunities. These educational and research programs meet the growing demands for accurate, credible information from the public member institutions and the State of Florida.

Educational Opportunities

This year was FAPTP's 25th year of their educational seminar that provides educational opportunities for medical personnel. This is a unique opportunity to further enhance the level of care for children with cancer and blood disorders.

Research and Reporting Systems

Research and statewide reporting systems not only provide the state and the public with research-based information on cancer incidence, but these programs also support investigators in studies conducted on both the state and national level.

Quality Assurance

Center directors from around the state are reimbursed with state funds through a contract with FAPTP to provide evaluation, based on established program standards, and consultation to Florida's CMS hematology/oncology programs.

FAPTP Statewide Patient Information Reporting System (SPIRS)

SPIRS is the **data collection** and **processing system** developed by the Florida Association of Pediatric Tumor Programs. SPIRS includes registration and follow-up data collected for each patient presenting at the major statewide cancer treatment programs.

SPIRS:

- Provides the foundation to identify patients treated outside FAPTP member institutions.
- Aids in determining the incidence of pediatric cancer in Florida.
- Establishes patterns of care for pediatric cancer patients.
- Provides essential program planning and development information to the State of Florida's CMS, and participating institutions.

Patients registered in **SPIRS** include all persons **under the age of twenty-one** who present at one of the cancer treatment programs with malignancies or potentially disabling benign tumors. Some patients present only for diagnosis and consultation, but most also seek treatment for their condition. Data on these patients are submitted by each treatment site to the FAPTP Central Office. FAPTP staff manages, processes, analyzes, and reports the information. Registration data include demographic and diagnostic information about each patient.

There are several opportunities for research available to members of the Florida Association of Pediatric Tumor Programs. FAPTP members participate in research studies through their own statewide-developed protocols, the Children's Oncology Group, and the H. Lee Moffitt Cancer Center CCOP Research Base.

Appendix 1

Cancer Control Research Advisory Council (C-CRAB)

MEMBER NAME	AGENCY REPRESENTING
C-CRAB Chairperson JoBeth H. Speyer, MSW* Director Cancer Information Service	Cancer Information Service
C-CRAB Co-Chairperson Robert H. Cassell, MD, PhD* Physician	American Cancer Society
Past C-CRAB Chairperson Clarence H. Brown, III, MD* President/CEO M. D. Anderson Cancer Center Orlando	A representative from a statutory teaching hospital affiliated with a community based cancer center
C-CRAB Director Brian J. Calkins Program Administrator Florida Association of Pediatric Tumor Programs	C-CRAB
Michael Alberts, MD* Assoc. Center Director of Clinical Affairs H. Lee Moffitt Cancer Center & Research Institute	H. Lee Moffitt Cancer Center & Research Institute
Joyce A. Allan, MPH, CTR Cancer Registrar Registry Solutions	Florida Tumor Registrars
Guy I. Benrubi, MD Professor University of Florida College of Medicine	Obstetric & Gynecologic Society
Joanne L. Bujnoski, DO Radiation Oncologist Center for Cancer Care	Florida Osteopathic Association
Rose Marie A. Cossick Real Estate Broker	General Public as a Consumer Advocate
Michele M. Delafranchi, LCSW Medical System Clinical Social Worker M. D. Anderson Cancer Center-Orlando	Florida Society of Oncology Social Workers
Marcia W. DeSonier, RN, LCSW* Coordinator Cancer Support Services	Florida Hospital Association
Honorable Carl J. Domino State Representative State of Florida, House of Representatives	House of Representatives

MEMBER NAME	AGENCY REPRESENTING
James V. Fiorica, MD Chief, Gynecologic Oncology H. Lee Moffitt Cancer Center & Research Institute	Florida Society of Clinical Oncology
Deborah W. Glotzbach* Program Administrator DOH Comprehensive Cancer Control Bureau of Chronic Disease Prevention	Florida Dept. of Health
Stephen L. Golder, MD Radiation Oncologist Sarasota Oncology Center	Florida Medical Association
Cynthia M. Harris, PhD Director, Institute of Public Health Florida A & M University	Florida A & M University, Institute of Public Health
William H. Hartmann, MD	Univ. of South Florida, College of Medicine
Stephen P. Hunger, MD University of Florida	Florida Pediatric Society
D. Wayne Jenkins, MD* Medical Director M. D. Anderson Cancer Center Orlando	Statutory Teaching Hospital Affiliated with a Community-Based Cancer Center
John W. Kilkenny, III*, MD, FACS University of Florida	Univ. of Florida, College of Medicine
Director, School Health Program Department of Education	Florida Dept. of Education
Robert S. Kirsner, MD Physician University of Miami/Dept of Dermatology	School of Medicine, University of Miami
Jerry M. Layne, DDS, MD	Florida Dental Association
James W. Lynch, Jr., MD* University of Florida, Health Sciences Center	University of Florida, Shands Cancer Center
Donna M. Malvey, PhD Assistant Professor USF, College of Public Health	USF, College of Public Health, MDC-56
Thomas A. Marsland, MD	Association of Community Cancer Centers
John W. Mason, MD	Florida Society of Pathologists
George R. McSwain, MD Manatee Surgical Associates	American College of Surgeons

MEMBER NAME	AGENCY REPRESENTING
Dorothy F. Parker* FCCCI Program Director UM/Sylvester Comprehensive Cancer Center	UM/Sylvester Comprehensive Cancer Center
Stephen Todd Parrish Director Orange County Legislative Affairs	General Public as a Consumer Advocate
Shyam B. Paryani, MD Florida and Georgia Radiation Oncology Group	Florida Radiological Society
Honorable Jim Sebesta Florida State Senator State of Florida	Member of the Senate Appointed by the President of the Senate
Joseph M. Stasio, DO Family Medicine Residency Program College of Osteopathic Medicine Nova Southeastern University	Southeastern College of Osteopathic Medicine
James L. Talbert, MD FAPTP President Emeritus University of Florida	Florida Association of Pediatric Tumor Programs, Inc. (FAPTP)
D. Reel Talbott Attorney	General Public as Consumer Advocate

* Denotes member of the Executive Committee

Cancer Control Research Advisory Council (C-CRAB) Mandate

C-CRAB Mandate

(From Section 240.5121, Florida Statutes)

- **Advise the Governor, the Legislature, and state agencies** with respect to cancer control and research in Florida, including methods of enforcing and implementing laws concerned with cancer control, research, and education.
- **Approve** an annual “**program** for cancer control and research to be known as the Florida Cancer Plan.” The Plan should include “recommendations for the coordination and integration of medical, nursing, paramedical, lay, and other plans concerned with cancer control and research.”
- **Committees** shall be **formed to address:**
 - Cancer plan evaluation: tumor registry, data retrieval systems, and epidemiology of cancer in the state and its relation to other areas;
 - Cancer prevention;
 - Cancer detection;
 - Cancer patient management: treatment, rehabilitation, terminal care, and other patient-oriented activities;
 - Cancer education: lay and professional;
 - Unproven methods of cancer therapy: quackery and unorthodox therapies;
 - Investigator-initiated project research.
- **Develop** a plan for the **care and treatment** of cancer patients; recommend the establishment of standard requirements for the organization, equipment, and conduct of cancer units or departments in hospitals and clinics; recommend the designation of cancer units following a survey of the needs and facilities.
- Pending the availability of funds, **recommend** the awarding of **grants** and **contracts** to qualified profit or non-profit associations or governmental agencies in order to plan, establish, or conduct programs in cancer control or prevention, cancer education and training, and cancer research.
- Pending the availability of funds, **develop** and **update** a **pamphlet** on the treatment alternatives for the effective management of breast cancer. Develop and implement an educational program, including distribution of the pamphlet, to inform citizen groups, associations, and voluntary organizations about early detection and treatment of breast cancer.
- **Formulate** and put into effect a **continuing educational program** for the prevention of cancer and its early diagnosis and disseminate to hospitals, cancer patients, and the public, information concerning the proper treatment of cancer.

Appendix 3

Steering Committee Members

MEMBER NAME	AGENCY REPRESENTED
Bruce Black	American Cancer Society
Brian Calkins	Cancer Control and Research Advisory Board (C-CRAB)
Patricia Colantonio	Pinellas County Health Department and SW Regional Cancer Control Collaborative
Marcia DeSonier	Baptist Hospital, Pensacola, C-CRAB and NW Regional Cancer Control Collaborative
Jan Domlesky	Cancer Information Service
Michael Franklin	American Cancer Society
Deborah Glotzbach	Florida Department of Health
Cynthia Harris	Florida A & M University, C-CRAB NW Regional Cancer Control Collaborative
Sue Higgins	Florida Department of Health
Lori Belle-Isle	American Cancer Society
Dr. Wayne Jenkins	M.D. Anderson Cancer Center Orlando, C-CRAB
Tom Kean	Strategic Health Concepts, Inc.
Karen Klubertanz	North Central Florida Health Planning Council, Inc. and NE Regional Cancer Control Collaborative
Lil Lash	American Cancer Society
Sherry Meyer	Susan G. Komen (South Florida Affiliate) and SE Regional Cancer Control Collaborative
Theodis Mitchell	Division of Cancer Prevention and Control, Centers for Disease Control and Prevention
Dorothy Parker	Florida Comprehensive Cancer Control Initiative
Phyllis Rochester	Division of Cancer Prevention and Control, Centers for Disease Control and Prevention
JoBeth Speyer	Cancer Information Service, C-CRAB
Cynthia Vinson	National Cancer Institute

Florida Cancer Plan 2003 Acronyms

Agency for Health Care Administration (AHCA)
American Association of Retired Persons (AARP)
American Cancer Society (ACS)
American College of Surgeons (ACOS)
American College of Surgeons Commission on Cancer (ACOSCO)
Area Health Education Centers (AHEC)
Association of Community Cancer Centers (ACCC)
Breast and Cervical Cancer Program (BCCP)
Cancer Information Service (CIS)
Centers for Disease Control and Prevention (CDC)
Department of Education (DOE)
Department of Health (DOH)
Department of Elder Affairs (DOEA)
Florida Agricultural and Mechanical University (FAMU)
Florida Association of Pediatric Tumor Programs (FAPTP)
Florida Cancer Control and Research Advisory Council (C-CRAB)
Florida Cancer Data System (FCDS)
Florida Comprehensive Cancer Control Initiative (FCCCI)
Florida Dialogue on Cancer (FDOC)
Florida Hospital Association (FHA)
Florida Medical Association (FMA)
Florida Medical Quality Assurance Inc. (FMQAI)
Florida Nurses Association (FNA)
Florida Osteopathic Medical Association (FOMA)
Florida Peer Review Organization (FL PRO)
Florida Society of Clinical Oncology (FLASCO)
Florida Society of Oncology Social Workers (FSOSW)
Intercultural Cancer Council (ICC)
National Cancer Institute (NCI)
Oncology Nursing Society (ONS)

Terminology

- 1. Age-adjusted rate** A rate (e.g., incidence or mortality rate) that mathematically adjusts for differences in the age composition of populations. It is useful when comparing one group to another. Expressed as a rate per 100,000 population. All age-adjusted rates in this document are based on the 2000 U.S. standard population.
- 2. BRFSS** The Behavioral Risk Factor Surveillance System – The largest, continuously conducted telephone health survey in the world. It is conducted by each state under the guidance of the Centers for Disease Control and Prevention (CDC). The purpose of the survey is to uniformly collect data on the variety of behaviors and conditions that place adults at risk for chronic disease, injuries, and preventable infectious diseases that are the leading causes of morbidity and mortality in the U.S.
- 3. Cancer** A term for diseases in which abnormal cells divide without control. Cancer cells can invade nearby tissues and can spread through the bloodstream and lymphatic system to other parts of the body.
- 4. Cancer incidence** Cancer incidence is the number of newly diagnosed cases of cancer occurring in a population in a given period of time, usually one year.
- 5. Cancer incidence rate** A rate that is calculated by dividing the number of newly-diagnosed cases of cancer in a specific population by the number of people in that population. Expressed as a rate per 100,000. It can be a crude or age-adjusted rate.
- 6. Cancer mortality rate** A rate that is calculated by dividing the number of deaths from cancer in a specific population by the number of people in that population. Expressed as a rate per 100,000. It can be a crude or age-adjusted rate.
- 7. Chemotherapy** Treatment with anticancer drugs.
- 8. Digital Rectal Exam (DRE)** An exam in which a healthcare professional inserts a lubricated, gloved finger into the rectum to feel for abnormal areas.
- 9. Fecal Occult Blood Test (FOBT)** A test to check for blood in stool.
- 10. Grade** A system of classifying cancer cells in terms of how abnormal they appear under a microscope. The grading system provides information about the probable growth rate of the tumor and its tendency to spread. The systems used to grade tumors vary with each type of cancer. Grading plays a role in treatment decisions.
- 11. In situ** Noninvasive cancers; tumors in which cancer cells have not spread to nearby tissue. Also referred to as carcinoma in situ.

- 12. Mortality rate** A rate expressing the proportion of a population who die of a disease, or of all causes. The numerator is the number of persons dying; the denominator is the total population in which the deaths occurred. To produce a rate that is a manageable whole number, the fraction is usually multiplied by 100,000 to produce a rate per 100,000. This rate is also called “crude death rate.”
- 13. Prostate-specific antigen test** A test that measures the level of an enzyme (PSA) in the blood that may increase due to diseases of the prostate gland, including prostate cancer.
- 14. Screening** Testing healthy individuals for a specific disease or condition, such as cancer. This is different from diagnostic testing, which is done when a person has signs or symptoms of a disease. However, the same test can serve both purposes, e.g., mammograms and prostate-specific antigen tests can be used for both screening and diagnosis.
- 15. Stage of disease** A system of categorizing tumors based on their size and how far they have spread. Local stage is often referred to as early, and regional and distant are referred to as late because it reflects when the cancer was found in relation to how long it has been growing. The stage of a cancer when it is diagnosed is referred to as the stage at diagnosis.
- 16. Tumor** An abnormal mass of tissue that results from excessive cell division. Tumors perform no useful body function. They may be either benign (not cancerous) or malignant (cancerous).