



Florida State Cancer Plan 2010





CHARLIE CRIST
GOVERNOR

September 29, 2010

Dear Floridians:

Cancer is a leading concern of all Floridians. Florida ranks second in the nation in cancer incidence and mortality, and recent data shows that approximately 275 Floridians are diagnosed with cancer each day.

Since cancer is a major public health concern, it is imperative for Florida to take a concerted and comprehensive approach to reduce death and illness due to cancer. Therefore, it is with great pleasure that I present the 2010 Florida Cancer Plan and the accompanying Florida Cancer Plan Guide. The 2010 Plan and Guide were designed to assist Florida's partners in their efforts to reduce the impact of cancer in all forms and phases.

The 2010 Plan and Guide were achieved through the dedication of Florida's leading cancer specialists and partners who are committed to providing a plan of action to help prevent, reduce, and control cancer. They are living documents, which will continue to evolve as progress is made in achieving the prioritized goals and strategies. Please join us in our fight against cancer and in helping to improve the quality of life for those affected by cancer.

I pay tribute to all of Florida's cancer survivors, their loved ones, and those who have treated and supported cancer survivors for their determination, expertise, and compassion in improving Floridians quality of life. I applaud the efforts of the numerous devoted Florida organizations and individuals who provide cancer prevention, education, early detection, treatment, and quality of life services for all Floridians.

Thank you for your dedication and contributions toward making Florida cancer free.

Sincerely,

A handwritten signature in blue ink that reads "Charlie Crist".

Charlie Crist

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 488-2272 • Fax (850) 922-4292

Dear Cancer Partner:

We are pleased to present to you the Florida Cancer Plan and the accompanying, Florida Cancer Plan Guide: Building Blocks to Reduce the Burden (hereafter referred to as the "FCP Guide"). The Florida Cancer Plan was created through a joint effort between the Florida Cancer Control and Research Advisory Board, the Florida Cancer Plan Council, and the Florida Department of Health. This Florida Cancer Plan builds on the strong foundation provided by the Florida Cancer Plan 2003 - 2006.

Although Florida continues to have the second highest cancer burden in the country, we have made significant strides in reducing this burden for Floridians. The Florida Cancer Plan is a culmination from a broad spectrum of expertise from across the state. It outlines our goals and defines strategies to further reduce the cancer burden.

We wish to thank the many Floridians, throughout the state, whose contributions and participation in cancer control activities have strengthened our fight against cancer and, especially, those committed individuals who have given their time, resources, and effort to help create and implement this cancer plan.

We invite you to learn more about cancer control activities in Florida and the role each one of us can play in helping win our battle against this disease.

Florida Department of Health

Cancer Control and
Research Advisory Council

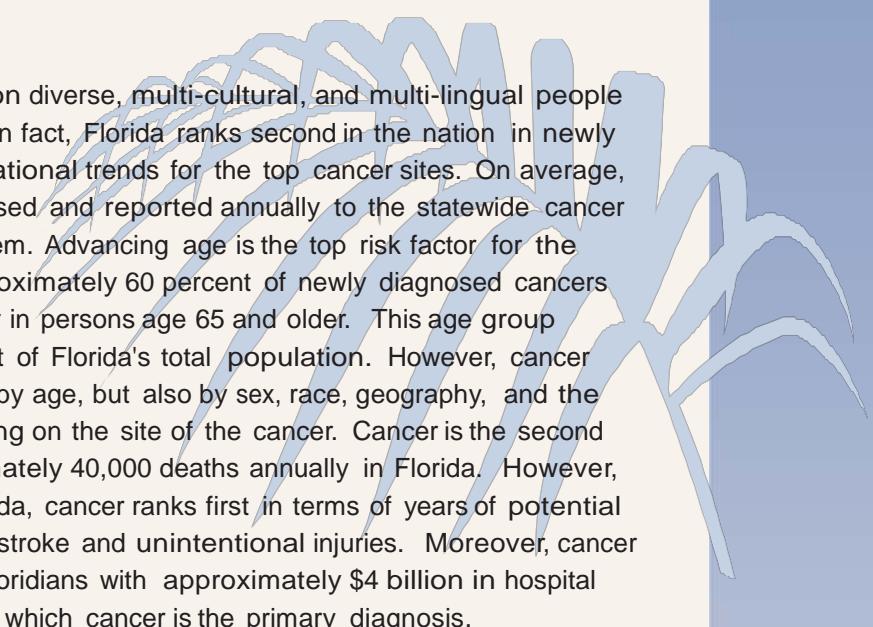
Florida Cancer Plan
Council



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Executive Summary



Florida is home to more than 19 million diverse, multi-cultural, and multi-lingual people for whom cancer is a personal issue. In fact, Florida ranks second in the nation in newly diagnosed cancer cases and mirrors national trends for the top cancer sites. On average, there are 100,000 new cancers diagnosed and reported annually to the statewide cancer registry, the Florida Cancer Data System. Advancing age is the top risk factor for the development of cancer. Overall, approximately 60 percent of newly diagnosed cancers and 70 percent of cancer deaths occur in persons age 65 and older. This age group accounts for approximately 18 percent of Florida's total population. However, cancer occurrence in Florida differs not only by age, but also by sex, race, geography, and the stage of disease at diagnosis depending on the site of the cancer. Cancer is the second leading cause of death with approximately 40,000 deaths annually in Florida. However, of the leading causes of death in Florida, cancer ranks first in terms of years of potential life lost, surpassing heart disease and stroke and unintentional injuries. Moreover, cancer constitutes an economic burden on Floridians with approximately \$4 billion in hospital charges for in-patient hospital care in which cancer is the primary diagnosis.

The Florida Cancer Plan was created through a collaborative effort with Florida's cancer stakeholders. The state's current cancer control efforts are focused to build on the previous cancer plan's successes and outlined to address future strategies to achieve the plan's four goals. These goals include building partners, providing cancer prevention education, ensuring accessibility, and improving quality of life for all Floridians.

The Florida Cancer Plan provides an overview of the cancer burden in Florida, health disparities by population, specific behavioral and preventive measures that may reduce one's risk of cancer, and early detection techniques by 10 specific cancer sites or classifications. These cancer sites and classifications include breast, cervical, childhood, colorectal, lung, lymphoma, oral and pharyngeal, ovarian, prostate, and melanoma of the skin. These specific cancer sites have been included because they are either the most common cancer sites or are some of the most receptive to prevention and early detection. More importantly, when addressed through public health and policy, decreasing the incidence and mortality of these cancers can reduce the burden of cancer in Florida and nationwide.

A network of dedicated individuals leads and implements these cancer efforts. They volunteer hundreds of hours to the governor-appointed Florida Cancer Control and Research Advisory Council, the Florida Cancer Plan Council, and regional collaboratives.

In addition to the Florida Cancer Plan, the cancer stakeholders have developed a supplementary document, the Florida Cancer Plan Guide. It is a working document where cancer partners develop strategies toward achieving the cancer plan goals. Please see Appendix D.

What You Can Do To Fight Cancer In Florida!

If you are a Floridian, you can:

- Quit smoking and avoid secondhand smoke
- Maintain a nutritious diet
- Be physically active each day
- Know when to be screened and get screened
- Consider enrolling in a clinical trial if you have cancer
- Get involved with your local cancer collaborative by contacting the Florida Department of Health
- Support those living with cancer

If you are a community or Faith Based Organization, you can:

- Provide cancer prevention education
- Promote cancer screening
- Support cancer service providers
- Support those living with cancer

If you are an employer or a hospital, you can:

- Maintain a smoke-free environment
- Provide healthy foods
- Promote physical activity
- Promote cancer screening
- Provide health insurance
- Support those living with cancer

If you are a policy maker, you can:

- Promote systems changes that will increase cancer screenings
- Join the comprehensive cancer control efforts in Florida in a way that directly contributes to the coordination and success of the movement at the state and collaborative level.¹
- Support policies that are effective and will lead to environmental and behavioral changes that impact cancer.²
- Encourage constituents to join you in eliminating cancer by building awareness and advocacy for cancer prevention, early detection, access to quality care, eliminating disparities in health, and increasing survival.³
- Support Florida initiatives regarding tobacco settlement and enforcement of Clean Indoor Air Act.⁴

¹ C-Change, The Comprehensive Cancer Control Movement Ten Years of Success 1998 to 2008, p. 15-16.

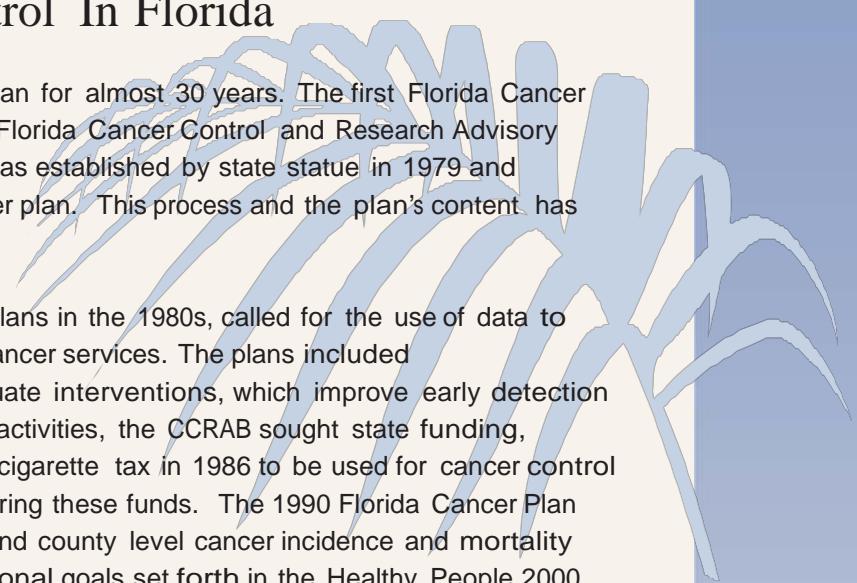
² Ibid

³ Ibid

⁴ Ibid

History Of Cancer Control In Florida

The State of Florida has had a cancer plan for almost 30 years. The first Florida Cancer Plan was written and approved by the Florida Cancer Control and Research Advisory Council (CCRAB) in 1981. The CCRAB was established by state statute in 1979 and mandates the approval of a state cancer plan. This process and the plan's content has evolved over the years.



The first cancer plan, and subsequent plans in the 1980s, called for the use of data to identify high risk groups and gaps in cancer services. The plans included recommendations to develop and evaluate interventions, which improve early detection and assess patient care. To fund these activities, the CCRAB sought state funding, including the allocation of a proposed cigarette tax in 1986 to be used for cancer control programs, but was unsuccessful in securing these funds. The 1990 Florida Cancer Plan was the first to include detailed state and county level cancer incidence and mortality data. It also linked Florida data to national goals set forth in the Healthy People 2000 objectives. In 1993, the Florida Cancer Plan updated data from the 1990 plan and established four priorities: (1) lung cancer, (2) breast and cervical cancer, (3) access to preventive care and screening, and (4) statewide cancer control efforts. In addition, the plan included recommended emerging issues, which were to be explored in future plans. These issues were prostate and colorectal cancer screening and skin cancer. These issues were addressed and goals were reported in the 1994 Florida Cancer Plan Update.

The 1998-1999 Florida Cancer Plan was prepared and approved by the CCRAB in 1997. Its priorities were access to care and insurance issues, tobacco use among youth, access to breast and cervical cancer screening, and awareness about prostate cancer screening and treatment options. The emerging issues in this plan were colorectal cancer screening, skin cancer, and genetic testing.

The last Florida Cancer Plan 2003-2006 was developed through a collaborative effort with the CCRAB and the Florida Department of Health Comprehensive Cancer Control (CCC) Program. The Cancer Plan was approved by the CCRAB in 2003. It was developed to outline a strategic plan for statewide comprehensive cancer control efforts and to provide cancer data by cancer site. The Florida Cancer Plan 2003-2006 identified the state's 12 priority goals, the strategies, and the proposed partners necessary to implement these initiatives.

The Florida Cancer Plan Council (FCPC) was created through guidance by the Centers for Disease Control and Prevention (CDC) and other federal partners, at the 2004 national Comprehensive Cancer Control Leadership Institute. The FCPC oversees the partners' efforts toward accomplishing Florida Cancer Plan's goals, provides technical assistance, and supports the regional collaboratives. The FCPC membership voted to focus their initial efforts on four of the 12 goals. These four goals were: (1) increase behaviors associated with primary prevention among Floridians of all ages, (2) increase communication and collaboration among public and private cancer control stakeholders statewide, (3) reduce factors that contribute to disparities in Florida's cancer burden, and (4) enhance the quality of life for Florida's families and friends with cancer.

The FCPC members developed four affinity groups and conducted business through e-mails and conference calls. The affinity groups were successful in creating a FCPC brochure to be used as a marketing tool, developing two online, cancer educational

modules for health professionals, strengthening cancer networks, and revising educational materials to be more culturally and linguistically appropriate.

For this current edition, the CCC Program and the FCPC consulted with an expert in System Dynamics Modeling (please see Appendix A for further detail) to refine the cancer plan's goals. This cancer plan was developed through a collaborative process involving CCRAB and FCPC members and Florida cancer experts who provided the leadership, support, and guidance to implement the identified strategies in this year's Florida Cancer Plan.

FLORIDA CANCER PLAN COUNCIL (FCPC)

The FCPC is comprised of volunteer cancer stakeholders from across the state who coordinate cancer control efforts. The FCPC has continued over the years to provide leadership and direction. Some of the FCPC'S activities have included implementing the Florida Cancer Plan, coordinating statewide cancer control efforts and contributing partners, assuring accountability, and supporting the regional collaboratives. The FCPC represents 25 areas across Florida that include the chairs of the regional cancer collaboratives, the American Cancer Society, Cancer Information Services, cancer hospitals, universities, the Susan G. Komen Foundation, and cancer survivors.

CANCER CONTROL RESEARCH AND ADVISORY COUNCIL (CCRAB)

The CCRAB is the legislatively mandated state council responsible for advising the legislature, the Governor, and the State Surgeon General to provide solutions and policy alternatives on how to reduce the cancer burden in Florida. The CCRAB monitors cancer data, trends, and disparities and evaluates and promotes effective interventions to help in cancer prevention, screening, and treatment. Also, the CCRAB develops position papers on cancer-related legislation and state policy issues and is responsible for approving the state cancer plan. An annual report outlining the CCRAB's activities is submitted to the Governor and the State Surgeon General on February 15th of each year. For more information on the CCRAB, please visit www.ccrab.org. The 35 members of the CCRAB are leaders in health care, education, cancer research and treatment, and Florida government. Many are cancer survivors.

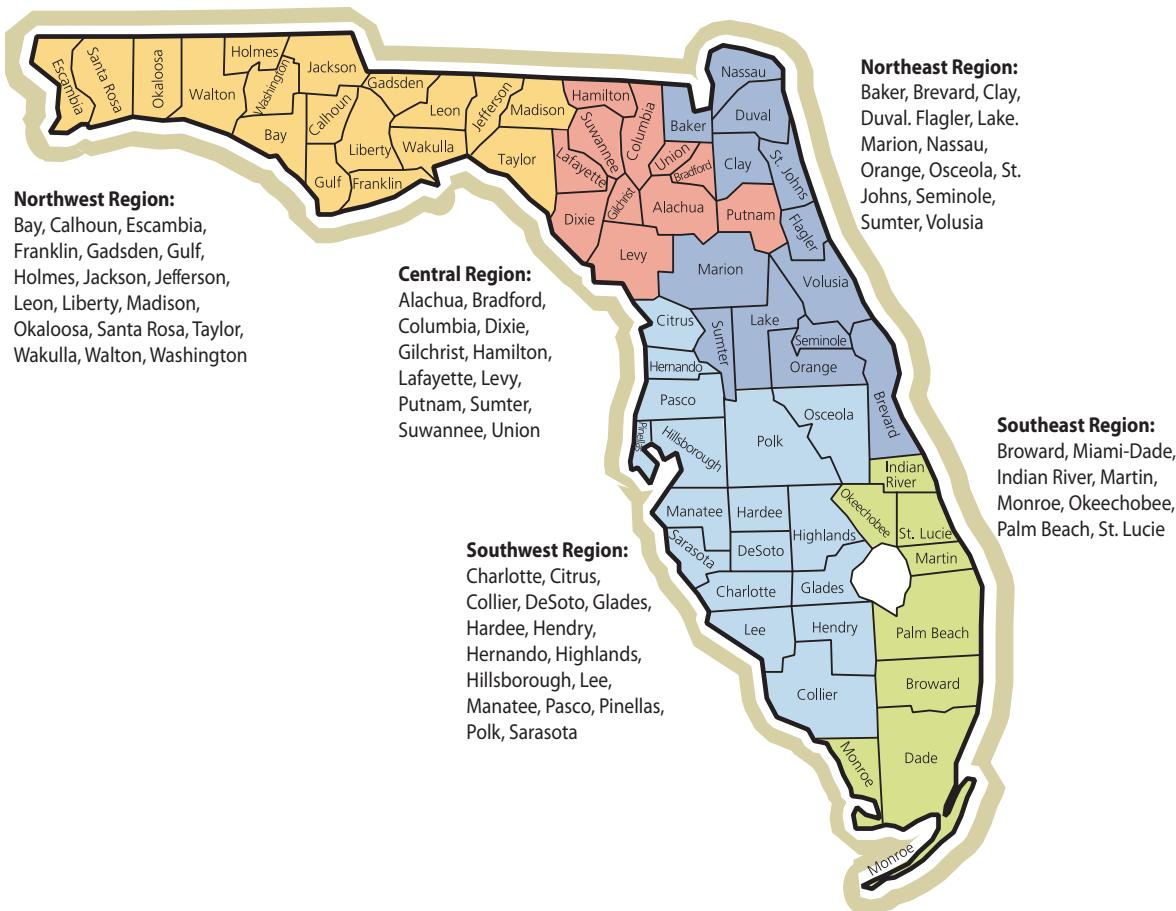
REGIONAL CANCER COLLABORATIVES

Due to Florida's geographically large and diverse state, there is a need for more localized planning as well. In 2000, the U.S. Congress appropriated funds to develop comprehensive regional cancer control plans in Florida. Funding was awarded to the University of Miami, Sylvester Comprehensive Cancer Center through a cooperative agreement with the CDC as part of their CCC Program. This resulted in the Florida Comprehensive Cancer Control Initiative (FCCCI), which established four regional cancer control collaboratives covering all 67 Florida counties (see map below). From 2000 to 2003, cancer control stakeholders in each of the four regions were invited to participate in a strategic planning process. From this, four regional cancer control plans were developed. In addition to regional goals, objectives, and strategies, each plan included detailed county-level cancer and demographic data, as well as a directory of cancer resources. The regional plans were integrated into the 2003-2006 Florida Cancer Plan, and representatives from each regional collaborative continue to be active members of the FCPC.

AMERICAN CANCER SOCIETY

The American Cancer Society is the nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives and diminishing suffering from cancer through research, education, advocacy and service. In Florida, the American Cancer Society is a leader in educating the public about cancer prevention, early detection and treatment options, as well as providing patients critical services to help them triumph over cancer. It has led successful efforts to utilize public policy to decrease tobacco use, including providing leadership to help pass the state's clean indoor air laws, guarantee funding for tobacco prevention and education and raise the state's tobacco tax by \$1 per pack. The American Cancer Society also has been a leader in advocating for state funding for cancer research, as well as supporting Florida institutions seeking research funding from the Society's nationwide research program.

REGIONAL CANCER CONTROL COLLABORATIVES



Northwest FL Collaborative <http://www.nwfcc.net/>

North Central FL Collaborative <http://www.ncfcancercontrol.org/>

Southeast FL Collaborative <http://sfccc.med.miami.edu/>

Southwest Collaborative <http://www.swflccc.com/>

The Structure of the Plan and Remarks on Its Use of Data

The Cancer Plan serves as a guide for healthcare professionals, policy makers, and community members to understand Florida's cancer incidence, mortality rate and screening rates, and to identify partnership opportunities in Florida's cancer control activities. The accompanying Florida Cancer Plan Guide provides stakeholders with general strategies to personalize their cancer plan, build coalitions, and effectively address Florida's cancer needs. (See Appendix D for an abridged version of the Florida Cancer Plan Guide.) The strategies listed in this cancer plan are not prioritized, nor considered a comprehensive list but may provide initial guidance for Florida cancer stakeholders.

The Cancer Plan:

- 1) Defines the state's cancer burden
- 2) Outlines the four major goals for cancer control
- 3) Identifies overarching strategies as a crosscutting tool
- 4) Identifies cancer site specific strategies
- 5) Provides a background on the various statewide cancer partners

Cancer remains the second leading cause of death for Floridians, after heart disease. Cancer is not just one disease, nor can it be defined through any single dataset. For this reason, the Florida Cancer Plan includes a variety of data sources to provide a more comprehensive understanding of cancer and to assess the appropriate interventions. Incidence data are provided by the state cancer registry, the Florida Cancer Data System (FCDS) for the period from 1981 through 2006. Mortality data are provided by the Florida Department of Health Office of Vital Statistics for the most current available year (2006 or 2007). In addition, screening data are provided by the Florida Behavioral Risk Factor Surveillance System (BRFSS), with the exception of when Florida data are compared to the national screening rates in which the source is the CDC BRFSS. The timeliness of the data depends on the data source. More specifically, in the FCDS there is an approximate year to a year-and-a-half time lapse from when a cancer diagnosis is reported by a physician to when the data is released. Each facility, laboratory, and practitioner is required to report the data within six months of each diagnosis and within six months of the date of each treatment. Consequently, there is an inherent time lag between data collection by the registry and when cancer data are available for data analysis, dissemination, and surveillance activities. Data sources for this cancer plan include cancer incidence and mortality rates from Florida's cancer registry, the FCDS, Florida's BRFSS, Surveillance Epidemiology and End Results (SEER), Florida Community Health Assessment Resource Tool Set (CHARTS), and the Office of Vital Statistics.

Cancer is the leading cause of death for all people in the U.S. under the age of 65 and the second leading cause of death for people of all ages.

National Vital Statistics Reports



Cancer In Florida...A Snapshot

Number of New Cancer Cases by Sex and Race, Florida 2006

| | All Cancers | Lung & Bronchus | Prostate | Breast | Colorectal | Oral & Pharyngeal Cancer* | Melanoma | Ovary | Cervix |
|-----------------|----------------|-----------------|---------------|---------------|---------------|---------------------------|--------------|--------------|------------|
| †Florida | 100,303 | 16,154 | 14,043 | 12,826 | 10,173 | 2,749 | 3,388 | 1,478 | 907 |
| Female | 46,787 | 7,306 | | 12,826 | 4,939 | 841 | 1,342 | 1,478 | 907 |
| Male | 53,442 | 8,835 | 14,043 | | 5,222 | 1,904 | 2,046 | | |
| Black | 8,888 | 1,153 | 1,704 | 1,226 | 986 | 211 | | 117 | 159 |
| White | 88,506 | 14,755 | 11,837 | 11,203 | 8,914 | 2,470 | 3,388 | 1,315 | 719 |
| Black Female | 4,162 | 405 | | 1,226 | 530 | 78 | | 117 | 159 |
| White Female | 41,236 | 6,769 | | 11,203 | 4,270 | 743 | 1,342 | 1,315 | 719 |
| Black Male | 4,718 | 746 | 1,704 | | 456 | 133 | | | |
| White Male | 41,216 | 7,976 | 11,837 | | 4,633 | 1,725 | 2,046 | | |

Source of Data: Florida Cancer Data System

*Oral Cancer consists of the following sites: lip, tongue, salivary glands, boor of mouth, gum and other mouth, nasopharynx, tonsil, oropharynx, hypopharynx, other buccal cavity, and pharynx.

†Florida incidence total counts and rates throughout this report include 1,140 new cancer cases in persons of "other" races, 882 cases with unknown race, 44 cases with unknown or unspecified sex, and 2 cases with unknown age. Totals by sex include cases with unknown age and race, as well as cases with "other" race. Totals by race include unknown sex and age.

During 2006, physicians diagnosed 100,303 new primary cancer cases among Floridians, an average of 275 cases per day. Cancer occurs predominantly among older people, as age is the top risk factor. Approximately 60 percent of the newly diagnosed cancers in 2006 occurred in persons age 65 and older; this age group accounts for 18 percent of Florida's population. The four most common cancers in Floridians were lung and bronchus (16,154 cases), prostate (14,043 cases), female breast (12,826 cases), and colorectal (10,173 cases), which accounted for 57 percent of all new cases in blacks and 53 percent in whites. Fifty-three percent of new cancers were diagnosed in males. The number of new cancer cases in Florida's five most populous counties (Broward, Miami-Dade, Hillsborough, Orange, and Palm Beach), which represent 42 percent of Florida's population, accounted for 39 percent of the new cancer cases in Florida in 2006.

Over the 26-year period from 1981 to 2006, males had a higher incidence (age-adjusted incidence rate) than females. Among blacks, the incidence among males was between 55 percent and 102 percent higher than among females. Among whites, the incidence among males was between 28 percent and 53 percent higher than among females. White females had higher age-adjusted incidence rates than black females in all 26 years. The racial disparity varied between 10 percent and 27 percent. Black males had higher age-adjusted incidence rates than white males in all years, except in 1987, 1988, and 2006. The racial disparity between black and white males increased from 1989 until 1995; however, it has steadily declined since 1996.

Between 1981 and 2007, advances in prevention, early detection, and treatment of cancer have decreased cancer death rates by nearly 18 percent.

FCDS

Number Cancer Deaths Cases by Sex and Race, Florida 2006

| | All | Lung & | Prostate | Breast | Colorectal | Bladder | Oral & Pharyngeal Cancer* | Melanoma | Ovary | Cervix |
|--------------|---------------|---------------|--------------|--------------|--------------|--------------|---------------------------|------------|------------|------------|
| †Florida | 39,938 | 11,795 | 2,079 | 2,605 | 3,692 | 1,048 | 593 | 657 | 955 | 301 |
| Female | 18,281 | 4,996 | | 2,605 | 1,804 | 290 | 181 | 188 | 955 | 301 |
| Male | 21,653 | 6,797 | 2,079 | | 1,888 | 758 | 412 | 469 | | |
| Black | 3,725 | 906 | 325 | 340 | 399 | 59 | 54 | | 72 | 56 |
| White | 35,731 | 10,774 | 1,735 | 2,223 | 3,249 | 974 | 531 | 657 | 876 | 240 |
| Black Female | 1,736 | 327 | | 340 | 207 | 26 | 18 | | 72 | 56 |
| White Female | 16,280 | 4,620 | | 2,223 | 1,569 | 258 | 161 | 188 | 876 | 240 |
| Black Male | 1,988 | 578 | 325 | | 192 | 33 | 36 | | | |
| White Male | 19,448 | 6,153 | 1,735 | | 1,680 | 716 | 370 | 469 | | |

Source of Data: Florida Cancer Data System

*Oral Cancer consists of the following sites: lip, tongue, salivary glands, boor of mouth, gum and other mouth, nasopharynx, tonsil, oropharynx, hypopharynx, other buccal cavity, and pharynx.

† Florida total counts include 265 deaths of persons of "other" races and 10 with unknown race; 4 deaths were recorded with unknown sex. Totals by sex include deaths with unknown and "other" races; totals by race include deaths with unknown sex.

During 2006, a total of 39,938 Floridians died from cancer; an average of 110 deaths per day. Cancer occurrence and death happens predominantly among older people as age is the top risk factor. Approximately 72 percent of cancer deaths in 2006 were in persons age 65 and older. Moreover, males accounted for 54 percent of total cancer deaths. Although 89 percent of cancer deaths were among whites, a greater percentage of blacks died from cancer at younger ages than did whites. The percentage of cancer deaths in people under age 65 was 45 percent among blacks and 26 percent among whites.

In 2006, the top sites for cancer deaths were lung and bronchus (11,795), colorectal (3,692), female breast (2,605), and prostate (2,079). In addition, deaths from cancers for which preventative health screening is available (breast, cervical, colorectal, and prostate cancers) accounted for 30 percent of all cancer deaths in blacks and 21 percent in whites.

Over the 26-year period from 1981 to 2006, the age-adjusted mortality rates for all cancers combined decreased by 13 percent among females and 22 percent among males. Despite the greater decline in mortality for males in the past 26 years, the difference in mortality rates between the sexes persists. In 2006, the rate for males was 47 percent greater than for females. Moreover, the age-adjusted mortality rates decreased 29 percent among blacks and 16 percent among whites, between 1981 and 2006. Furthermore, the total cancer mortality rates declined in all sex-race groups between 1981 and 2006: 34 percent among black males, 20 percent among black females, 20 percent among white males, and 13 percent among white females.

More information about the burden of cancer in Florida is provided in the Florida Annual Cancer Report, an epidemiological series, available on the Florida Department of Health's web site at www.doh.state.fl.us/disease_ctrl/epi/cancer/CancerIndex.htm or the FCDS web site at www.fcds.med.miami.edu.

CANCER SCREENING DATA

The Behavioral Risk Factor Surveillance System (BRFSS) is an anonymous population-based telephone surveillance system designed to collect data on health conditions, behaviors, and emerging health issues. The BRFSS survey data have been widely used to monitor health behavior and health status at state and national levels.

Current Cancer Screening Practices,* Florida, 2008

| | Breast Cancer Screening | | Cervical Cancer Screening Pap | Colorectal Cancer Screening | | Prostate Cancer Screening | |
|-----------------------|-------------------------|------|----------------------------------|-----------------------------|------|---------------------------|------|
| | Mammogram | CBE | | FOBT | C/S | PSA | DRE |
| Overall | 65.8 | 66.2 | 66.2 | 21.0 | 56.2 | 75.6 | 53.9 |
| Gender | | | | | | | |
| Female | 65.8 | 66.2 | 66.2 | 19.3 | 53.8 | | |
| Male | | | | 23.0 | 59.1 | 75.6 | 53.9 |
| Race/Ethnicity | | | | | | | |
| NH White | 66.2 | 68.3 | 68.3 | 21.8 | 58.8 | 79.4 | 57.0 |
| NH Black | 69.2 | 72.6 | 72.6 | 24.9 | 55.5 | 74.3 | 63.0 |
| Hispanic | 63.4 | 57.3 | 57.3 | 13.0 | 42.0 | 52.5 | 28.9 |

Source of Data: FL BRFSS

*Percentage of adults who had the recommended cancer screening:

NH - Non-Hispanic

Breast Cancer Screening

- Mammogram – Percentage of women 40 years of age and older who received a mammogram in the past year
- Clinical Breast Exam (CBE) – Percentage of women 18 years of age and older who had a CBE in the past year

Cervical Cancer Screening

- Pap Smear (Pap) – Percentage of women 18 years of age and older who received a Pap in the past year

Colorectal Cancer Screening

- Fecal Occult Blood stool Test (FOBT) – Percentage of adults 50 years of age and older who received a FOBT in the past year
- Colonoscopy or Sigmoidoscopy (C/S) – Percentage of adults 50 years of age and older who received a C/S in the past five years

Prostate Cancer Screening

- Prostate Specific Antigen (PSA) Test – Percentage of men 50 years of age and older who received a PSA test in the past two years
- Digital Rectal Exam (DRE) – Percentage of men 50 years of age and older who received a DRE in the past two years

SKIN CANCER BEHAVIORAL DATA

The need for information on sun protection and skin cancer prevention led to a collaborative effort between the Florida Department of Health, Bureau of Epidemiology and Florida's CCC Program. Two questions were developed and added to the 2005 Florida BRFSS to collect data on behaviors related to tanning. The same questions were included in the 2006 survey.

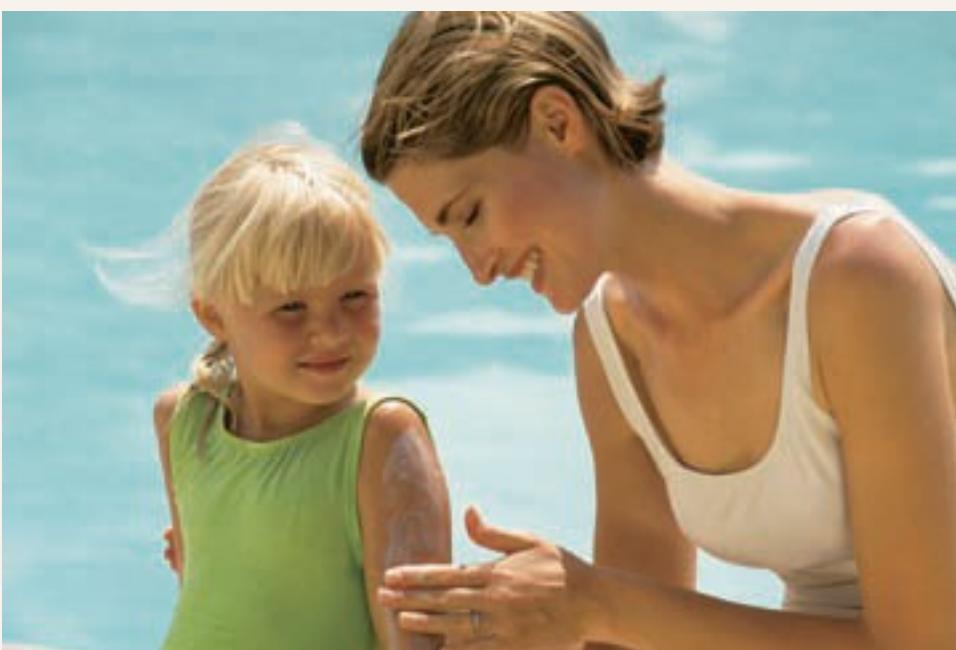
Tanning Practices and Product Use,* Florida, 2006

| Practice/Product Use | Percent |
|---|---------|
| Tan Enhancer | 2.3 |
| Less than SPF 15 | 6.0 |
| Greater than or equal to SPF 15 | 28.3 |
| Do not use any skin protection products | 14.9 |
| Do not purposely tan | 48.6 |
| | |
| Yes, re-apply | 78.7 |
| No, re-apply | 21.3 |

Source: FL BRFSS

*Approximately, 10,000 Floridians' responses to the following question:
When you are tanning, either outside or on an indoor tanning bed, what products do you usually apply to your skin? For those who do purposely tan, do you reapply sun block?

SPF = Sun protection factor



Setting The Course

CANCER PLAN GOALS

The purpose of the Florida Cancer Plan is to outline the state's goals, objectives, and strategies necessary to reduce the burden of cancer on individuals, families, and communities in Florida.

This Florida Cancer Plan was developed based on the tenets of the previous Florida Cancer Plan 2006. After an analysis of the previous plan and working with a consultant, the FCPC, CCRAB, and the Florida Department of Health CCC Program revised the cancer plan goals. The consensus among the members was for the previous cancer plan goals to be redefined and simplified into four goals. These four goals are:

Goal One: A coordinated approach among public and private cancer control stakeholders to implement cancer activities statewide.

Goal Two: Floridians practice the healthy behaviors associated with prevention of cancer or to reduction of risk.

Goal Three: Floridians have access to appropriate health information and effective health services for the timely detection, diagnosis, and treatment of cancer.

Goal Four: Floridians affected by cancer are aware of and have access to quality, appropriate services for quality of life, palliative care, and survivorship.

Each cancer site or classification has specific strategies that address each of the state's four goals. However, the FCPC and the CCRAB recognized that there are also overarching strategies applicable to each of the cancer sites. These strategies are categorically delineated and defined by programmatic components.

This Florida Cancer Plan is the first of two documents for cancer stakeholders to use in assessing the cancer burden and planning cancer control initiatives. The cancer stakeholders have developed a complementary document called the Florida Cancer Plan Guide.

“I do not want the word “cancer” to define who I am. I am a wife, mother, sister, daughter, friend, and teacher. Those are the words that define me.”

Grizel Arencibia, cancer survivor.

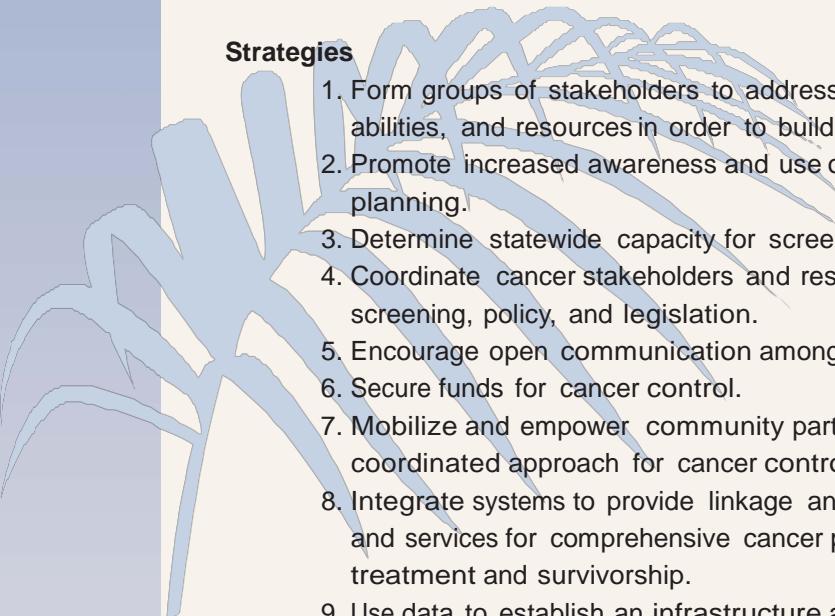
COMPONENTS AND OVERARCHING STRATEGIES

The cancer stakeholders who were instrumental in developing this cancer plan have identified 10 components that are overarching and affect each of the nine specific cancer sites. Thus, each component and the applicable strategies are outlined below to ensure these areas will be addressed in cancer control activities. A brief definition of each component is offered and has the strategies prioritized. These strategies will not be repeated again for each particular cancer site; however, there are certain exceptions especially pertinent for a particular type cancer that will be repeated.

I. INFRASTRUCTURE: CAPACITY

Building statewide capacity among individuals, groups, and organizations is essential for all aspects of cancer care. This includes formal and informal procedures, organizational policies, and leaders who create associations which are essential for planning and implementing successful cancer efforts.

Strategies

- 
1. Form groups of stakeholders to address strategies based on data, interest, abilities, and resources in order to build momentum.
 2. Promote increased awareness and use of reliable data sources in practice and planning.
 3. Determine statewide capacity for screening and treatment.
 4. Coordinate cancer stakeholders and resources to support cancer education, screening, policy, and legislation.
 5. Encourage open communication among stakeholders.
 6. Secure funds for cancer control.
 7. Mobilize and empower community partners to develop and support a coordinated approach for cancer control.
 8. Integrate systems to provide linkage and support with information, resources, and services for comprehensive cancer prevention, screening, diagnosis, treatment and survivorship.
 9. Use data to establish an infrastructure and build capacity.
 10. Support programs that ensure a competent, standard-based, medical workforce.

II. LIFESTYLE

Personal health is affected by the individual's behaviors in daily life. These include habits, preferences, and personal choices.

Strategies

1. Reduce smoking use.
2. Promote smoke free policies for work and community settings.
3. Promote personal responsibility with health.
4. Promote healthy diet, weight, and physical activity behaviors.
5. Promote sun safe measures.
6. Educate on safe sex practices.
7. Use behavioral data to identify and implement appropriate cancer control initiatives.

III. DISPARITIES

Disease incidence and mortality rates can be substantially different between racial, ethnic, gender, and economic groups.

Strategies

1. Assess cancer and behavioral data to identify populations with disparate cancer rates.
2. Ensure cancer educational materials are appropriate for the populations at risk.
3. Increase cancer screening and participation in clinical trials for the populations at risk.
4. Promote research that focuses on disparate populations to identify causes.
5. Use data to identify and implement appropriate cancer control initiatives to address health disparity issues.

IV. ACCESS TO CARE

The ability for Floridians to access the appropriate healthcare resources is critical for ensuring timely and effective care, and enhancing quality of life.

Strategies

1. Identify barriers including transportation, socio/cultural factors, and language that interfere with access to care.
2. Reduce barriers for cancer care and related services.
3. Coordinate care resources and improve linkages to ensure access to cancer care for all populations.
4. Identify and promote cancer prevention and care services for all populations.

V. EDUCATION

Education is an essential component in promoting and maintaining healthy behaviors which leads to more informed decisions, and strengthens the spectrum of healthcare disciplines.

Strategies

1. Increase opportunities for continuing medical education for health professionals.
2. Create and disseminate culturally and linguistically appropriate cancer materials for Floridians.
3. Develop cancer-specific public awareness campaigns to promote education and screening for the timely detection, diagnosis, and treatment of cancer.
4. Create and disseminate educational materials for policy makers.
5. Promote and support the implementation of research-tested interventions.
6. Provide information and resources for cancer caregivers.
7. Use data to promote and inform populations on cancer prevention, detection, diagnosis, treatment, services, research, survivorship, and palliative care.

Approximately one third of the most common cancers are due to lifestyles - poor diet, obesity, and lack of physical activity.

American Institute of Cancer Research

VI. RESEARCH

Active seeking and collecting of knowledge through experimentation, data inquiries, studies, surveys, focus groups, and other modalities need to be used in all aspects of care.

Strategies

1. Advocate for research advancements for priority cancers and assist with accurate cancer data collection.
2. Promote integration of genomic advances into practice.
3. Raise awareness of genomics and its importance in various aspects of cancer.
4. Promote and support continued research into aspects of cancer prevention, screening, risk reduction, care, and survivorship.
5. Raise awareness and acceptance of clinical trials as an option.
6. Increase enrollment into clinical trials.
7. Raise physician awareness on patient participation in clinical trials.
8. Use data to support research initiatives.

VII. SURVIVORSHIP

Once a person is diagnosed with cancer, the individual is considered a cancer survivor. Cancer survivors face unique physical, psychosocial, and economic issues of cancer, from diagnosis until the end of life.

Strategies

1. Identify and promote cancer-survivor and palliative-care services for cancer survivors and care givers.
2. Increase cancer survivors' awareness of and access to comprehensive survivorship services, which address cancer survivors' needs throughout the full spectrum of cancer care, from diagnosis to the end of life.
3. Disseminate information about resources and services for cancer survivors, their families, friends, and caretakers using a variety of methods and technologies.
4. Promote expansion of successful patient navigation programs within Florida's healthcare systems as appropriate for specific survivor populations.
5. Promote and support organizational partnerships that decrease barriers to survivorship resources for minorities and underserved populations.
6. Use data to promote and inform populations on cancer survivorship and palliative care.
7. Improve record keeping systems for patients with cancer.

VIII. POLICY LEGISLATION

Federal, state, and local regulations, including statutes, bills, rules, administrative codes and laws, shape policy. These policies include healthcare practices which may be allowed, enforced, provided forbidden, and enhanced through these vehicles. Making changes to these regulations, at any level, is a complex process.

Strategies

1. Mobilize partners and advocacy groups to develop and implement policy and environmental changes.
2. Provide education for legislation that enhances cancer control.
3. Link advocacy and legislative groups to address cancer plan goals.

4. Support policies that ensure health insurance coverage for cancer prevention, screening, and treatment for all Floridians.
5. Support actions and policy for healthcare coverage for all Floridians.
6. Support policies that ensure quality core healthcare standards.

IX. ENVIRONMENTAL FACTORS

The external atmosphere a person is living in creates positive and negative factors in one's environment, that affect their personal health, including their risk for cancer.

Strategies

1. Encourage a multi-disciplinary approach in educating and raising awareness on environmental risk factors in regards to cancer based on data
2. Provide information on environmental risk factors associated with cancer.
3. Support policies and procedures to reduce or eliminate environmental factors associated with cancer.

X. PATIENT NAVIGATION

The process of assisting patients through the network of services to facilitate communication, coordinate care with providers, and decrease barriers to care. There may be community navigators, acute care navigators, and survivor navigators in all cancer types.

Strategies

1. Provide support and resources for a cancer patient navigation system based on data.
2. Increase use of patient navigators in the acute and community settings.
3. Provide training opportunities for cancer caregivers and health professionals.
4. Compile a database of cancer resources to assist with care navigation.

The National Cancer Institute's Division of Cancer Control and Population Sciences funds over 900 grants valued at almost \$400 million including surveillance, epidemiology, health services, behavioral science and cancer survivorship.



Specific Cancer Sites

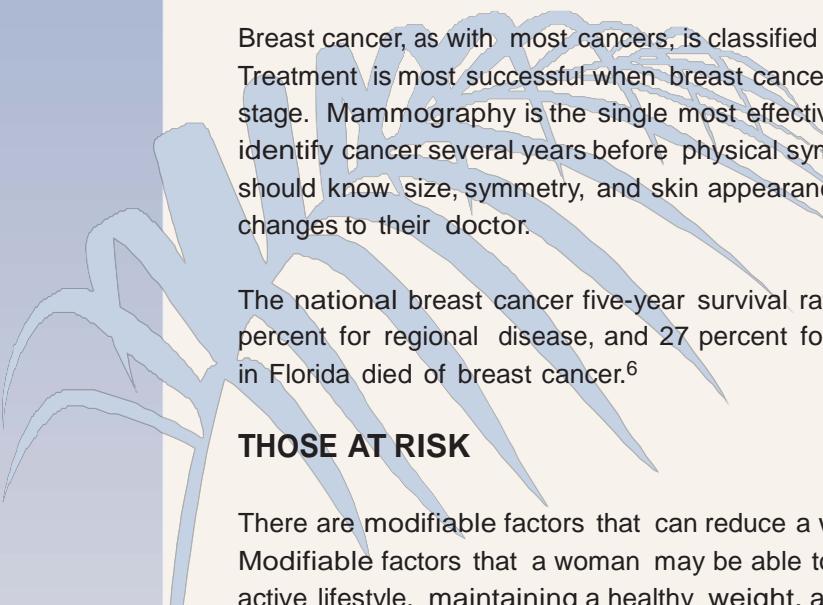
BREAST CANCER

October is Breast Cancer Awareness Month

Lifetime Risk of Developing Breast Cancer is 1 in 8 Women⁵

OVERVIEW

Breast cancer is predominantly a disease affecting women. In fact, breast cancer is the most common cancer among women, excluding basal and squamous skin cancer in the United States. However, a small number of men also develop breast cancer. Breast cancer is the second most common cause of cancer death in females, second only to lung cancer. However, among Black females in Florida, there is little difference between the lung cancer death rate and the breast cancer death rate.



Breast cancer, as with most cancers, is classified on its extent of spread in the body. Treatment is most successful when breast cancer is discovered early - in the localized stage. Mammography is the single most effective method of early detection, since it can identify cancer several years before physical symptoms develop. Nevertheless, women should know size, symmetry, and skin appearance of their breasts and report any changes to their doctor.

The national breast cancer five-year survival rate is 98 percent for localized disease, 84 percent for regional disease, and 27 percent for distant disease. In 2007, 2,599 women in Florida died of breast cancer.⁶

THOSE AT RISK

There are modifiable factors that can reduce a woman's risk of getting breast cancer. Modifiable factors that a woman may be able to control include having a physically active lifestyle, maintaining a healthy weight, and reducing alcohol consumption. Risk increases with the amount of alcohol consumed. To reduce the risk of breast cancer, the American Cancer Society recommends 45 to 60 minutes of physical activity or exercise, five or more days a week. The American Cancer Society also recommends maintaining a healthy weight throughout life by balancing food intake with physical activity and avoiding excessive weight gain.

Breast feeding a baby and having a first child before the age of 30 also decreases a woman's risk of developing breast cancer. Postmenopausal women who take estrogen and progesterone hormone therapy have a higher risk of breast cancer. At this time, there appears to be few strong reasons to recommend long-term use of postmenopausal hormone therapy. Women should discuss the risks and benefits of hormone replacement therapy, including the possible impact on cancer risk, with their healthcare provider before starting therapy or if they have been on hormones for an extended period of time.

Non-modifiable factors include gender, age, family history, previous radiation treatment to the chest area, previous breast cancer, race/ethnicity, breast tissue characteristics, and

5 Surveillance Epidemiology and End Results (SEER) Stat Breast Cancer Fact Sheet. Retrieved from <http://seer.cancer.gov/statfacts/html/breast.html>.

6 Florida Community Health Assessment Resource Tool Set (CHARTS). Retrieved from <http://www.floridacharts.com/charts/DeathQuery.aspx>.

genetic factors. Being a woman is the main risk factor for developing breast cancer. The risk increases with age, with two-thirds of breast cancers occurring in women over the age of 55.

While 70-80 percent of the women who get breast cancer do not have a family history, having a mother, sister, or daughter with breast cancer doubles a woman's risk. Women with mutations in either the BRCA1 or the BRCA2 gene account for 5-10 percent of breast cancers, and have up to an 80 percent chance of getting breast cancer during their lifetimes. Often these women develop breast cancer at a younger age than those without the gene mutation. These women are also at increased risk for developing ovarian cancer. Other gene mutations can also increase a woman's risk of developing breast cancer, as well as some other types of cancer.

A woman with cancer in one breast has a 3- to 4-fold increased risk of developing a new cancer in the other breast or in another part of the same breast. This is different from a recurrence (return) of the first cancer. Women with denser breast tissue (as seen on a mammogram) have more glandular tissue and less fatty tissue and have a higher risk of breast cancer.

Women diagnosed with certain benign breast conditions may have an increased risk of breast cancer. Women should communicate with their physicians and be aware of their breast tissue type and if it puts them at increased risk for breast cancer.

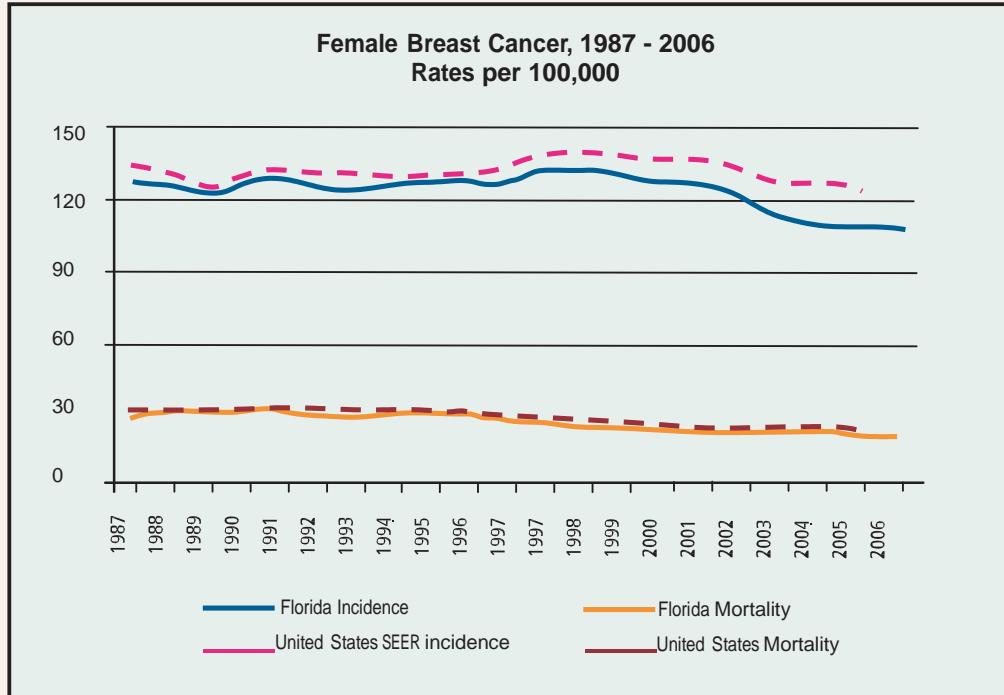
CANCER BURDEN

Florida's 2006 mortality rate for breast cancer of 20.5 deaths per 100,000 women is currently slightly better than the national Healthy People 2010 target of 22.3 deaths per 100,000 women.⁷ Florida also met the Healthy People 2010 mammography target of 70 percent utilization among women age 40 and over: in 2006, 78 percent of Florida women reported having had a mammogram within the last two years.

Uninsured women who have breast cancer are about 2.5 times more likely to be diagnosed at Stage III or IV than privately insured women.

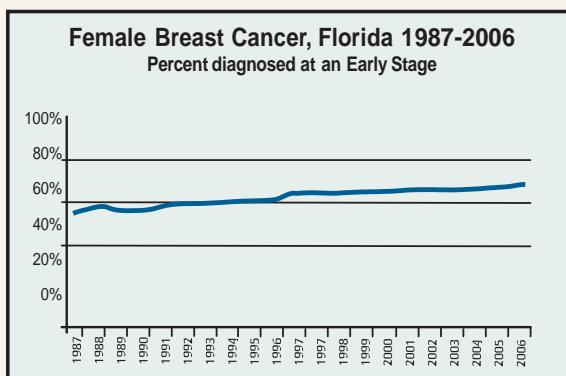
American Cancer Society



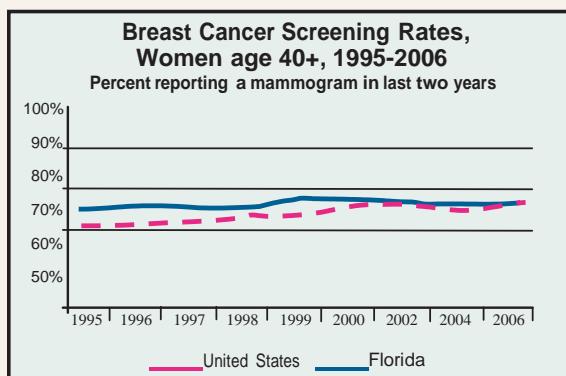


Source of data: Florida Cancer Data System

While female breast cancer rates in Florida are slightly lower than national rates, the mortality rates are nearly identical.



Source of data: Florida Cancer Data System

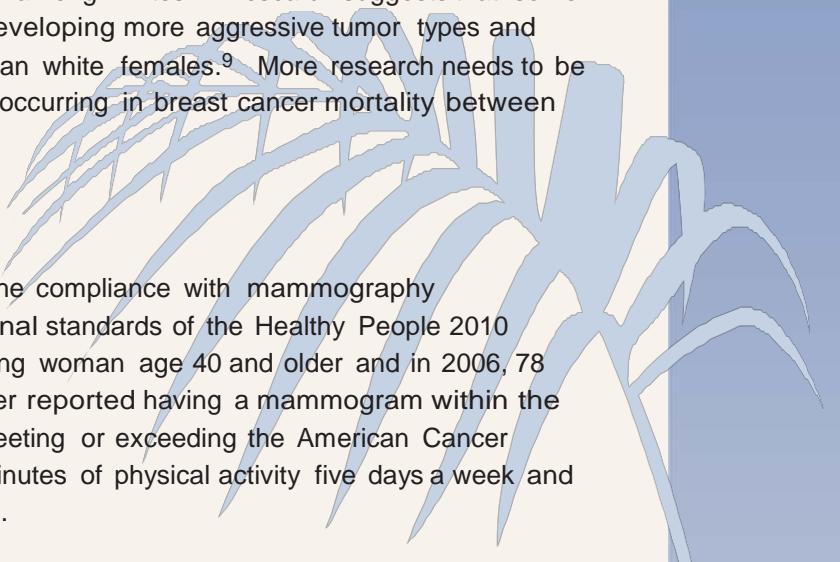


Source of data: CDC BRFSS Interactive website

The percentage of female breast cancer cases diagnosed at an early, more treatable stage, in Florida has increased 25 percent in the past 20 years. Reported screening rates among Floridians are similar to screening rates reported nationally.

DISPARITIES

In Florida, over 95 percent of females diagnosed with breast cancer are age 40 or older. Breast cancer is more common in white females; however, the breast cancer mortality rate is higher among black females. Age-adjusted mortality rates of breast cancer decreased by 32 percent among white females and by 16 percent among black females between 1981 and 2006, increasing this racial disparity. In 2006, the mortality rate



among blacks was 33 percent higher than among whites.⁸ Research suggests that some of the disparity is due to black females developing more aggressive tumor types and having different types of breast cancer than white females.⁹ More research needs to be done to understand the racial disparities occurring in breast cancer mortality between white and black females.

BEHAVIORAL MEASURES

The main measured behavioral factor is the compliance with mammography recommendations. Florida met the national standards of the Healthy People 2010 mammography target of 70 percent among women age 40 and older and in 2006, 78 percent of Florida women age 40 and over reported having a mammogram within the last two years. Women should also be meeting or exceeding the American Cancer Society's recommendation for 45 to 60 minutes of physical activity five days a week and eating a diet rich in fruits and vegetables.

Women are encouraged to discuss screening recommendations with their doctors. Based on history, risk factors, and any symptoms including the results of the clinical breast exam, they will agree on an age for them to start screening mammography and their intervals for screening.

Guidelines for routine screening:

The United States Preventative Services Task Force (USPSTF) website <http://www.ahrq.gov/clinic/uspstf/uspsbrca.htm>, recommends biennial screening mammography for women aged 50 to 74 years and states that the decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms. The USPSTF recommends against teaching breast self-examination (BSE).

The American Cancer Society, website http://www.cancer.org/docroot/PED/content/ped_2_3x_ACS_Cancer_Detection_Guidelines_36.asp, states that yearly mammograms are recommended starting at age 40 and continuing for as long as a woman is in good health. They state that women should know how their breasts normally look and feel and report any breast change promptly to their health care provider. They state that breast self-exam (BSE) is an option for women starting in their 20s.

FLORIDA BREAST CANCER STRATEGIES

1. Increase breast cancer screenings for women over age 50.
2. Increase outreach efforts to high-risk populations to educate women about screening options and refer those for appropriate screening.
3. Increase access for women to quality, accredited mammography facilities with reasonable waiting time for obtaining service.
4. Educate about signs and symptoms and promote breast self-awareness.
5. Increase awareness of inflammatory breast cancer for healthcare providers and women.

⁸ FCDS Florida Annual Cancer Report Epidemiological Series: 2006 Incidence and Mortality.

⁹ American Cancer Society retrieved from <http://www.cancer.org>.

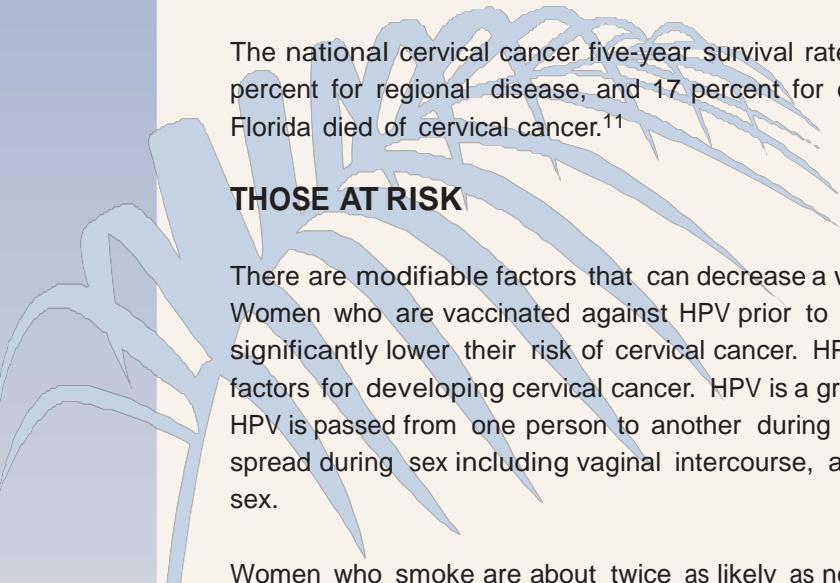
CERVICAL CANCER

January is Cervical Cancer Awareness Month

Lifetime Risk of Developing Cancer of the Cervix Uteri is 1 in 145 Women¹⁰

OVERVIEW

Cervical cancer is cancer of the lower part of the uterus that connects to the vagina. Cervical cancer is highly preventable and is caused by a virus called the human papillomavirus, or HPV, which is spread through sexual contact. Abnormal cervical cells rarely cause symptoms, but detection of the earliest changes leading to cancer development is possible through the use of Pap tests. Periodic Pap test screening as recommended by healthcare providers can prevent the majority of invasive cervical cancers. When abnormal cells are found and treated early, cervical cancer can be prevented or cured.



The national cervical cancer five-year survival rate is 92 percent for localized disease, 58 percent for regional disease, and 17 percent for distant disease. In 2007, 262 women in Florida died of cervical cancer.¹¹

THOSE AT RISK

There are modifiable factors that can decrease a woman's risk for cervical cancer. Women who are vaccinated against HPV prior to becoming sexually active can significantly lower their risk of cervical cancer. HPV infection is one of the major risk factors for developing cervical cancer. HPV is a group of more than 100 related viruses. HPV is passed from one person to another during skin-to-skin contact. HPV can be spread during sex including vaginal intercourse, anal intercourse, and even during oral sex.

Women who smoke are about twice as likely as non-smokers to get cervical cancer. Women who get regular Pap tests decrease their risk of cervical cancer by catching abnormal cells before they advance to cancer. Maintaining a healthy weight and healthy lifestyle decreases one's risk of cervical cancer.

Non-modifiable risk factors include family history and immunosuppression.

Human immunodeficiency virus (HIV), the virus that causes AIDS, damages the body's immune system and seems to make women more at risk for HPV infections. This may be what increases the risk of cervical cancer in women with AIDS.

Poverty is a risk factor for cervical cancer. Many women with low incomes do not have readily available access to adequate healthcare services, including Pap tests. This means they may not get screened or treated for pre-cancerous cervical disease. If a mother or sister had cervical cancer, a woman's chances of developing the disease increase by two to three times.

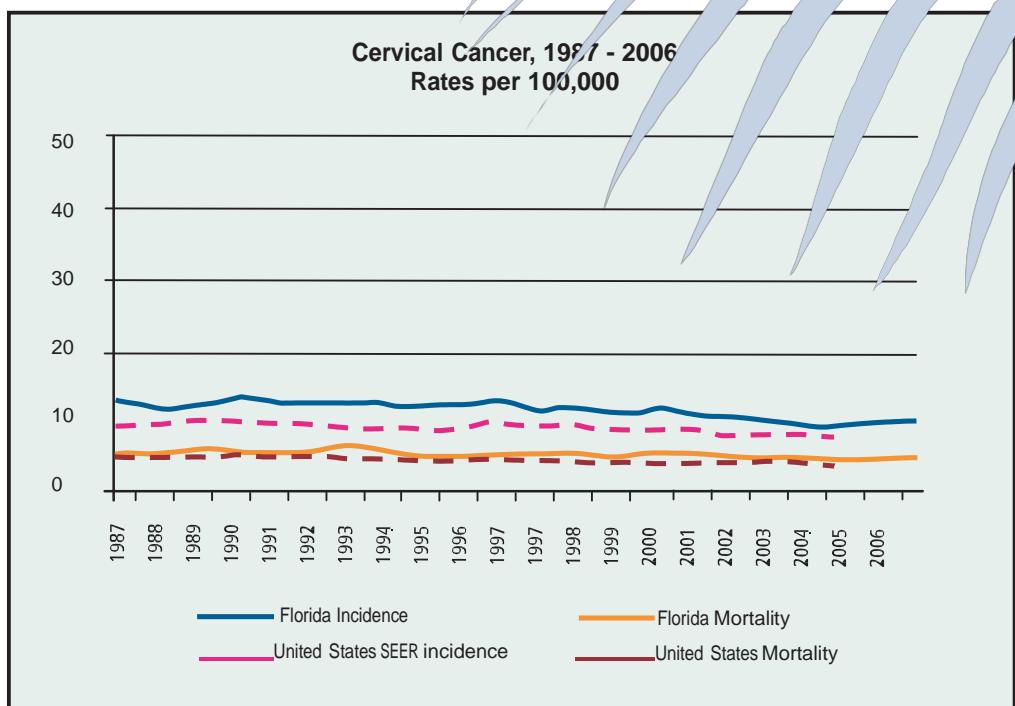
10 Surveillance Epidemiology and End Results (SEER) Stat Prostate Cancer Fact Sheet. Retrieved from <http://seer.cancer.gov/statfacts/html/prost.html>.

11 Florida Community Health Assessment Resource Tool Set (CHARTS) retrieved from <http://www.floridacharts.com/charts/DeathQuery.aspx>.

CANCER BURDEN

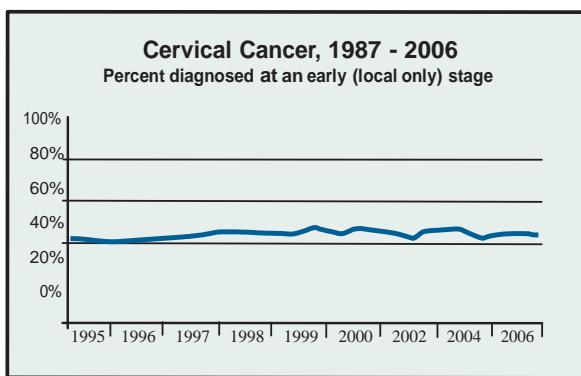
While the disease is almost totally treatable or preventable with routine screening, almost 300 women die each year in Florida from cervical cancer.

Florida's 2006 mortality rate for cervical cancer of 2.7 deaths per 100,000 is 35 percent above the Healthy People 2010 target of 2.0 deaths per 100,000 women.¹²

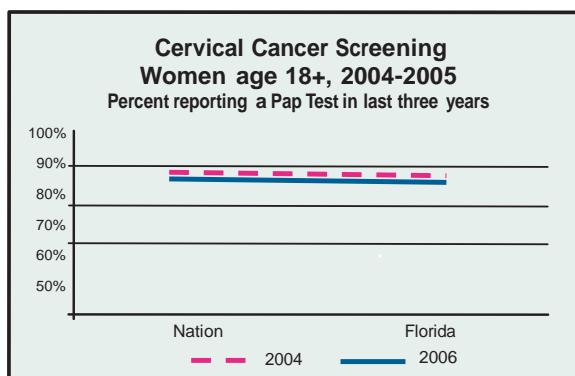


Source of data: Florida Cancer Data System

While cervical cancer rates in Florida are higher than in the nation as a whole, the mortality rates are nearly identical.



Source of data: Florida Cancer Data System



Source: CDC BRFSS Interactive website

In Florida, the percentage of cervical cancer cases diagnosed at an early, more treatable stage has increased slightly in the past 20 years. Reported screening rates are similar nationally and among Floridians.

12 Florida Cancer Data System Retrieved from <http://fcds.med.miami.edu/>.

DISPARITIES

Nearly twice as many black women die from cervical cancer as white women. Poverty, access to care, education, and insurance coverage may somewhat explain these disparities.

Black females had higher incidence rates than white females in all 26 years of reported data to the FCDS. In 2006, the rate of cervical cancer for black females was 26 percent more than the rate among whites.

Age-adjusted cervical cancer mortality rates among blacks was 69 percent higher than that among whites in 2006.

BEHAVIORAL MEASURES

Presently, Florida does not meet the national Healthy People 2010 Pap test target of 90 percent of women aged 18 years and older receiving a screening Pap test within the preceding three years. According to Florida BRFSS 2008 data, 83 percent of Florida women reported having a Pap test within the last three years.¹³ All women aged 18 and older should be aware of the importance of Pap test screening.

The public needs to be aware and informed about the HPV vaccine. The most significant behavioral step parents can take is to get their daughters vaccinated against HPV prior to becoming sexually active. To learn more about the Advisory Committee on Immunization Practices (ACIP) recommendations and guidelines please visit <http://www.cdc.gov/vaccines/recs/default.htm>.

PREVENTION AND EARLY DETECTION

Primary prevention is available through the HPV vaccine. Women who receive the HPV vaccine still need Pap tests. Regular Pap tests can find abnormal cervical cells when they are most easily treatable.

Prevention and early detection are possible for cervical cancer. The primary method of diagnosing cervical cancer is through Pap testing. A Pap test involves examining cells taken from the cervix. Women should begin Pap tests by age 21 or within three years of sexual activity and continue annually until a woman has three consecutive normal Pap tests. Then a woman should receive a Pap test every three years.

FLORIDA CERVICAL CANCER STRATEGIES

1. Increase screening rates, especially in high-risk populations.
2. Educate on the availability of the HPV vaccine in accordance with the Advisory Committee on Immunization Practices (ACIP).
3. Educate youth on safe sex practices.
4. Educate women on cervical cancer screening and provide access to effective health services for the timely detection, diagnosis, and treatment of cancer.

CHILDHOOD CANCER

September is Childhood Cancer Awareness Month

OVERVIEW

Cancer occurs less frequently in children than in adults. Children account for less than one percent of cancer diagnoses in Florida. Despite this relatively small percentage, approximately 750 new cases of cancer are diagnosed in children in Florida each year and cancer remains the leading cause of death by disease in children. The types of cancers seen in children are also quite different than those seen in adults, with leukemia being most common, followed by brain tumors, lymphomas, and then embryonal tumors. Melanoma is increasing in occurrence in children in Florida and nationally.

Cancer in children is usually treated at specialized centers of which there are 16 in Florida. Because children with cancer are treated at a time of rapid physical, psychological, and developmental growth, they are particularly susceptible to long-term complications associated with cancer treatment.

Overall survival for childhood cancer has improved dramatically with current estimates that 80 percent of children diagnosed with cancer will be cured of their disease.

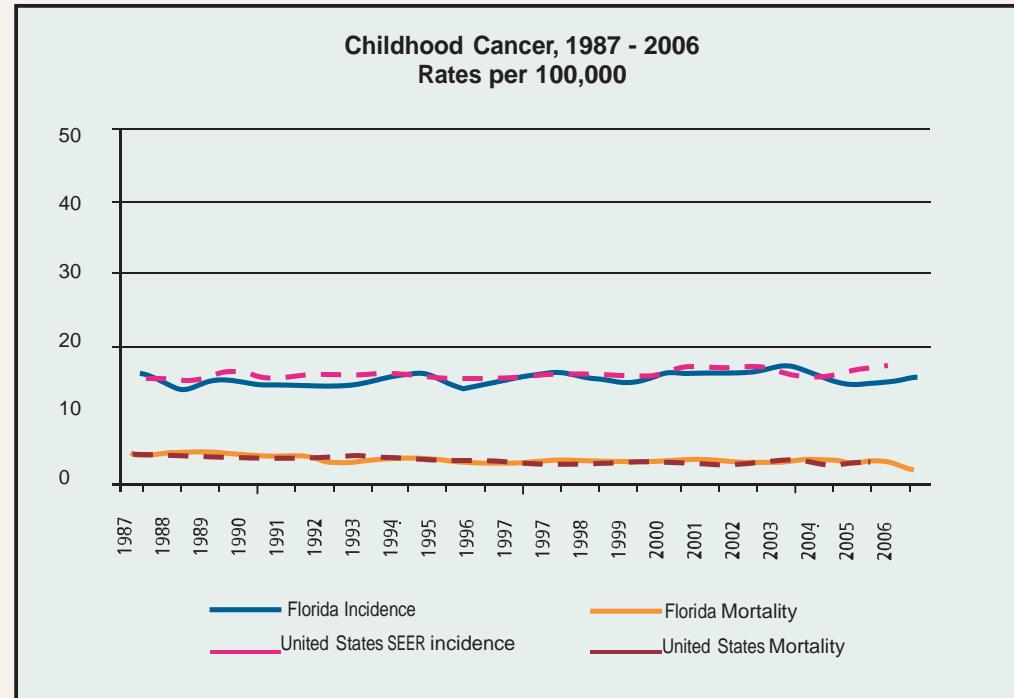
THOSE AT RISK

The majority of childhood cancers are caused by non-modifiable risk factors such as genetic predisposition. Prior exposure to radiation or chemotherapy can also result in secondary malignancies. While lifestyle related risks of the individual are the main factors leading to cancers in adults, these factors have diminished significance in childhood cancer.

Modifiable factors to decrease the risk of childhood cancers include limiting a child's exposure to UVA and UVB rays.



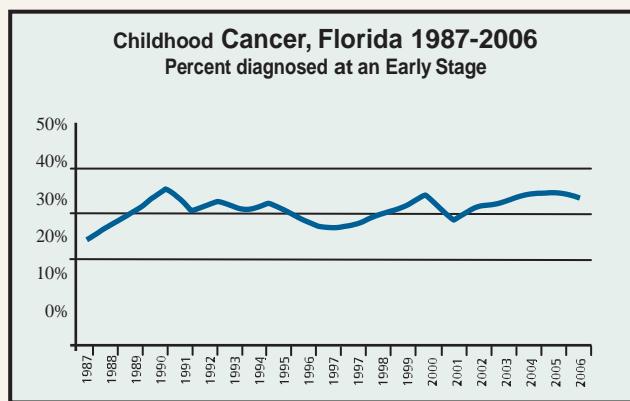
CANCER BURDEN



Source of data: Florida Cancer Data System

The cancer rates of Florida's children under age 20 are similar to the national rates.

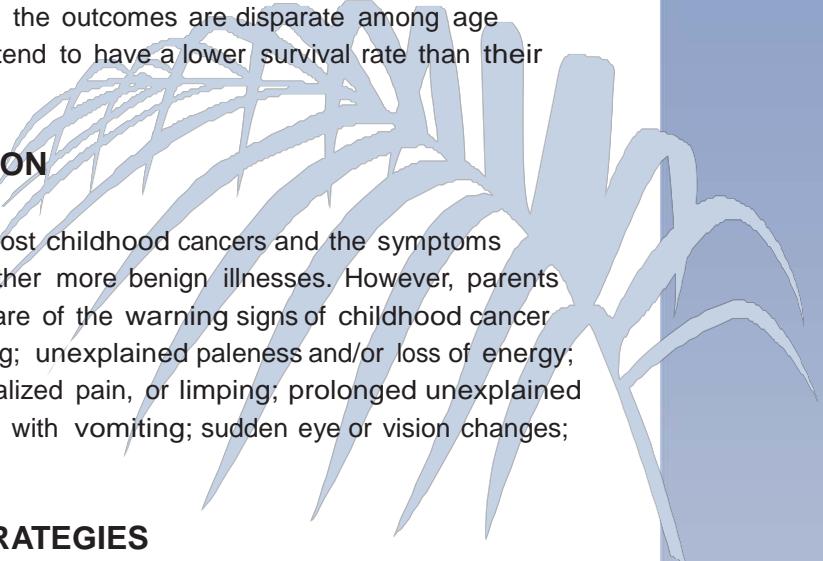
The percentage of childhood cancers diagnosed at an early stage has increased 37 percent since 1987.



Source of data: Florida Cancer Data System

DISPARITIES

In Florida, childhood cancers account for less than one percent of all cancers diagnosed in the state. Childhood cancer is a diverse group of rare malignancies, in which the most frequently diagnosed is acute lymphocytic leukemia (ALL) and tumors affecting the central nervous system. In early childhood, ages 0 to 4, many malignancies are a result of developmental changes during gestation as compared to post-birth exposure effects in the development of cancers for adolescents.



Overall, survival rates for most childhood cancers are consistently higher in white children than in black children. Moreover, the outcomes are disparate among age subpopulations. Specifically, adolescents tend to have a lower survival rate than their younger counterparts.

PREVENTION AND EARLY DETECTION

There are no specific screening tests for most childhood cancers and the symptoms associated with cancer may mimic many other more benign illnesses. However, parents and primary care physicians should be aware of the warning signs of childhood cancer which 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.

FLORIDA CHILDHOOD CANCER STRATEGIES

1. Ensure access and support to comprehensive, multidisciplinary, age appropriate cancer care for children and adolescents with cancer.
2. Foster support of long-term follow-up services for children, adolescents, and young adults.
3. Require that primary care physicians and health professionals have appropriate education in the late effects of cancer treatment and appropriate screening for these effects.
4. Assure appropriate palliative care (expertise in symptom management) and end-of-life services for children in Florida.
5. Identify resources to offer support to siblings of children with cancer.

While dramatic improvements in survival have been achieved for cancer patients at age 15 or younger, and steady improvement has been made against many cancers among adults over age 40, little or no progress has been seen in the adolescent and young adult population. In fact, among those aged 25 to 35, survival has not improved in more than two decades, and survival trends show a worse prognosis for young adults diagnosed with cancer today than 25 years ago.

American Cancer Society,
Lance Armstrong Foundation, National
Cancer Institute

COLORECTAL CANCER

March is Colorectal Cancer Awareness Month

Lifetime Risk of Developing Colorectal Cancer is 1 in 19 for Women and Men¹⁴

OVERVIEW

Colorectal cancer is a cancer affecting the large bowel or lower digestive tract. It can develop along any point in the lining of the large intestine or rectum. Colorectal cancer is the third most common type of cancer and the second most common cause of cancer death for both males and females combined, second only to lung cancer. The disease is largely preventable for the majority of the population through a variety of screening programs aimed at detecting pre-malignant growths (also called polyps) in the intestine and removing them prior to the development of the cancer.

Early detection of the cancer is critically important, as survival is nearly 90 percent when colorectal cancer is removed before it has spread beyond the intestinal wall. Individuals may be completely unaware of the presence of disease until more advanced stages when survival from the cancer drops considerably. Despite recent advancements in the treatment of this disease, prevention and early detection remain the best ways to combat this common and lethal condition.

The national colorectal cancer five-year survival rate is 91 percent for localized disease, 70 percent for regional disease, 11 percent for distant disease. In 2007, 3,710 people in Florida died of colorectal cancer.¹⁵

THOSE AT RISK

There are modifiable factors that will decrease a person's risk of getting colon cancer. People who maintain a healthy low-fat diet low in processed and red meats, maintain an appropriate weight, and exercise regularly significantly decrease their risk of colorectal cancer. Decreasing alcohol consumption lowers a person's risk as well. People with type 2 diabetes and smokers have a higher mortality rate from colorectal cancer. There are non-modifiable factors that increase a person's risk of colorectal cancer. These factors include being over age 50, having had polyps or colorectal cancer before, having a history of ulcerative colitis or Crohn's disease, having a family history of colorectal cancer, or having certain family syndromes.

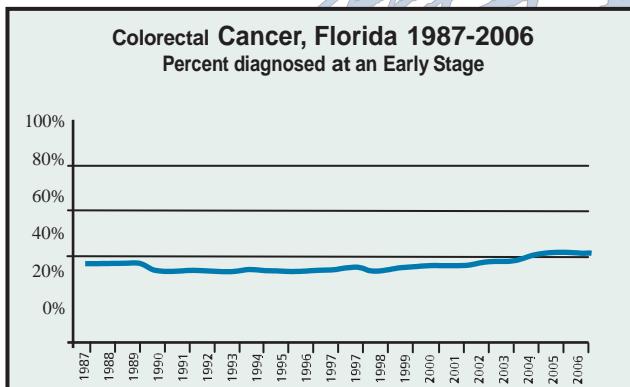
Colorectal cancer affects men and women equally and is seen in all races and ethnicities, but race and ethnicity can affect a person's risk of developing the disease. African Americans and Jews of Eastern European descent (Ashkenazi Jews) have a higher colorectal cancer risk. The reasons for this are not yet understood.

14 Surveillance Epidemiology and End Results (SEER) Stat Colorectal Cancer Fact Sheet. Retrieved from <http://seer.cancer.gov/statfacts/html/colorect.html>.

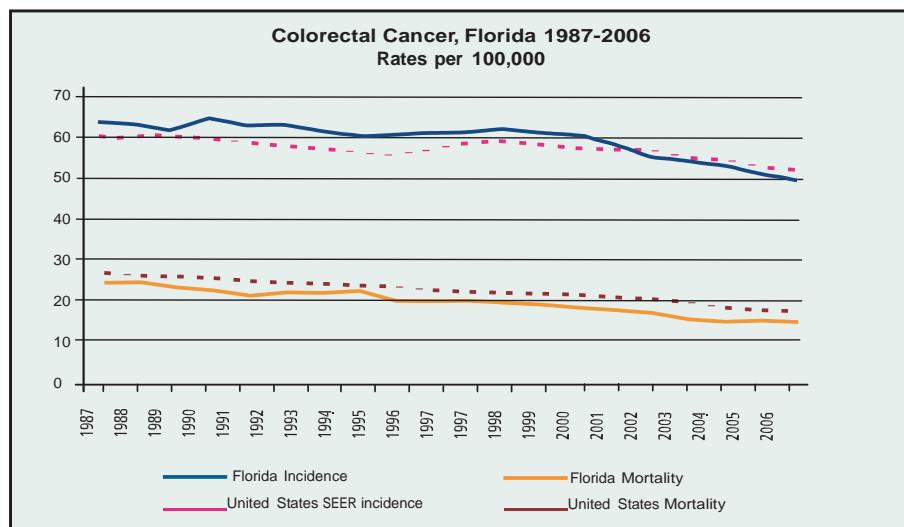
15 Florida Community Health Assessment Resource Tool Set (CHARTS). Retrieved from <http://www.floridacharts.com/charts/DeathQuery.aspx>.

CANCER BURDEN

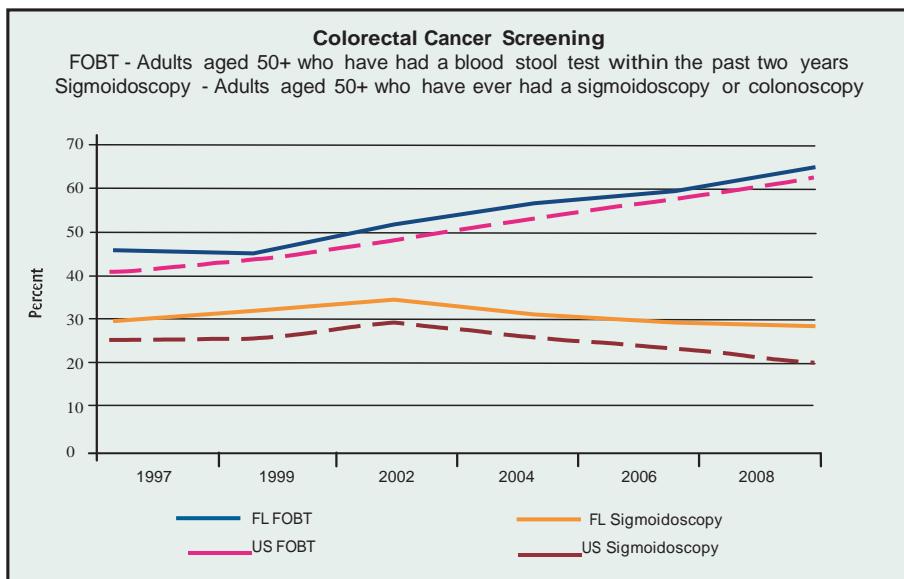
Colorectal cancer incidence and mortality rates in Florida and the nation are similar.



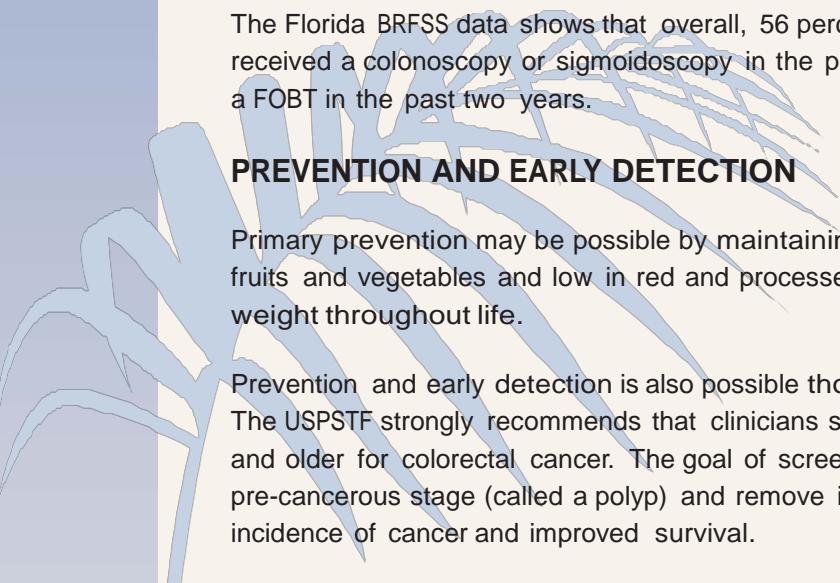
Source of data: Florida Cancer Data System



Source: CDC BRFSS Interactive website



Source: CDC BRFSS Interactive website



The percentage of colorectal cancer cases diagnosed at an early, more treatable stage in Florida has increased 13 percent in the past 20 years (33 percent in 1987 versus 37 percent in 2006).¹⁶ Fifty percent of patients in Florida were diagnosed at an advanced stage.

DISPARITIES

Over the 26-year period since 1981, incidence rates increased among blacks by 19 percent in females and 2 percent in males. Incidence rates for whites declined by 31 percent in females and by 33 percent in males in the same period.

Mortality rates for both black females and black males were higher than for their white counterparts by 41 percent and 31 percent, respectively.¹⁷

BEHAVIORAL MEASURES

The Florida BRFSS data shows that overall, 56 percent of Floridians age 50 and older received a colonoscopy or sigmoidoscopy in the past five years, and 30 percent received a FOBT in the past two years.

PREVENTION AND EARLY DETECTION

Primary prevention may be possible by maintaining a healthy lifestyle, a diet high in fruits and vegetables and low in red and processed meats, and maintaining a healthy weight throughout life.

Prevention and early detection is also possible through a variety of screening techniques. The USPSTF strongly recommends that clinicians screen men and women 50 years of age and older for colorectal cancer. The goal of screening is to identify cancer at an early, pre-cancerous stage (called a polyp) and remove it completely, leading to a lower incidence of cancer and improved survival.

A variety of screening tests, as recommended by the American Cancer Society and other national organizations, are available to accomplish this goal. Screening testing involves evaluating the colon or stool for trace amounts of blood leaked from the cancer or polyp, through radiographic evaluation (air contrast double barium enema), or through direct visualization with a flexible sigmoidoscopy or colonoscopy. These tests should be repeated throughout an individual's lifetime.

A person at higher risk for cancer based on family history or previous cancer may need to be screened more often or prior to age 50, or both.

FLORIDA COLORECTAL CANCER STRATEGIES

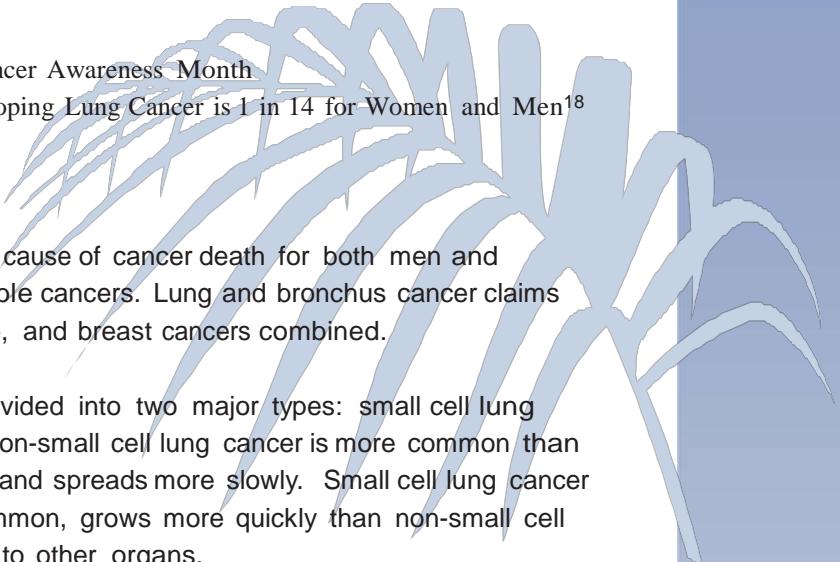
1. Increase the percentage of Floridians over the age of 50 screened for colorectal cancer.
2. Educate the population on colorectal cancer screening and provide access to effective health services for the timely detection, diagnosis, and treatment of cancer.
3. Promote healthy lifestyle practices including avoiding tobacco use, increasing physical activity and fruit and vegetable consumption.

16 Florida Cancer Data System Retrieved from <http://fcds.med.miami.edu/>.

17 Florida Cancer Data System Retrieved from <http://fcds.med.miami.edu/>.

LUNG AND BRONCHUS CANCER

November is Lung Cancer Awareness Month
Lifetime Risk of Developing Lung Cancer is 1 in 14 for Women and Men¹⁸



OVERVIEW

Lung and bronchus cancer is the leading cause of cancer death for both men and women and is one of the most preventable cancers. Lung and bronchus cancer claims more lives each year than colon, prostate, and breast cancers combined.

Cancer that begins in the lungs can be divided into two major types: small cell lung cancer and non-small cell lung cancer. Non-small cell lung cancer is more common than small cell lung cancer and usually grows and spreads more slowly. Small cell lung cancer (also known as oat cell cancer) is less common, grows more quickly than non-small cell lung cancer, and is more likely to spread to other organs.

The national lung and bronchus cancer five-year survival rate is 53 percent for localized disease, 24 percent for regional disease, and 4 percent for distant disease. In 2007, 11,650 people in Florida died of lung and bronchus cancer.¹⁹

THOSE AT RISK

There are modifiable risk factors that can significantly decrease a person's risk of getting lung and bronchus cancer. The CDC reports that in the United States about 90 percent of lung cancer deaths in men and almost 80 percent of lung cancer deaths in women are due to cigarette smoking. Other factors that contribute to lung cancer risk include cigar and pipe smoking and environmental ("secondhand") tobacco smoke.

Secondhand smoke, smoke from other people's cigarettes, is also harmful to non-smokers. The smoke contains more than 4,000 chemical agents, at least 250 are known to be harmful, and 50 of these are known to cause cancer.²⁰ Every year, about 3,000 nonsmokers in the United States die from lung cancer due to secondhand smoke.²¹

A small percentage of lung and bronchus cancers are caused by non-modifiable risk factors including exposure to radon, pollution, having other lung diseases, and race/ethnicity. The lung and bronchus cancer risk of a person who has smoked one pack of cigarettes per day for at least 15 years is approximately 10 percent, with this risk higher in black men and lower in white women. The risk of lung and bronchus cancer also appears to have a genetic component since persons with a first-degree family relative with lung and bronchus cancer (parents, siblings, or children) may have twice the lung and bronchus cancer risk of those without a family history of the disease. CDC research has shown that on average, smokers die 13 to 14 years earlier than non-smokers.

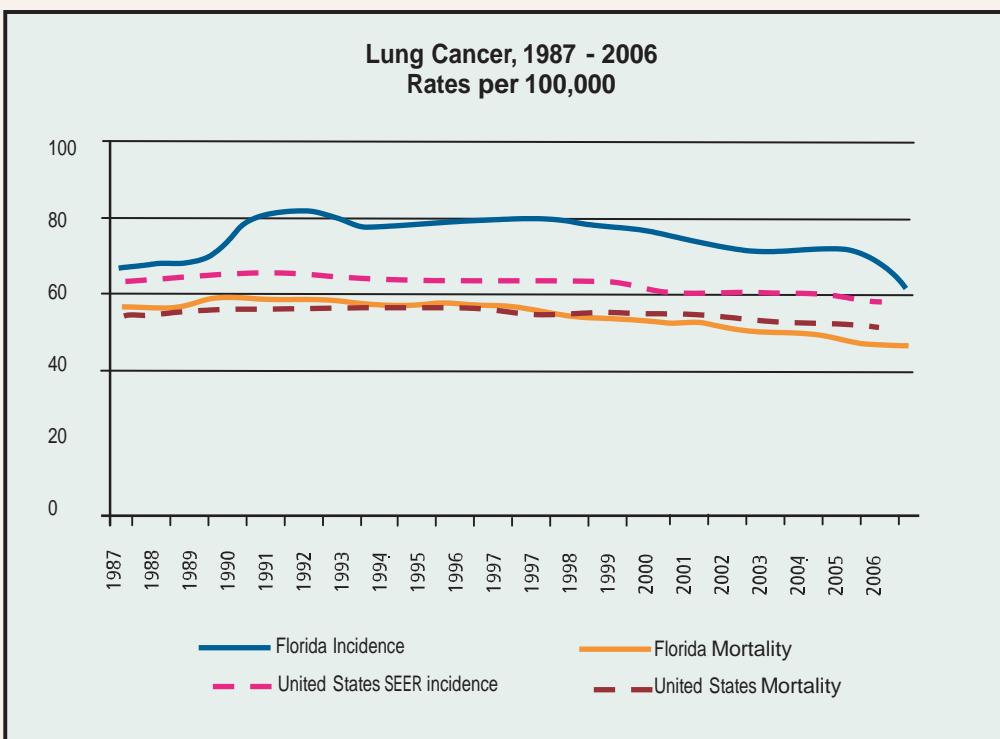
18 Surveillance Epidemiology and End Results (SEER) Stat Lung Cancer Fact Sheet. Retrieved from <http://seer.cancer.gov/statfacts/html/lungb.html>.

19 Florida Community Health Assessment Resource Tool Set (CHARTS). Retrieved from <http://www.floridacharts.com/charts/DeathQuery.aspx>.

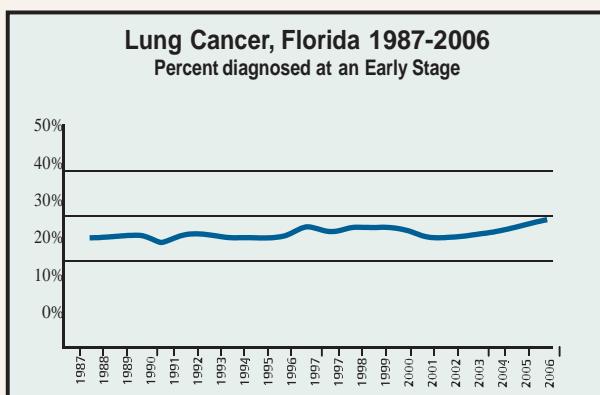
20 National Cancer Institute. Retrieved from <http://www.cancer.gov/cancertopics/factsheet/Tobacco/ET>
Environmental Protection Agency "Setting the Record Straight: Secondhand Smoke is a Preventable Health Risk" 21 Retrieved from <http://www.epa.gov/smokefree/pubs/strfs.html>.

CANCER BURDEN

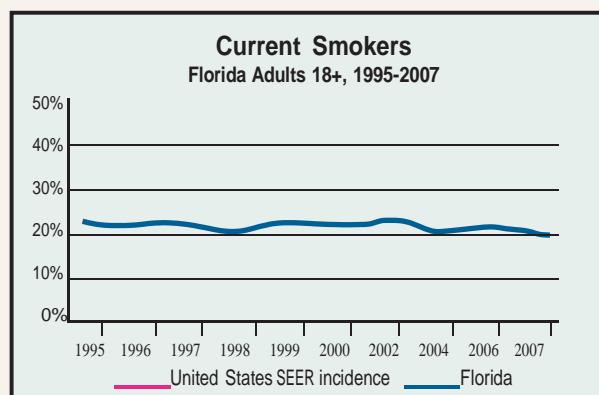
The FCDS reports there were 16,154 new lung and bronchus cancers diagnosed in 2006.



Source of data: Florida Cancer Data System



Source of data: Florida Cancer Data System



Source: CDC BRFSS Interactive website

The percentage of lung and bronchus cancer diagnosed at an early, more treatable, stage is low at approximately 19 percent.

Florida's 2006 mortality rate for lung and bronchus cancers of 48.3 deaths per 100,000 persons is 8 percent above the national Healthy People 2010 target of 44.9.

Adults who are exposed to secondhand smoke at home or at work increase their risk of developing lung cancer by 20% to 30%.

CDC

DISPARITIES

Incidence rates of cancer of the lung and bronchus are higher among males than among females. Incidence rates have decreased among males, and have increased 59 percent in white females, and 55 percent in black females since 1981.

Black males have higher age-adjusted mortality rates of cancers of the lung and bronchus than white males.

White females have had higher age-adjusted mortality rates than black females since 1981. Mortality rates increased among both black and white females by 24 percent and 37 percent, respectively, from 1981 to 2006.²²

BEHAVIORAL MEASURES

Although smoking rates have decreased 18 percent since 1987, Florida's current smoking rate of 17.5 percent as of 2008, does not meet the Healthy People 2010 target of tobacco use by 12 percent or less of adults.²³ Exposure to secondhand smoke in Florida households is estimated at 13 percent.

Among Florida's youth, in 2009, 5.4 percent of middle school students and 14.3 percent of high school students smoked at least once during the past 30 days (current cigarette use). Since 1998, the prevalence of current cigarette smoking has decreased by 70.8 percent among middle school students and 47.8 percent among high school students.²⁴

PREVENTION AND EARLY DETECTION

Primary prevention is possible to prevent the majority of lung and bronchus cancer cases. The best way to prevent lung and bronchus cancer is to not use tobacco products, to quit if you already do, and to avoid people who smoke.

Smoking cessation has immediate health benefits for both men and women of all ages. The earlier one quits, the better the health benefit. According to the American Cancer Society, research has shown that people who quit before age 50 reduce their risk of dying in the next 15 years by half compared with those who continue to smoke.

There is no recommended early detection screening tests for lung cancer.

FLORIDA LUNG AND BRONCHUS CANCER STRATEGIES

1. Eliminate or reduce adult tobacco use.
2. Eliminate or reduce youth tobacco use.
3. Reduce exposure to secondhand smoke.
4. Support policies that reduce use and exposure to tobacco.
5. Support research to find treatment.
6. Increase participation in clinical trials.

22 Florida Cancer Data System Retrieved from <http://fcds.med.miami.edu/>.

23 FL BRFSS 2008 Survey Retrieved from http://www.doh.state.fl.us/disease_ctrl/epi/brfss/index.htm.

24 Florida Youth Tobacco Survey Retrieved from

http://www.doh.state.fl.us/disease_ctrl/epi/Chronic_Disease/FYTS/Intro.htm.

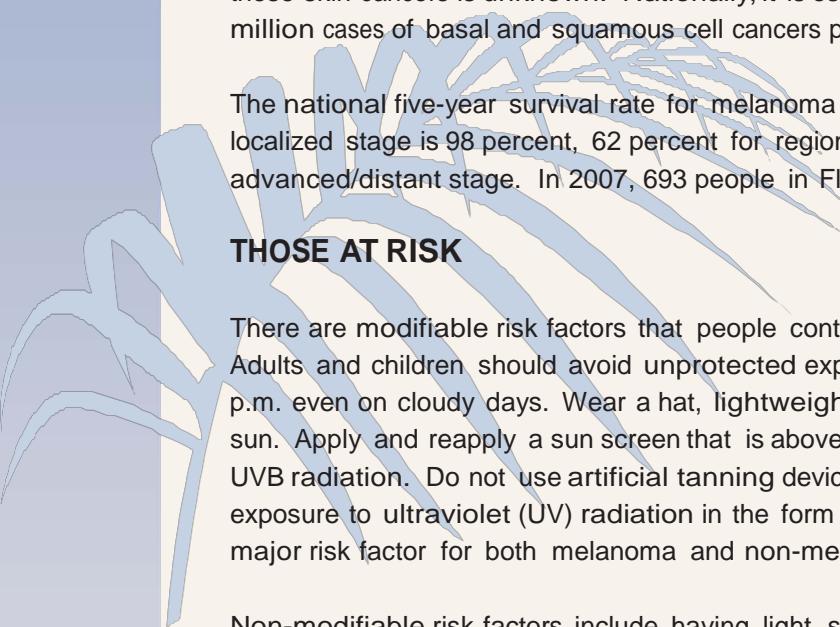
MELANOMA OF THE SKIN

May is Skin Cancer Awareness Month

Lifetime Risk of Developing Melanoma of the Skin is 1 in 53 for Women and Men²⁵

OVERVIEW

Skin cancer is the most common cancer in the United States. Nearly all skin cancers are preventable by limiting unprotected exposure to the sun. When skin cancers occur, most can be treated successfully if detected early – even melanoma, the most serious type of skin cancer. Skin cancers are divided into two major categories: melanoma and non-melanoma skin cancers. Non-melanoma skin cancers, such as basal and squamous cell carcinomas, are much more common. However, because it is not a requirement to report non-melanoma skin cancers to central cancer registries, the exact number of these skin cancers is unknown. Nationally, it is estimated that there are more than 1 million cases of basal and squamous cell cancers per year.



The national five-year survival rate for melanoma of the skin when detected at a localized stage is 98 percent, 62 percent for regional stage, and 15 percent for advanced/distant stage. In 2007, 693 people in Florida died of skin cancer.²⁶

THOSE AT RISK

There are modifiable risk factors that people control to reduce their risk of skin cancer. Adults and children should avoid unprotected exposure to sun between 10 a.m. and 4 p.m. even on cloudy days. Wear a hat, lightweight clothing, and sun glasses when in the sun. Apply and reapply a sun screen that is above SPF 15 and protects against UVA and UVB radiation. Do not use artificial tanning devices such as tanning beds. Excessive exposure to ultraviolet (UV) radiation in the form of sunlight or tanning booths is a major risk factor for both melanoma and non-melanoma skin cancers.

Non-modifiable risk factors include having light skin color, a personal or family history of melanoma, the presence of moles and freckles, and infection with certain HPV. Risk factors for basal and squamous cell cancers also include a personal or family history of skin cancer and light-skin color.

CANCER BURDEN

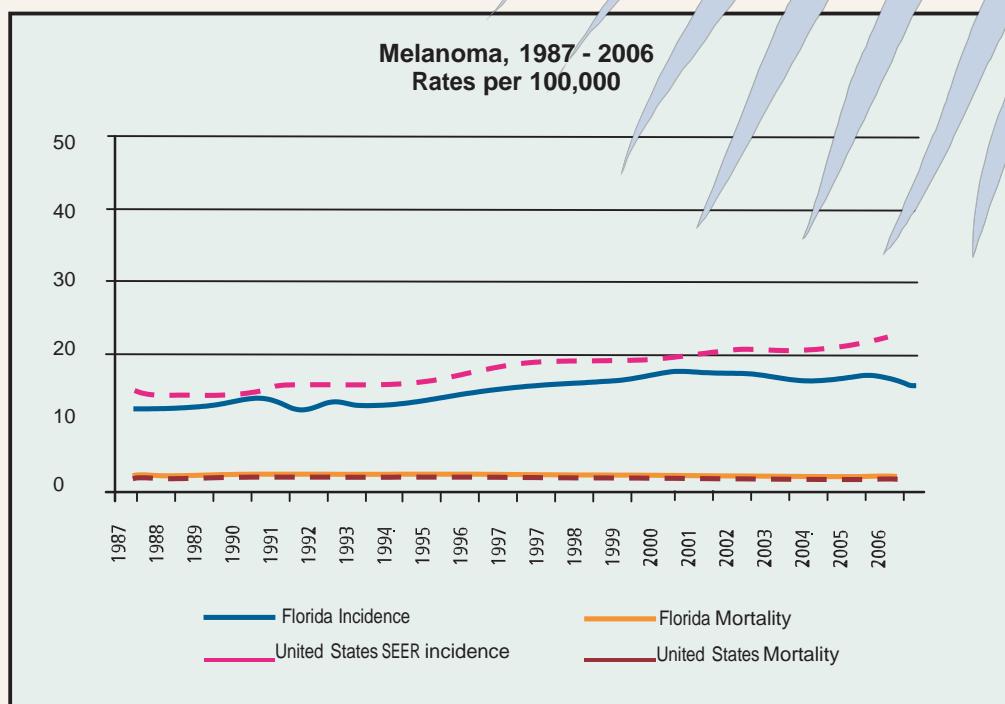
In the United States, an estimated 62,480 new cases of melanoma will be diagnosed in 2008, and an estimated 8,420 people will die from this disease (these numbers exclude basal cell, squamous cell, and other skin cancers). Florida has the second largest number of cases of melanoma in the country with an estimated 4,430 cases in 2008. While non-melanoma skin cancer rates increase with age for both men and women under age 40, melanoma is the second most common cancer type.

25 Surveillance Epidemiology and End Results (SEER) Stat Melanoma of the Skin Cancer Fact Sheet. Retrieved from <http://seer.cancer.gov/statfacts/html/melan.html>.

26 Florida Community Health Assessment Resource Tool Set (CHARTS). Retrieved from <http://www.floridacharts.com/charts/DeathQuery.aspx>.

In 2006, 3,388 Floridians were diagnosed with melanoma, and there were 657 deaths from this cancer. The age-adjusted incidence rate was 17.6 per 100,000 persons, compared to 19.8 for the United States (2006 data). The age-adjusted mortality rate for Florida was 3.1, compared to 2.7 for the United States.

Melanoma of the skin has been the cancer with the greatest occurrence increase over the past 20 years both nationally and in Florida.



Source of data: Florida Cancer Data System

DISPARITIES

The incidence and mortality rates are higher among white males than white females. Age-adjusted incidence rates have increased by 64 percent among white males and by 30 percent among white females since 1981. The disparity between sexes increased from 24 percent in 1981 to 56 percent in 2006. Over the time period from 1981 to 2006, mortality rates increased by 29 percent for white males, while the rates decreased by 15 percent for white females. White males had higher mortality rates than white females in all years. The rate for white males was 95 percent higher than the rate among females in 1981, and 188 percent higher in 2006.

BEHAVIORAL MEASURES

The two main measured behavioral factors to reduce the risk for melanoma of the skin is to limit one's exposure to the sun and to apply and reapply a sun screen that is above SPF 15 and protects against UVA and UVB radiation. According to the approximately 10,000 Floridians who responded to the skin cancer questions on the Florida BRFSS, almost 21 percent reported that they either did not use any sun protection products or else used an inadequate protection strength product, almost half reported that they do not purposely tan. Furthermore, a strong majority of them reported that they do reapply sunscreen.

PREVENTION AND EARLY DETECTION

Primary prevention is possible to reduce a person's risk of skin cancer. The incidence of skin cancer can be reduced by reducing exposure to the main risk factor, UV radiation from sun exposure. Preventive measures, such as avoiding peak daytime sun exposure, avoiding use of indoor UV tanning salons, seeking shade while outdoors, wearing sun protective clothing, and using sunscreen with SPF 15 or higher, are effective ways to prevent skin cancer.

Early detection may be accomplished through a visit to a healthcare provider in an office setting or through an organized screening program, and by recognition of potentially dangerous skin lesions by patients and/or family members. The most common sign of skin cancer is a change in the skin. In general, melanoma is observed using the ABCDE principles: A) asymmetric; B) irregular borders; C) a variety of colors or very dark in color; D) a diameter greater than 6 mm (the size of a pencil eraser), and E) evolving or enlarging size or shape. Not all melanomas fit all these criteria, however, and not all skin lesions that do fit the ABCDE criteria are actually cancerous. Still, these are valuable principles to keep in mind and any suspicious skin lesions should be evaluated and, if necessary, biopsied.

Early detection not only improves survival, but also reduces costs and disability, as care for advanced and terminal diseases accounts for the majority of healthcare costs and most of the side effects associated with melanoma treatment.

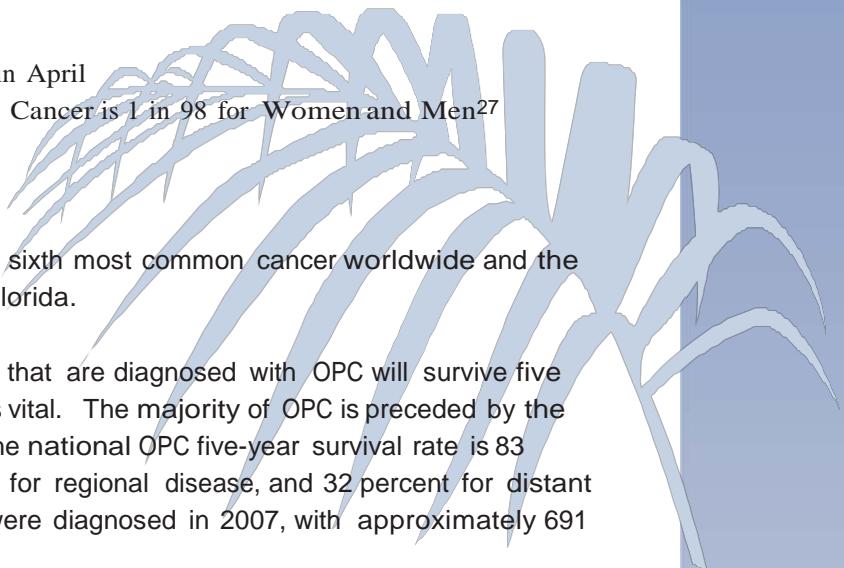
FLORIDA MELANOMA OF THE SKIN STRATEGIES

1. Promote "sun wise" school policies for students, teachers, and staff in Florida's schools.
2. Promote implementation of research-tested interventions to promote sun awareness in public schools.
3. Restrict the use of tanning beds to those over age 18 and ensure that current regulations are enforced.

The United States Preventative Services Task Force (USPSTF) website <http://www.ahrq.gov/clinic/uspstf/uspsskca.htm>, concludes that the current evidence is insufficient to assess the balance of benefits and harms of using a whole-body skin examination by a primary care clinician or patient skin self-examination for the early detection of cutaneous melanoma, basal cell cancer, or squamous cell skin cancer in the adult general population.

ORAL CANCER

Oral Cancer Awareness Week is in April
Lifetime Risk of Developing Oral Cancer is 1 in 98 for Women and Men²⁷

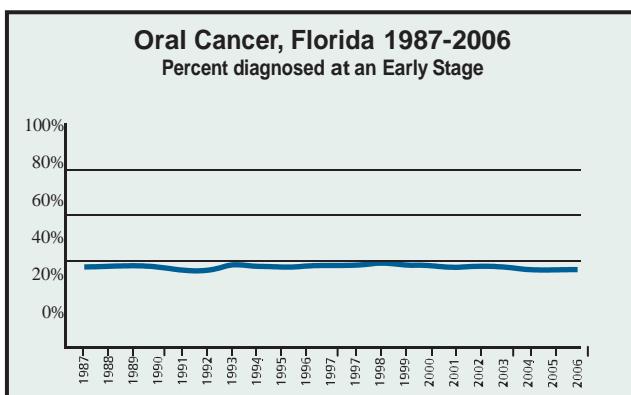


OVERVIEW

Oral and Pharyngeal Cancer (OPC) is the sixth most common cancer worldwide and the fifth leading cause of cancer deaths in Florida.

Currently, only 60 percent of the people that are diagnosed with OPC will survive five years or more. Early detection of OPC is vital. The majority of OPC is preceded by the patient having premalignant lesions. The national OPC five-year survival rate is 83 percent for localized disease, 54 percent for regional disease, and 32 percent for distant disease. In Florida, 2,749 cases of OPC were diagnosed in 2007, with approximately 691 deaths.²⁸

THOSE AT RISK



Source: CDC BRFSS Interactive website

While rates of oral cancers in Florida are slightly higher than in the nation as a whole, the mortality rates are similar.

The percentage of oral cancers diagnosed at an early, more treatable stage has remained low at 31 percent. Florida does not meet the Healthy People 2010 target of 50 percent of oral cancers diagnosed in an early stage.

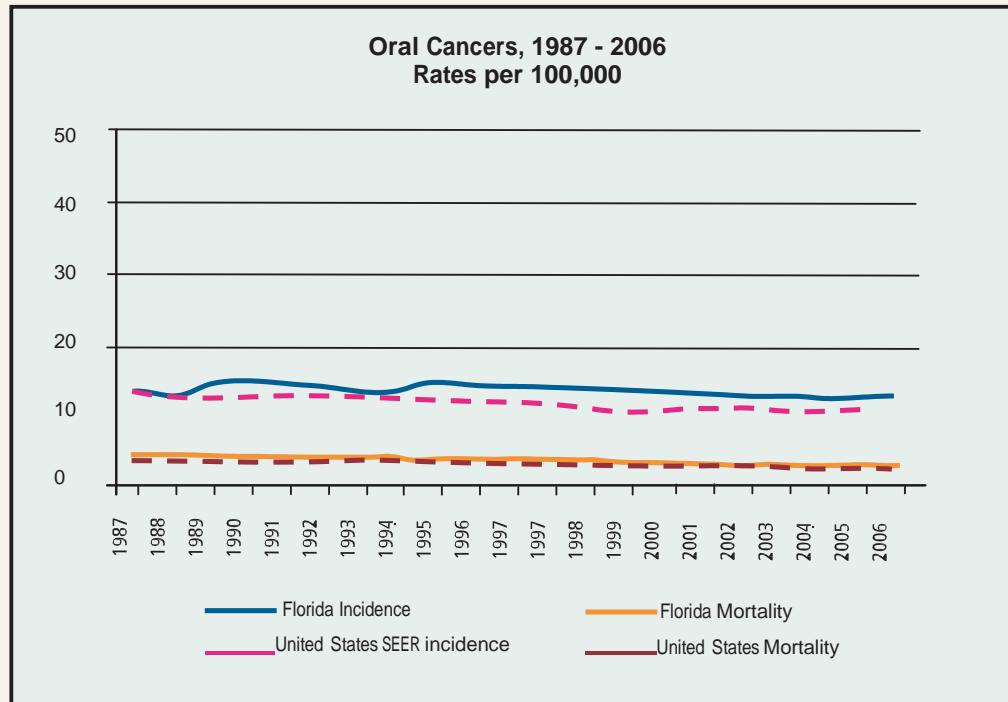
A diet low in fruits and vegetables is associated with an increased risk of developing either oral or colorectal cancer.

American Cancer Society

27 Surveillance Epidemiology and End Results (SEER) Stat Oral Cancer Fact Sheet. Retrieved from <http://seer.cancer.gov/statfacts/html/oralcav.html>.

28 Florida Community Health Assessment Resource Tool Set (CHARTS). Retrieved from <http://www.floridacharts.com/charts/DeathQuery.aspx>.

CANCER BURDEN



Source of data: Florida Cancer Data System

DISPARITIES

Males of both races have age-adjusted incidence rates two to six times the rates among females. From 1987-2006, rates declined 53 percent among black males and 22 percent among black females. Among males, blacks showed a decline by 53 percent while whites showed an increase by 3 percent.

Males have higher mortality rates than females. Five-year relative survival is substantially higher in whites than in blacks, and is particularly low in black males. Moreover, the disparity in relative survival is apparent across virtually all stages, ages, and anatomical sites.

BEHAVIORAL MEASURES

Florida's 2006 mortality rate for oral cancers of 2.5 deaths per 100,000 persons meets the Healthy People 2010 target of 2.7. In 2004, Florida also met the Healthy People 2010 screening target of 20 percent of adult Floridians over the age of 40 reporting receiving an oral cancer screening exam by their dentist. However, Florida does not meet the Healthy People 2010 target of 50 percent of oral cancers diagnosed in an early stage.

African American men have the highest risk of developing oral cancer compared to any other group in the US population.

(National Institute of Dental and Craniofacial Research)

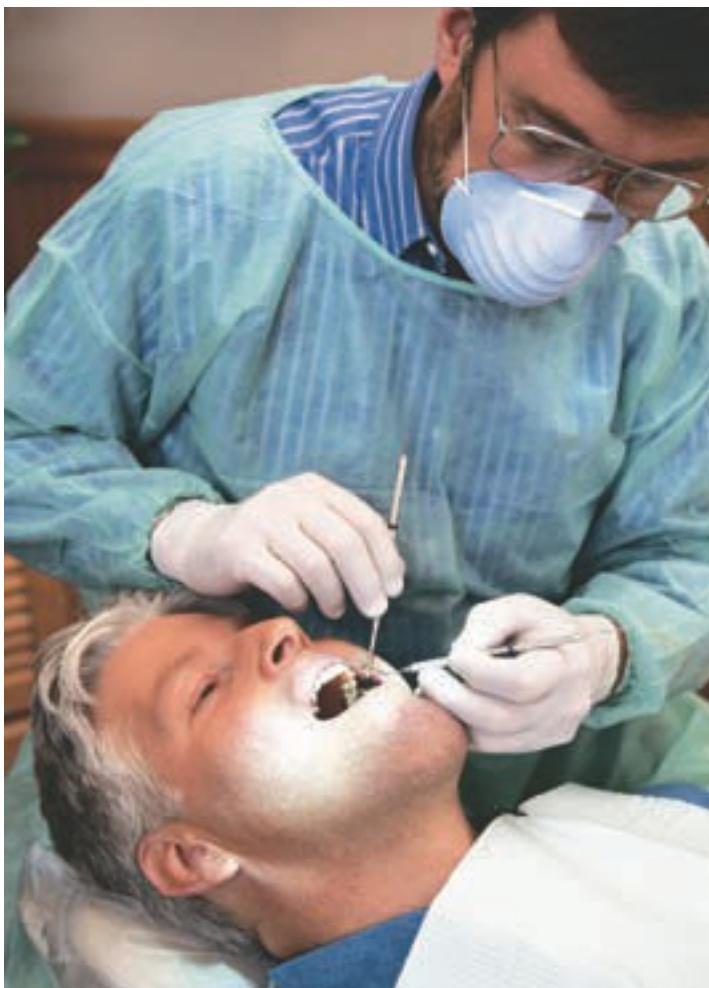
PREVENTION AND EARLY DETECTION

Primary prevention is possible to reduce a person's risk of OPC. Primary prevention measures include not smoking or using any tobacco products and decreasing alcohol consumption. Approximately 75 percent of patients diagnosed with OPC are tobacco smokers or chewers or are excessive alcohol users or all. Women receiving the HPV vaccination will be at reduced risk of HPV related OPC. HPV may also contribute to approximately 20 percent to 30 percent of OPC cases.

Early detection and screening are possible through regular dental or physical exams, or both.

FLORIDA ORAL CANCER STRATEGIES

1. Raise awareness and increase training of dentists, physicians, and allied health professionals in effective OPC screening.
2. Support tobacco control efforts, especially smokeless tobacco use, and its impact on the development of OPC.
3. Increase OPC screening by trained health professionals.
4. Support efforts to ensure health plan coverage of oral screening exams for adults.
5. Educate on HPV and its relationship with OPC.



OVARIAN CANCER

September is Ovarian Cancer Awareness Month

Lifetime Risk of Developing Ovarian Cancer is 1 in 71 Women²⁹

OVERVIEW

Ovarian cancer is a malignancy, that begins in one or both ovaries. The most common form of ovarian cancer is epithelial ovarian carcinomas, which account for 85 percent to 90 percent of all ovarian cancer cases. Stromal cell tumors are the next most common, accounting for five to seven percent of ovarian cancers. Over half of stromal tumors are found in women older than 50, but about five percent of stromal tumors occur in girls.

The national ovarian cancer five-year survival rate for is 94 percent for localized disease, 73 percent for regional disease, and 28 percent for distant disease. In 2007, 980 women in Florida died of ovarian cancer.³⁰

THOSE AT RISK

Modifiable risk factors that decrease a woman's risk of ovarian cancer include use of oral contraceptives and having children prior to the age of 30. The longer you use oral contraceptives, the lower your risk might be. The decrease in risk may last up to 25 years after the use of oral contraceptives has ended. Women who have undergone tubal ligation (sterilization) are at decreased risk of developing ovarian cancer.

There are many non-modifiable risk factors that increase a woman's risk of ovarian cancer including being over age 55, having a family history of ovarian cancer, having had previous breast, endometrial, or colon cancer, carrying the BRCA1 or BRCA2 genes, and being of Ashkenazi (Eastern European) Jewish descent. Hormone replacement therapy is associated with an increased risk of ovarian cancer in postmenopausal women.

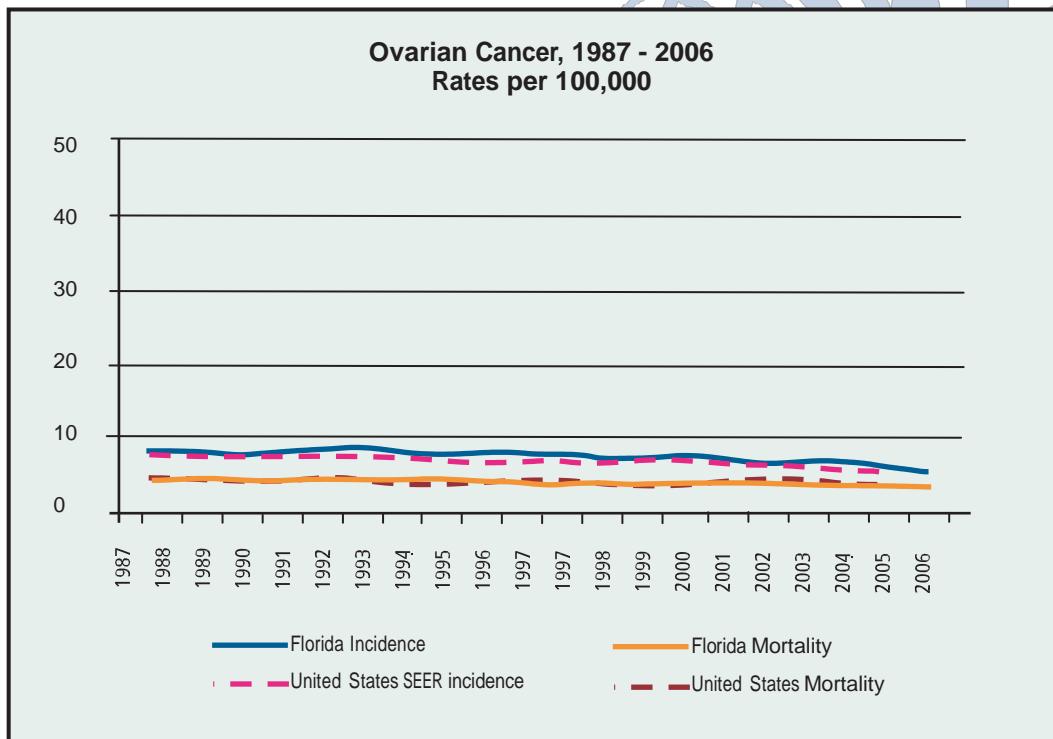
“The experience helped me to understand the importance of communication between doctors and patients.”

Anonymous, breast cancer survivor.

29 Surveillance Epidemiology and End Results (SEER) Stat Ovarian Cancer Fact Sheet.
Retrieved from <http://seer.cancer.gov/statfacts/html/ovary.html>.

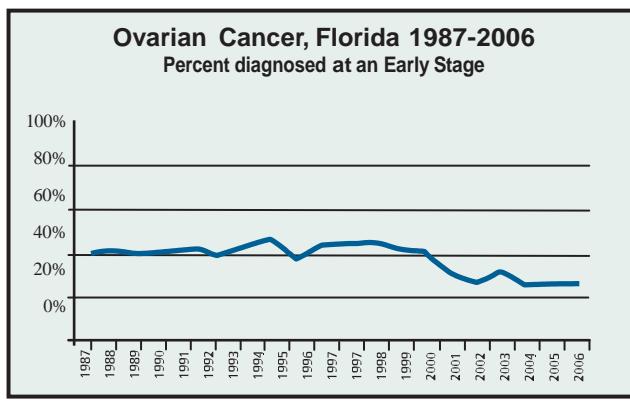
30 Florida Community Health Assessment Resource Tool Set (CHARTS). Retrieved from <http://www.floridacharts.com/charts/DeathQuery.aspx>.

CANCER BURDEN



Source of data: Florida Cancer Data System

Incidences and mortality rates of ovarian cancer are similar between Florida and the nation.



Source of data: Florida Cancer Data System

The lower percentages of early stage ovarian diagnosis from 2001 forward represent a change in stage coding, not a true change underlying the disease.

DISPARITIES

The incidence rate of ovarian cancer was 37 percent higher among whites than among blacks in 2006.

Since 1981, ovarian cancer mortality rates have decreased by 28 percent among black females and by 17 percent among white females. The mortality rate among white females was 28 percent higher than that of black females in 2006.

BEHAVIORAL MEASURES

There are no specific behaviors that reduce the risk for ovarian cancer. However, incorporating healthy nutrition and physical activity are important in maintaining one's health. Women should be informed of the risks and symptoms by their doctor about personal and family medical history that may put them at risk for ovarian cancer.

PREVENTION AND EARLY DETECTION

Primary prevention may not be possible, but avoiding modifiable risk factors will decrease a woman's risk of getting ovarian cancer.

Early detection and diagnosis of ovarian cancer is possible through symptom recognition and regular pelvic examinations, preferably performed by a gynecologist. The USPSTF recommends against routinely providing CA 125 screening to patients without symptoms.

FLORIDA OVARIAN CANCER STRATEGIES

1. Raise awareness of health professionals on the signs and symptoms of ovarian cancer.
2. Promote and raise awareness of genetic links and testing options.
3. Increase awareness among Florida women about ovarian cancer and its signs and symptoms.
4. Promote clinical trial participation.



PROSTATE CANCER

September is Prostate Cancer Awareness Month
Lifetime Risk of Developing Prostate Cancer is 1 in 6 Men³¹

OVERVIEW

Prostate cancer is the most commonly diagnosed cancer and the second leading cause of cancer death in men. In Florida, 14,043 new cancer cases and 2,079 cancer deaths were related to prostate cancer in 2006.³²

For patients whose tumors are diagnosed at the localized-regional stage, they have a 100 percent five-year relative survival rate after surgery or external beam radiation therapy. Those diagnosed with advanced or metastatic stages have a 31 percent five-year survival rate.

The national prostate cancer five-year survival rate for men is 100 percent for localized disease, 100 percent for regional disease, and 31 percent for distant disease. In 2007, 2,153 men in Florida died of prostate cancer.³³

THOSE AT RISK

Factors that may increase the risk of developing prostate cancer include:

- Age – As a man ages, his risk to be diagnosed with prostate cancer increases. The average age of patients at the time of diagnosis is 65.
- Family history of prostate cancer – A man's risk is higher if his father or brother had prostate cancer. Relative risk increases with higher numbers of affected family members, their degree of relatedness, and the age at which they were affected.
- Race – The disease is more common in black men than in white men, including Hispanic white men. It is less common in Asian and American Indian men.
- Diet and dietary factors – Some studies suggest that men who eat a diet high in animal fat may be at an increased risk for prostate cancer.

In the US, African American men have the highest incidence rate for prostate cancer and are more than twice as likely as White men to die of the disease. White women have the highest incidence rate for breast cancer, although African American women are most likely to die from the disease.

(National Cancer Institute)

31 Surveillance Epidemiology and End Results (SEER) Stat Prostate Cancer Fact Sheet. Retrieved from <http://seer.cancer.gov/statfacts/html/prost.html>.

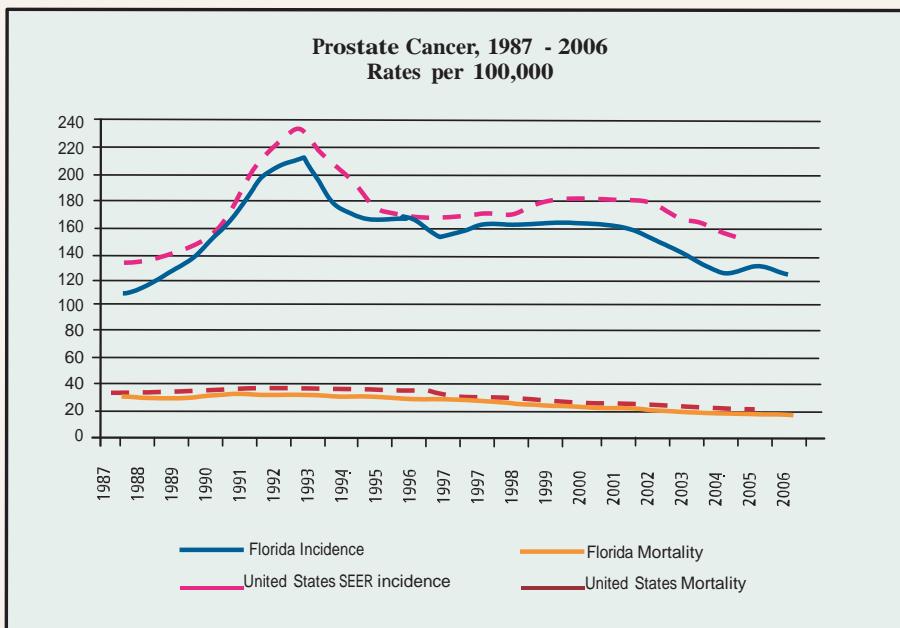
32 Florida Cancer Data System Retrieved from <http://fcds.med.miami.edu/>.

33 Florida Community Health Assessment Resource Tool Set (CHARTS). Retrieved from <http://www.floridacharts.com/charts/DeathQuery.aspx>.

CANCER BURDEN

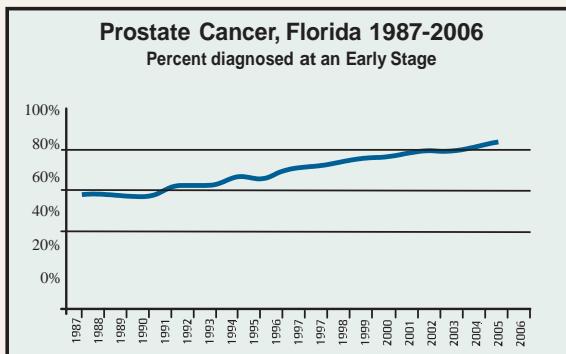
Florida's 2006 mortality rate for prostate cancer of 18.9 meets the Healthy People 2010 target of 28.8 deaths per 100,000 men.

Florida's 2006 overall mortality rate for prostate cancer of 18.9 per 100,000 meets the Healthy People 2010 target of 28.8 deaths per 100,000 men. However, when stratifying by race/ethnicity, black men is the only racial/ethnic group that has not met the Healthy People 2010 goal for the nation relating to prostate cancer. In 2006, the reported mortality rate for prostate cancer in Florida was 17 per 100,000 for white men and 48 per 100,000 for black men.³⁴

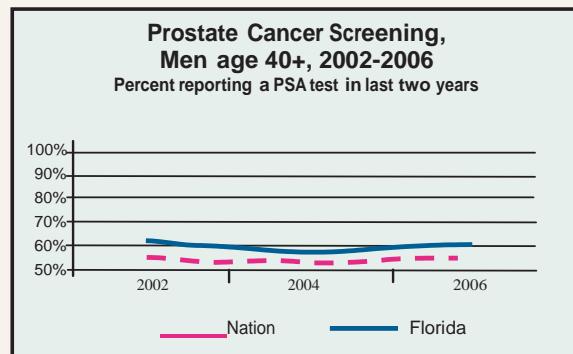


Source of data: Florida Cancer Data System

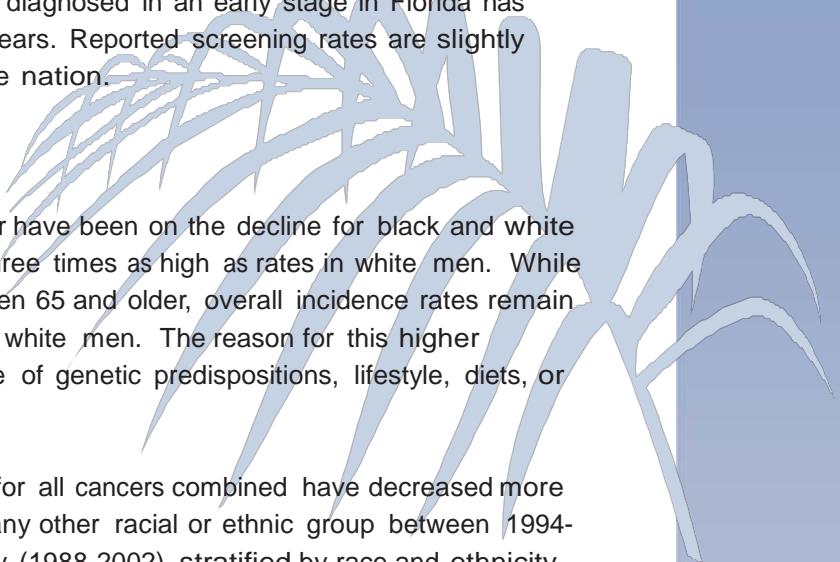
While prostate cancer detection rates in Florida are slightly lower than in the nation as a whole, the mortality rates are nearly identical. The introduction of Prostate Specific Antigen (PSA) testing may explain the “spike” in prostate cancer rates in the early 1990s. Since the introduction of PSA testing, the incidence of local regional disease has increased, whereas the incidence of advanced or metastatic disease has decreased.



Source of data: Florida Cancer Data System



Source: CDC BRFSS Interactive website



The percentage of prostate cancer cases diagnosed in an early stage in Florida has increased by 52 percent in the past 20 years. Reported screening rates are slightly higher among Floridians compared to the nation.

DISPARITIES

Although death rates for prostate cancer have been on the decline for black and white men, rates in black men remain nearly three times as high as rates in white men. While incidence rates have become stable in men 65 and older, overall incidence rates remain significantly higher in black men than in white men. The reason for this higher incidence is unclear, but may be reflective of genetic predispositions, lifestyle, diets, or access to care.

While the incidence and mortality rates for all cancers combined have decreased more among African American men than for any other racial or ethnic group between 1994-2003, survival data from the SEER registry (1988-2002), stratified by race and ethnicity and adjusted by age and stage at diagnosis, show poorer survival for African Americans (compared with white and Hispanic) males with prostate cancer. Recent findings indicate the same problems minorities and the medically underserved face while gaining access to cancer prevention and screening programs at the initial diagnosis (i.e. access to healthcare, insurance coverage, lack of knowledge, awareness, mistrust, lack of cultural appropriateness, health literacy) remain for those who survive their cancer. Thus, it has been recommended as an important priority to increase the number of community-based survivor programs directed to racial and ethnic minorities and the poor.

In a recent review of the literature examining cancer survivorship outcomes (physiologic, psychosocial), health services and quality of care, and health-promoting behaviors and lifestyles, show there is a lack of available evidence for how survivors from racial and ethnic groups fare in these areas. Better surveillance systems are needed in these areas.

BEHAVIORAL MEASURES

There are no specific behaviors that reduce the risk for prostate cancer. However, incorporating healthy nutrition and physical activity are important in maintaining one's health. Men should be informed by their doctor about personal and family medical history that may put them at higher risk for prostate cancer.

PREVENTION AND EARLY DETECTION

The PSA blood test and Digital Rectal Examination (DRE) are the primary screening tools used to detect prostate cancer. Among researchers and clinicians, there has been a persistent concern relative to the sensitivity, specificity, and positive predictive value of prostate cancer screening and early detection modalities currently recommended for use.

In response, national institutes, medical organizations, and cancer societies, all have formulated position statements, recommendations, and/or guidelines for prostate cancer screening. This listing is inclusive of the USPSTF, the American Medical Association, the American Cancer Society, the American College of Preventive Medicine, the American College of Physicians, the American College of Radiology, the American Society of Internal Medicine, and the American Urological Association. While they all acknowledge the importance of early detection to prostate cancer control, they vary in

support of the prostate cancer screening procedures, in the election of prostate cancer screening schedule, and in their support of a specific prostate cancer screening guideline (AHRQ Screening Guidelines Appendix F).

Although the value of PSA screening remains controversial, men who present for periodic health examinations should be made aware of the availability of PSA testing so that they can make informed decisions about their individual need for routine screening. Discussion should include the implications for treatment versus continued monitoring, if positive values are found.

FLORIDA PROSTATE CANCER STRATEGIES

1. Disseminate appropriate prostate cancer education targeted to disparate population.
2. Support high quality prostate cancer research and the development of collaborative research networks across Florida.
3. Increase outreach efforts to minority men to educate on prostate cancer risk reduction behaviors and informed decision making on prostate cancer screening.
4. Increase healthcare provider utilization of the informed decision making process to address screening and treatment options for prostate cancer.
5. Increase health communication and health education efforts to educate the public, policy makers, and the healthcare sector about the major issues relating to prostate cancer.
6. Raise awareness of survivorship needs.
7. Increase healthcare professionals' knowledge, skills, and practice to address prostate cancer prevention, diagnosis, treatment, rehabilitation, and support for prostate cancer, as well as improve access and appropriate utilization of high quality prostate cancer care.



Appendices



Appendix A

SYSTEM DYNAMICS MODELING

The Comprehensive Cancer Control (CCC) Program staff hired a consultant with an expertise on System Dynamic Thinking/Modeling (SDM) to focus on implementing systems thinking approaches with strategic planning efforts. Ultimately, the intent was to create readiness for the CCC Program to develop an evidence-based system dynamics support tool that will monitor and assess the performance of planning efforts.

The work was conducted over several phases beginning with interviewing CCC Program staff, identifying key components of the program, developing a work plan that outlines the scope and activities in creating a systems dynamics modeling tool specific to the CCC Program's work and the strategic opportunities. The next phase required convening a design team and providing the necessary training on the core competencies of system dynamics modeling. The final phase was providing training to the Florida Cancer Plan Council (FCPC) and submitting a final report to the CCC Program with recommendations.

RECOMMENDATIONS:

1. The first step is always internal staff dialogue. What do we have energy and resources for and what would an effort look like that included SDM as part of the process? How are decisions currently made about resource allocation with your partners and what evidence-base would be helpful to inform their decision-making?
2. Next, it may be helpful to engage others in the Bureau of Chronic Disease Prevention and Health Promotion who are struggling with similar issues. Questions might include:
 - How are decisions currently being made in the bureau?
 - What are the commonalities with our chronic disease target audiences and risk factors that might benefit from systems thinking approaches?
 - What drives health disparities in Florida and what common actions or interventions would require an integrated effort?
3. Engaging FCPC members with these recommendations is also important since many of members were involved in the second workshop. It would be important to prepare beforehand and provide the members with the necessary resources to think critically about the desired outcomes and the role SDM could play in making better informed decisions.
4. Lastly, consider working within a region to identify and develop the resources necessary to create effective decision-support tools (i.e. system dynamics models) for the region. Undoubtedly, the models developed for each cancer would have benefits for all states struggling with similar disease burdens.

Appendix B

COMMISSION ON CANCER

A Program Of The American College Of Surgeons

MISSION

The Commission on Cancer (CoC) is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care.

HISTORY

Established by the American College of Surgeons (ACoS) in 1922, the multidisciplinary CoC performs the following activities in healthcare settings:

1. Establish standards to ensure quality, multidisciplinary, and comprehensive cancer care delivery.
2. Conduct surveys to assess compliance with those standards.
3. Collect standardized data from CoC-approved health care settings to measure cancer care quality.
4. Use data to monitor treatment patterns and outcomes and enhance cancer control and clinical surveillance activities.
5. Develop effective educational interventions to improve cancer prevention, early detection, cancer care delivery and outcomes.

MEMBERSHIP

Multidisciplinary membership is comprised of 97 individuals who are either surgeons representing the ACOS or representatives from the 42 national, professional organizations affiliated with the CoC. These individuals each participate in one of the standing committees or in one of the 13 Disease Site Teams that work to pursue the CoC's goals by:

- Establishing standards for 1,433 CoC-approved cancer programs and evaluating and accrediting programs according to those standards.
- Overseeing a nationwide network of more than 1,600 physician-volunteers who provide state and local support for CoC and American Cancer Society cancer control initiatives.
- Providing oversight and coordination for educational programs of the CoC, which are geared towards surgeons, physicians, cancer registrars, cancer program administrators, and others.
- Providing clinical oversight and expertise for CoC standard-setting activities and for the development, review, and dissemination of patient care guidelines.
- Overseeing and coordinating national site-specific studies of patterns of care and outcomes of patient management through the annual collection, analysis, and dissemination of data for all cancer sites.

IMPACT IN FLORIDA

In 2008, approximately 70 hospital cancer programs in Florida had received CoC approval. The location of each CoC-approved program and the services they provided can be accessed by Floridians using the American Cancer Society's Hospital Locator Service at www.cancer.org. Cancer Liaison Physicians at each hospital serve as community liaisons between their cancer program and the CoC. Each approved hospital performs one or more quality improvement studies annually at its institution and submits its cancer registry data to the National Cancer Database. Annual state meetings for Cancer Liaison Physicians are held to provide regular updates to community physicians on CoC initiatives and activities.

QUALITY INITIATIVES

All CoC-approved hospital cancer programs submit their cancer registry data to the National Cancer Database, the largest prospective cancer database in existence. This information is analyzed and reported back to participating hospitals, allowing for quality assessment at the local level. The ongoing CoC Electronic Quality Improvement Project for 2008-2009 includes evaluating the use of adjuvant (supplementary) chemotherapy in surgically resected advanced colon cancer, the use of radiation, hormonal therapy, and chemotherapy in breast cancer, and proper lymph node assessment in surgically resected colon cancer. Cancer programs receive regular updated reports on their adherence to these national guidelines to promote quality patient care.

FUTURE GOALS

The CoC works to continually update its standards to meet the demands of contemporary, evolving cancer care. Recent advances include changes to reporting requirements for cancer staging to ensure accurate data submission on the National Cancer Database and the use of cancer staging and national care guidelines in treatment planning for cancer patients. Ongoing efforts in electronic reporting will ultimately provide real-time, immediate feedback to cancer programs to ensure adherence to accepted guidelines of care.

All hospital cancer programs in Florida are encouraged to seek CoC approval, ensuring quality cancer care for patients close to their home.

The evaluation should focus on issues of greatest concern to stakeholders, while efficiently using time and resources. A written plan that summarizes evaluation goals and procedures and outlines the stakeholders' roles and responsibilities is essential. The plan should include evaluation questions and practical methods for sampling, data collection, data analysis, and interpretation. Stakeholders can help prioritize the questions to determine which are critical, are likely to improve the partnership, and can be answered with available resources. Questions may include the following:

- What should the partnership accomplish and how will it be demonstrated?
- What activities will the partnership undertake to accomplish its goals?
- What factors might help or hinder the accomplishment of its goals?

- Who are the partners (number, diversity, and participation levels)?
- How do partners work together?
- What partnership outcomes should be measured?

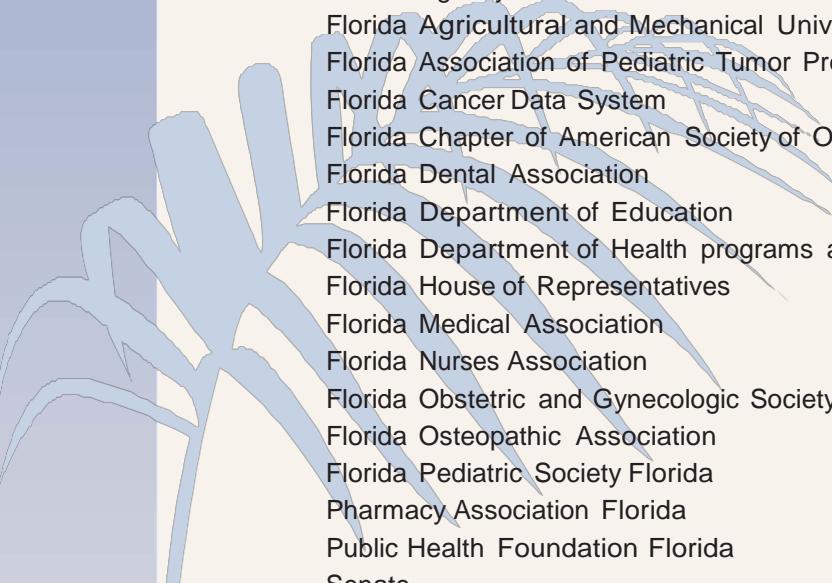
The evaluation design is linked to the priority questions, and the choice of design has implications for what data will be collected and how. A pre-post-test design uses a comparison group to measure the partnership on given parameters before and after it implements planned improvement strategies, or both. A case study design is used to study the partnership's context, history, structure, and function. Case studies usually rely on multiple sources of information such as observations, interviews, audiovisual material, documents, and reports.



Appendix C

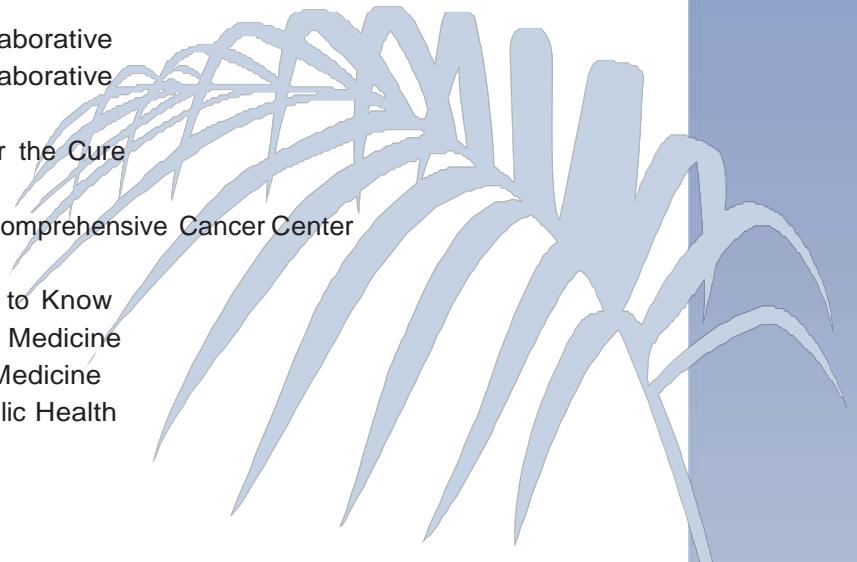
CANCER PARTNERS

We wish to acknowledge the following dedicated organizations who, over the years, have worked with the DOH to reduce the cancer burden for Floridians.



American Cancer Society
American College of Surgeons
Barry University
Cancer Control and Research Advisory Council (CCRAB)
C-Change
Centers for Disease Control and Prevention (CDC)
Florida Agency for Healthcare Administration
Florida Agricultural and Mechanical University
Florida Association of Pediatric Tumor Programs
Florida Cancer Data System
Florida Chapter of American Society of Oncology
Florida Dental Association
Florida Department of Education
Florida Department of Health programs and county health departments
Florida House of Representatives
Florida Medical Association
Florida Nurses Association
Florida Obstetric and Gynecologic Society
Florida Osteopathic Association
Florida Pediatric Society Florida
Pharmacy Association Florida
Public Health Foundation Florida
Senate
Florida Society of Clinical Oncology
Florida Society of Pathologists
Florida Tumor Registrars
General Public Consumer Advocate
H. Lee Moffitt Cancer Center & Research Institute
Jackson Memorial Hospital
Leukemia and Lymphoma Society
M.D. Anderson Cancer Orlando
Mayo Clinic
National Association of Chronic Disease Directors
National Association of Consumer Advocates
National Cancer Institute/Cancer Information Service
National Ovarian Cancer Coalition
Northeast Florida Cancer Collaborative
Northwest Florida Cancer Collaborative
Nova Southeastern College of Osteopathic Medicine
Nova Southeastern University
Oncology Nursing Society
Ovarian Cancer National Alliance

Shands Hospital
Southeast Florida Cancer Collaborative
Southwest Florida Cancer Collaborative
St. Petersburg College
Susan G. Komen Foundation for the Cure
Tallahassee Memorial Hospital
University of Miami Sylvester Comprehensive Cancer Center
University of Florida
University of Florida/CDC Right to Know
University of Florida College of Medicine
University of Miami School of Medicine
University of South Florida Public Health



Appendix D

FLORIDA CANCER PLAN 2010 GUIDE: Building Blocks to Reduce the Burden

The Florida Cancer Plan Guide: Building Blocks to Reduce the Burden is to be used in tandem with the Florida Cancer Plan. The Florida Cancer Plan provides the “large picture” of planning with general strategies defined. The Florida Cancer Plan Guide serves as a working document, which grows off the Florida Cancer Plan and allows each stakeholder group to use the general strategies to create a vision for their specific planning activities. Both documents were created through collaborative efforts of members of the Florida Cancer Control and Research Advisory Council, the Florida Cancer Plan Council, and the Florida Department of Health.

The Center for Disease Control and Prevention created the Guidance for Comprehensive Cancer Control Planning Volume 2: Toolkit as a resource for the national comprehensive cancer control programs. This toolkit was based upon the collective expertise and insight from six model planning states.

The CDC toolkit was instrumental in the framework for developing the Florida Cancer Plan Guide. Based on the toolkit, the Florida Cancer Plan Guide incorporated six important areas of comprehensive cancer control - the “building blocks” for planning and implementation. The Florida Cancer Plan Guide uses the “building blocks” to provide guidance for stakeholder groups to map out their cancer control activities and identifying outcomes.

Initially, a stakeholder group will review and incorporate the building blocks for comprehensive cancer control planning to guide them in the developing their local collaborative and to focus their cancer control efforts.

BUILDING BLOCKS OF COMPREHENSIVE CANCER CONTROL PLANNING



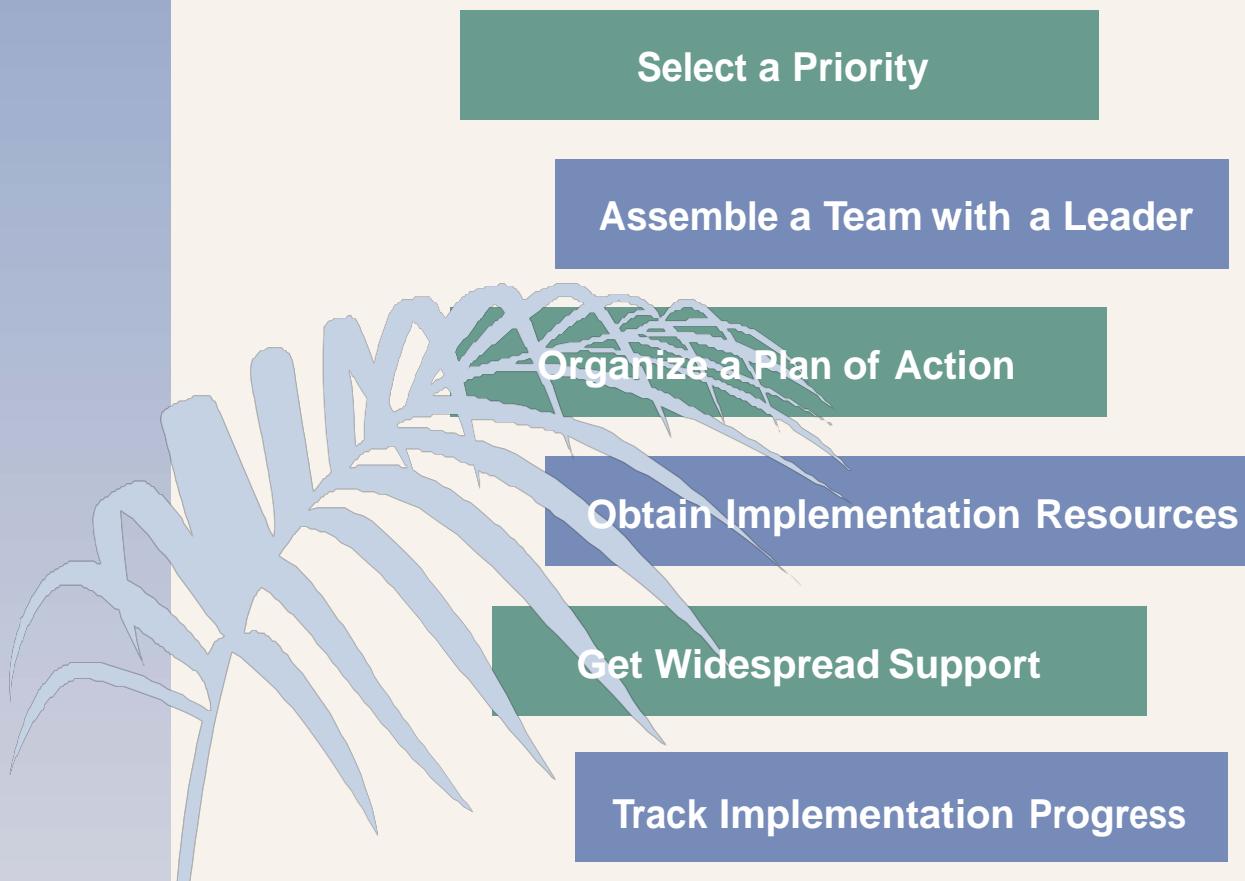
Next, the stakeholder group can utilize the Florida Cancer Plan Guide to provide guidance on the next steps in implementing cancer control activities in cooperation with the building blocks of comprehensive cancer control for implementation.

“Whether I wanted to believe it or not, my surgeon confirmed it with three words, "YOU HAVE CANCER."

Pamela Burnett, cancer survivor.

The Florida Cancer Plan Guide includes a tool to assist stakeholder groups in succinctly recording their prioritized cancer control activities, in an action plan format. The action plan template (See next page) outlines a step by step process to achieve the prioritized goal.

BUILDING BLOCKS OF COMPREHENSIVE CANCER CONTROL IMPLEMENTATION



ACTION PLAN TEMPLATE

Terminology

Abnormal results for breast and cervical cancer exams require that additional exams need to be done promptly to determine if an abnormal condition exists. Up to 20 percent of exams need further studies. Only 1-2 percent of these further studies will have results that indicate cancer.

Biopsy: Removal of cells or tissue for an examination by a pathologist to determine whether disease is present. The three most common biopsies are 1) incisional biopsy, in which only a sample is removed 2) excisional biopsy, in which an entire lump or suspicious area is removed, and 3) needle biopsy, in which a sample of tissue or fluid is removed with a needle. When a wide needle is used to remove tissue, the samples are called core biopsies. When a thin needle is used and fluid removed, the procedure is called a fine needle aspiration.

Breast Cancer: Malignant tissue growth in the breast, which is usually in the ducts or lobules.

Cancer: A term for diseases in which abnormal cells divide without control. Cancer cells can invade and can spread to other parts of the body through the blood and lymph systems. There are several main types of cancer.

Cancer screening: Checking for changes in tissue, cells, or fluids that may indicate the possibility of cancer when there are no symptoms.

Colonoscopy: An examination of the rectum and entire colon using a lighted instrument called a colonoscope. A colonoscope allows the physician to remove polyps or other abnormal tissue for examination under a microscope.

Cervical Cancer: Malignant tissues of the cervix (the organ connecting the uterus and vagina).

Clinical breast exam: A breast exam preformed by a healthcare provider.

Colposcopy: The examination of vaginal and cervical tissues by means of a colposcope which is a magnifying lens. Colposcopy is used to select sites of abnormal cells for biopsy in patients with abnormal Pap tests.

Diagnostic Procedures: Exams used to diagnose disease or health status.

Digital mammogram: A technique that uses a computer rather than an x-ray film to record x-ray images of the breast.

Digital rectal exam (DRE): A test in which the healthcare provider inserts a lubricated, gloved finger into the rectum to feel for abnormal areas.

Fecal Occult Blood Test (FOBT): A test to check for blood in the stool. Small samples of stool are placed on a special card and sent to a doctor or laboratory for testing. Blood in the stool may be a sign of colorectal cancer.

Malignant: Cancerous.

Normal results for breast and cervical cancer exams require no immediate follow-up.
You return to regular screening schedules as determined by your provider.

Pap Test: A screening test to find cell changes in the cervix. Cells are collected from the cervix. When abnormal cells are identified, the patient will need follow-up testing such as repeat Pap screening or colposcopy.

Pre cancerous: A term for a growth that is not yet, but may become, cancerous.

Prostate-specific antigen test (PSA): A test that measures the level of an enzyme (PSA) in the blood that increases due to diseases of the prostate gland, including prostate cancer.

Risk factor: Something that increases a person's chance of developing a disease.

Sigmoidoscopy: A procedure in which the physician or healthcare provider looks inside the rectum and the lower part of the colon (sigmoid colon) through a flexible lighted tube. During the procedure, the physician or healthcare provider may collect samples of tissues or cells for closer examination.

Stage: The size and extent of a cancer, including whether the disease has spread from the original site into surrounding tissue and other parts of the body.

- In situ - early cancer that is present only in the layer of cells in which it began.
- Localized - cancer that is limited to the organ in which it began, without evidence of spread.
- Regional - cancer that has spread beyond the original (primary) site to nearby lymph nodes or organs and tissues.
- Distant - cancer that has spread from the primary site to distant organs or distant lymph nodes.
- Unknown - used to describe cases for which there is not enough information to indicate a stage.

Screenings: Exams to find abnormal tissue at the earliest most treatable stages.

Screening Mammogram: An x-ray of the breast taken to check for breast cancer that can detect cancer before a lump is felt.

Ultrasound: A procedure in which high-energy frequency sound waves are bounced off internal tissue or organs and make echoes. The echo patterns are shown on the screen of an ultra sound machine. Breast ultrasound may be used to see whether a lump is solid or filled with fluid.

Appendix F

Agency for Healthcare Research and Quality Screening Guidelines U.S. Preventive Services Task Force Screening Guidelines

The U.S. Preventive Services Task Force (USPSTF) was convened by the Public Health Service to rigorously evaluate clinical research in order to assess the merits of preventive measures, including screening tests, counseling, immunizations, and preventive medications.

| Men's Cancer Screenings | | | |
|--------------------------------|--------------------------------|--------------------------|--------------------------|
| CANCER | SCREENING METHOD | AGE TO START | TIME FRAME |
| Colon/rectum | fecal occult blood test (FOBT) | 50 | yearly |
| Colon/rectum | colonoscopy | 50 | every 10 years |
| Colon/rectum | sigmoidoscopy | 50 | every 5 years |
| Prostate gland | digital rectal exam | 50 | discuss with your doctor |
| Prostate gland | PSA blood test | 50 | discuss with your doctor |
| Skin | full-body skin exam | discuss with your doctor | discuss with your doctor |

| Women's Cancer Screenings | | | |
|----------------------------------|--------------------------------|--------------------------|--------------------------|
| CANCER | SCREENING METHOD | AGE TO START | TIME FRAME |
| Breast | mammogram | 50 | every 2 years |
| Cervix | Pap test | 21 | discuss with your doctor |
| Colon/rectum | fecal occult blood test (FOBT) | 50 | yearly |
| Colon/rectum | colonoscopy | 50 | every 10 years |
| Colon/rectum | sigmoidoscopy | 50 | every 5 years |
| Skin | full-body skin exam | discuss with your doctor | discuss with your doctor |

The guidelines provided are for informational purposes only. To determine which screenings are appropriate

For additional information visit the Agency for Healthcare Research and Quality's website at: <http://www.ahrq.gov/clinic/cps3dix.htm#cancer>.

Appendix G

My Cancer Story

STORY 1:



"On October 9, 2003 my life was changed forever as I heard the words from the physician "The tests show that you have Multiple Myeloma." Momentarily, I became numb and speechless. Sometimes challenges in life can seem very surreal. I have worked 17 years as a Licensed Clinical Social Worker on the Bone Marrow Transplant Unit at Shands Hospital at the University of Florida. As the BMTU social worker, I complete pre-transplant psychosocial evaluations, provide counseling, crisis intervention, referrals to community resources, facilitate the BMTU Patient/Family Support Group. Although work experience had given me some knowledge of this disease and the treatment process, my challenge now was not to intellectualize this or look for the outside in. Neither was denial an option. I had to face it head on. I had to accept it, cope with it and more importantly survive it. I educated myself about the disease and its treatments, pulled from my inner strength used to cope with previous crises, relied on my spiritual faith, asked others for help, accepted support from others and to this very day, remain hopeful that someday there will be a cure. This October will be 6 years since I was first diagnosed.

My journey as a cancer advocate, educator, and facilitator did not start nor does it end with my employment. I have volunteered in the community and several cancer organizations for more than 15 years. I am a Co-Regional Coordinator for the Florida Society of Oncology Social Workers, a member of the Shands Hospital Cancer Committee, a volunteer and member on the local board of the American Cancer Society and volunteer for the Leukemia & Lymphoma Society. My volunteer work and advocacy has afforded me many opportunities to enhance my knowledge and skills and more importantly, to help others cope with life's adversities. June 3, 2007, I completed the half marathon at the "Rock-n-Roll" Marathon in San Diego. I am grateful for the support and assistance from all of the people throughout this State and Country who make a difference in the lives of all cancer survivors, families and caregivers.

STORY 2:

"Melanoma – While I had worked with melanoma for years I was surprised to be told that I had it on my left ear. And later I was more surprised when it recurred after the original melanoma was removed. This led to complete removal of my left ear, a skin graft, and local radiation treatment at the Moffitt unit at Tampa General Hospital. All of this would not have been possible without many clinical research reports on the treatment of melanoma which continues to evolve. Based on the extent of the melanoma in my recurrence I received treatment with Interferon which was determined on the basis of numerous clinical trials. When I discussed changes to the care with my practitioner at Moffitt, he kindly reminded me that variation in my treatment would create a series of one – that is me. This response kept me with the program which for me is periodic follow-up to check for recurrences. However, I know I would not be here today without the foundation of medical research and the care that I have received from a number of dedicated professionals."

STORY 3:

"Miss Florida Teen USA Kayla Collier was 15 when she first visited a tanning salon so the stage lights at a local pageant wouldn't make her fair skin look ghostly white. Later that year, as she tried on homecoming dresses, her mother noticed what looked like a scab on her back. It turned out to be skin cancer.

And though she can't definitively link the tanning to the cancer, Collier, now 18 and healthy, won't be back under the bulbs. Last week, her voice catching, she asked Sunshine State lawmakers to ban people under 16 from using tanning beds."

STORY 4:

"I have worked in the field of cancer for over 20 years, got mammograms, and did what I thought were the right things to prevent cancer. When a routine mammogram showed something suspicious seven years ago, my first thought was, "I can't get cancer – I work in the field! I should be exempt!" But, that's not the way things go. After looking into my options and getting several opinions, I had a lumpectomy, radiation therapy, and hormone therapy. Because I was treated where I work, going to appointments seemed like going to meetings! I guess I was somewhat detached and thought of my treatment as a way of learning about cancer treatment from the perspective of a patient, and checking out how much information is given to patients. I hope I wasn't a typical patient because I don't remember receiving a lot of information. At the time, I wondered if that was because I worked in the field. But maybe I did get information but blocked it out at the time, like many people do when they are overwhelmed with making medical decisions. The experience helped me to understand the importance of communications between doctors and patients, and to realize that health care professionals should not assume patients have all the information they need. Having seen cancer from many sides – as a professional, a patient, and a family member of people with cancer - I'm glad that there are so many caring and concerned professionals available to help. I hope that the Florida Cancer Plan will serve as a guide for agencies and individuals to continue to work toward reduce the burden of cancer in our state."



Anonymous

STORY 5:

"Millions of people are diagnosed with cancer every year, but not me; so I thought. Then in the month of November 2002, I was told I was one in that million.

For eighteen months I was misdiagnosed and told that I had fatty tissue, when in fact I had breast cancer. This diagnosis of breast cancer left me stunned and speechless. "This is just not true," I told myself. I did not believe what I just heard. Whether I wanted to believe it or not, my surgeon confirmed it with three words, "YOU HAVE CANCER." I screamed!

After numerous operations, radiation treatments, staph infection and a failed breast implant brought on new illnesses such as diabetes, hypertension, bleeding ulcers, and the worst of it, DEPRESSION. I attempted a "foolish act," which could have cost me my life. Instead of acting on it, I sought professional help, which was the BEST decision I ever made. This became a part of my recovery process which led me to assist others who were diagnosed with cancer.

In 2004, the opening of a cancer support center was weighing heavily on my heart. I wanted to provide a place for cancer patients and their families to come and discuss their problems or issues; a place to voice their frustrations; a place to have their needs met so that the stress in their lives, caused by their illness, can be alleviated. I felt that without this type of interpersonal support they could lose all hope and feel they have no one to turn to during their health, spiritual or financial strains. I wanted them to know that they can trust me, because I am one of them...A SURVIVOR who did not give up HOPE or faith; a battle that was won by the grace and mercy of God. In 2006, after reading the Book of Acts from the bible the birth of The Beautiful Gate Cancer Resource Center was born with the mission to provide all who enter through the gate with the support they need."

STORY 6:

A Florida cervical cancer survivor and participant in the Florida Breast and Cervical Cancer Early Detection Program reported that her participation in the program was the kindest thing that has ever happened to her family. She said everyone was so caring and she hopes that no woman is ever afraid to come in and get the help they need.

**"I had to face it head on. I
had to accept it, cope with
it and more importantly
survive it."**

Gale Smith, cancer survivor.

Anonymous

STORY 7:

"Terrified, scared, and shocked. My body shook uncontrollably. I gathered all my strength to explain to my daughters that I was not going to die. I was ready to fight for my life. I met with the oncology team, underwent CT scans and MRI screenings, and resigned from work. The plan was to receive neo-adjuvant chemotherapy followed by a bilateral mastectomy with complete lymph node dissection. I prayed for the strength to endure the treatment. I prepared my daughters for worst case scenarios. But I promised them, as well as family and close friends, that this was a challenge I had to face and overcome. My faith was my source of strength; my family was my motivation not to give up.

The night before my first chemo was an emotional struggle. I was taking medication that would reduce the side effects of a drug that would kill all the cells in my body. My husband's words changed my perspective. He said that the chemo was going to kill what it needed to in order to save my life. The side effects included loss of appetite, fatigue, and soreness. My count was one down, five to go. The side effects increased, but each chemo visit was one closer to the last one. I had time to reflect on the privilege to fight for my life. While I was self absorbed and consumed by my situation, I was determined to demonstrate a positive attitude in how I was handling it.

The surgery to me was the final step in the treatment plan. It was over; it was gone. Each today was better than yesterday. The next few months included the tissue expander exchange for the silicone breast implants, followed by surgery.

I do not want the word "cancer" to define who I am. During this difficult time, I completed my doctoral studies. I love life and savor every minute with loved ones. I live in the present. I have fewer fears. I am a wife, mother, sister, daughter, friend, and teacher. Those are the words that define me."

STORY 8:

Paul A. Pitel, MD

"Like many people, my choice of career in the cancer field was profoundly affected by my exposure to a specific individual. As a 2nd year medical student at Brown, we had an elective on medical ethics taught by the head of Pediatric Hematology-Oncology. I was fascinated to watch Dr. Ed Forman range across the biology of his practice, to the psychology of working with very ill patients and their families, to the ethical questions raised by research on children. I was starting to be hooked.

The greatest improvements in caring for children with cancer probably fall into a few broad areas. First, supportive care – antibiotics, hematopoietic stimulants (such as G-CSF), pain control – are profoundly better. CVAC's were not yet invented. Second, imaging modalities have improved to a revolutionary degree. When I started my practice, CT scans were rare and poor quality. MRI and PET, among others, simply did not exist. Last, our understanding of tumor biology, affecting diagnosis and risk assessment, has changed to an extraordinary degree.

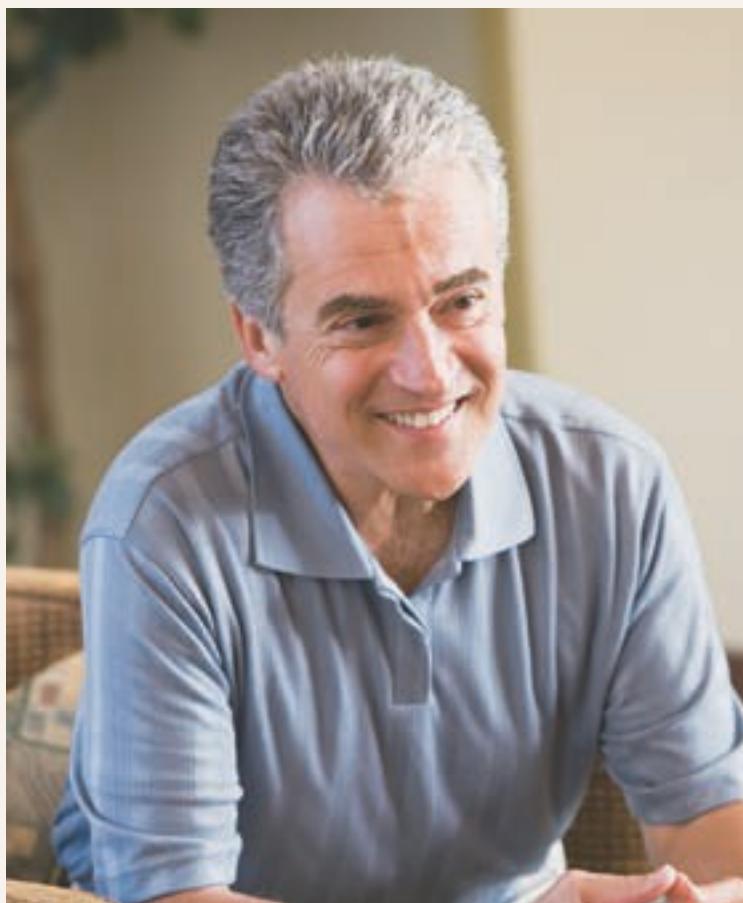
My greatest disappointments, in terms of change in cancer care during my career, fall into three broad areas. First, the United States has not yet figured out how to insure

people to receive all the benefits modern medicine can provide. This is even more profound when it affects children. Second, the “bad diseases” – high risk neuroblastoma, very high-risk ALL, relapsed disease – are still very difficult to cure. Last, I still do not fully understand – and do not accept – the very low levels of adult patient accrual onto oncology therapeutic protocols. The gap between adult and pediatric practice remains too great.

A cancer-related program I really enjoy working with is the Florida Division of the American Cancer Society in its Reach Out to Cancer Kids (R.O.C.K.) programs. These include R.O.C.K. Camp, R.O.C.K. Family Weekends, and the College Scholarship Program. These are all terrific.”

“I know I would not be here today without the foundation of medical research and the care that I have received”.

John Mason, cancer survivor.



ADDITIONAL RESOURCES

Resources for community cancer partners.

For Information About Cancer:

Contact your local health department or healthcare provider for information about resources and programs in your area.

National Cancer Institute's toll-free and confidential: 1-800-4-CANCER or 1-800-422-6237
(Para información en Español) or www.cancer.gov or www.cancer.gov/espanol (Para información en Español)

American Cancer Society is toll-free: 1-800-227-2345 or visit www.cancer.org
(http://www.cancer.org/docroot/ESP/ESP_0.asp para información en español.)

Centers for Disease Control and Prevention: <http://www.cdc.gov/cancer/index.htm>

Cancer Control Research and Advisory Council (CCRAB): www.moffitt.org

FLORIDA CANCER CONTROL:

Breast and Cervical Cancer Early Detection, Colorectal Cancer Control and the Comprehensive Cancer Control Program: 850-245-4330 or
<http://www.floridashealth.com/> or e-mail directly cancer@doh.state.fl.us

Florida Cancer Data System Florida's cancer registry: <http://fcds.med.miami.edu>

Tobacco Prevention Program: 850-245-4144 or
DHAT_TobaccoControlProgram@doh.state.fl.us

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