
# Florida Cancer Control & Research Advisory Council

## General Membership Meeting

**Friday, September 29, 2017**
**10:00 a.m. to 3:00 p.m.**
**Stabile Research Building – Trustees Boardroom**
**Moffitt Cancer Center**

Florida Cancer Control
& Research Advisory Council

# Mission Statement

**The Florida Cancer Control and Research Advisory Council was established by the Florida Legislature in 1979, under Florida Statute 1004.435, with the purpose of advising the Legislature, Governor, and Surgeon General on ways to reduce Florida's cancer burden.**

Florida Cancer Control & Research Advisory Council

# General Membership Meeting Agenda

**Friday, September 29, 2017**
**10:00 a.m. – 3:00 p.m.**
**Moffitt Cancer Center – Stabile Research Building – Trustees Boardroom**
**1-800-206-6032; Passcode 7451520#**

| | | |
|---|---|---|
| 10:00 a.m. | **Welcome, Introductions & Mission Moment** | *Dr. Chris Cogle* |
| 10:10 a.m. | **Approval of Minutes from May 12, 2017 Meeting** | *Dr. Chris Cogle & Council* |
| 10:15 a.m. | **Florida Cancer Plan Progress Report** | *Drs. Chris Cogle & Clement Gwede* |
| 11:30 a.m. | **Florida Department of Health Updates** | *Dr. Celeste Philip* |
| 12:00 p.m. | ***Break*** | |
| 12:15 p.m. | **Working Lunch – CDC Presentation by Dr. Lisa Richardson, Director of CDC's Division of Cancer Prevention and Control** | *Dr. Lisa Richardson* |
| 1:15 p.m. | **Florida Consortium of National Cancer Institute Centers Program Report** | *Dr. Celeste Philip & Council* |
| 1:30 p.m. | **Biomedical Research Advisory Council (BRAC) Update** | *Dr. Danny Armstrong* |
| 2:00 p.m. | **2018 Legislative Session Preview** | *American Cancer Society Cancer Action Network* |
| 2:30 p.m. | **CCRAB Annual Report due February 2018** | *Dr. Chris Cogle* |
| 2:55 p.m. | **Next CCRAB Meeting** | *Dr. Chris Cogle* |
| 3:00 p.m. | **Recap & Adjourn** | *Dr. Chris Cogle* |

Florida Cancer Control & Research Advisory Council

# Florida Cancer Control & Research Advisory Council Membership

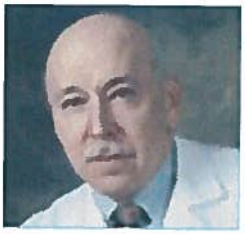
*(September, 2017)*

**Chair**
Christopher Cogle, MD
University of Florida Shands Cancer Center
Senate President's Appointee

**Vice Chair**
Clement Gwede, Ph.D., MPH, RN, FAAN
H. Lee Moffitt Cancer Center & Research Institute

Celeste Philip, MD, MPH
Florida's Surgeon General

Jessica Bahari-Kashani, MD
Florida Medical Association



Robert Cassell, MD, Ph.D.
Association of Community Cancer Centers

Asher Chanan-Khan, MD
Florida Hospital Association

Marti Coley Eubanks
Nemours Children Hospital
House Speaker's Appointee

Lawrence Hochman, DO, FACRO
Florida Osteopathic Medical Association

Erin Kobetz, Ph.D., MPH
Sylvester Comprehensive Cancer Center
University of Miami

Duane Mitchell, MD, Ph.D.
University of Florida Shands Cancer Center

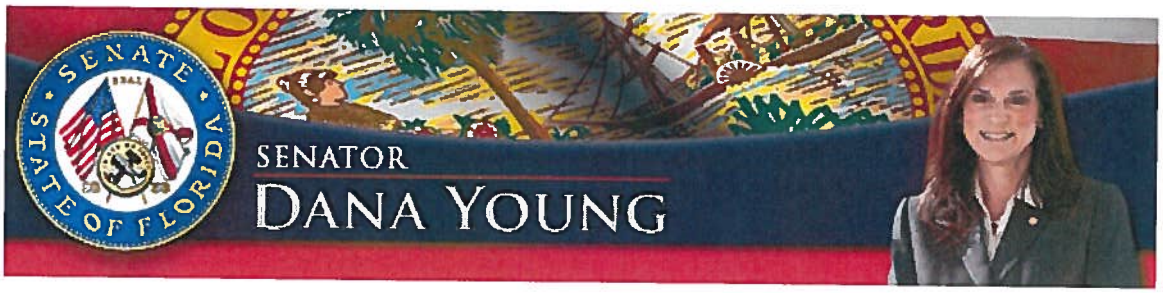
Theresa Morrison, Ph.D., CNS-BC
Florida Nurses Association

Amy Smith, MD
Arnold Palmer Hospital for Children
Governor's Appointee

Megan Wessel, MPH
American Cancer Society

Senator Dana Young
Senate President's Appointee

TBD
House Speaker's Appointee




Dana Young, a sixth generation Floridian, was born and raised in Tallahassee, Florida. In November 2010, she was elected to the Florida House of Representatives and served District 60 until November 2016. In November 2016, she was elected to the Florida Senate (Tampa – 18th District), where she continues the proud family tradition of public service after her father Don Duden (Former Assistant Secretary of the Department of Environmental Protection), her grandfather, Former Florida Senate President Randolph Hodges, and her uncle, Rep. Gene Hodges who also served in the Florida House of Representatives.

Senator Young is a product of the Florida public school system, and received her undergraduate degree in Political Science from Florida State University. In pursuit of her interest of the law and public policy, Senator Young graduated from the University of Virginia School of Law in 1993, and then returned home to Florida to begin her legal career at Fowler, White, Boggs, P.A. As a member of the firm's Regulated Industries Department, Senator Young represented a broad spectrum of businesses, landowners, and individuals in areas of regulatory compliance, permitting, zoning, and administrative law proceedings.

In October 2014, then Representative Young was tapped by Speaker Crisafulli as Majority Leader to serve for the 2015 and 2016 legislative sessions. This follows two years serving as Majority Whip and Deputy Majority Leader under Speaker Will Weatherford. In April 2013, she was appointed by Governor Scott to the Florida Defense Support Task Force. From 2011-2012 she served as Chairman of the influential Hillsborough County Legislative Delegation. She also serves on the Board of Tampa's Lowry Park Zoo. In 2013 she was appointed to the Board of Trustees for the Florida Aquarium, The Florida Coalition Against Domestic Violence. In 2014 she was appointed to serve on the U.S. Global Leadership Coalition's Florida Advisory Committee. Senator Young is a member of GOPAC's Advisory Board which helps promote the ideas and policies being implemented at the state level, as well as assist with electing new generations of Republican leaders. In August 2017, Senator Young was appointed to the National Conference of State Legislature's (NCSL) Innovations in State Health Systems Task Force. This task force consists of 35 members and was created to examine the issues and opportunities faced by state policymakers as they reform their state's health systems.

Sen. Young has worked tirelessly to pass legislation aimed at creating an exceptional business climate and a world class quality of life for Floridians. In her legislative career she has sponsored and passed numerous bills, which are now law here in Florida

She and her husband, Matt, have been married for over 20 years and have two daughters, Alexandra and Carson.

# CCRAB Newsletter

JULY/AUGUST 2017

## 1. Meeting with FL DOH about Cancer Prevention and Control Programs

On July 12th, 2017, Drs. Christopher Cogle, Clement Gwede and Bobbie McKee met in Tallahassee with Dr. Celeste Philip and the Florida Department of Health staff to review the Department's cancer prevention and control programs. The group reviewed the activities of and provided feedback to the Biomedical Research Program, Florida Cancer Data System, Breast and Cervical Cancer Detection Program, Colorectal Cancer Control Program, Comprehensive Cancer Control Program, and the Department's new Lung Cancer Screening Program. Specific updates will be provided at the CCRAB meeting on September 29th in Tampa.

## 2. Meeting among Chairpersons of CCRAB, BRAC and PCAC

On July 18th, 2017, Dr. Cogle met with Dr. Danny Armstrong, chairperson of the Biomedical Research Advisory Council (BRAC), and Dr. Tom Stringer, chairperson of the Prostate Cancer Advisory Council (PCAC), to share each other's activities, priorities and plans. The group also discussed their respective annual reports and the gap in funding highly meritorious Bankhead-Coley grant applications. The chairpersons agreed to participate in each other's council meetings and to meet again in one year.

## 3. CCRAB Member & Staff Spotlight: Bobbie McKee

CCRAB has a new staff liaison, Dr. Bobbie McKee. Bobbie joined Moffitt's Government Relations team in the role of External Board Manager, and will be providing the necessary support to assist the Council in fulfilling its responsibilities. Prior to this position, Bobbie graduated from the University of Central Florida with a Ph.D. in Public Affairs in 2016, and worked in advocacy and public policy at the American Cancer Society from 2005 to 2015. We look forward to working with Bobbie.

## 4. Next Meeting Friday, September 29, 2017 at Moffitt Cancer Center

The next CCRAB meeting will be held on Friday, September 29th from 10:00 a.m. to 3:00 p.m. in the Stabile Research Building at Moffitt Cancer Center. Special guest presenter Dr. Lisa Richardson will inform Florida CCRAB's efforts by sharing her expertise as the CDC's Director of the Division of Cancer Prevention and Control.

Florida CANCER CONTROL & Research ADVISORY COUNCIL

The Florida Cancer Control and Research Advisory Council (CCRAB) was established by the Florida Legislature in 1979 with the purpose of advising the Legislature, Governor, and Surgeon General on ways to reduce Florida's cancer burden. Dr. Christopher Cogle is the Chair of CCRAB, and Dr. Clement Gwede is the Vice Chair.

# MINUTES

**FLORIDA CANCER CONTROL AND RESEARCH ADVISORY COUNCIL**
**GENERAL MEMBERSHIP MEETING**
**FRIDAY, MAY 12, 2017 10:00 a.m. – 3:00 p.m.**
**Moffitt Cancer Center-Stabile Research Building**
**Board of Trustees Room**

**Council Members in Attendance**

- Jessica Bahari-Kashani, MD - Florida Medical Association (By Phone)
- Robert Cassell, MD, PhD - Association of Community Cancer Centers
- Asher Chana-Kahn, MD – Florida Hospital Association (By Phone)
- Christopher R. Cogle, MD - University of Florida - Senate President's Appointee *(Chair)*
- Marti Coley Eubanks – Nemours Children's Hospital - House Speaker's Appointee (By Phone)
- Clement Gwede, PhD., MPH, RN, FAAN - Moffitt Cancer Center *(Vice Chair)*
- Lawrence Hochman, DO, FACRO - Florida Osteopathic Medical Association
- Celeste Philip, MD – Florida's Surgeon General for Health, Florida Department of Health
- Amy Smith, MD – Arnold Palmer Hospital for Children – Governor's Appointee
- Megan Wessel, MPH - American Cancer Society

## Other Council Members In Attendance

- Dr. Daniel Armstrong – Chair, Florida Biomedical Research Advisory Council
- David J. Lee PhD – Florida Cancer Data System
- Gary Levin, BA, CTR – Florida Cancer Data System
- Merritt Martin - Moffitt Cancer Center
- Laura Lenhart - Moffitt Cancer Center
- Sandra Stonecypher - Moffitt Cancer Center
- Heather Youmans - American Cancer Society (By Phone)
- Sam Mooneyham, Florida Department of Health (by phone)
- Tara Hylton - Florida Cancer Data System (By Phone)
- Sam Mooneyhan, Florida Department of Health (By Phone)
- Gregg Smith, Florida Department of Health (By Phone)
- Bonnie Gaughan-Bailey, Florida Department of Health (By Phone)
- Felicia Dickey, Florida Department of Health (By Phone)
- Marian Banzhaf, Florida Department of Health (By Phone)
- Shannon Hughes, Florida Department of Health (By Phone)
- Kelly O'Dare, Florida Department of Health (By Phone)
- Lauren Porter, Florida Department of Health (By Phone)
- Kaitlyn Barningham, Florida Department of Health (By Phone)
- Dinithia Sampson Florida Department of Health (By Phone)

**CCRAB Members Not in Attendance**

- Dr. Lawrence Hochman
- Mohammad Jahanzeb
- Asher Chanan-Khan

**Welcome**

Dr. Chris Cogle began by welcoming all members and guests, and also briefly reviewing the day's agenda. Each Council member, guest, and participants by phone took a moment to introduce themselves to the room.

**Approval of Minutes**

Dr. Cogle led the motion to review and approve the meeting minutes from the October 14, 2016 meeting minutes. Dr. Philip noted a correction in the date on the top of the meeting minutes. That correction will be made. Dr. Clement Gwede and Marti Coley Eubanks motioned to approve the minutes. The Council concurred.

**CCRAB May 2017 Introduction**

Dr. Cogle presented a Power Point reviewing the mission of CCRAB and updated the Council on the top five causes of death nationally and in Florida, metrics on cancer deaths in Florida and also incidences of cancer in Florida. Moreover, Dr. Cogle spoke to the prioritization of topics for today's meeting. Priorities include previously agreed upon topics within the Cancer Plan Dashboard that require the Council's attention.

**Florida Cancer Plan Progress**

***Theme #1: Burden of Cancer***

Gary Levine, over the phone, provided progress on entering VA cancer data into the FCDS master-file. Tara Hylton outlined how FCDS will tackle inserting that amount of data. Dr. Celeste Philip added that this should be counted as a victory for CCRAB and that a plan should be developed to communicate this success to appropriate parties.

Dr. Cogle moved to the next outstanding item regarding clear language for non-hospital reporters to submit to FCDS per section 385.202 of Florida Statute. Dr. Philip added that she would be happy to work with our partners at the Department of Health in addressing better ways to enforce.

Tara Hylton updated the Council about FCDS incorporating screening, laboratory and cancer test results. Dr. Cogle offered CCRAB as a resource in the event that a workgroup was needed to guide DOH and FCDS on priority variables to collect.

***Theme #2: Best Defense is a Great Offense***

Dr. Philip suggested to consider issuing co-press releases between DOH and CCRAB about cancer related news.

Megan Wessel announced that the ACS is starting a tobacco national roundtable similar to the colorectal roundtable, which is expected to launch in Fall 2017.

The Council discussed the Mary Brogan early detection program and its need for financial support. Dr. Cogle offered the Council as an entity to endorse and advertise the significance and

impact of the program. Council members suggested methods for CCRAB to advocate for the program including presenting evidence at legislative committee meetings.

**Florida DOH Update by Dr. Celeste Philip**

Dr. Philip updated CCRAB on the DOH's regional cancer collaborative, telehealth advisory council, and palliative care task force.

**Florida Biomedical Research Advisory Council by Dr. Daniel Armstrong**

Dr. Armstrong updated CCRAB on the BRAC's cancer research program's, application number and funding rates.

Dr. Armstrong presented data that showed a merit gap in funding for the Bankhead-Coley funding mechanism. A large number of grant applications with high meritorious scores go unfunded each year. Dr. Cogle pointed out that these data demonstrate a specific need for the Bankhead-Coley program.

Dr. Duane Mitchell pointed to the high amount of investment that the State of Texas has placed in cancer prevention and research via its Cancer Prevention & Research Institute of Texas (CPRIT). The CPRIT arose from a citizen-led constitutional amendment in 2007 that authorized the state to issue $3 billion in bonds to fund cancer research and prevention programs in Texas. CCRAB Council members noted the similarities between Texas and Florida's population sizes and cancer burdens. A concluding point was made that the gap in cancer prevention and research funding between what is possible in Texas and what is actually invested in Florida represents an opportunity for improvement in the State of Florida.

**American Cancer Society Update by Mr. Matt Jordan**

Mr. Jordan presented an update of the American Cancer Society's priorities for the year.

**Florida Cancer Plan Progress – *Continued***

The Council then returned to discssing updates and progress on the Florida Cancer Plan.

***Themes #3-5***

Dr. Cogle reviewed the remaining goals of Themes #3-5. Many of the goals, if solely shouldered by CCRAB, would require ad hoc committees.

The Council discussed CCRAB being accountable for all 15 goals in the Florida Cancer plan. This strategy would require much more resources than currently available to CCRAB and its members.

After a thoughtful discussion, the Council re-affirmed their leadership role and responsibility in establishing the state's Cancer Plan every 5 years. The Cancer But the execution of the state's Cancer Plan would be the function of everyone in the state.

The Council members discussed special emphasis areas within the Cancer Plan, including:

- Funding for the Biomedical Research Program, especially Bankhead-Coley and James & Esther King programs
- HPV vaccination
- Colorectal cancer screening
- Telehealth
- Enhancing the Florida cancer registry at FCDS

**Open Discussion**

Dr. Cogle provided an opportunity for open discussion among Council members.

Dr. Cassell asked to make state legislator appointments to CCRAB a priority. The Council discussed member-candidates. Merritt Martin agreed to assist in contacting state legislative leaders.

Dr. Cogle thanked everyone for participating.

There being no further business, the meeting was adjourned at 3:00 PM Eastern Time on May 12, 2017.

# FLORIDA
# CANCER PLAN

# Florida Cancer Plan 2015-2020

## Theme #1: Burden of Cancer (Data and Surveillance)

- **Goal 1:** Expand the statewide data and surveillance program (FCDS) to facilitate accurate and timely cancer diagnosis collection and reporting inclusive of all Floridians
- **Goal 2:** Support the development of an outcomes-based statewide cancer integrated data repository to facilitate accurate identification of cancer patient treatments, outcomes and migration
- **Goal 3:** Link key screening, laboratory, and molecular cancer test results into the Florida cancer integrated data repository

## Theme #2: The Best Defense is a Great Offense (Prevention & Early Detection)

- **Goal 1:** Decrease the proportion of Floridians who use tobacco products, with particular emphasis on prevention of tobacco use amongst youth
- **Goal 2:** Promote healthy lifestyles and policies for Floridians to reduce the risk of cancer
- **Goal 3:** Increase the proportion of Floridians who receive appropriate cancer screenings

## Theme #3: Improving Patient Outcomes with Treatment (Access to Care)

- **Goal 1:** Support policies that will ensure health equity for all cancer patients and their caregivers
- **Goal 2:** Improve Floridian's access to high-quality, multidisciplinary oncology care
- **Goal 3:** Increase the number of Floridians with access to and participation in cancer clinical trials

## Theme #4: Beyond the Cancer Diagnosis Survivorship (Survivorship)

- **Goal 1:** Support education and awareness of cancer survivor needs in Florida
- **Goal 2:** Support policies that ensure all Floridians with cancer (and their caregivers) have access to resources that provide quality of life during and after therapy
- **Goal 3:** Support policies that ensure all Floridians with incurable cancer have access to resources that provide dignified end of life care

## Theme #5: Florida as a Cancer Care and Research Destination

- **Goal 1:** Invest in Biomedical research – In Florida – For Floridians
- **Goal 2:** Support the development of a state biomedical workforce pipeline (STEMS K-12 and beyond)
- **Goal 3:** Facilitate Florida-based Telemedicine for genomics and other advanced cancer research analytics and high-quality care

# Florida Behavioral Risk Factor Surveillance System (BRFSS) Measures 2016

https://www.cdc.gov/brfss/brfssprevalence/


# TOBACCO

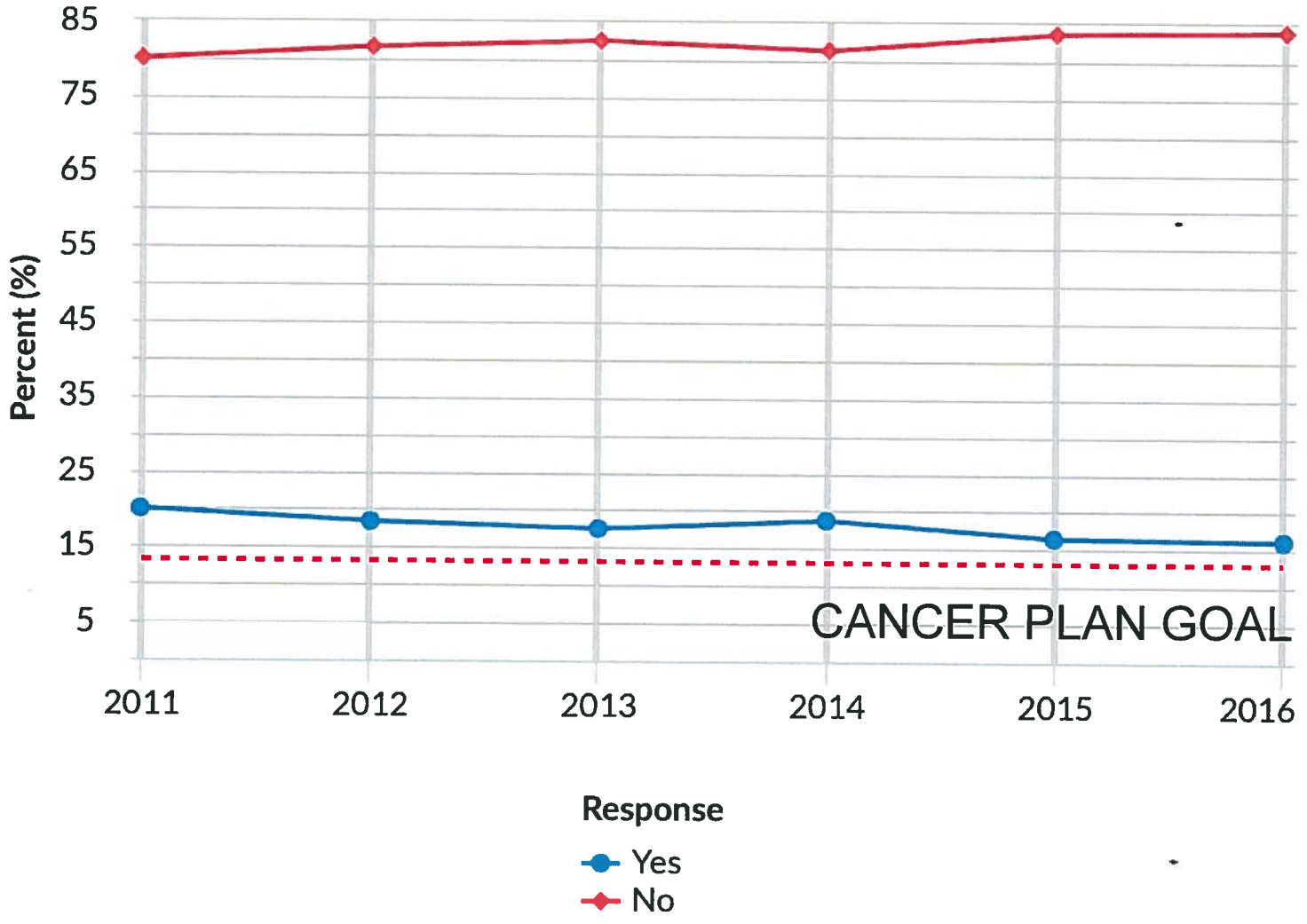
Florida - All available years

Adults who are current smokers (variable calculated from one or more BRFSS questions)

(Age-adjusted Prevalence)

View by: Overall

Response: ( All )



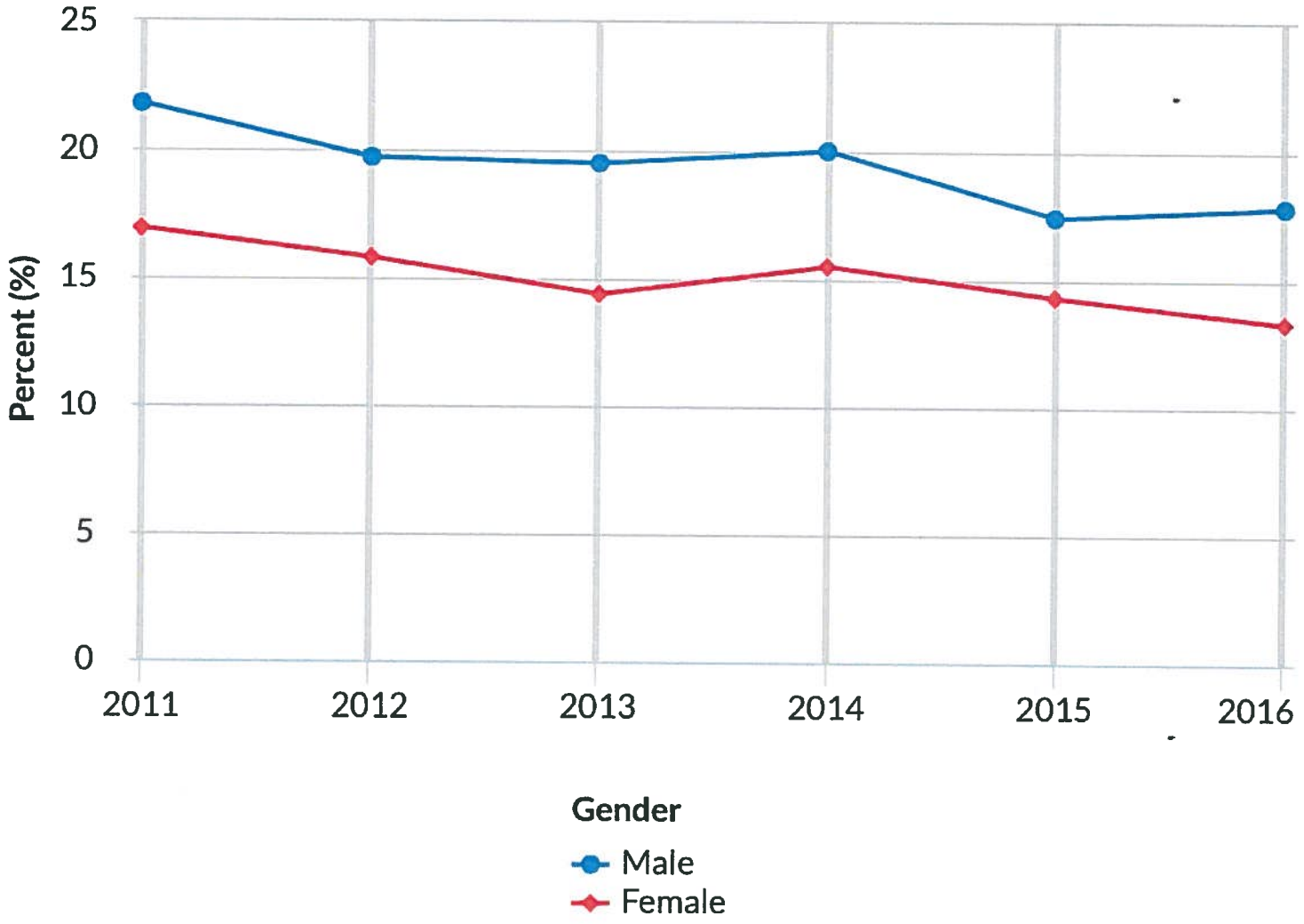
Florida - All available years

Adults who are current smokers (variable calculated from one or more BRFSS questions)

(Crude Prevalence)

View by: Gender

Response: Yes



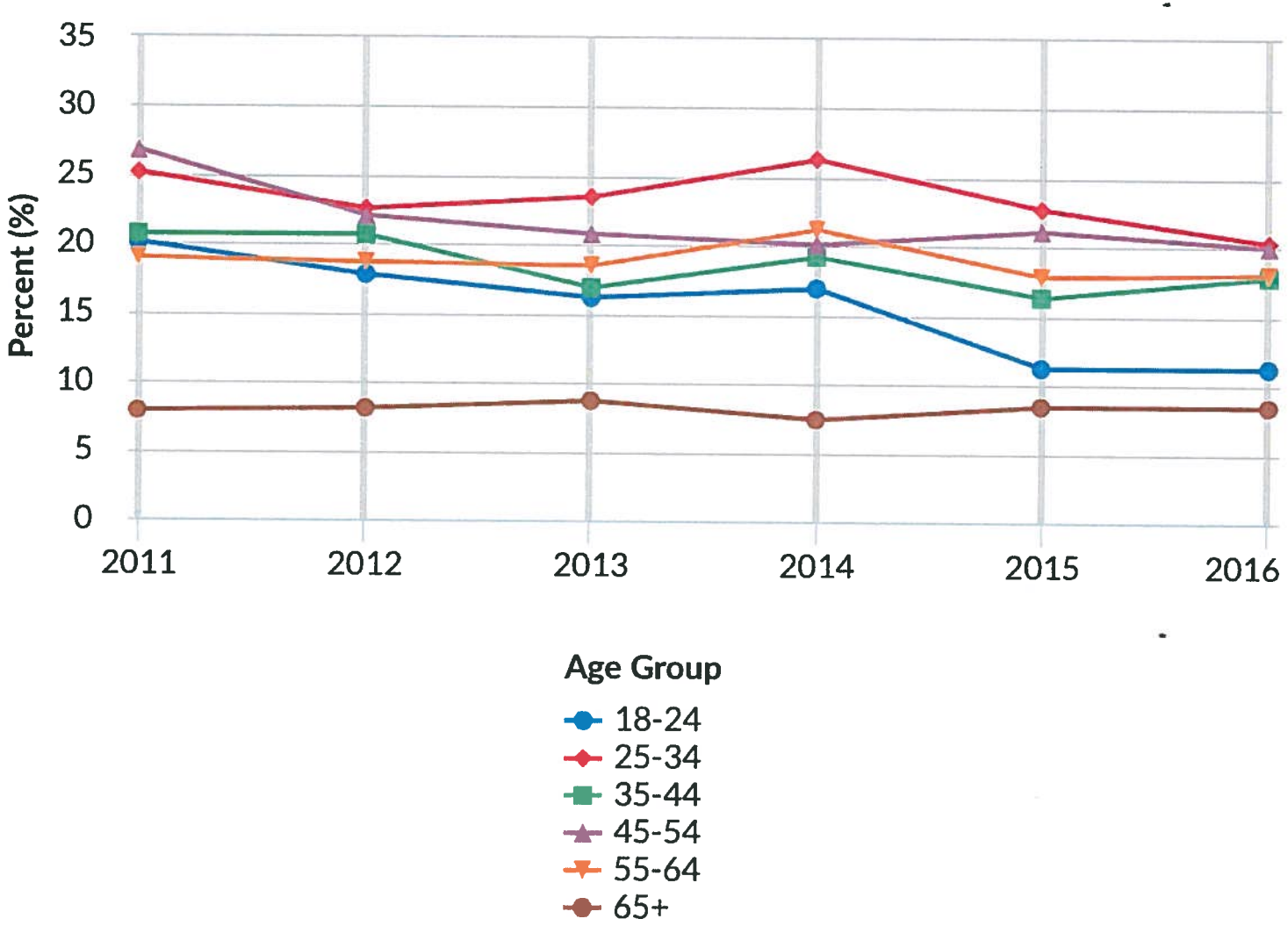
Florida - All available years

Adults who are current smokers (variable calculated from one or more BRFSS questions)

(Crude Prevalence)

View by: Age Group

Response: Yes



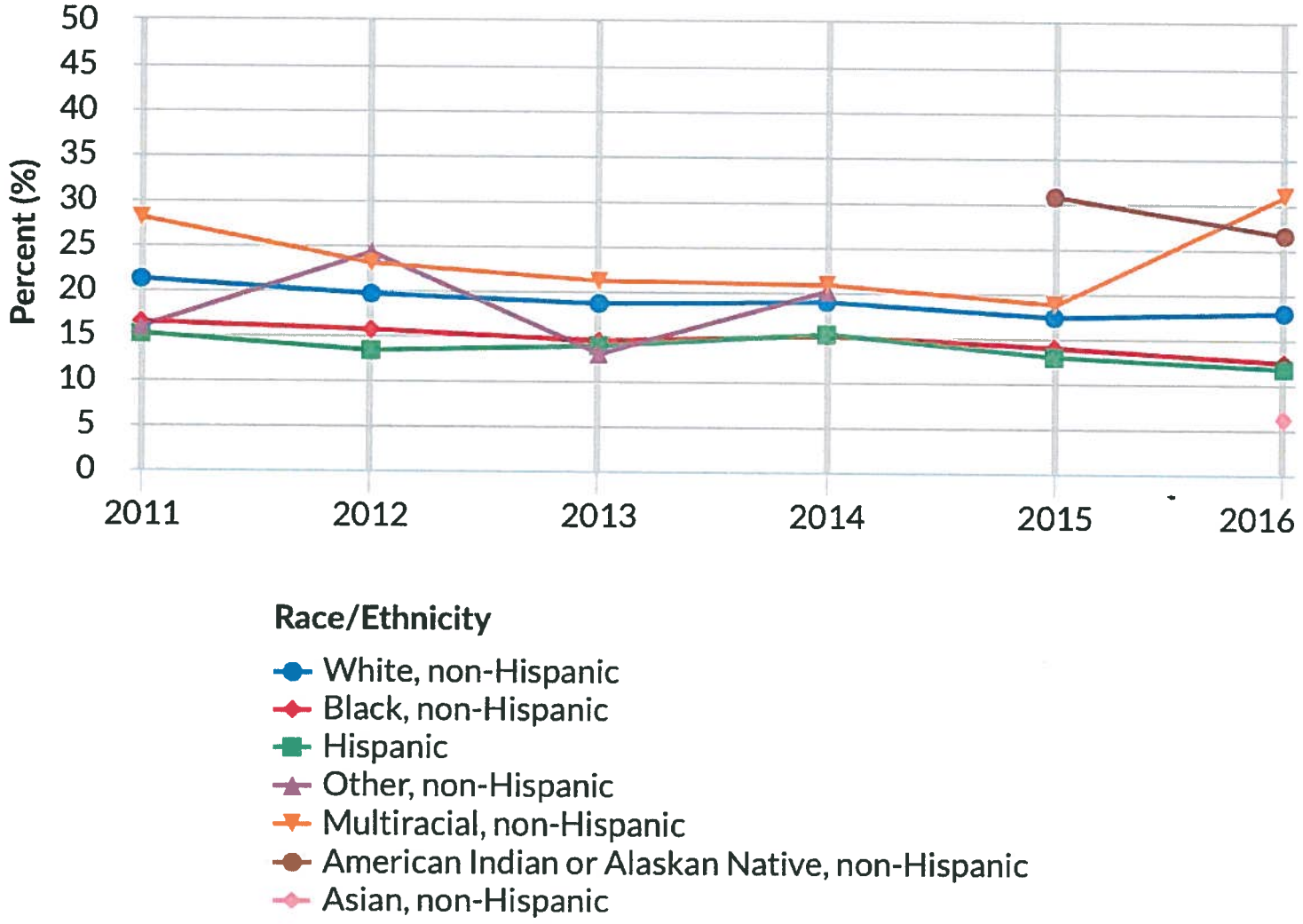
**Florida - All available years**

**Adults who are current smokers (variable calculated from one or more BRFSS questions)**

**(Crude Prevalence)**

**View by: Race/Ethnicity**

**Response: Yes**



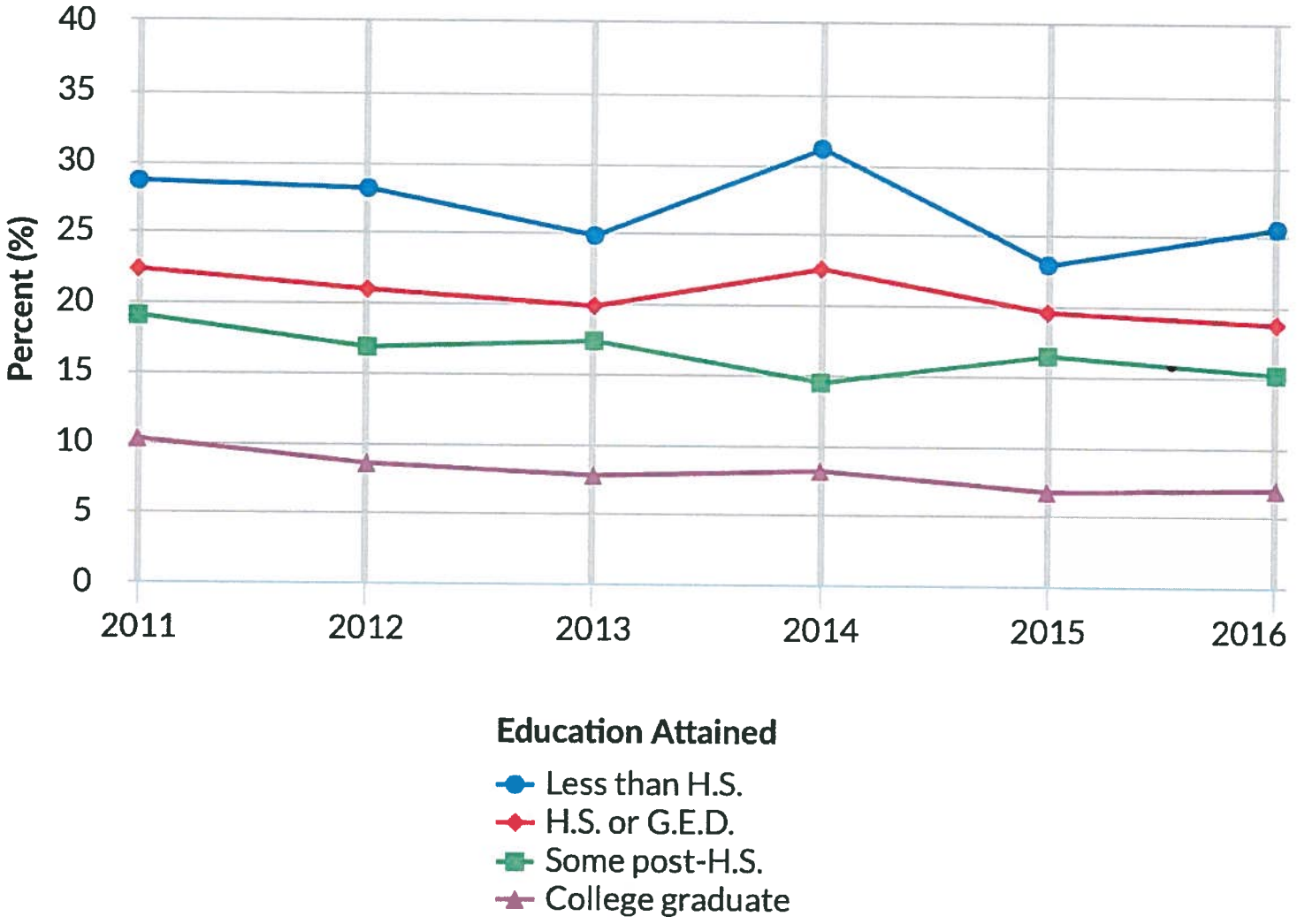
Florida - All available years

Adults who are current smokers (variable calculated from one or more BRFSS questions)

(Crude Prevalence)

View by: Education Attained

Response: Yes



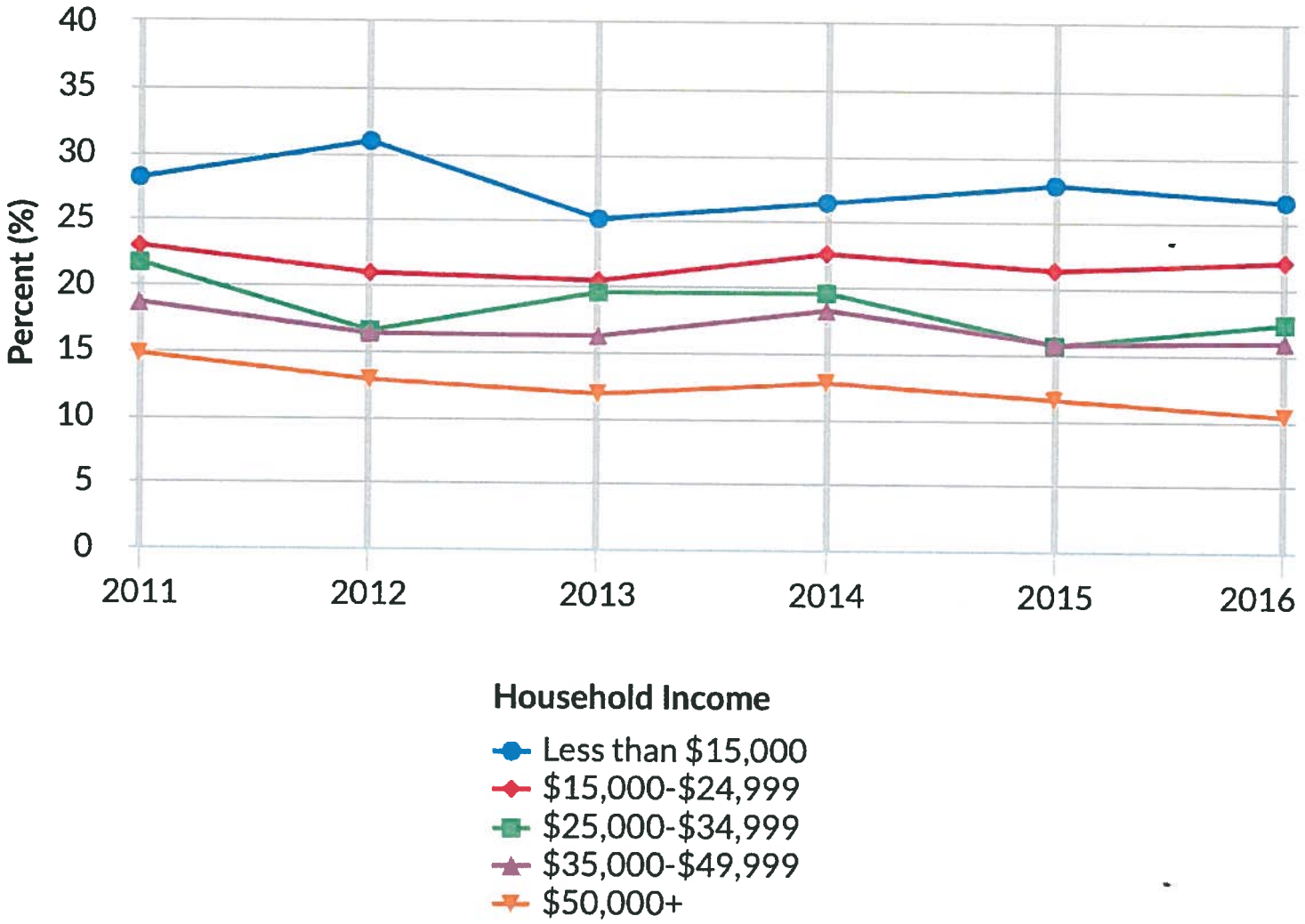
Florida - All available years

Adults who are current smokers (variable calculated from one or more BRFSS questions)

(Crude Prevalence)

View by: Household Income

Response: Yes



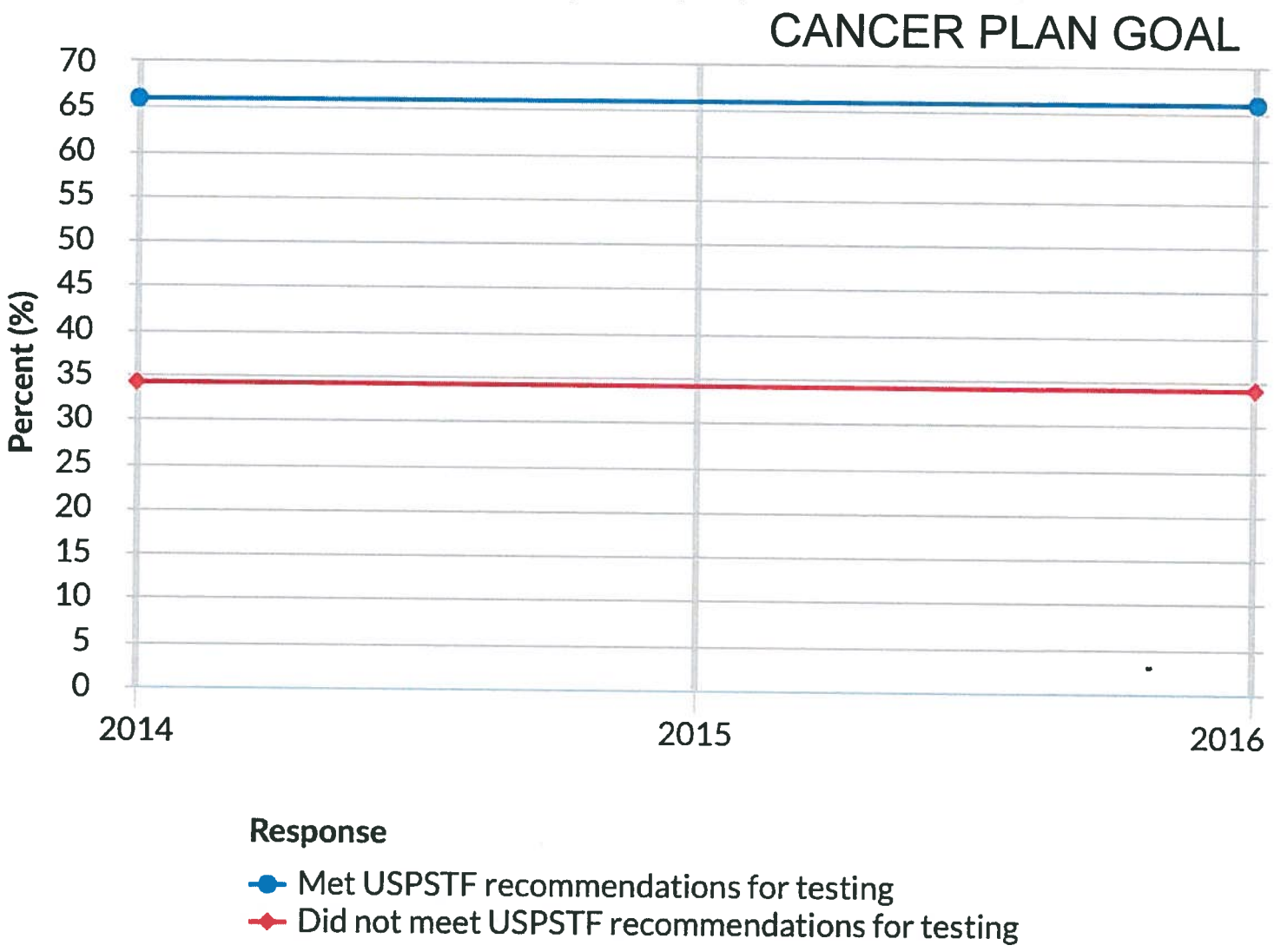
# COLORECTAL CANCER

Florida - All available years

Respondents aged 50-75 who have fully met the USPSTF recommendation (variable calculated from one or more BRFSS questions) (Age-adjusted Prevalence)

View by: Overall

Response: ( All )

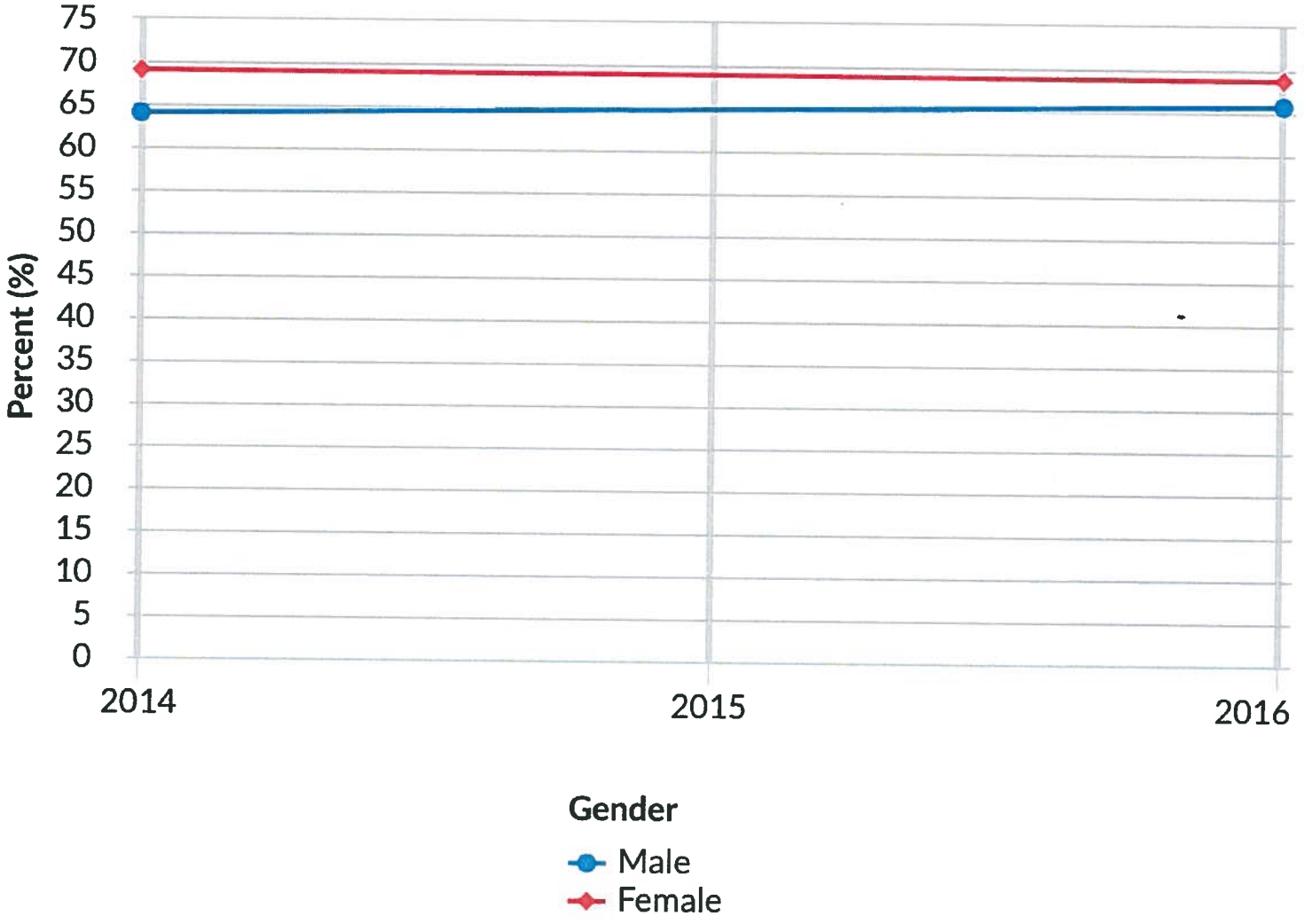


Florida - All available years

Respondents aged 50-75 who have fully met the USPSTF recommendation (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Gender

Response: Met USPSTF recommendations for testing

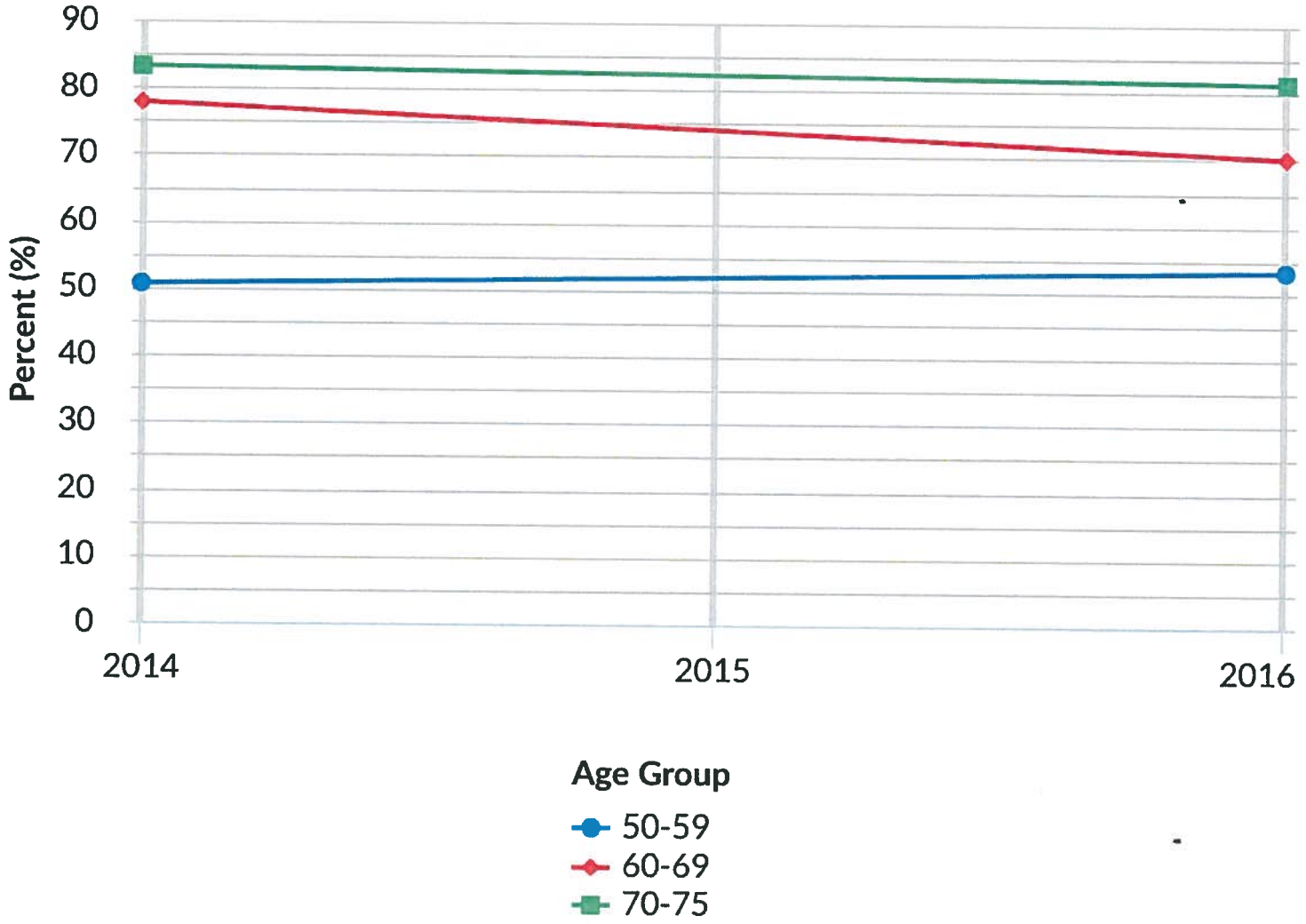


Florida - All available years

Respondents aged 50-75 who have fully met the USPSTF recommendation (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Age Group

Response: Met USPSTF recommendations for testing

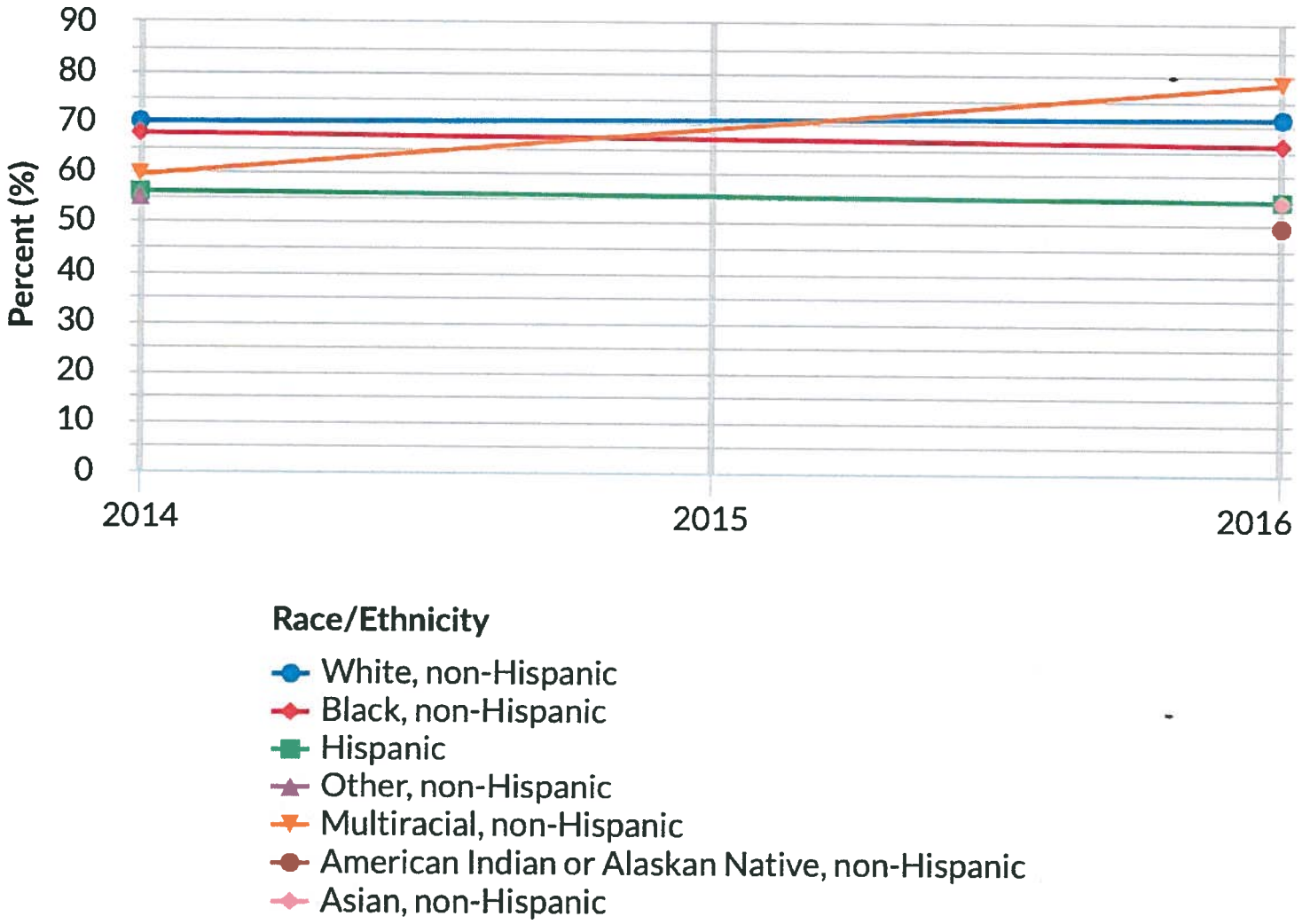


**Florida - All available years**

**Respondents aged 50-75 who have fully met the USPSTF recommendation (variable calculated from one or more BRFSS questions) (Crude Prevalence)**

**View by: Race/Ethnicity**

**Response: Met USPSTF recommendations for testing**

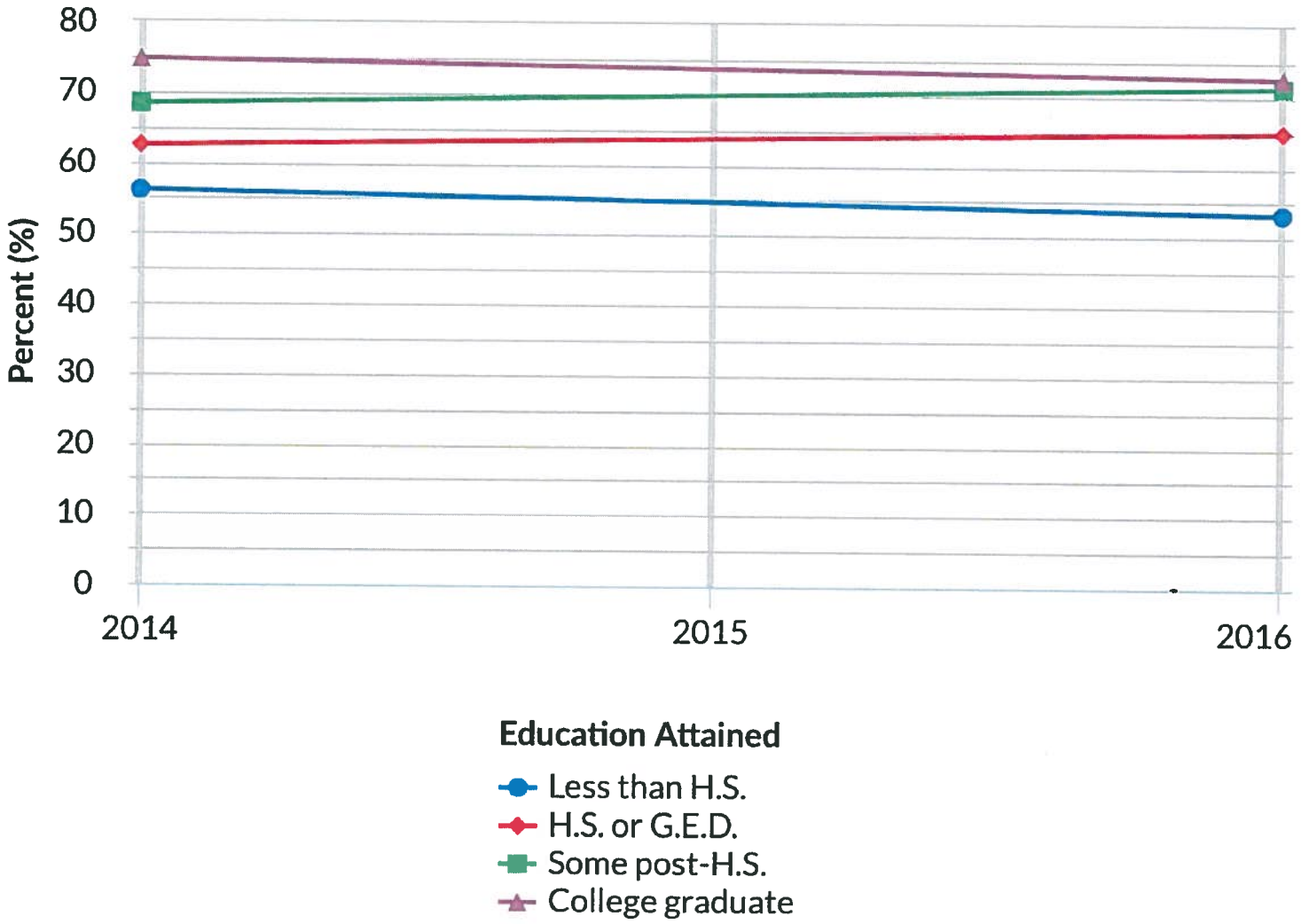


Florida - All available years

Respondents aged 50-75 who have fully met the USPSTF recommendation (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Education Attained

Response: Met USPSTF recommendations for testing



Florida - All available years

Respondents aged 50-75 who have fully met the USPSTF recommendation (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Household Income

Response: Met USPSTF recommendations for testing

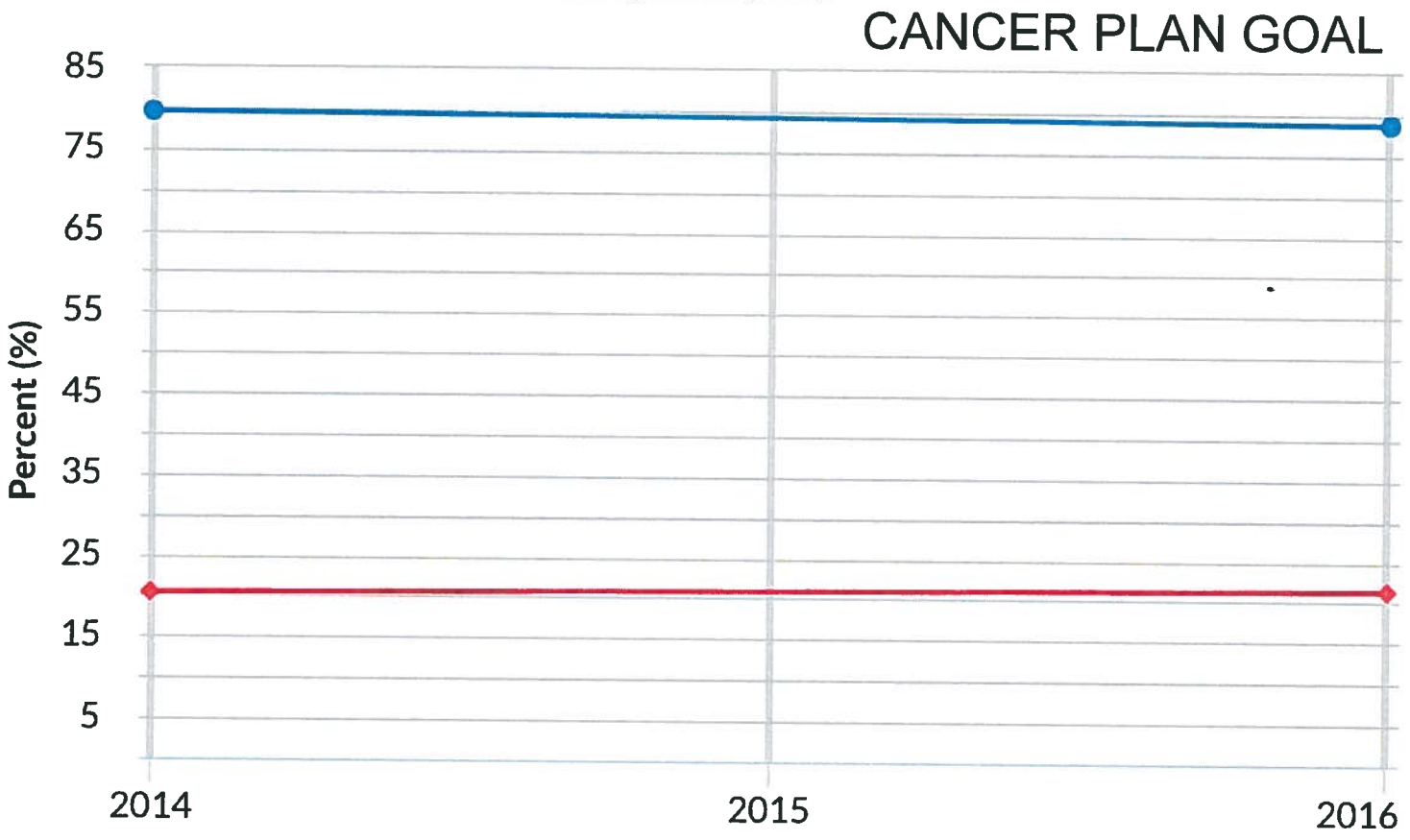
# PAP SMEARS

Florida - All available years

Women aged 21-65 who have had a pap test in the past three years (variable calculated from one or more BRFSS questions) (Age-adjusted Prevalence)

View by: Overall

Response: (All)

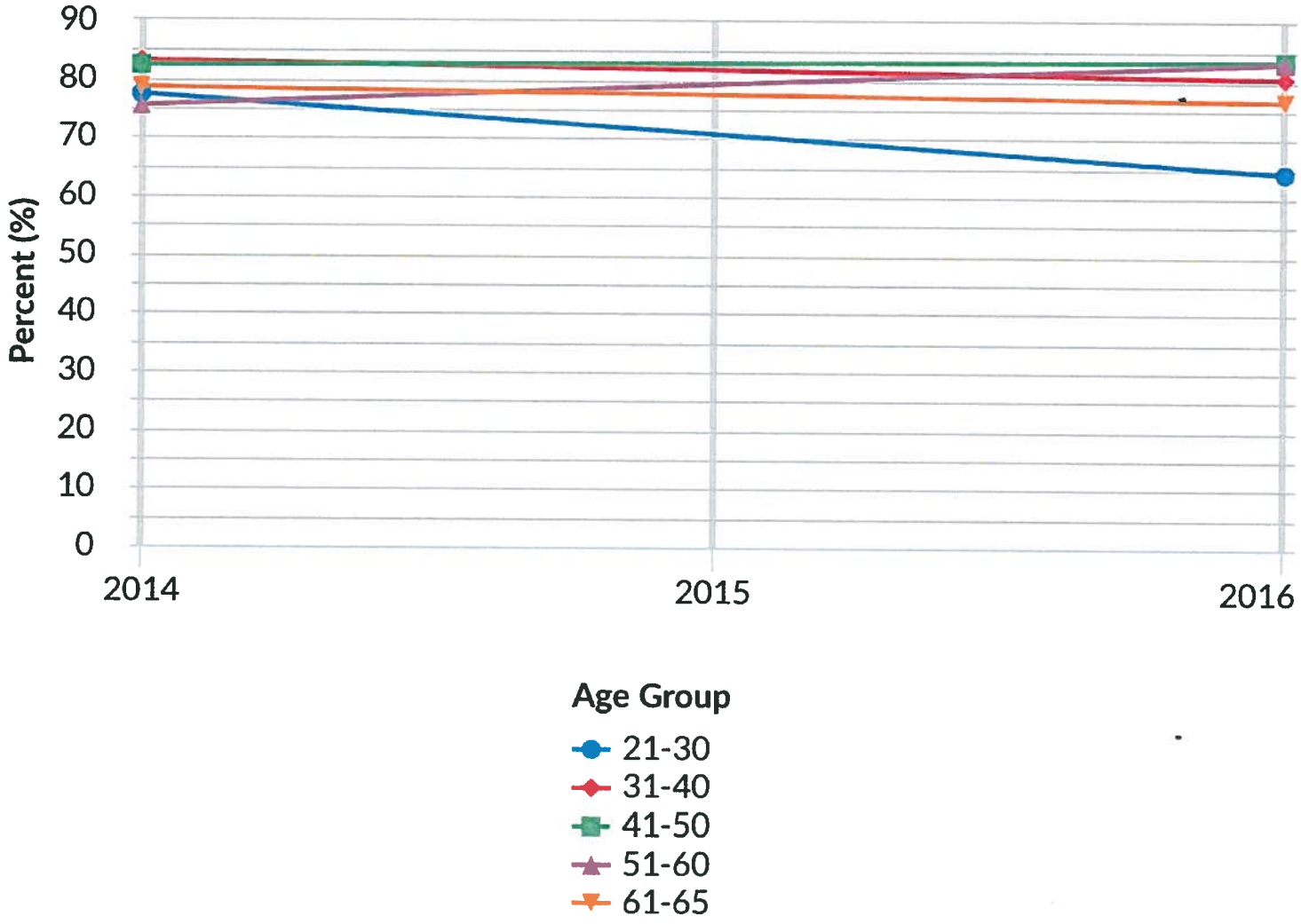


Florida - All available years

Women aged 21-65 who have had a pap test in the past three years (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Age Group

Response: Received a Pap test within the past 3 years

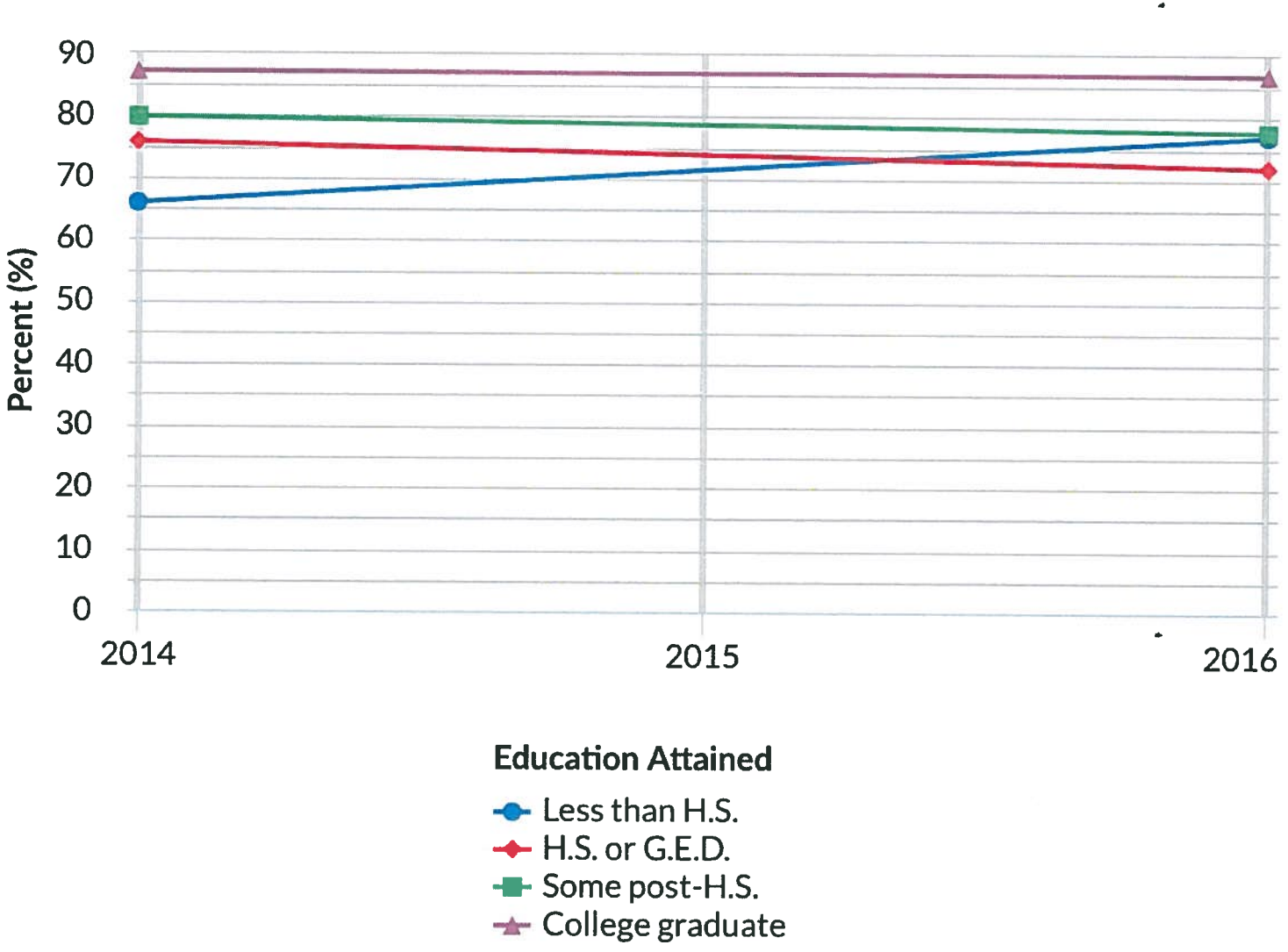


Florida - All available years

Women aged 21-65 who have had a pap test in the past three years (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Education Attained

Response: Received a Pap test within the past 3 years

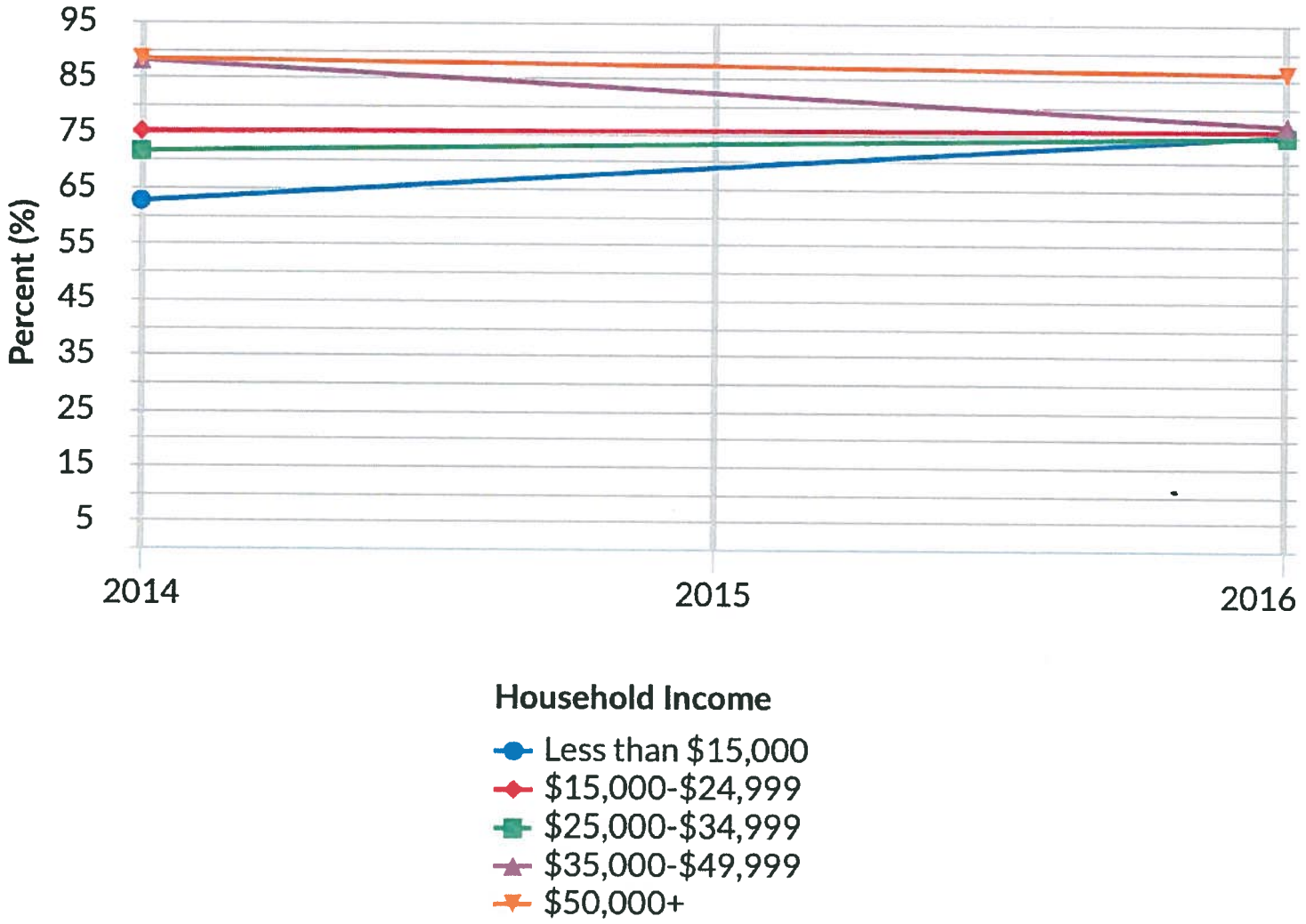


Florida - All available years

Women aged 21-65 who have had a pap test in the past three years (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Household Income

Response: Received a Pap test within the past 3 years

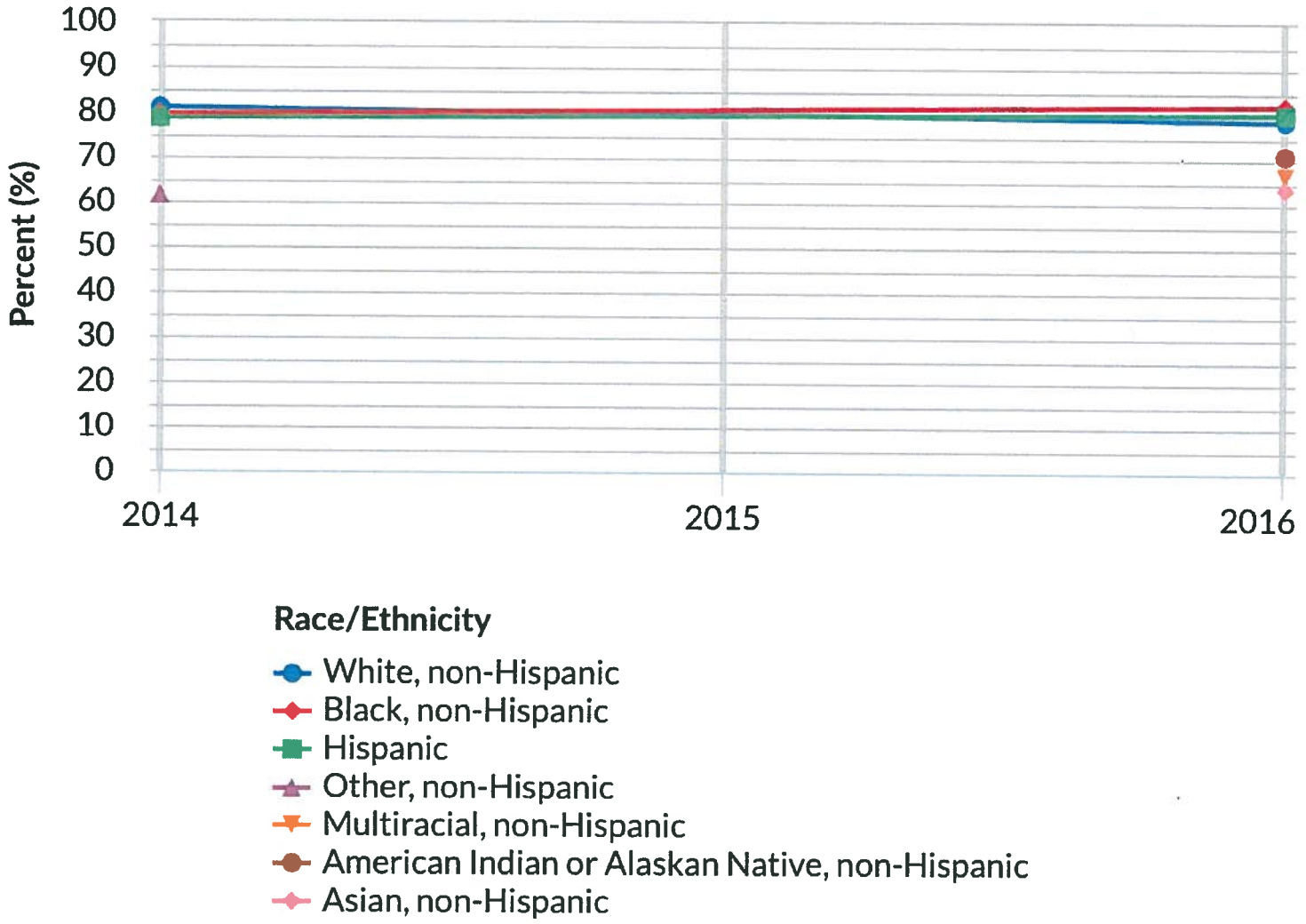


**Florida - All available years**

**Women aged 21-65 who have had a pap test in the past three years (variable calculated from one or more BRFSS questions) (Crude Prevalence)**

**View by: Race/Ethnicity**

**Response: Received a Pap test within the past 3 years**



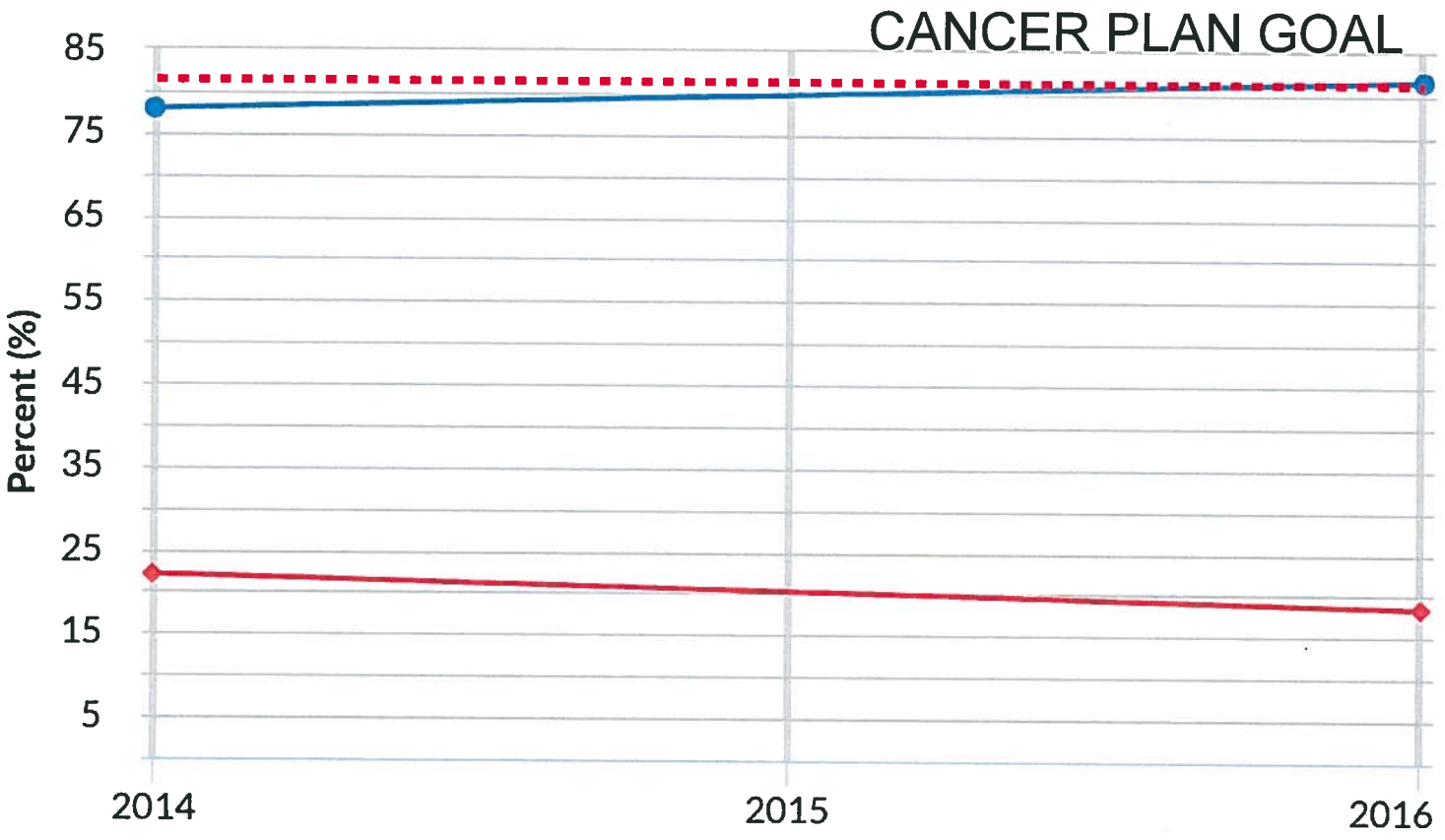
# MAMMOGRAMS

**Florida - All available years**

**Women aged 50-74 who have had a mammogram within the past two years (variable calculated from one or more BRFSS questions) (Age-adjusted Prevalence)**

**View by: Overall**

**Response: ( All )**

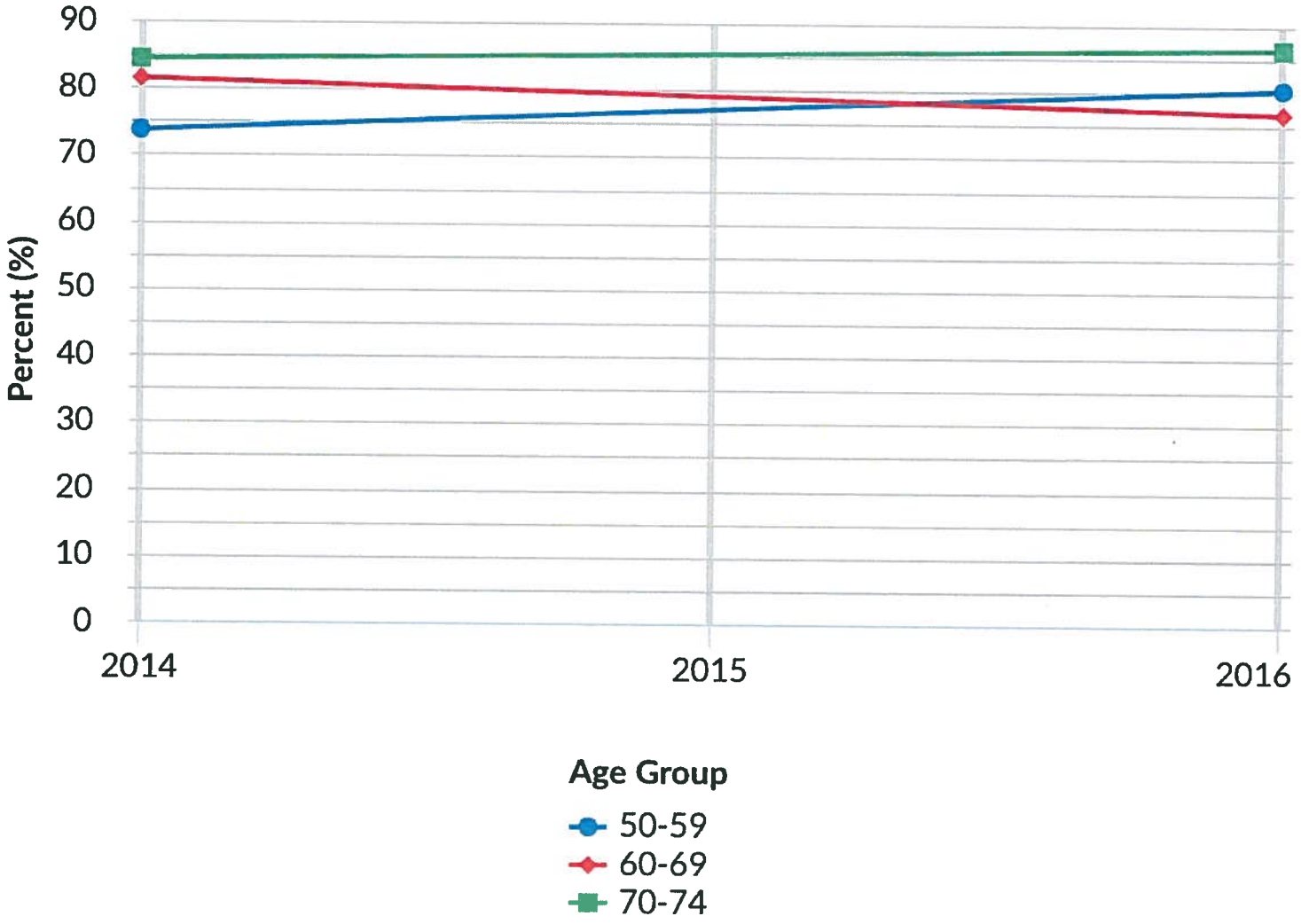


Florida - All available years

Women aged 50-74 who have had a mammogram within the past two years (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Age Group

Response: Received a mammogram within the past 2 years

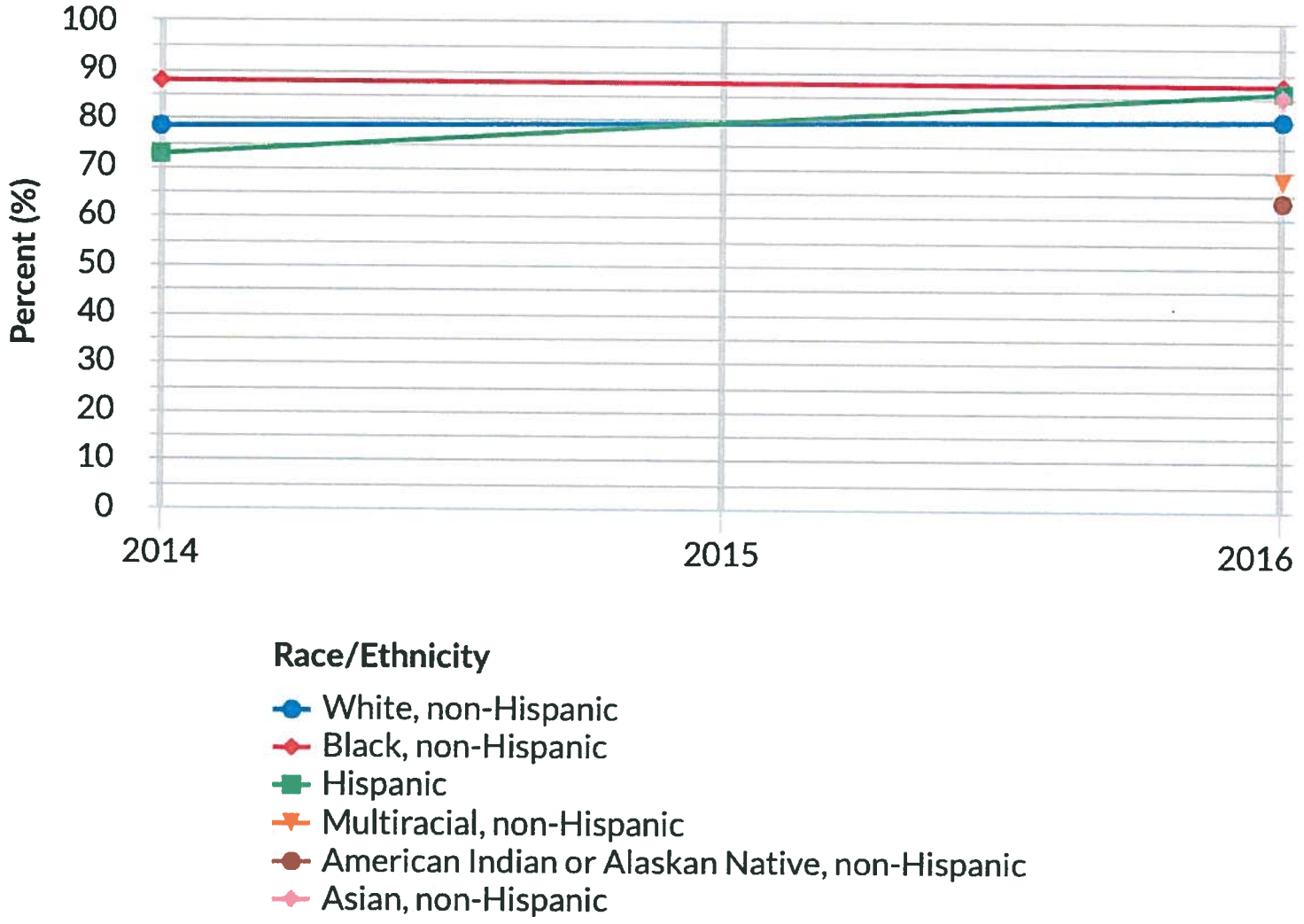


**Florida - All available years**

**Women aged 50-74 who have had a mammogram within the past two years (variable calculated from one or more BRFSS questions) (Crude Prevalence)**

**View by: Race/Ethnicity**

**Response: Received a mammogram within the past 2 years**

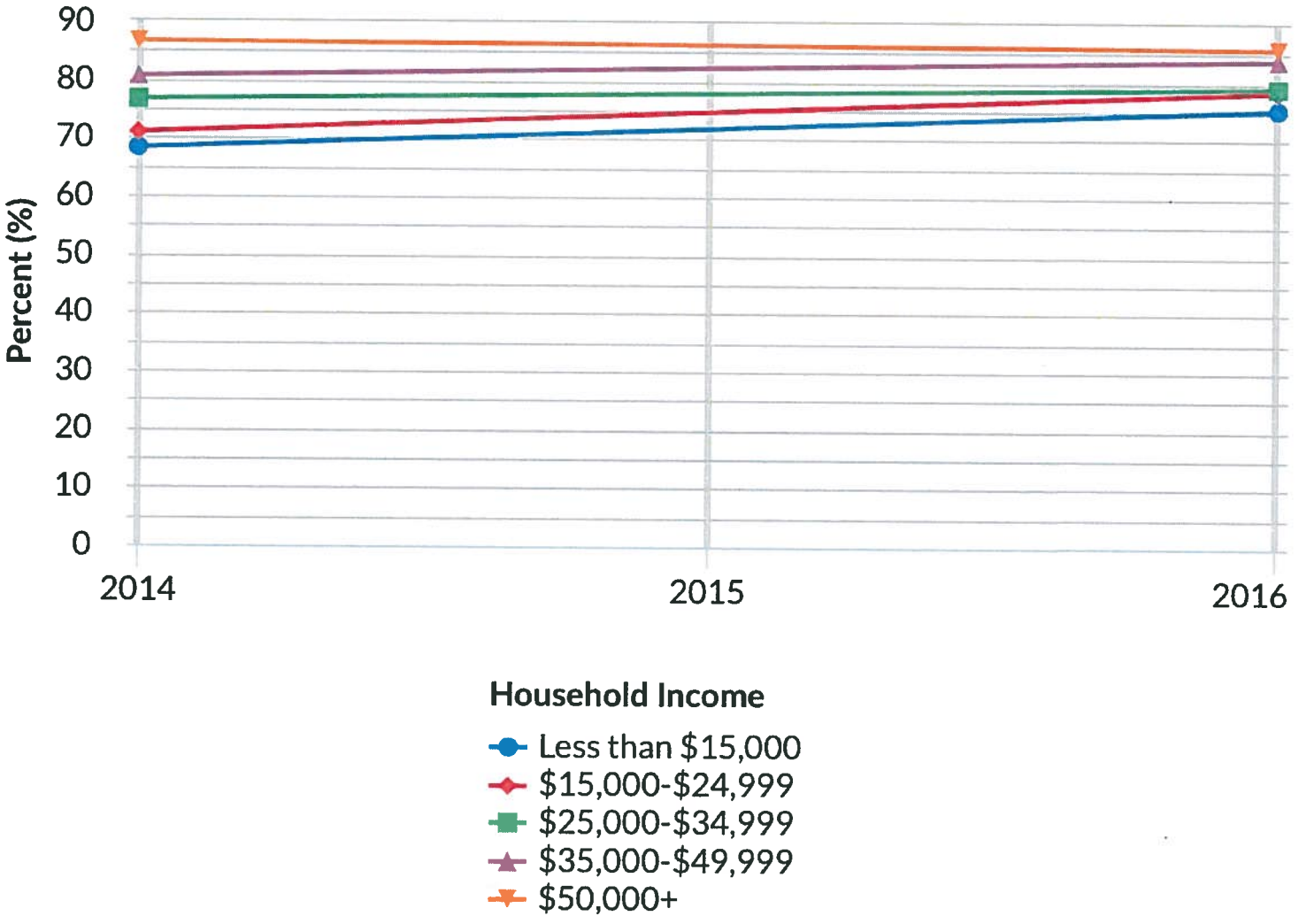


Florida - All available years

Women aged 50-74 who have had a mammogram within the past two years (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Household Income

Response: Received a mammogram within the past 2 years

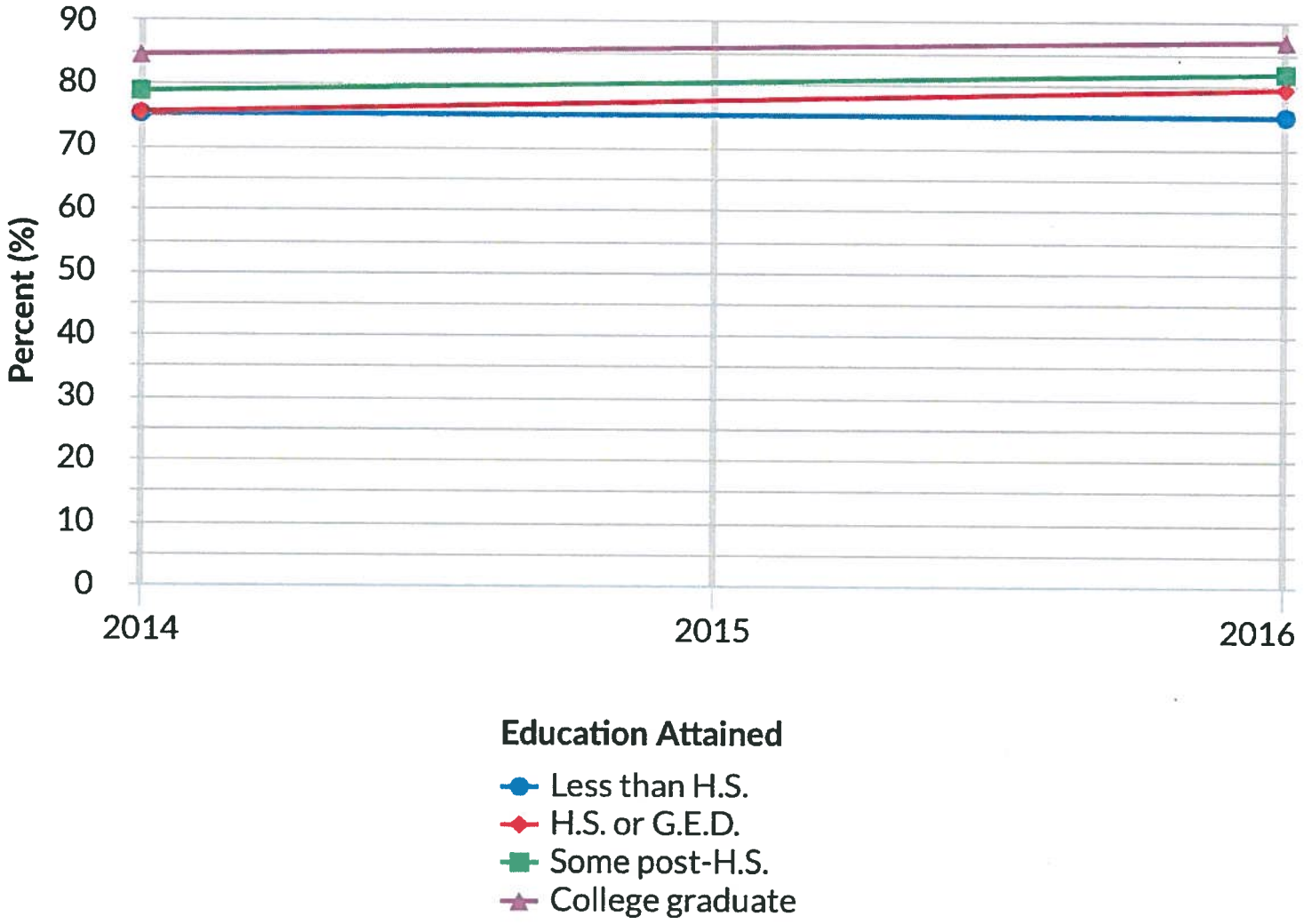


Florida - All available years

Women aged 50-74 who have had a mammogram within the past two years (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Education Attained

Response: Received a mammogram within the past 2 years



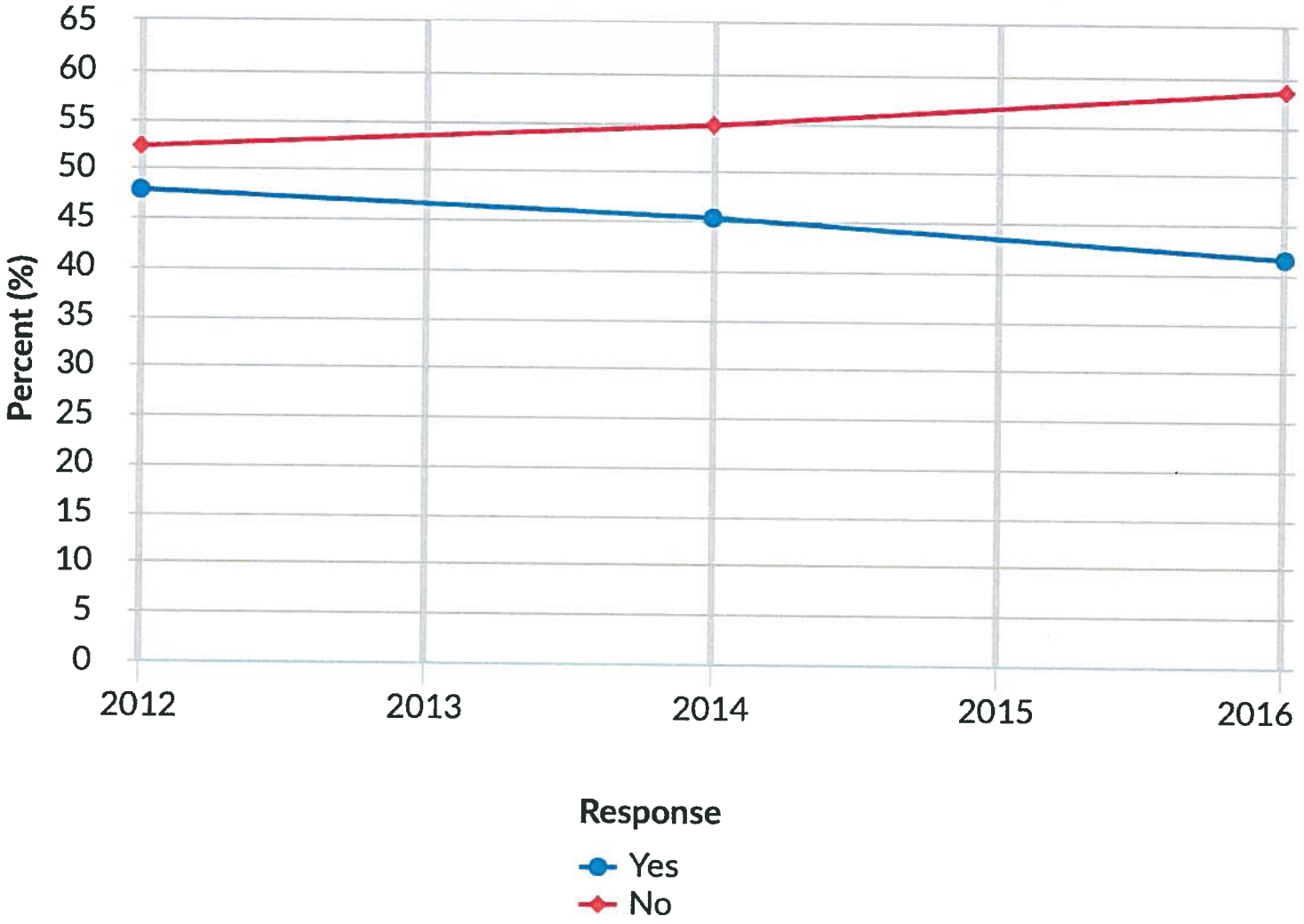
PSA

Florida - All available years

Men aged 40+ who have had a PSA test within the past two years (variable calculated from one or more BRFSS questions) (Age-adjusted Prevalence)

View by: Overall

Response: ( All )

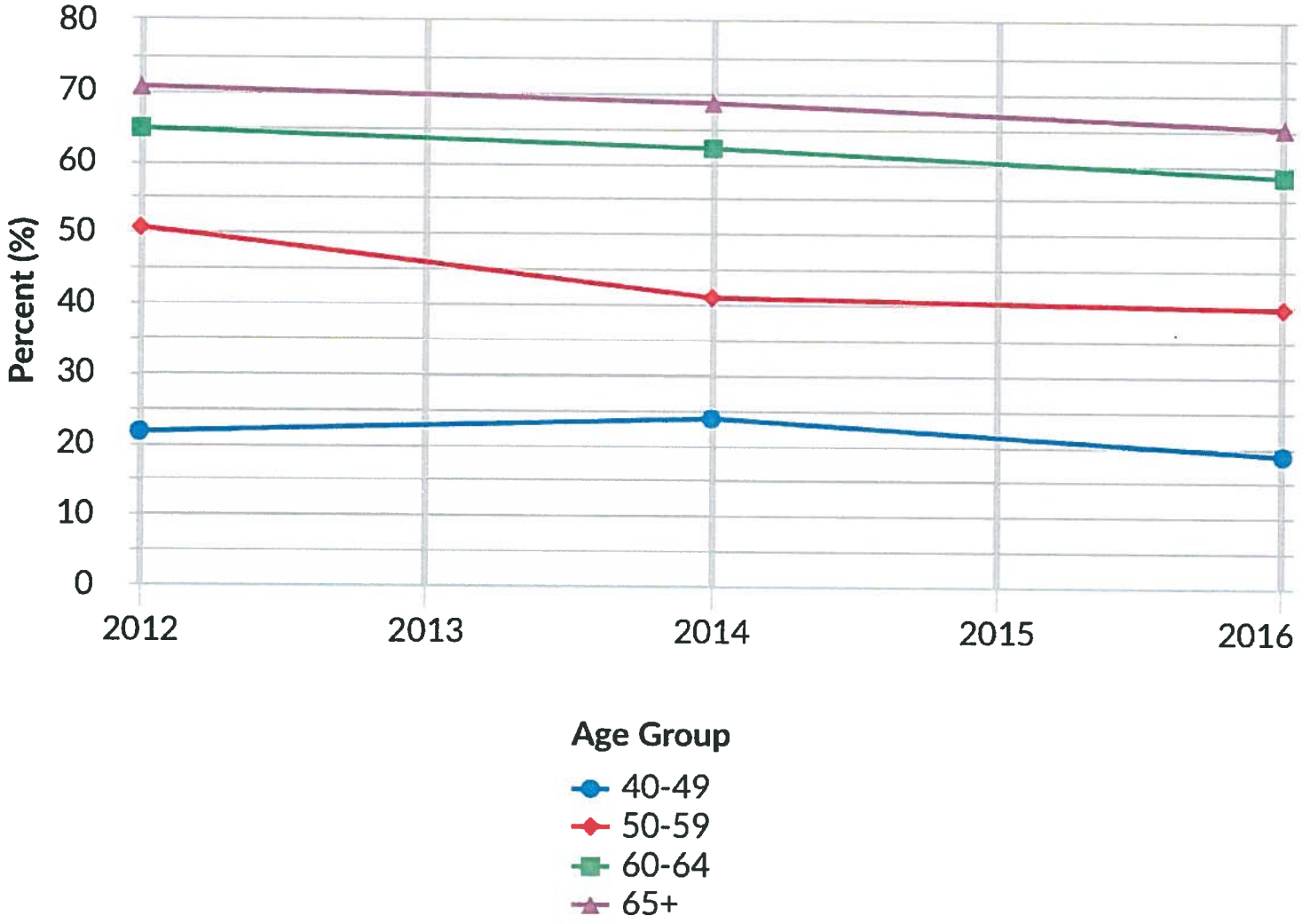


**Florida - All available years**

**Men aged 40+ who have had a PSA test within the past two years (variable calculated from one or more BRFSS questions) (Crude Prevalence)**

**View by: Age Group**

**Response: Yes**

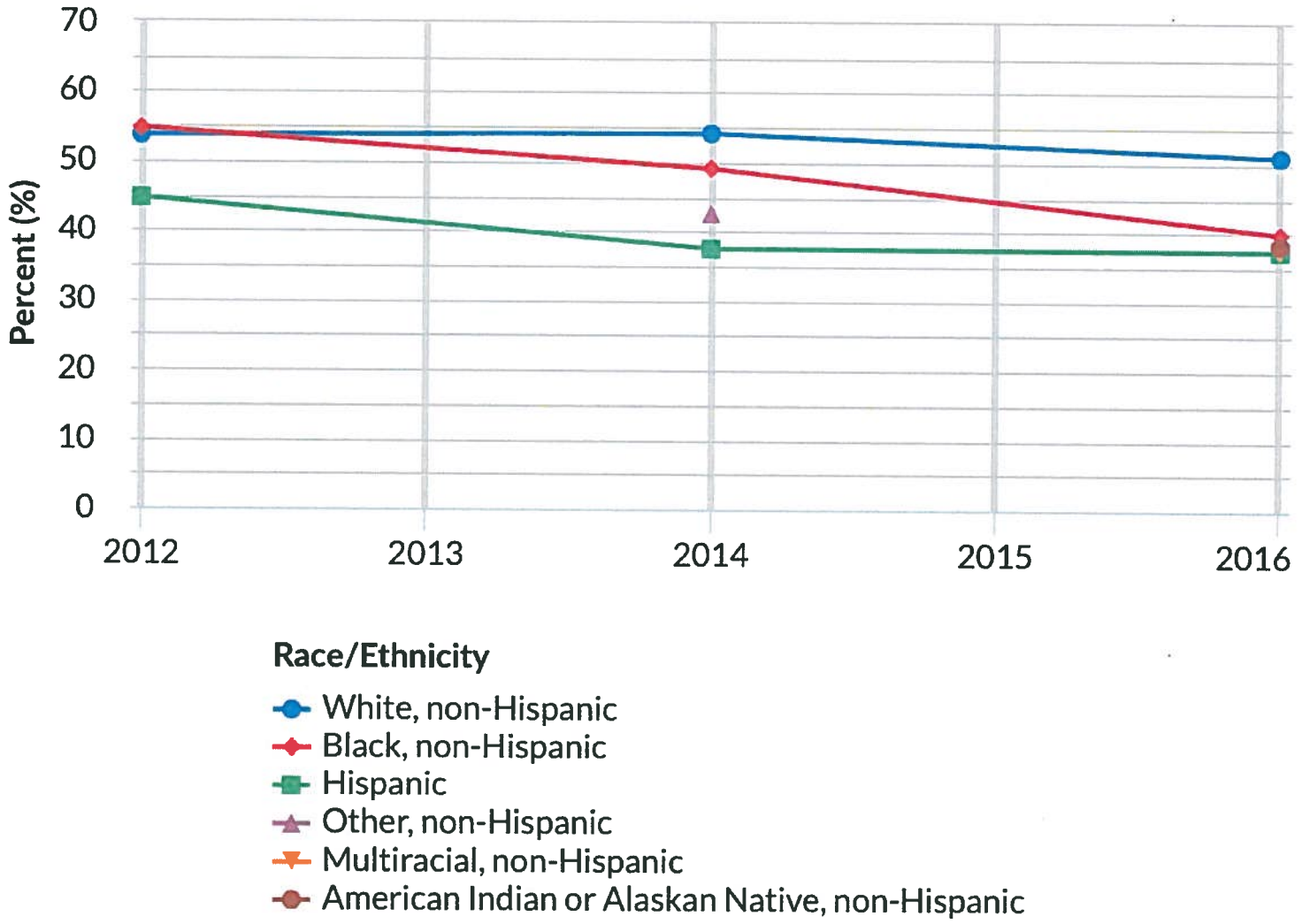


**Florida - All available years**

**Men aged 40+ who have had a PSA test within the past two years (variable calculated from one or more BRFSS questions) (Crude Prevalence)**

**View by: Race/Ethnicity**

**Response: Yes**

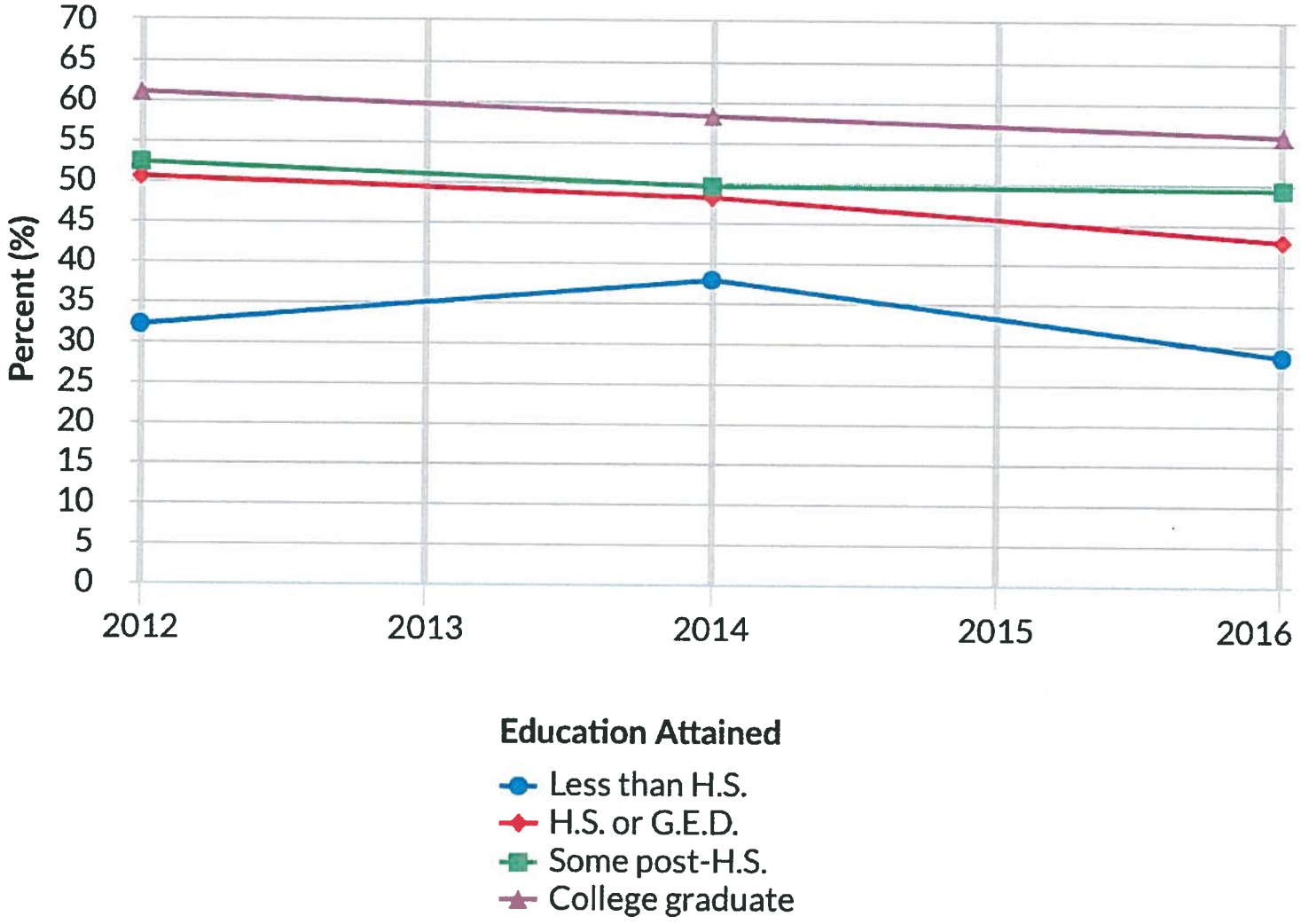


**Florida - All available years**

**Men aged 40+ who have had a PSA test within the past two years (variable calculated from one or more BRFSS questions) (Crude Prevalence)**

**View by: Education Attained**

**Response: Yes**

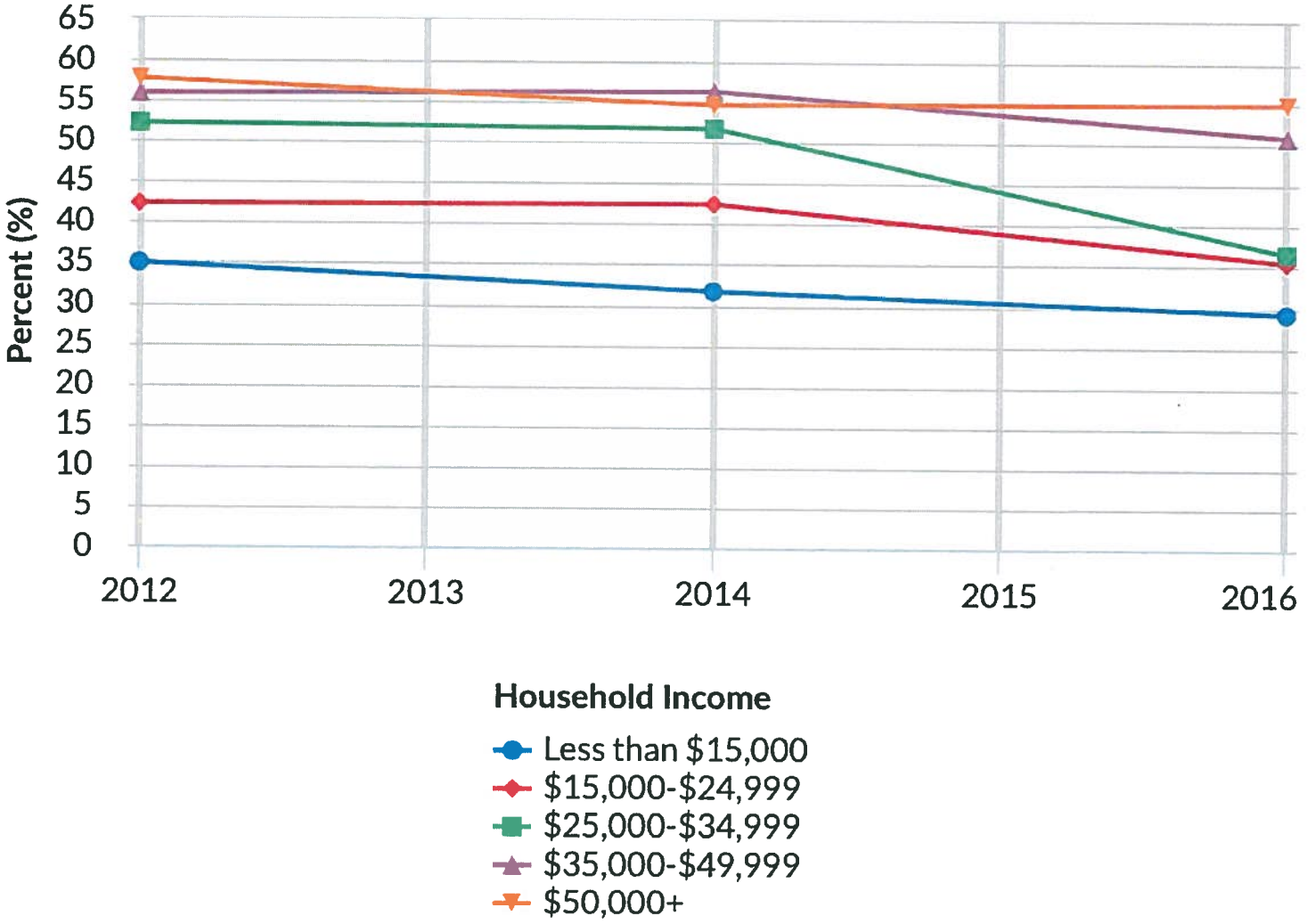


Florida - All available years

Men aged 40+ who have had a PSA test within the past two years (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Household Income

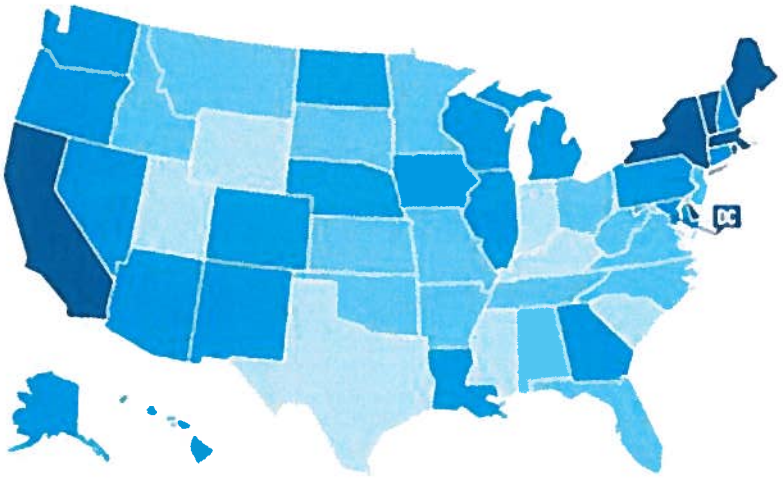
Response: Yes



# HPV Vaccination
# (Florida & U.S. Data)

# [HPV vaccination is the best way to protect your children from cancers caused by HPV]

Percentage of adolescent boys and girls who have received one or more doses of HPV vaccine*




**NATIONWIDE**

**6 OUT OF 10**

parents are choosing to get the human papillomavirus vaccine for their children.

National coverage is 60%

Coverage by state:

- 49% or less
- 50-59%
- 60-69%
- 70% or greater

## [CDC RECOMMENDS THE HPV VACCINE AT AGES 11-12]

Talk to your child's doctor about HPV cancer prevention

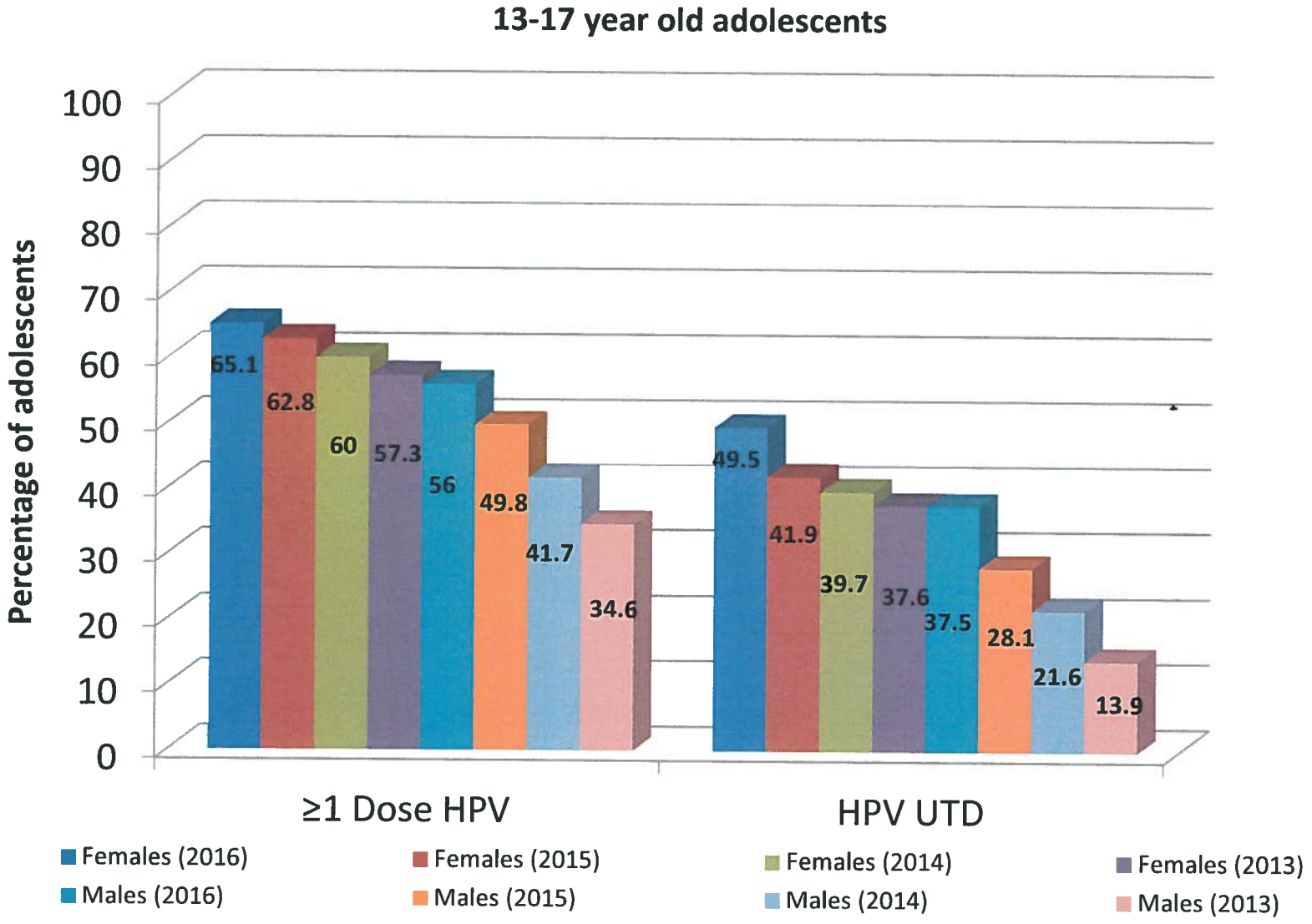
*Estimated coverage of the 4 human papillomavirus (HPV) vaccine among adolescents aged 13-17 years, National Immunization Survey-Teen, United States, 2016, [illegible] August 25, 2017

www.cdc.gov/hpv

NCIRD/ISD | August 25, 2017

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

# HPV Vaccination Trends in the U.S.: 2013-2016

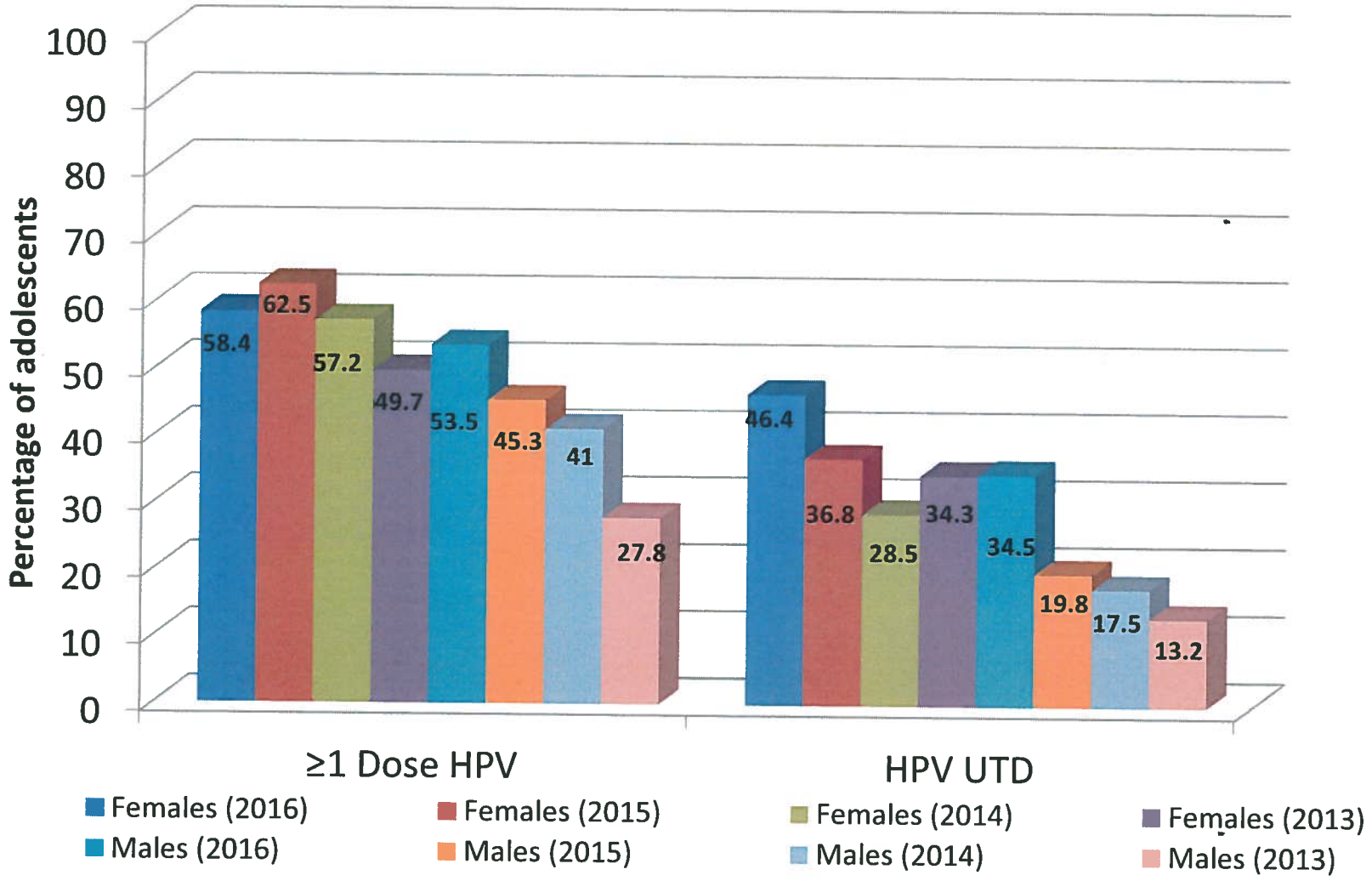



**HPV UTD indicates adolescents who received >3 doses and those who received 2 doses when the 1st vaccine dose was initiated before age 15 and the time between 1st & 2nd dose was at least 5 months minus 4 days.*

Source: CDC-MMWR, 2017-2014

# HPV Vaccination Trends in Florida: 2013-2016

**13-17 year old adolescents**




**HPV UTD indicates adolescents who received >3 doses and those who received 2 doses when the 1st vaccine dose was initiated before age 15 and the time between 1st & 2nd dose was at least 5 months minus 4 days.*

Source: CDC-MMWR, 2016-2014

| NIS-Teen Data-HPV Vaccination Rates (2016) | |
|---|---|
| **Florida** | **%** |
| ≥1 dose (Males & Females) | 55.3% |
| ≥1 dose: Males | 53.5% |
| ≥1 dose: Females | 58.4% |
| | |
| HPV UTD (Males & Females) | 40.4% |
| HPV UTD: Males | 34.5% |
| HPV UTD: Females | 46.4% |

# DOH UPDATES

August 2017 & September 2017

# Cancer Stakeholder

Florida Department of Health, Comprehensive Cancer Control Program

## PROGRAM SPOTLIGHT:

## Multiple strains of HPV are known to cause a variety of cancers.

**AUGUST IS NATIONAL IMMUNIZATION AWARENESS MONTH**

In the United States, approximately 26,900 new cancers will be attributed to human papillomavirus (HPV) each year: 17,600 (65 percent) among females and 9,300 (35 percent) among males. The number of cancers from HPV in the US by anatomic site are (probable average annual incidence, 2009–2013):[1]

**Oropharyngeal cancers (head and neck):**
11,600, both male and female (70 percent of oropharyngeal cancers attributable to HPV)

**Cervical cancer:**
10,600 (91 percent of cervical cancers attributable to HPV)

**Anal cancer:**
4,800, both male and female (91 percent of anal cancers attributable to HPV)

**Vulvar cancer:**
2,500 (69 percent of vulvar cancers attributable to HPV)

**Penile cancer:**
700 (63 percent of penile cancers attributable to HPV)

**Rectal cancer:**
700 (91 percent of rectal cancers attributable to HPV)

**Vaginal cancer:**
600 (75 percent of vaginal cancers attributable to HPV)

HPV tends not to cause acute health problems and is mostly cleared by the immune system naturally within two years of exposure. However, certain types of HPV do not go away and it is those that are linked to these cancers. Research has not yet revealed why HPV goes away in most, but not all, cases. There is no way to predetermine which people will develop cancer or other health problems.

The earlier a child is vaccinated the more effective the vaccine is at preventing transmission of HPV. The Advisory Committee for Immunization Practices recommends vaccinating boys and girls, ages 11 to 12 years old.[2] In general, girls and women can be vaccinated until age 26 and boys and men can be vaccinated until age 21.

Vaccines can be bivalent (covers two HPV strains), quadrivalent (covers four HPV strains) or 9-valent (covers 9 HPV strains) HPV vaccine. Bivalent is for girls only, while quadrivalent and 9-valent can be for either girls or boys. The Gardasil HPV 9-valent vaccine offers protection from more types of HPV. Providers can view supplemental information and guidance for 9-valent HPV vaccine online. Although a three dose regimen can be done for all HPV vaccine types, new guidelines were released following strong evidence that a two dose regimen at younger ages was as effective as the three dose 9-valent for girls and boys younger than 15 years.

To learn more about HPV vaccination series or Pap smear testing for cervical cancer, call your County Health Department or visit the Department's website.

Patients and parents should talk with their health care provider to determine if other recommended vaccines are needed. The latest information on vaccine recommendations, awareness toolkits and media tools can be found on the Centers for Diesease Control and Prevention (CDC) website. Parents and young adults are encouraged to visit CDC's Diseases and the Vaccines that Prevent Them website to learn more about vaccine-preventable diseases and recommendations. Health care providers can utilize the comprehensive adolescent toolkit, HPV Vaccine is Cancer Prevention, for materials when discussing vaccines with their patients.

**September is Ovarian Cancer Awareness Month** In the United States, ovarian cancer is the eighth most common cancer among women and will be diagnosed in an estimated 22,440 women in 2017.[3] In 2014 alone, Florida had 1,461 new cases and 1,011 deaths from ovarian cancer (age-adjusted).[4] The United States Preventive Services Task Force (USPSTF) recommends against routine screening for ovarian cancer unless one is in a high risk group, so education and awareness are the best defense.

High risk groups for ovarian cancer include women with BRCA1 and BRCA2 genetic mutations, the Lynch syndrome, or a family history of ovarian cancer. CDC's Inside Knowledge campaign has resources to help raise awareness of the signs and symptoms of ovarian cancer. For more resources on causes and prevention, screening, treatment, and research, visit the National Cancer Institute (NCI) website.

**September is also Prostate Cancer Awareness Month** Prostate cancer is the second most common male cancer in Florida, with over 11,000 new cases and 2,000 deaths from prostate cancer annually since 2012 (age-adjusted).[1] NCI estimates there will be 161,360 new cases and 26,730 deaths from prostate cancer in the U.S. in 2017.

The USPSTF recommendation is in the process of being updated. Draft recommendations no longer recommend against prostate specific antigen-based screening for prostate cancer for men between 55–69 years of age. The recommendation states the decision to be screened should be made by the individual and recommends clinicians inform men about potential benefitis and harms. The American Cancer Society (ACS) recommends that the discussion about screening take place at age 50 for men who are at average risk. For more information on prostate cancer including considerations for screening, visit the ACS and NCI websites.

1. *How Many Cancers Are Linked with HPV Each Year?* (2014, June 23). Retrieved June 30, 2017, from http://www.cdc.gov/cancer/hpv/statistics/cases.htm

2. Markowitz, L. E. (2014, August 29). Human Papillomavirus Vaccination: Recommendations of the Advisory Committee on Immunization Practices. Retrieved June 29, 2016, from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6305a1.htm

3. SEER Cancer Stat Facts: Ovarian Cancer. National Cancer Institute. Bethesda, MD, http://seer.cancer.gov/statfacts/html/ovary.html

Florida HEALTH

# State Update

## Health Systems Shoot for Higher HPV Vaccination

In the last year, dozens of health systems across Florida made great strides to improve their ability to identify and support patients in need of HPV vaccination. Through coordination with a network of cancer stakeholders including County and State Health Departments, the American Cancer Society, and Local Health Councils, individual health systems and provider sites began a process of procedural and technical changes that facilitated both patient and provider reminders, shown to be effective at increasing vaccination rates on average by 12 percent.

Although changes should be tailored to individual systems, key components include policy change, staff training and automation of reminder systems which prompt clinical staff of patients due for vaccination and facilitate reminder and recall mailings to patients. Policy and staff trainings focus on the clinical interaction between staff and patient, with more recent findings on the use of two dose HPV vaccination included in the educational component. Clinical interaction between patient and provider on HPV vaccination has been shown in numerous studies to be critical to increasing vaccination rates. Sometimes termed the "announce" method, providers who treat HPV vaccination as any other vaccine and simply tells the patient which vaccinations they will receive to stay on schedule has been shown to be far more effective at vaccinating compared to providers who discuss the vaccine before administration.

Tobacco Free Florida.com

# World Lung Cancer Day

**August 1 was World Lung Cancer Day**, which aims to celebrate those who have overcome lung cancer and commemorate those affected by the disease. Today, lung cancer is the leading cause of cancer deaths for both men and women in the country.[1]

This year, an estimated 19,000 Floridians will be diagnosed with lung cancer.[2] Cigarette smoking is the number-one risk for lung cancer.[3] In fact, smoking causes about nine out of 10 of all lung cancer deaths.[4,5]

Today, the risk of death is even greater because cigarettes have become deadlier than ever.[6] Between 1959 and 2010, the risk for lung cancer among female smokers increased tenfold and doubled among male smokers. These increases occurred even though smokers from 2000 through 2010 smoked fewer cigarettes a day than earlier smokers. One possible explanation for the higher rates of lung cancer, according to the 2014 Surgeon General's Report, is that filters and vent holes in most modern cigarettes may lead smokers to inhale more deeply pulling dangerous chemicals farther into their lungs.[7]

Furthermore, the number of tobacco-related deaths have increased worldwide. Tobacco use now kills more than 7 million people each year worldwide, according to a report from the World Health Organization.[8] Tobacco use continues to be the leading cause of preventable death worldwide.[9]

If you or a loved one smokes, the most important thing you can do to lower your risk for lung cancer is to quit. Tobacco Free Florida's Quit Your Way program offers free tools and services to help you get started. Just pick the one that's right for you and get the support you need.

**Visit tobaccofreeflorida.com to learn more.**

*1. U.S. Department of Health and Human Services. The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human .*

*2. Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014. .*

*3. American Cancer Society. Cancer Facts & Figures 2017. Atlanta: American Cancer Society; 2017. "Lung Cancer." Centers for Disease Control and Prevention Centers for Disease Control and Prevention, 31 May 2017. Web. 30 June 2017.*

*4. U.S. Department of Health and Human Services.The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014*

*5. U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: What It Means to You. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010 .*

*6. U.S. Department of Health and Human Services. The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014.*

*7. U.S. Department of Health and Human Services. The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014*

*8. World Health Organization. World No Tobacco Day 2017: Beating Tobacco for Health, Prosperity, the Environment and National Development. World No Tobacco Day 2017: Beating Tobacco for Health, Prosperity, the Environment and National Development. World Health Organization, 30 May 2017. Web. 30 June 2017.*

*9. "Fast Facts." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 29 Mar. 2017. Web. 03 July 2017.*

# Plans Are Essential

## Cancer Survivor Tips

Personalized medicine, also known as precision medicine, is a relatively new approach to cancer treatment and care that utilizes a patient's genetic information to tailor treatment decisions to that individual. It hopes to fill a gap in treatment knowledge and increase survival rates across many diseases areas including cancer. Generalized treatments can fail to address ailments for a select groups of patients and, for some diseases, alternative treatments can have limited success. Genetics has been postulated as a primary driver in differences in treatment outcomes. By identifying genetic differences in patients, personalized medicine could address these gaps in treatment outcomes by identifying unique treatments by genetic subpopulation. Currently, most personalized medicine is restricted to clinical trials and has not been integrated into routine care for the majority of patients. findings can be found here. Key points from the report include:

**Targeted therapies are cancer treatments** that utilize concepts from personalized medicine to address genetic differences in tumor cells. Most of these therapies interfere with specific proteins within a tumor to inhibit growth or spread. Unlike chemotherapy, which kills tumor cells, these treatments seek to stop the tumor development by acting on specific molecular targets. Several types of targeted therapies have been developed and many promising therapies have reached clinical trials. To learn more about targeted therapies visit the National Institutes of Health or their clinical trials website to find targeted therapy clinical studies.

# Small Steps to Living Healthy

**Healthiest Weight Florida is a public-private collaboration bringing together agencies, institutions, organizations and communities to help Floridians make more informed choices about active lifestyles and healthy eating.**

1. 2016. Maternal, Newborn, Child, and Adolescent Health: Breastfeeding. Retrieved from http://www.who.int/maternal_child_adolescent/topics/child/nutrition/breastfeeding/en/

2. 2014. Breastfeeding Lowers Your Breast Cancer Risk. Retrieved from https://www.mdanderson.org/publications/focused-on-health/october-2014/breastfeeding-breast-cancer-prevention.html

3. 2010. Health Benefits of Breastfeeding. Retrieved from http://www.unicef.org.uk/BabyFriendly/About-Baby-Friendly/Breastfeeding-in-the-UK/Health-benefits/

Every woman's journey to motherhood is different, but one of the first decisions a new mom makes is how to feed her child. Healthiest Weight Florida promotes breastfeeding year-round in hospitals, daycares and worksites and encourages health care professionals to join in this effort. Throughout National Breastfeeding Awareness Month in August, health care professionals will work to connect women to local resources and normalize breastfeeding in community settings. Based on 2016 data from the CDC, 81.8 percent of women in Florida have ever tried breastfeeding, up from 71.8 percent in 2013. This progress is due in part to events like Global Big Latch On, an annual event to bring women together around breastfeeding and offer peer support, and awards, such as the Florida Breastfeeding Friendly Child Care Award and the Florida Breastfeeding Friendly Employer Award, which encourage breastfeeding in multiple settings.

Choosing to breastfeed has many advantages for babies and mothers. Physical closeness, skin-to-skin contact and eye contact are all important aspects of early development and mother-child bonding. Breast milk provides vitamins, protein and fat – the ideal nutrition combination for infants. In addition, babies who are breastfed are less likely to have diarrhea, get ear infections or develop asthma or allergies.[1] Exclusive breastfeeding is recommended for the first six months after the baby is born and continued breastfeeding with the addition of solid foods is encouraged for 12 months or longer. Breastfeeding provides emotional bonding and nutritional benefits, and has been shown to lower breast cancer and ovarian cancer risk, especially if a woman breastfeeds for longer than a year.[2,3]

**The Florida Department of Health** offers a variety of programs, materials and resources to encourage breastfeeding friendly environments throughout the sunshine state. Visit the Healthiest Weight Florida website or the Florida Department of Health's Breastfeeding webpage for more information about breastfeeding.

# Cancer In the News

## General Cancer Related Articles

**How sharing cancer data can save lives**—*Science Daily, May 24, 2017*

**1999–2014 United States Cancer Statistics (USCS) Web-based Report**—*CDC, June 28, 2017*

**How sharing cancer data can save lives**—*Science Daily, May 24, 2017*

## Prevention Related Articles

**Percentage of Adults Aged ≥18 Years Who Walked ≥10 Minutes as a Method of Transportation, by Location of Residence — National Health Interview Survey, United States, 2005, 2010, and 2015**—*CDC, May 26, 2017*

**World No Smoking Day: Increasing the price of tobacco by 5% reduces consumption by 3.5%**—*Science Daily, May 29, 2017*

**Draft Research Plan: Primary Care Interventions to Prevent Tobacco and Nicotine Use in Children and Adolescents** —*USPSTF, June 22, 2017*

## Access to Care Related Articles

**Raised blood platelet levels 'strong predictor' of cancer**—*MNT, May 23, 2017*

**Open-access genetic screening for hereditary breast cancer is feasible, effective**—*Science Daily, May 27, 2017*

## Survivorship Related Articles

**Many patients with early-stage breast cancer receive costly, inappropriate testing**—*Science Daily, May 25, 2017*

**First large-scale genomic analysis of key acute leukemia will likely yield new therapies**—*Science Daily, July 3, 2017*

**Cancer cell lines predict drug response and accelerate personalized medicine**—*Science Daily, July 7, 2017*

**Nanomedicine opens door to precision medicine for brain tumors**—*Science Daily, July 12, 2017*

**Brain tumor: New inhibitor may fight glioblastoma expansion**—*MNT, July 25, 2017*

# Tools & Resources

**CancerCare presents the following Connect® Education Workshops (all are from 1:30–2:30 p.m. ET): All sessions are free and pre-registration is required.**

**Oct. 2:** Treatment Update on Liver Cancer

**Oct. 4:** What's New in the Treatment of Waldenstrom's Macroglobulinemia (WM)

**Oct. 5:** Progress in the Treatment of Indolent Non-Hodgkin Lymphoma r

**Oct. 6:** Update on Soft Tissue Sarcoma

**Oct. 19:** Living with Metastatic Breast Cancer

**Nov. 1:** Nov. 1: Update on the Treatment of Pancreatic Cancer

Participate by listening to these workshops on the telephone or via live streaming through the Internet. For more information or to register online, visit CancerCare online or call 1-800-813-HOPE (4673). Listen to past Connect Education Workshops as podcasts through CancerCare's website.

**Cancer and Careers is hosting an educational series for health care professionals (all are from: 1:00–2:00 p.m. ET unless otherwise noted) that covers practical and legal issues concerning balancing work and cancer.** All sessions are free and pre-registration is required. One continuing education credit will be provided free of charge to eligible oncology nurses and social workers upon approval from listed agencies.

**Sept. 13:** Disclosure, Privacy & Online Brand

**Sept. 21:** Educational Series for Healthcare Professionals: Returning to Work

**Oct. 11:** Working Through Treatment

**Nov. 16:** Educational Series for Healthcare Professionals: Health Insurance Options

**Dec. 13:** Balancing Work & Cancer Webinar: Body Confidence, Self-Confidence in the Workplace

Participate by listening to these workshops on the telephone or via live streaming through the Internet. For more information or to register online, visit CancerCare online or call 1-800-813-HOPE (4673). Listen to past Connect Education Workshops as podcasts through CancerCare's website.

**The National Colorectal Cancer Roundtable will host a webinar** on the latest colorectal cancer screening measures, progress and challenges and the transition to the next iteration of screening work.

**Oct. 3:** 80 by 2018 Progress

**CDC and National Cancer Institute (NCI) used state and federal statistics on cancer incidence and deaths to develop a data visualization website. Data can be viewed under a variety of filters including demographics, cancer trends, state overview, state rankings and more.** In addition, CDC's Division of Nutrition, Physical Activity, and Obesity has updated their data, trends and maps database. Data on weight status, food and beverage consumption and healthy habits can be downloaded to create datasets, maps, graphs and other visuals.

**The NCI in collaboration with the American Cancer Society,** the CDC and the North American Association of Central Cancer Registries released a series of digital resources and materials from their Annual Report to the Nation, which include downloadable graphics and social media messages.

**The National Academies of Sciences, Engineering, and Medicine's** roundtable on Health Literacy published proceedings from a workshop on communicating clearly about medicines.

**Leukemia & Lymphoma Society** recently updated several materials for patients and caregivers including co-pay assistance program, food and nutrition fact sheet and choosing a blood cancer specialist.

# Funding Opportunities

**Susan G. Komen® Miami/Ft. Lauderdale** announces funding opportunities to support efforts to reduce breast cancer disparities in Miami-Dade, Broward and Monroe Counties. Funding will prioritize efforts in reducing barriers to care and breast cancer education. Applicants may apply for the Community Grant Program which funds local breast cancer-related programs that are $10,000 or more. To apply email Patricia Sanchez. **Closing date is 12/8/17.**

**National Institutes of Health** released funding opportunity announcements (FOAs) for a variety of cancer related research projects:

**Dissemination and Implementation Research in Health** is a FOA to support innovative approaches to identifying, developing, testing, evaluating and/or refining strategies to disseminate and implement evidence-based practices into public health, clinical practice and community settings. For more information visit R01 (PAR-16-238), R21 (PAR-16-236) and R03 (PAR-16-237). **Closing dates vary.**

# Events

**2017 Cancer Programs Conference: Creating a Culture of Quality in Chicago, Ill. on Sept. 8–9, 2017**

**Changing Patterns of Cancer in Native Communities: Strength through Tradition and Science in Niagara Falls, N.Y. on Sept. 21–24, 2017.**

**2017 Cancer Programs Conference: Creating a Culture of Quality in Chicago, Ill. on Sept. 8–9, 2017.**

**NCCN Policy Summit: Redefining Quality Measurement in Oncology in Washington, D.C. on Sept. 25, 2017.**

**NCCN 12th Annual Congress: Hematologic Malignancies™ in San Francisco, Calif. on Oct. 7, 2017.**

**NCCN Patient Advocacy Summit: Addressing Survivorship in Cancer Care in Washington, D.C. on Dec. 1, 2017.**

**Annual Conference on the Science of Dissemination and Implementation in Health in Arlington, Va. on Dec. 4-6, 2017.**

**Methods for Evaluating Natural Experiments in Obesity in Bethesda, Md. on Dec. 5-6, 2017. Poster session abstract submission closes Aug. 31, 2017.**

# Collaboratives

Regional Cancer Control Collaboratives exist across the state and work to bring public and private partners together to reduce the burden of cancer. For information about what your regional collaborative in your area is doing, visit their websites listed below.

- **Northwest Florida Cancer Control Collaborative**
- **Northeast Florida Cancer Control Collaborative**
  **Facebook: NEFCCC**
- **North Central Florida Cancer Control Collaborative**
- **East Central Florida Cancer Control Collaborative**
- **Southeast Florida Cancer Control Collaborative**
  **Facebook: SoFla Fighting Cancer**
- **Southwest Florida Cancer Control Collaborative**
- **The Southeast American Indian Council (SEAIC) focuses on needs assessments, preventive education and quality of life for American Indians. Membership is open to anyone of American Indian heritage. Email Dewey Painter or call him at (904) 208-0857 for an application or for more information.**

To be added to the contact list for any of these collaboratives, send an email request to Cancer@flhealth.gov.

## About the Cancer Stakeholder

The Cancer Stakeholder is an e-newsletter, which includes the DOH cancer updates, cancer tools and resources, funding opportunities, events, research, and other information about cancer. The opinions expressed in the Cancer Stakeholder do not necessarily reflect the views of the Department or its staff. Please direct questions, comments and suggestions to the Comprehensive Cancer Control Program at cancer@flhealth.gov.

If you would like to be removed from this distribution list, please send an email with "Unsubscribe" written in the subject line to cancer@flhealth.gov. Please type in the body of the email the county where you reside. Please understand that unsubscribing from the Cancer Stakeholder will unsubscribe you from receiving future emails related to the Comprehensive Cancer Control Program, the Regional Cancer Control Collaboratives and the associated local and statewide cancer activities.

This electronic newsletter was funded by Cooperative Agreement U58/DP003872 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

For any questions or concerns regarding this newsletter or to include your information in a future issue:

**Sam.Mooneyhan@flhealth.gov**

**(850) 245-4444, ext. 3857**

# Draft Telehealth Advisory Council Report of Recommendations

## Executive Summary

*To be completed after main body has been drafted*

## Background

Chapter 2016-240, Laws of Florida, created the Telehealth Advisory Council (Council) to make recommendations to the Florida Governor and Legislature about telehealth. The law designated the Secretary of the Agency for Health Care Administration (Agency) as the Council Chair and the State Surgeon General (or designee) as a member. The Agency's Secretary and the Surgeon General were then directed to appoint thirteen Council members representing specific provider and stakeholder groups. The Council was charged to review survey and research findings and to employ that information to develop recommendations to increase the use and accessibility of services provided via telehealth in the state.

The law also directed the Agency, the Florida Department of Health, and the Florida Office of Insurance Regulation to survey health care facilities, licensed professionals, insurance plans, and Health Maintenance Organizations (HMOs) regarding availability, utilization, and coverage of telehealth services in the state. The Agency was designated to compile the survey and research findings; and to submit a report of those findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2016. **(Attachment 1)**

The Council is required to submit its report of recommendations to the Governor, Senate President, and the House Speaker by October 31, 2017. This Telehealth Advisory Council Report of Recommendations represents the members' findings from detailed discussions and deliberations during the course of ten (10) public meetings hosted in various regions of the state; and as informed by formal presentations from approximately 30 individual providers, stakeholders, and national experts **(Attachment 2)** as well as numerous public comments, the Florida telehealth survey results, and national and state research compiled by members and Agency staff. All meeting information, including the speaker presentations, survey results, and research materials, have been archived on a dedicated Council website for reference as needed. This report, when viewed in its electronic format, contains direct links to source information or meeting materials when appropriate.

## Introduction

The United States, including Florida, is experiencing a shortage of health care professionals to serve a growing and aging population. Data from the U.S. Health Resources and Services Administration (HRSA) Bureau of Health Workforce indicated there were 615 federally designated Health Professional Shortage Areas (HPSAs) within the state for primary care, dental care, and mental health therapists in June 2014. More recent data from the bureau shows the number of HPSAs in Florida grew to 623 by December of 2016.[i] The Florida Department of Health has projected a need for 3,060 additional primary care physicians in the state by 2025.[ii] The existing and emerging deficiencies in the physician and health care workforce is a driver of innovation as the industry explores new strategies to extend the reach of existing healthcare professionals. The adoption and use of telehealth technology is one strategy that is gaining momentum nationally to help address these workforce deficiencies.

The United States Department of Health and Human Services notes that telehealth is not a type of healthcare service; it is a means or method used to deliver health care.[iii] The standard of care for providing health services should not alter based on the mode of delivery.[iv] Telehealth services can enable real-time (synchronous) communication between patients and healthcare practitioners through video conferencing; facilitate the storage and forwarding (asynchronous) of clinical data to offsite location for evaluation by specialist teams; and support remote monitoring of patient's chronic conditions via sensors and monitoring equipment. Telehealth technology is evolving into wearable and even implantable devices (mobile health) that detect information such as EKG readings.[v] While these technologies offer promising solutions, the adoption and expansion of telehealth also presents specific challenges to facilities, professionals, payers, and others. This report is intended to address the specific challenges that were identified in the Florida Report on Telehealth Utilization and Accessibility and through stakeholder testimony and research provided to the Council. The report presents six specific areas with identifiable obstacles for the expansion of telehealth: the definition of telehealth, health insurance coverage, reimbursement for telehealth, health practitioner licensure, patient/consumer protection, and technology.

The information presented to and reviewed by the Council demonstrates clear benefits from utilizing telehealth technology and the provision of distant health services. There remain significant opportunities to increase access and enhance the quality of services provided to vulnerable populations, especially in isolated communities, both rural and urban.[vi]

## Defining Telehealth

The Council heard testimony from numerous stakeholders on a broad array of telehealth applications. The value and utility of telehealth crosses most health service disciplines including but not limited to primary medical care, specialty care, chronic disease management, behavioral health, physical and occupational therapies, speech therapy, pharmacy, and home

health. There are as many definitions of telehealth or telemedicine as there are use cases and applications.

The American Telemedicine Association uses the terms telemedicine and telehealth interchangeably. Others use the term telemedicine as a specific reference to the practice of medicine and telehealth as an encompassing term inclusive of the broader scope of health care. Experts and stakeholders expressed the need for a clear definition of telehealth.[vii] Healthcare practitioners indicated the need for a definition that will clarify the use of technological modalities as a viable way to treat patients within their scope of practice. Health plans noted the need for clarity in the allowable modes of telehealth for coverage and reimbursement purposes.

Recommendation(s):

There are several definitions for "telemedicine" in Florida regulations, but none for "telehealth". These definitions for telemedicine do include the broader language associated with the term "telehealth". Although the terms telemedicine and telehealth are commonly used interchangeably, the term telehealth denotes the depth and range of the uses and modalities. The Council determined the need for a broad definition of telehealth in order to provide clarity on acceptable uses of current technology for treating patients, without becoming a barrier to technological innovations in the future.

To ensure clarity, the Council recommends that a definition of telehealth should be included in statute and inclusive of six key components:

1. Telehealth can be used for providing health care and public health services
2. Telehealth includes synchronous and asynchronous modalities
3. Practitioners treating Florida patients must be appropriately licensed in Florida or appropriately supervised by a licensed Florida healthcare practitioner as prescribed by law or rule
4. Healthcare practitioners must treat within the scope of their practice
5. Telehealth can be healthcare practitioner to healthcare practitioner or healthcare practitioner to patient
6. There must be no limitations on geographic or site locations

The Council offers the following language as a clear definition of telehealth for Florida:

*Telehealth means the mode of providing health care and public health services through synchronous and asynchronous information and communication technology by a Florida licensed healthcare practitioner, within the scope of their practice, who is located at a site other than the site where a recipient (patient or licensed healthcare practitioner) is located.*

## Health Insurance and Telehealth

A large proportion of Florida healthcare stakeholders identify issues surrounding coverage and reimbursement as primary policy concerns influencing the delivery and growth of telehealth services. Healthcare facilities and practitioners have reported through surveys and testimony to the Council a lack of adequate coverage and reimbursement for health care services provided using telehealth technologies. Some stakeholders have expressed hesitancy to invest in telehealth programs, citing that without some assurance regarding reimbursement they are unable to determine a positive Return-On-Investment (ROI). Confirming these reports from healthcare practitioners, a majority of Florida's licensed health insurers indicated in their response to the state's Telehealth Utilization and Accessibility survey they offer only limited coverage, if any, for telehealth services.[viii] Among Florida insurers that do cover telehealth, coverage is typically limited to specific circumstances and methodologies or require special coding.[ix]

Executive leaders from the *American Telemedicine Association* and the *Center for Connected Health Policy*, the nation's federally funded national telehealth policy resource center, presented information to the Council during April 2017. As of September 2017, both organizations' websites indicate thirty-four (34) states and the District of Columbia have established health insurance parity laws to address gaps in coverage for telehealth services.[x] According to a report published in August from the Center for Connected Health Policy, only three of the states with telehealth parity laws explicitly mandate reimbursement parity.[xi] Coverage and reimbursement parity laws apply varyingly to private and public payer plans in each state where they exist. Some states limit coverage and reimbursement based on modality and/or location.

The Council members have emphasized the importance of establishing a clear distinction between telehealth insurance *coverage parity* and *reimbursement parity*. The Council recognizes telehealth coverage parity as a requirement of health plans to include benefits for services provided via telehealth, when possible and appropriate, to the same extent the plan covers the same services provided in-person. Coverage parity is silent regarding the amount of payment for telehealth services. The Council recognizes telehealth reimbursement parity as a requirement of health plans to pay healthcare facilities and practitioners for covered telehealth services at an equivalent rate as the in-person reimbursement for the same service.

Policies governing the nation's primary public health care programs, Medicare and Medicaid, also play a key role in shaping Florida's telehealth landscape. These Federal programs strongly influence how states are able to serve senior and vulnerable populations, including patients who are dually eligible for both Medicare and Medicaid. There are efforts underway among members of Congress to modify current Medicare payment guidelines to support the expanded use of telehealth services nationally. States, including Florida, have greater flexibility to develop policy for their Medicaid programs and enjoy full authority to establish guidelines for coverage

of employees through state employee group health insurance programs, worker's compensation, and similar state-sponsored programs.

The national paradigm shift among private and public payers toward quality and performance-based payment models serves as another driver to increase telehealth utilization. These value-based payment arrangements incentivize health care practitioners to achieve the triple aim of increasing access to health care services for all persons, providing the highest possible quality of care, and minimizing costs. The thoughtful integration of telehealth modalities into healthcare practitioner workflows can strongly support practitioners in meeting these goals.

Coverage of telehealth services, whether voluntary or required, has also led to new discussions around network adequacy requirements among health insurers and their stakeholders. The National Association of Insurance Commissioners (NAIC) has developed a Managed Care Network Adequacy Model Act as a guide for state lawmakers for evaluating insurers' provider networks. This model includes potential uses for telehealth in meeting a state's network adequacy requirements. If adopted, these measures offer a valuable benefit and incentive for health plans to cover telehealth services.

## Telehealth Insurance Coverage

A number of healthcare facilities and licensed health practitioners have implemented successful telehealth programs and have reported real benefits in terms of cost savings, quality outcomes, and customer satisfaction. Others have been more reluctant to move toward the use of innovative technologies without stronger assurance that a return on their investment is achievable. One approach taken by some states to provide such assurance is through implementing laws requiring insurers to cover health services offered through telehealth when possible and appropriate, known as coverage parity. Coverage parity for telehealth services does not require health plans to provide any new service lines or specialties, and is intended to ensure patients have options for how they may be seen by healthcare practitioners, including in-person or virtually.[xii]

## Recommendation(s):

In order to increase access and use of telehealth in Florida, there must be an increase in healthcare practitioners offering services via telehealth. The limited or lack of reimbursement for telehealth service stifles the expansion of the use of this modality to treat patients. The Council recommends the following:

1. Florida's legislature require Florida-licensed health insurance plans (excluding Medicare) provide *coverage* for healthcare services provided via telehealth if coverage is available for the same service when provided in person.

The intent of this recommendation is to ensure appropriate insurance coverage for the use of telehealth in treating patients. Any legislative language developed should not require insurers to add additional service lines or specialties, mandate a fee-for-service arrangement, inhibit value based payment programs, or limit healthcare insurers and practitioners from negotiating contractual coverage terms.

## Telehealth Insurance Reimbursement

Telehealth *reimbursement parity* is recognized by the Council as a requirement of health plans to pay healthcare practitioners and facilities for covered telehealth services at an equivalent rate as the in-person reimbursement for the same service.[xiii] The Council received a great deal of input from healthcare practitioners, healthcare facilities, payers, and stakeholders through research findings, survey data, and direct testimony regarding reimbursement for telehealth services. Reimbursement parity is a complex issue that must be considered from a variety of perspectives. A majority of practitioners, for example, contend that adequate funding of telehealth through reimbursement parity will serve to stimulate greater adoption of telehealth, which would increase access to care and reduce overall health care spending over time. Conversely, some payers and researchers predict that enhanced access through telehealth will increase utilization, which would result in increased spending under traditional fee-for-service payment models. Others suggest a time-limited requirement for payment parity would stimulate telehealth use until value-based payment models more fully mature to better support telehealth as a quality enhancement and cost reduction strategy. State policymakers must also consider whether forced payment parity stifles individual providers' ability to competitively promote their telehealth programs to payers and other stakeholders separately from their in-person services.

The Council recognizes that the current and evolving national paradigm shift toward quality and performance-based health care payment models has significant potential to drive greater market use of telehealth. The U.S. Center for Medicare and Medicaid Services (CMS) is a primary driver of health care policy nationally and has launched a variety of value-based programs over recent years designed to reward healthcare practitioners for more favorable outcomes and restrict reimbursement for services resulting in less favorable outcomes and/or higher costs. Those CMS programs include:

- Hospital Value-Based Purchasing Program (HVBP)
- Hospital Readmission Reduction Program (HRR)
- Value Modifier Program (aka: Physician Value-Based Modifier or PVBM)
- Hospital Acquired Conditions Program (HAC)
- End-State Renal Disease Quality Initiative Program (ESRD)
- Skilled Nursing Facility Value-Based Program (SNFVBP)
- Home Health Value Based Program (HHVBP)

An increasing number of private and commercial health plans have adopted similar strategies to contain costs and improve care outcomes among their provider networks. Council members acknowledge that thoughtful planning and implementation of integrated telehealth strategies can assist practitioners in more efficiently and effectively meeting the foundational goals of value-based payment methodologies.

### Recommendation(s):

The Council recommends that the Florida legislature require Florida licensed health insurance plans (excluding Medicare plans) to offer reimbursement for covered health care services provided via telehealth. The intent of this recommendation is to ensure appropriate insurance reimbursement for the use of telehealth in treating patients. Any legislative language developed should not require insurers to add additional service lines or specialties, mandate fee-for-service arrangements, inhibit value based payment programs, or limit healthcare insurers and practitioners from negotiating contractual coverage terms.

## Medicare

Although Medicare is a federal program, Medicare laws and regulations often influence how states are able to serve vulnerable populations, including patients who are dually eligible under both the Medicare and Medicaid programs. There are many caveats governing telehealth coverage under current Medicare payment guidelines, including strict requirements for the geographic location and care setting of patients and limitations to specific technological modalities. The United States Congress is currently considering several bills that would expand or modify Medicare telehealth policy. One example is the Medicare Telehealth Parity Act, a bipartisan effort that would incrementally expand Medicare coverage for telehealth to include allied healthcare practitioner such as physical therapists, occupational therapists, audiologists, speech-language pathologists, and others; would allow a wider variety of telehealth modalities to be covered; and would expand the list of qualifying geographic locations.[xiv] The Council finds the current Medicare policies related to telehealth coverage and reimbursement to be a significantly limiting factor to growth and innovation, and supports congressional efforts to expand coverage and reimbursement of telehealth in Medicare.

### Recommendation(s):

It is the consensus of the Council that the State of Florida support modifications to Medicare telehealth laws that would expand coverage to include remote patient monitoring as well as store and forward modalities; expand of the types of healthcare practitioners covered; and revise or eliminate the existing geographic and place of service requirements.

## Medicaid

The Florida Medicaid fee-for-service rules were updated in June 2016 to expand the availability of telehealth reimbursement to a broader array of licensed healthcare practitioners. Similar to Medicare, Medicaid coverage in Florida is currently limited to live video conferencing and pays the practitioner that provides the diagnosis only.[xv] With the vast majority of Florida Medicaid

beneficiaries enrolled in managed care, Florida's Medicaid Managed Care plans are authorized to cover telehealth services with greater flexibility, although there is no state mandate for coverage. Based on survey responses from Florida licensed health plans and HMOs, coverage for telehealth is currently greatest among Florida Medicaid Managed Care plans and Affordable Care Act Exchange Plans.[xvi]

### Recommendation(s):

The Council members and multiple stakeholders have praised Florida Medicaid for its support of the expanded use of telehealth within the Statewide Medicaid Managed Care program, as well as its continued efforts to modify administrative rules governing the Medicaid Fee-for-Service program to support the use of telehealth. The Council recommends the Agency consider modifications to the Medicaid telehealth fee-for-service rule to include coverage of *store and forward* and *remote patient monitoring* modalities in addition to live video conferencing. The Council also recommends the Agency work with the Medicaid Managed Care plans to promote the expansion of telehealth utilization statewide.

### Insurance Network Adequacy

The National Association of Insurance Commissioners (NAIC) defines network adequacy as "a health plan's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all health care services included under the terms of the contract". Network adequacy minimum requirements are established to ensure consumers have access to needed care without unreasonable delay. The NAIC has developed a Model Network Adequacy Act for use by states in developing laws around this issue. The Act includes provisions allowing healthcare practitioners who offer services via telehealth to be included in the plan network for purposes of network adequacy.[xvii] Colorado was the first state to allow insurers to count available telehealth services in meeting network adequacy requirements for certain specialties.[xviii]

### Recommendations(s):

The Council supports the NAIC provisions related to telehealth as a means to ensure network adequacy among health plans and HMOs.

## Health Practitioner Licensure and Telehealth

The ability for technology to bring health care to the patient irrespective of location expands the market reach of healthcare practitioners in Florida. Health care professionals residing in Florida are able to treat patients in other states, even globally where authorized. This expansion of health care access conversely allows Florida patients to receive care from licensed healthcare practitioners anywhere in the world. Assurances for patient protections and provider accountability are imperative in these arrangements. In order to ensure adequate protections and enforcement, Florida's providers, stakeholders, and payers provided strong testimony to

the Council encouraging a requirement that all health care professionals providing care to Florida residents using telehealth be licensed in Florida, regardless of where the provider is physically located.

## Interstate Licensure

To ensure patient protection and healthcare practitioner accountability, the Council recommends practitioners be licensed in the state in which the patient resides. The Council acknowledges time and expense burdens associated with attaining licensure in multiple states as a potential barrier to expanding healthcare practitioners' use of telehealth. One opportunity to address this challenge is through the establishment of interstate licensure compacts. Nine (9) licensed health care professions currently have or are developing interstate compacts involving multiple states **(Attachment 3)**, including Florida's current licensure compact for nursing as adopted by the Florida legislature in 2016[xix]. Licensure compacts are established when a certain number of states enact the same legislation, intended to streamline administrative processes without undercutting the specific licensure requirements of any participating state. It is important to note that compacts may actually increase the eligibility requirements for licensure in some cases. Provider participation in a compact is voluntary, and the state maintains jurisdiction over all practitioners providing care to patients within its borders. Compact provisions vary from profession to profession and include distinct requirements and provisions for differing professions. The Federation of State Medical Boards' (FSMB) Interstate Medical Licensure Compact creates an expedited process for eligible physicians to apply for licensure in compact states.[xx] The Nurse Licensure Compact creates a multi-state license similar to a driver's license, where the initial licensing state and other compact participating states all recognize the license.[xxi] Although, different in implementation, the intent is to provide a less onerous process for practitioners seeking licenses in multiple states while maintaining the high standards of Florida licensure.

### Recommendation(s):

In order to ensure the highest possible standard of care for Florida patients while allowing health professionals to expand their patient reach, the Council recommends the following:

1. Maintain the requirement of Florida licensure for health practitioners treating patients in Florida. This recommendation requires no change to current regulations and does not inhibit the use of telehealth to treat patients.

2. Participate in health care practitioner licensure compacts that ensure equivalent or increased licensure requirements as Florida, when available and appropriate.

## Telehealth Standards of Care

It is imperative that Florida licensed practitioners understand and comply with established standards of care whether treating patients in person or through telehealth. The Florida Department of Health (Department), which is responsible for the licensure and regulation of the more than 800,000 health professionals in the state, provided information to the Council

clarifying that current rules are not intended to preclude Florida licensed practitioners from using telehealth within their authorized scope of practice and established standards of care. The Department is working to increase awareness and education among licensed health professionals regarding their ability to employ telehealth within their practices. The Department recognizes telehealth as a modality for providing health services as opposed to a separate service, meaning the state's established standards of care developed by each regulatory health care board are applicable whether care is provided in person or using telehealth.

A number of stakeholders, primarily ancillary health care professionals (i.e. Physical Therapists, Occupational Therapists, Audiologists, Speech-Language Pathologists, etc.), have indicated a need for specific statutory authority to develop telehealth practice standards related to telehealth, similar to the authority given to Boards of Medicine and Osteopathic Medicine.[xxii] Other stakeholders deem the use of the general standard of care provisions in regulation sufficient for practitioner oversight.

### Recommendation(s):

The Council acknowledges Florida's current standards of care as sufficient for general regulatory oversight of patient care; and recognizes each healthcare regulatory board has direct authority for establishing appropriate standards based on knowledge and insight for their respective practitioners.

To ensure clarity for Florida licensed healthcare practitioners and stakeholders regarding the ability to use telehealth as a modality of care, the Council recommends:

1. The Department of Health and health care regulatory boards continue to educate and raise awareness among licensees about their ability to utilize telehealth modalities as a means treat patients when appropriate.

2. The Florida legislature provide health care regulatory boards and councils specific statutory authority to develop standards of care rules for telehealth, if the boards deem it necessary and appropriate.

## Patient/Consumer Protection

Health care practitioners' responsibilities to patients are the same no matter which modality of care is used; and likewise patients should have confidence in the standard of care they receive, whether delivered in-person or through telehealth. Patients should expect competent, confidential care and to receive accurate, timely, and complete information so that they may make informed decisions about their care.

Health care practitioners and stakeholders also have a responsibility to manage risks related to fraud and abuse in the delivery of healthcare services. There is no known evidence suggesting a higher risk of abuse or fraud involving telehealth over any other mechanism of care. A provider who bills for a disproportionate amount or frequency of services would warrant an audit of

their treatment and billing practices, whether providing healthcare services via telehealth or a more traditional modality of care.

## Patient-Provider Relationships & Continuity of Care

While there is a significant and growing body of evidence supporting the use of telehealth to expand and improve the provision of health care services, the use of telehealth does not automatically diminish issues related to patient care, including coordination of care among multiple providers. Ideally, when a patient receives care, information from the episode is integrated into coordinated Electronic Health Records (EHRs) or similar systems and made available to inform other treatments and services. There is some concern among providers and payers, under increasing financial risk for patient care outcomes, regarding the high potential for care fragmentation or service duplication that can result when patients seek or receive care outside of established provider networks. Similar to visits that occur in non-network urgent care centers, non-network direct to patient telehealth services could result in episodic care without the information ever being shared with the patient's primary care provider or health plan - thus creating health care information silos. Although the Council recognizes the ability for healthcare providers and patients to establish a relationship through telehealth, they also note the importance of ensuring that patient care is coordinated among treating providers.

### Recommendation(s):

The Council supports initiation of healthcare practitioner-patient relationships through telehealth technology; and discourages the adoption of policies that would require patients to see a practitioner in-person before receiving care through telehealth.

## Patient Consent

Prior to providing healthcare services, practitioners are required to ensure patients (or legal proxies) are aware of the specific benefits, risks, and alternative courses of action they may take for their care; and must receive and document patient consent. This is typically achieved through an informed consent, which also relates to providers' liability and legal exposure. In the case of telehealth, it may be particularly beneficial for patients to know the potential risks, and to understand that a condition or treatment may require a provider to defer to in-person services. Section 766.103, Florida Statutes, governs the provision of medical consent for treatment and is applicable regardless of the care delivery mechanism.

### Recommendation(s):

The Council recommends maintenance of the current consent laws in Florida. The Council notes that additional consent requirements may add unnecessary barriers for both providers and patients attempting to utilize telehealth services.

## Telehealth & Prescribing

Many medical conditions and procedures require prescription medications as a component of the treatment plan. Both federal and state law governs appropriate prescribing, in particular the prescribing of controlled substances. The Ryan Haight Online Pharmacy Consumer

Protection Act (Ryan Haight Act) is a federal law that provides guidelines for the prescribing of controlled substances through the internet. The Ryan Haight Act affirmatively recognizes telehealth as a viable means of creating a treating relationship for the purpose of prescribing controlled substances.[xxiii] This federal regulation prohibits the prescribing of a controlled substance based solely on answering a questionnaire.

In Florida, medical doctors (allopathic and osteopathic), dentists, podiatrists, and some advanced registered nurses and physician assistants can prescribe controlled substances. Section 456.42, Florida Statutes, provides requirements for prescribing of controlled substances. The Florida Medical Boards' rules on telehealth, additionally, prohibit the prescribing of opioids without an in-person visit – with the limited exceptions of treating of psychiatric disorders, treating patients in a licensed health care facility, and treating patients in an emergency medical situation.[xxiv] These rules also specify requirements needed to ensure a complete record for any prescriptions. Although other health practitioners who prescribe do not have specific standard of care provisions, the Ryan Haight Act and scope of practice laws do provide boundaries for prescribing controlled substances when delivering care.

### Recommendation(s)

The Council supports the establishment of provider-patient relationships through telehealth and recommends rejecting any provision that would require an in-person examination prior to treating and prescribing medication via telehealth. Limited exceptions should be made for controlled substances as currently outlined in the Boards of Medicine and Osteopathic Medicine rules.

## Technology

The technology used to provide telehealth services is well established; it has existed for more than 40 years. Rapidly evolving technological innovation in the current market is making telehealth an increasingly accessible tool for both providers and patients. Healthcare practitioners have noted, however, some overarching technological barriers to effective telehealth implementations.[xxv] Primary examples include limited access to technology and system networks (internet connectivity) in isolated communities, equipment costs, and challenges related to interoperability with other health care technologies and documentation systems. Noting continually increasing technological capability and decreasing costs, the Council has noted technology as a diminishing barrier in implementing telehealth programs.

### Technology and Patient Access

Recognizing that some populations may have lower access to computers in a way that would enable them to be used for telehealth, Council members noted that many health services can be provided virtually through less expensive mobile devices such as smartphones. A vast majority of the United States population now have a cellphone of some kind, including 92% of adults with an income of less than $30,000 a year. The Florida Public Service Commission

operates and administers the federal LIFELINE program in Florida, which provides free or discounted mobile phones (including smartphones) to individuals who are eligible and enrolled in certain social services programs.[xxvi] Several of Florida's Medicaid Managed Care plans promote LIFELINE services to their members in order to support health care management through access to internet-based services.

Approximately ten percent of American adults are "smartphone-only" internet users – meaning they own a smartphone and do not have traditional broadband service at home.[xxvii] This growing independence from in-home broadband services, however, does not diminish the need for a strong broadband network in order for telehealth services to expand. Florida has been very successful in implementing broadband connections throughout the state and is considered one of the top ten "most connected states" by Broadband Now, a national organization that compiles data from the Federal Communications Commission (FCC), the U.S. Census Bureau, broadband providers, resellers, IP-verified customers and other sources. Currently, over 97% of Floridians have access to wireline services and 100% have access to mobile broadband services. A small segment of the population in Florida, about 600,000 individuals, have access to the internet through mobile broadband only.[xxviii] Mobile broadband allows individuals to access the internet from their mobile devices. Telephone and data service providers, however, typically set limits on the amount of data a user can consume. These limits can inhibit some individuals from using their devices to receive health services via telehealth due to the additional costs imposed by telephone and data service providers for exceeding data limits.

### Technology and Healthcare Facilities/Practitioners

Florida health care providers specifically identified the cost of equipment needed to treat patients using telehealth as a barrier.[xxix] The growing telehealth market and innovative technological landscape, however, indicate ongoing price point reductions. Additionally, research and stakeholder input suggests that telehealth technology is available at varying price points.[xxx] The Council is supportive of payment parity for telehealth services as a strategy to address initial technical cost concerns among providers, offering a clearer path toward Return On Investment (ROI). There are also federal grant funding programs available to support implementation of telehealth programs. Information about the availability of funding and resources to assist providers is available through the nation's federally funded Regional Telehealth Resource Centers. The Southeastern Telehealth Resource Center provides resources and guidance to providers in Florida for implementing and expanding telehealth services at varying price points.[xxxi]

Health care facilities and practitioners also identify interoperability gaps between health technology vendors as a challenge at the national and state level. Florida health care facilities have indicated through survey responses that a lack of interoperability between providers is a barrier to development and implementation of telehealth programs. A bipartisan focus group conducted by Health Affairs and the national Bipartisan Policy Center identified the lack of interoperability between electronic health record systems and medical devices as a barrier to

telehealth expansion.[xxxii] In addition to the challenges related to interoperability between health care provider data systems, there is also a lack of interoperability between telehealth technology and electronic health record (EHR) platforms.[xxxiii] Insufficient interoperability among information systems has the potential to increase communication gaps and hinder the continuity of patient care. Technology vendors and health care organizations are working to improve systems' interoperability through implementations that support data exchange, such as the national eHealthExchange and Carequality. The eHealthExchange is a growing network of exchange partners (ie. health care professionals) who securely share clinical information over the Internet across the United States, using a standardized approach. Exchanges leverage a common set of technical and data standards, legal agreements, and governance. Participants are able to securely share health information with each other, without additional customization and separate legal agreements. Carequality is advancing EHR interoperability by brokering agreements among health IT vendors to implement a framework for point-to-point health information exchange. In Florida, the Agency for Health Care Administration (Agency) provides governance for the statewide Heath Information Exchange (HIE) program, which promotes interoperability and offers services that allow sharing of patient information between healthcare providers when needed.

Recommendation(s):

The Council notes that technology-related barriers for providers will continue to decrease as technological advances and market forces drive cost reductions. Significant barriers remain, however, related to interoperability of health care information systems. Specific challenges to interoperability include varying administrative policies among states and providers, such as privacy laws – leading to misalignment, confusion, misinterpretation and sometimes over-restrictive interpretations of those laws.

Noting diminishing technological barriers, the Council recommends:

1. The Agency identify existing resources for health information exchange; existing and potential solutions to expanding interoperability and pathways to potential solutions.
2. Florida continue promotion of existing programs and services available to increase access to technology, access to broadband networks, and improved interoperability.
3. Education opportunities be offered by medical schools and healthcare practitioner associations related to the utilization to telehealth to treat patients. Educational opportunities should include training on technology system security and HIPAA and requirements needed to ensure the appropriate standard of care.

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[xxv] Florida Report on Telehealth Utilization and Accessibility. Agency for Health Care Administration. December 31, 2016.
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[xxix] Florida Report on Telehealth Utilization and Accessibility. Agency for Health Care Administration. December 31, 2016.
[xxx] Faison, Lauren. Expanding Care Through TeleHealth. Tallahassee Memorial Healthcare. Presentation June 20. 2017.
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[xxxii] Marchibroda, J. "A Policy Dialogue On Connected Health." Health Affairs. N.p., 2013. Web. 15 Dec. 2016
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# CDC

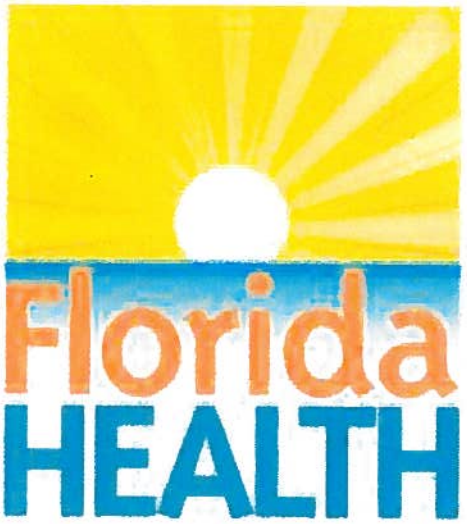
# PRESENTATION

# Lisa C. Richardson, MD, MPH

Lisa C. Richardson, MD, MPH, is the Director of CDC's Division of Cancer Prevention and Control (DCPC). As director of DCPC, she provides leadership and direction for all scientific, policy, and programmatic issues related to four national programs: the Colorectal Cancer Control Program, the National Breast and Cervical Cancer Early Detection Program, the National Comprehensive Cancer Control Program, and the National Program of Cancer Registries. Dr. Richardson's public health service includes the following: medical director for the National Breast and Cervical Cancer and Early Detection Program (1997-1998), medical officer in CDC's Division of Blood Disorders (1998-2000) and later served as the division director, faculty member at the University of Florida in Medical Oncology collaborating with the Florida Cancer Data System funded by CDC's National Program of Cancer Registries (2000-2004), medical officer in the DCPC's Epidemiology and Applied Research Branch (2004), team lead for Scientific Support and Clinical Translation Team supporting the National Comprehensive Cancer Control Program (2006-2009). From 2010 to 2013, Dr. Richardson served as DCPC's Associate Director for Science and helped set scientific priorities to maintain high-caliber integrity in public health activities.

Dr. Richardson received her medical degree and Bachelor of Science from the University of North Carolina at Chapel Hill and her Master in Public Health from the University of Michigan, School of Public Health. Her public health knowledge and expertise has well-positioned her for leading DCPC.

# FLORIDA CONSORTIUM OF NCI CENTERS PROGRAM REPORT




# Florida Consortium of National Cancer Institute Centers Program

Report to the Cancer Control and Research Advisory Council

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July 1, 2017

Rick Scott
Governor

Celeste Philip, MD, MPH
Surgeon General and Secretary

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## Background

The Florida Consortium of National Cancer Institute (NCI) Centers Program was established in section, 381.915, Florida Statutes, to enhance the quality and competitiveness of cancer care in Florida, further a statewide biomedical research strategy directly responsive to the health needs of Florida's citizens, and capitalize on the potential educational opportunities available to students. The Department shall make payments to Florida-based cancer centers recognized by the National Cancer Institute at the National Institutes of Health as NCI-designated cancer centers or NCI-designated comprehensive cancer centers, and cancer centers working toward achieving NCI designation. Annual funding for the program is subject to an appropriation in the General Appropriations Act.

Statute directs the Department to calculate an allocation fraction in combination with tier-designated weights in distributing funds to participating cancer centers. The allocation fraction for each participating cancer center is based on specific cancer center factors outlined in statute. Tier-designated weights are based on the NCI status of the center. The tier-designated weights are as follows:

- Tier 1: Florida-based NCI-designated Comprehensive Cancer Centers
- Tier 2: Florida-based NCI-designated Cancer Centers
- Tier 3: Florida-based cancer centers in pursuit of designation as either a NCI-designated Cancer Center or NCI-designated Comprehensive Cancer Center

Currently, there are three participating cancer centers: H. Lee Moffitt Cancer Center, University of Florida Shands Cancer Hospital, and University of Miami Sylvester Comprehensive Cancer Center. The three cancer centers are referred to as the Florida Academic Cancer Center Alliance.

## Reporting Requirements

Beginning July 1, 2017, and every 3 years thereafter, the Florida Department of Health, in conjunction with participating cancer centers, shall submit a report to the Cancer Control and Research Advisory Council on specific metrics relating to cancer mortality and external funding for cancer-related research in the state. The report includes:

1. An analysis of trending age-adjusted cancer mortality rates in the state, which must include, at a minimum, overall age-adjusted mortality rates for cancer statewide and age-adjusted mortality rates by age group, geographic region, and type of cancer, which must include, at a minimum: lung cancer, pancreatic cancer, sarcoma, melanoma, leukemia and myelodysplastic syndromes, and brain cancer.

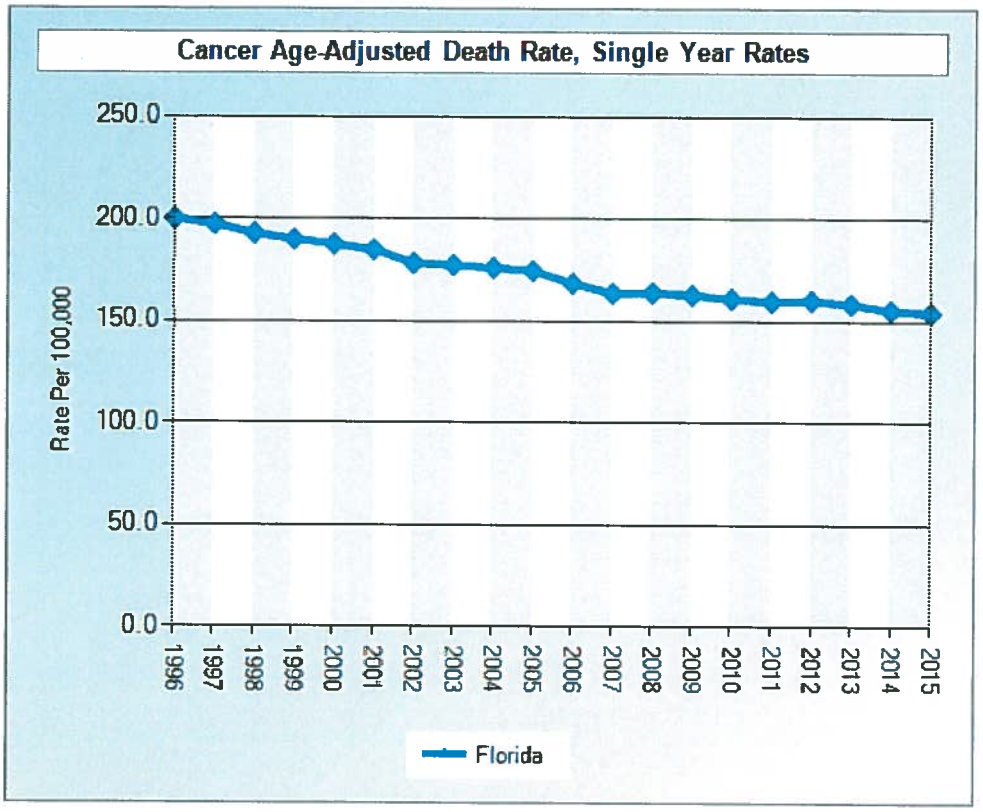
2. Information on trends in overall federal funding, broken down by institutional source, for cancer-related research in the state.

3. A list and description of collaborative grants and interinstitutional collaboration among participating cancer centers, a comparison of collaborative grants in proportion to the grant totals for each cancer center, a catalogue of retreats and progress of seed grants using state funds, targets for collaboration in the future and reports on progress regarding such targets where appropriate.

An Analysis of Trending Age-Adjusted Cancer Mortality Rates in Florida

Florida has the second highest cancer burden in the nation. In 2011, cancer surpassed heart disease as the leading cause of death and remains one of the top two leading causes of death in Florida. Overall, the age-adjusted death rates of cancer has decreased by 22.9% over the past 20 years in Florida.

Current data on age-adjusted death rates for cancers throughout this report were provided by Florida Health CHARTS which is administered by the Department's Bureau of Vital Statistics.

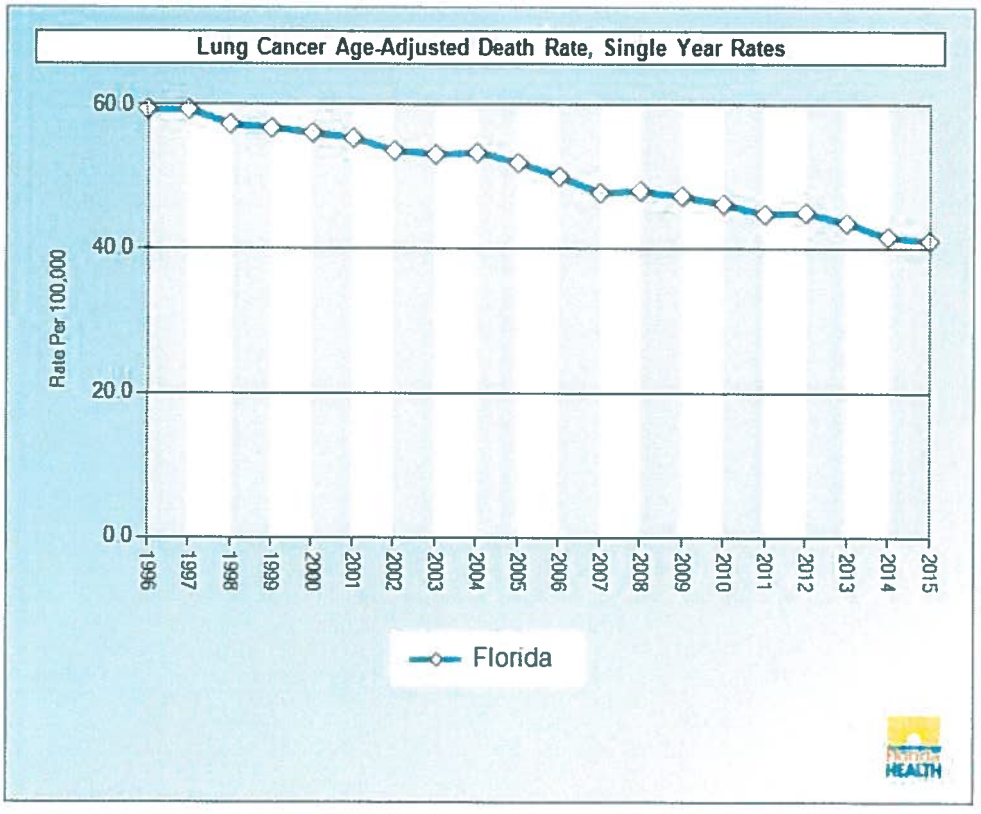



Lung cancer is a disease which consists of uncontrolled cell growth in tissues of the lung. This growth may lead to metastasis, which is the invasion of cancer cells into adjacent tissue and infiltration beyond the lungs. The vast majority of primary lung cancers are carcinomas of the lung, derived from epithelial cells. The most common cause of lung cancer is long-term exposure to tobacco smoke. The occurrence of lung cancer in nonsmokers, who account for as many as 15% of cases, is often attributed to a combination of genetic factors, radon gas, asbestos, and air pollution including secondhand smoke.

Lung cancer death rates have steadily declined over the last 20 years in the state of Florida. The death rate from lung cancer is significantly greater in the 40-64 age group with the highest death rate in the 65 and older population.

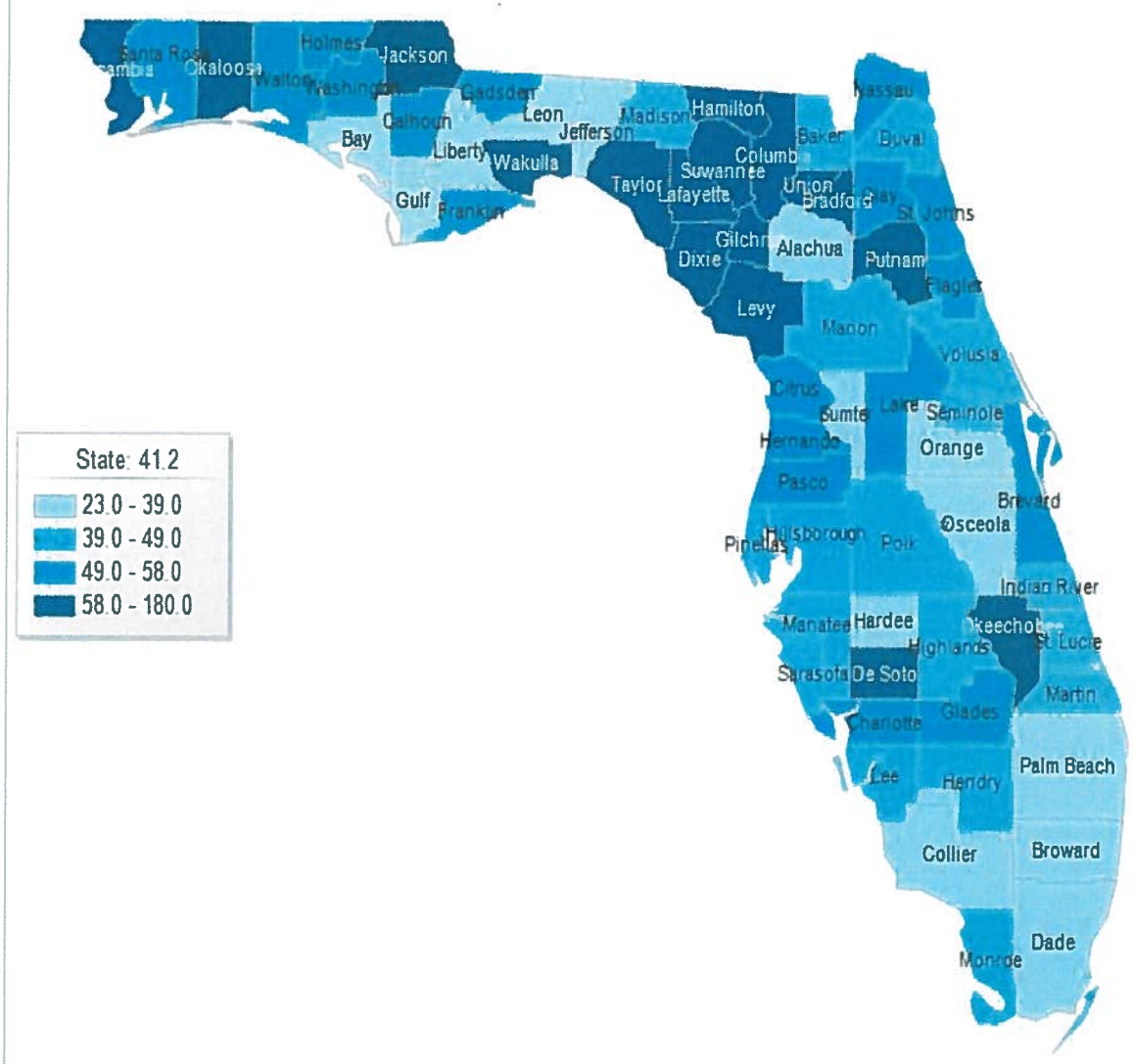
| Lung Cancer Age-Adjusted Death Rate, Single Year Rates per 100,000, 2010-2015 | |
|---|---|
| Years | Rate |
| 2015 | 41.2 |
| 2014 | 41.7 |
| 2013 | 43.6 |
| 2012 | 45.1 |
| 2011 | 44.9 |
| 2010 | 46.2 |

| Lung Cancer Age-Adjusted Death Rate, Single Year Rates per 100,000 by Age Group, 2010-2015 | | | | |
|---|---|---|---|---|
| Years | 0-19 Years of Age | 20-39 Years of Age | 40-64 Years of Age | 65+ Years of Age |
| 2015 | 0 | 0.6 | 46.3 | 234.1 |
| 2014 | 0 | 0.4 | 43.6 | 241.7 |
| 2013 | 0 | 0.4 | 47.6 | 248.9 |
| 2012 | 0 | 0.6 | 47.1 | 258.9 |
| 2011 | 0.1 | 0.5 | 47 | 257.2 |
| 2010 | 0 | 0.5 | 48.5 | 264.1 |



The highest death rates from lung cancer occur in rural counties and are concentrated in the Florida Panhandle. Higher death rates are, in part, contributed to decreased access to prevention services, diagnostics, treatment, and higher rates of adult smoking.

**Lung Cancer Age-Adjusted Death Rate, Per 100,000, 2015**

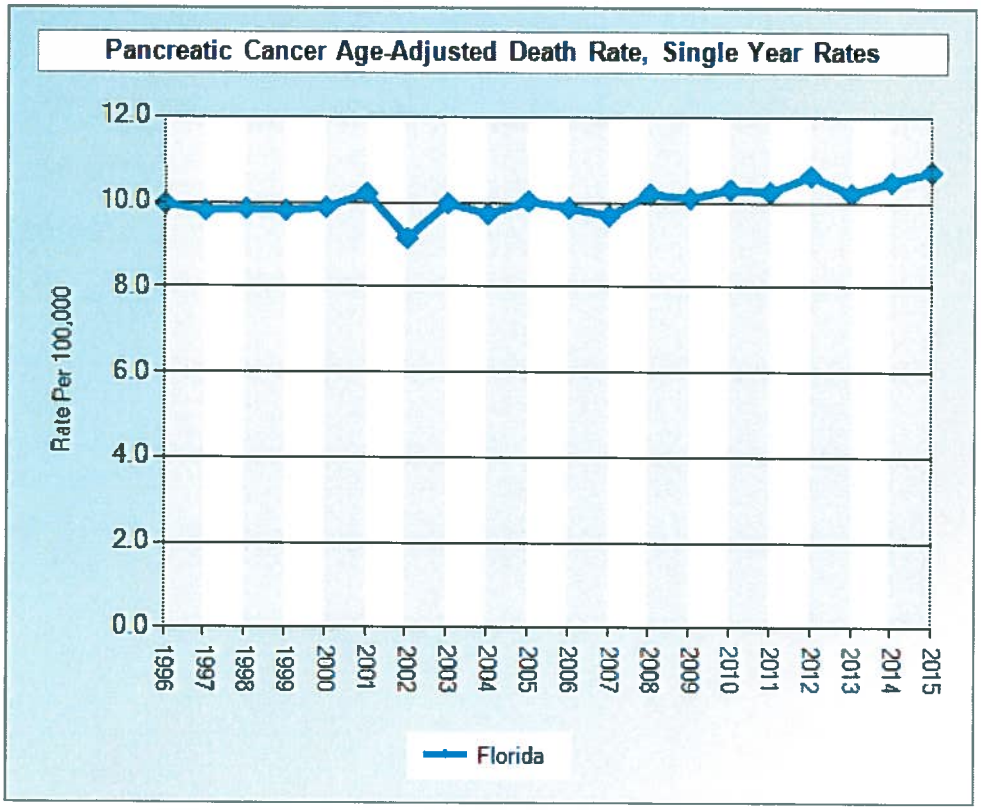



Data source: Florida Department of Health, Bureau of Vital Statistics

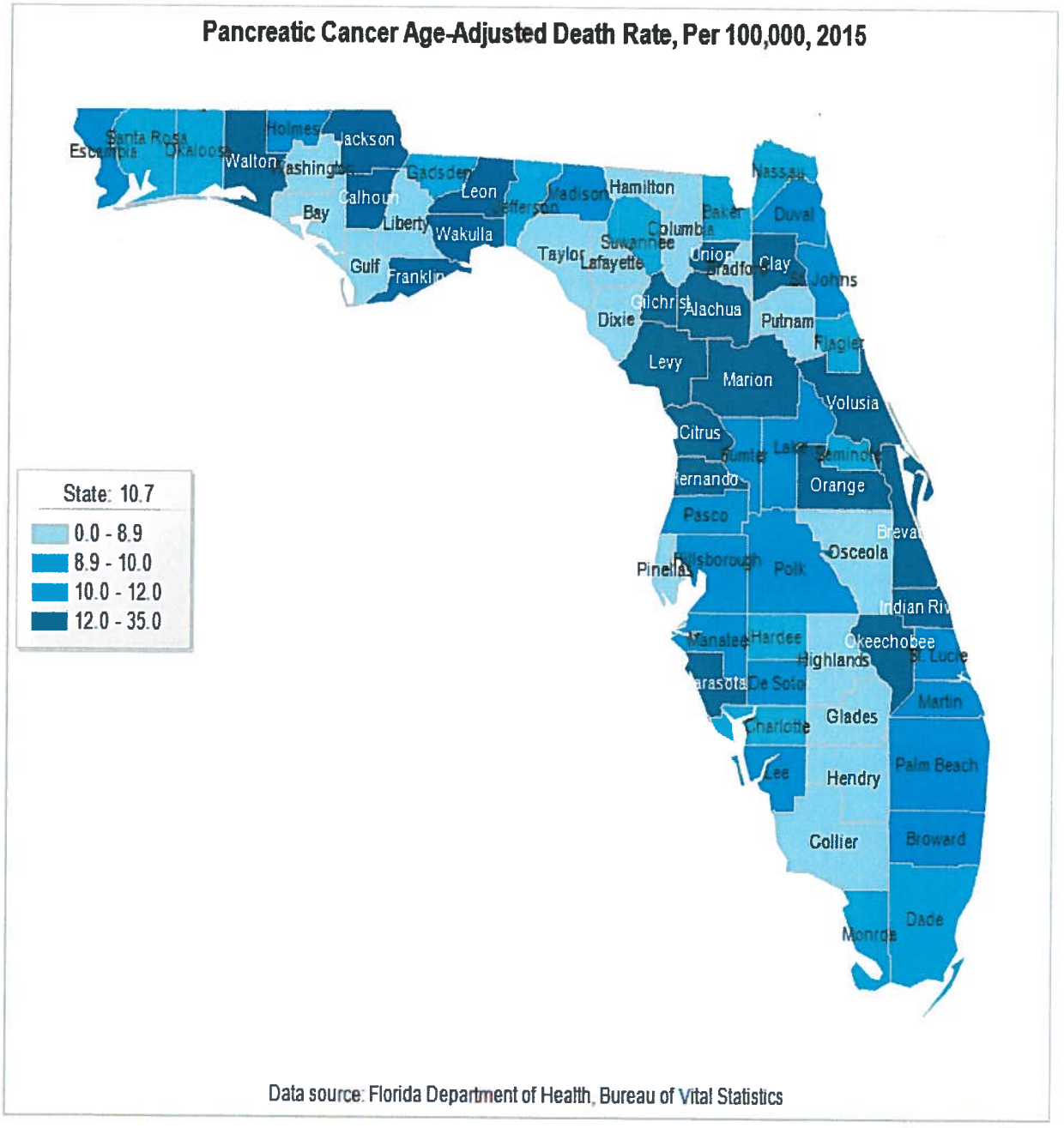
Pancreatic cancer is a disease in which malignant (cancerous) cells form in the tissues of the pancreas. The pancreas is a gland located behind the stomach and in front of the spine. The pancreas produces digestive juices and hormones that regulate blood sugar. Cells called exocrine pancreas cells produce the digestive juices, while cells called endocrine pancreas cells produce the hormone. Most pancreatic cancers start in the exocrine glands.

| Pancreatic Cancer Age-Adjusted Death Rate. Single Year Rates per 100,000, 2010-2015 | |
|---|---|
| Years | Rate |
| 2015 | 10.7 |
| 2014 | 10.5 |
| 2013 | 10.2 |
| 2012 | 10.6 |
| 2011 | 10.3 |
| 2010 | 10.3 |

| Pancreatic Cancer Age-Adjusted Death Rate, Single Year Rates per 100,000, 2010-2015 | | | | |
|---|---|---|---|---|
| Years | (0-19 Years of Age) | (20-39 Years of Age) | (40-64 Years of Age) | (65+ Years of Age) |
| 2015 | 0 | 0.2 | 11 | 62.8 |
| 2014 | 0 | 0.1 | 10.3 | 62.1 |
| 2013 | 0 | 0.2 | 9.8 | 60.4 |
| 2012 | 0 | 0.2 | 11.1 | 61 |
| 2011 | 0 | 0.3 | 10.1 | 59.9 |
| 2010 | 0 | 0.2 | 10.4 | 59.4 |



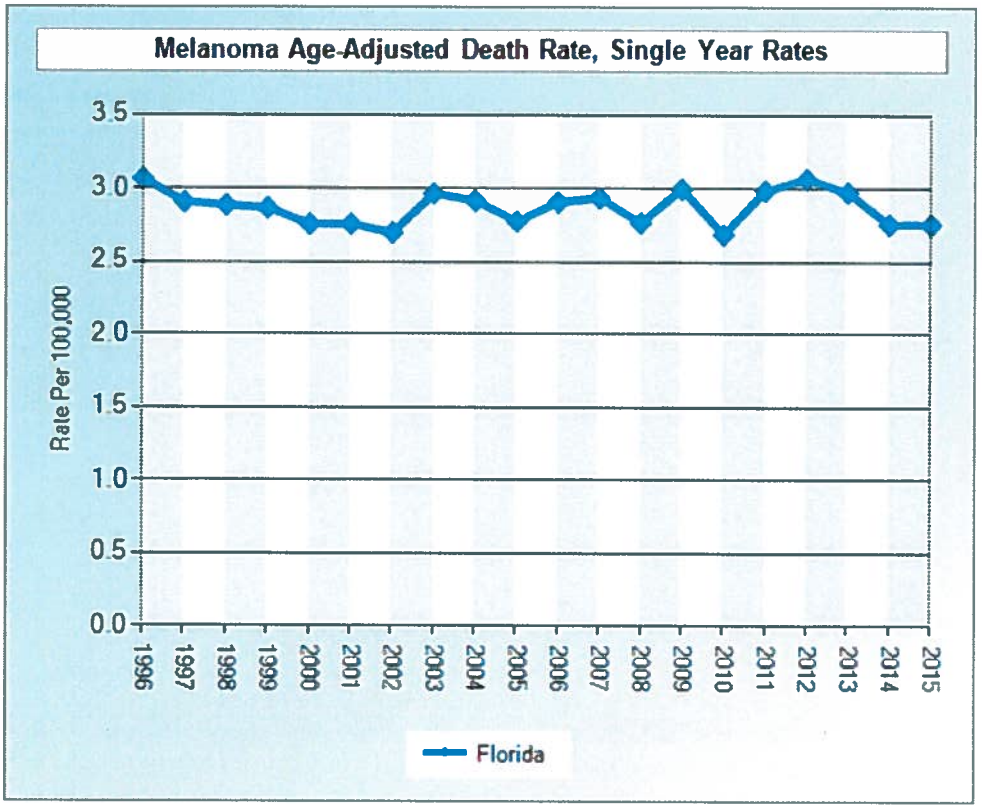
High death rates due to pancreatic cancer are widespread in Florida. There is no specific region of concentration. There is an increased death rate in some rural counties.



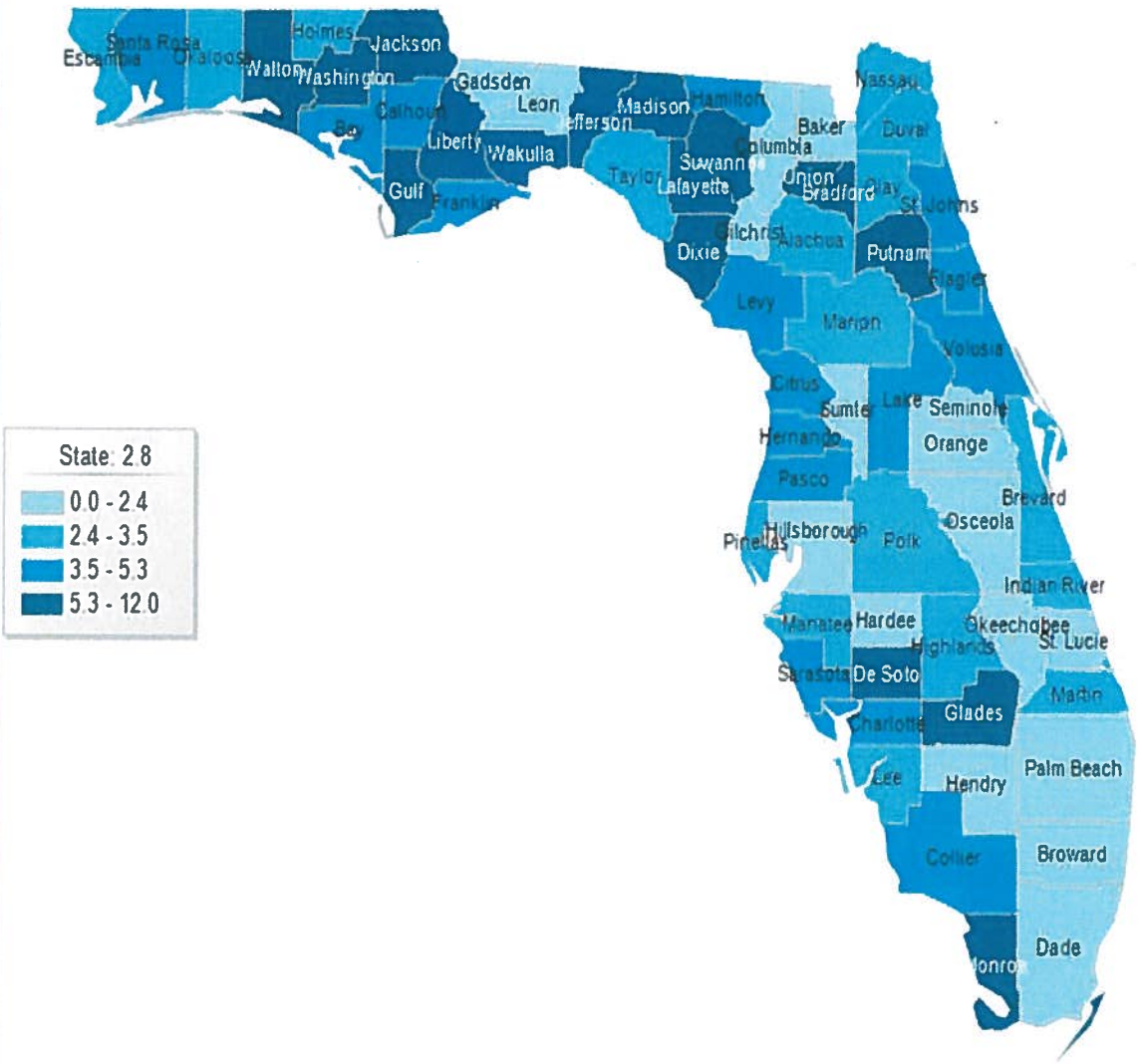
Melanoma is a malignant tumor of melanocytes. Such cells are found predominantly in skin, but are also found in the bowel and the eye (see uveal melanoma). Melanoma is one of the less common types of skin cancer, but causes the majority (75%) of skin cancer related deaths. Melanocytes are normally present in skin, being responsible for the production of the dark pigment melanin. The age-adjusted death rate has stayed relatively constant since 2010 with a slight increase in 2011 through 2013 but taking a decline in 2014 that is consistent with 2010. The death rate for children and adolescents (0-19 years), is the highest in comparison with the other six cancers presented in this report.

| Melanoma, Age-Adjusted Death Rate, Single Year Rates per 100,000, 2010-2015 | |
|---|---|
| Years | Rate |
| 2015 | 2.8 |
| 2014 | 2.8 |
| 2013 | 3 |
| 2012 | 3.1 |
| 2011 | 3 |
| 2010 | 2.7 |

| Melanoma, Age-Adjusted Death Rate, Single Year Rates per 100,000, 2010-2015 | | | | |
|---|---|---|---|---|
| Years | (0-19 Years of Age) | (20-39 Years of Age) | (40-64 Years of Age) | (65+ Years of Age) |
| 2015 | 2.8 | 0.3 | 3.3 | 13.8 |
| 2014 | 2.8 | .03 | 3 | 14.6 |
| 2013 | 3 | 0.5 | 3.4 | 15.3 |
| 2012 | 3.1 | 0.6 | 3.5 | 15.3 |
| 2011 | 3 | 0.5 | 3.4 | 15 |
| 2010 | 2.7 | 0.3 | 3.6 | 12.5 |



## Melanoma Age-Adjusted Death Rate, Per 100,000, 2015

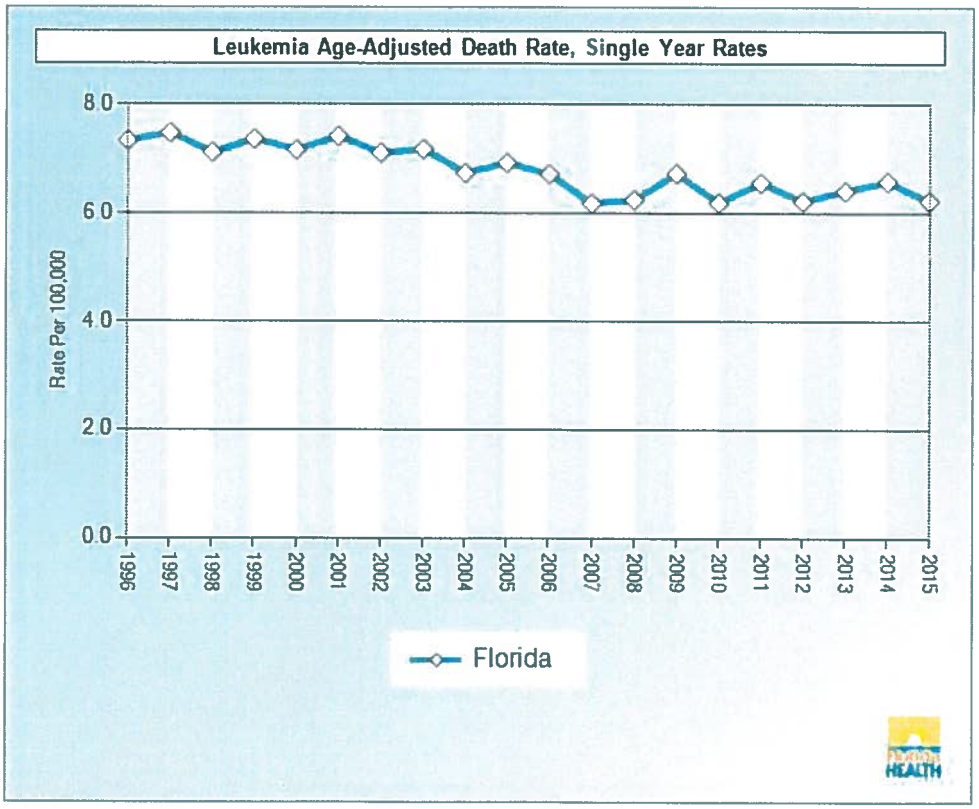



Data source: Florida Department of Health, Bureau of Vital Statistics

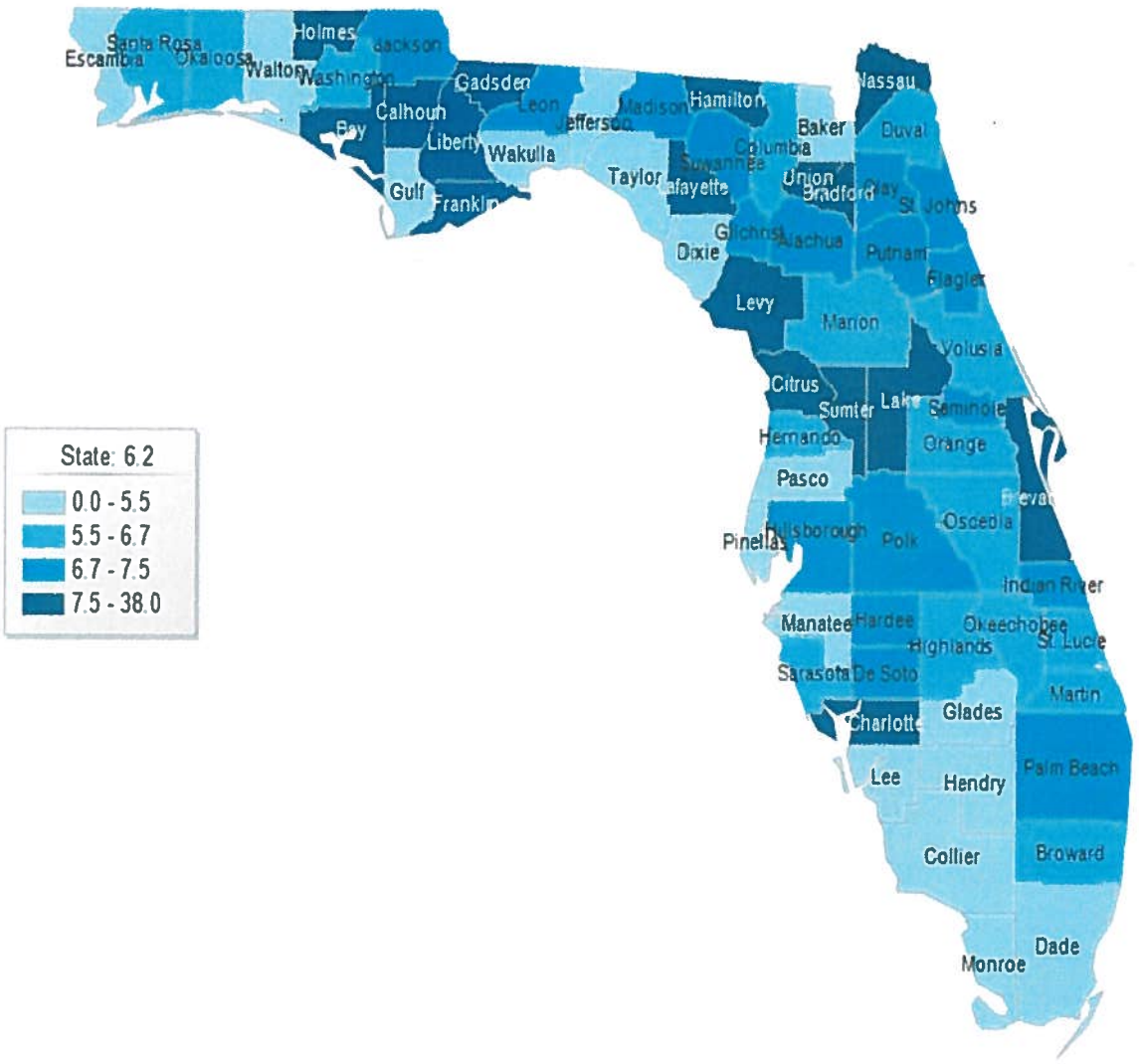
Leukemia is a cancer of the blood or bone marrow characterized by an abnormal increase of blood cells, usually leukocytes (white blood cells). Leukemia is a broad term covering a spectrum of diseases. It is part of the broad group of diseases called hematological neoplasms. The age-adjusted death rate has reduced slightly over the past 20 years and rates increase with age. Leukemia impacts the 0-19 age group slightly more than some of the cancers described in this report.

| Leukemia Cancer, Age-Adjusted Death Rate, Single Year Rates per 100,000, 2010-2015 | |
|---|---|
| Years | Rate |
| 2015 | 6.2 |
| 2014 | 6.6 |
| 2013 | 6.4 |
| 2012 | 6.2 |
| 2011 | 6.6 |
| 2010 | 6.2 |

| Leukemia Cancer, Age-Adjusted Death Rate, Single Year Rates by Age Group per 100,000, 2010-2015 | | | | |
|---|---|---|---|---|
| Years | (0-19 Years of Age) | (20-39 Years of Age) | (40-64 Years of Age) | (65+ Years of Age) |
| 2015 | 0.7 | 1.2 | 4.6 | 35.7 |
| 2014 | 0.6 | 1.2 | 5.2 | 37 |
| 2013 | 0.6 | 0.9 | 4.7 | 37.4 |
| 2012 | 0.5 | 1 | 4.4 | 36.5 |
| 2011 | 0.5 | 1.2 | 4.6 | 38.7 |
| 2010 | 0.6 | 1.2 | 4.7 | 35.2 |



## Leukemia Age-Adjusted Death Rate, Per 100,000, 2015

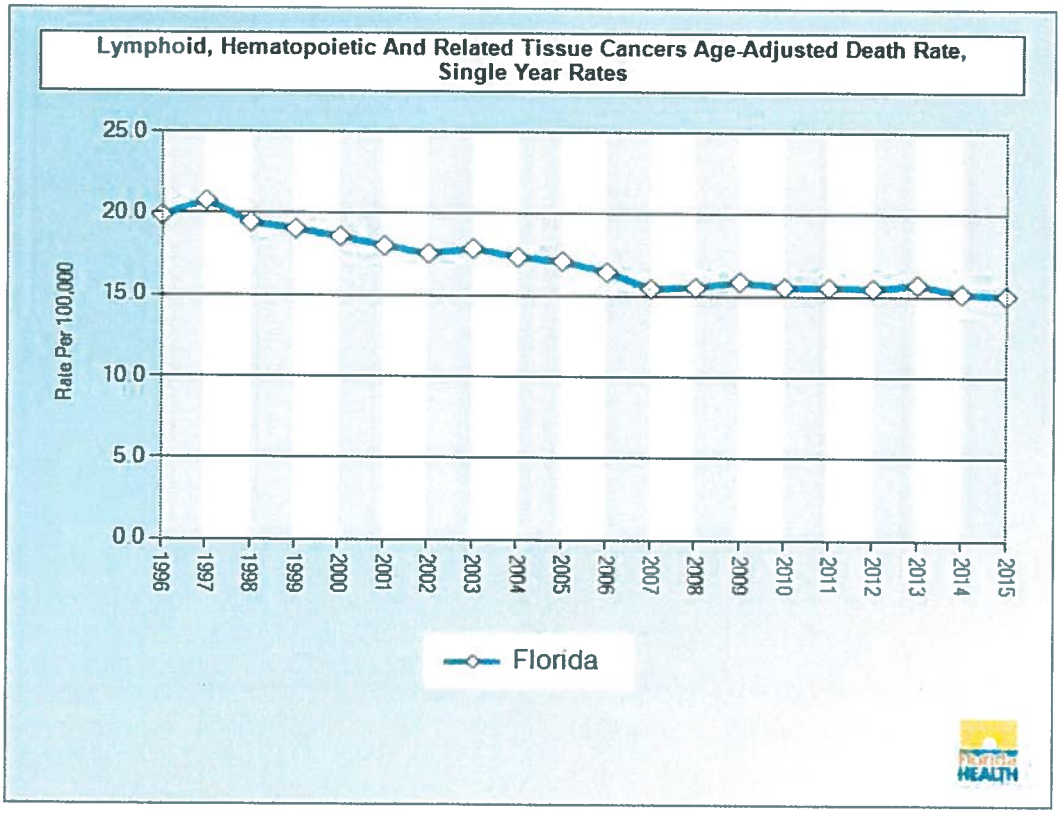



Data source: Florida Department of Health, Bureau of Vital Statistics

Sarcoma (Lymphoid, Hematopoietic and Related Tissue Cancers), are cancers stated or presumed to be primary, of lymphoid, hematopoietic and related tissue. Specific sarcoma cancer data in Florida is not available. Soft tissue sarcoma begins in various soft tissues including muscle, fat, blood vessels, nerves, tendons, and linings of joints. Soft tissue sarcoma can occur anywhere but is most common in the abdomen, arms and legs. Some risk factors found to be associated with soft tissue sarcoma are radiation, damaged lymph system and exposure to certain chemicals. Lifestyle factors are not linked to increased risk of soft tissue sarcoma.

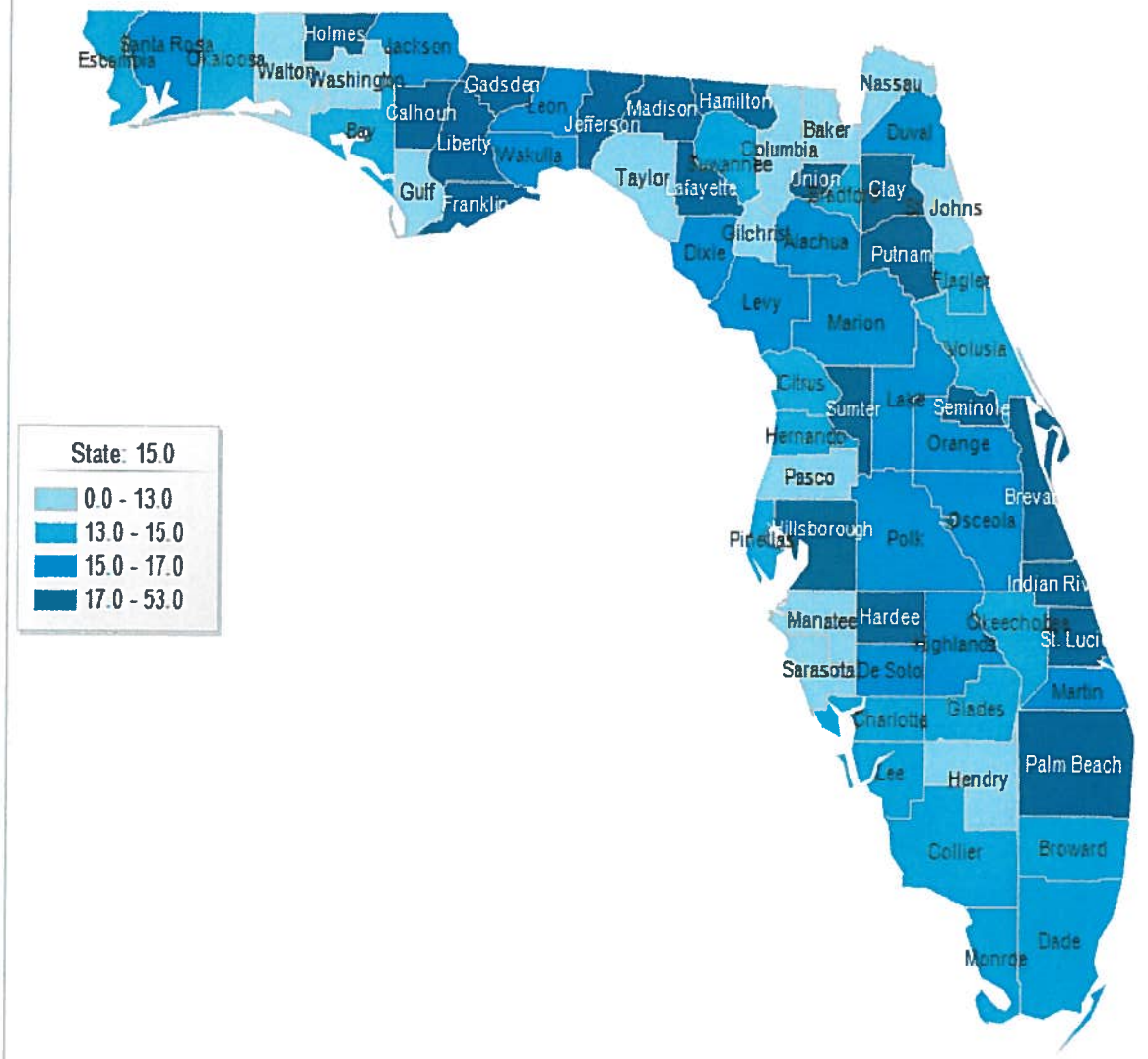
| Lymphoid, Hematopoietic and Related Tissue Cancers, Age-Adjusted Death Rate, Single Year Rates per 100,000, 2010-2015 | |
|---|---|
| Years | Rate |
| 2015 | 15 |
| 2014 | 15.2 |
| 2013 | 15.7 |
| 2012 | 15.5 |
| 2011 | 15.5 |
| 2010 | 15.6 |

| Lymphoid, Hematopoietic and Related Tissue Cancers, Age-Adjusted Death Rate, Single Year Rates by Age Group per 100,000, 2010-2015 | | | | |
|---|---|---|---|---|
| Years | (0-19 Years of Age) | (20-39 Years of Age) | (40-64 Years of Age) | (65+ Years of Age) |
| 2015 | 0.9 | 1.8 | 12.4 | 87.9 |
| 2014 | 0.7 | 2 | 12.3 | 88.1 |
| 2013 | 0.7 | 2 | 12.5 | 92.1 |
| 2012 | 0.5 | 1.9 | 11.9 | 91.9 |
| 2011 | 0.6 | 2 | 12 | 92 |
| 2010 | 0.7 | 2.1 | 12.8 | 90.3 |



Lymphoid, hematopoietic and related tissue cancer death rates have steadily declined in the past 20 years in Florida. Death rates for these cancers increase with age, as with most other cancers. Some rural counties have a significantly higher death rate which could be attributed to decreased access to diagnostic care and treatment.

**Lymphoid, Hematopoietic And Related Tissue Cancers Age-Adjusted Death Rate, Per 100,000, 2015**

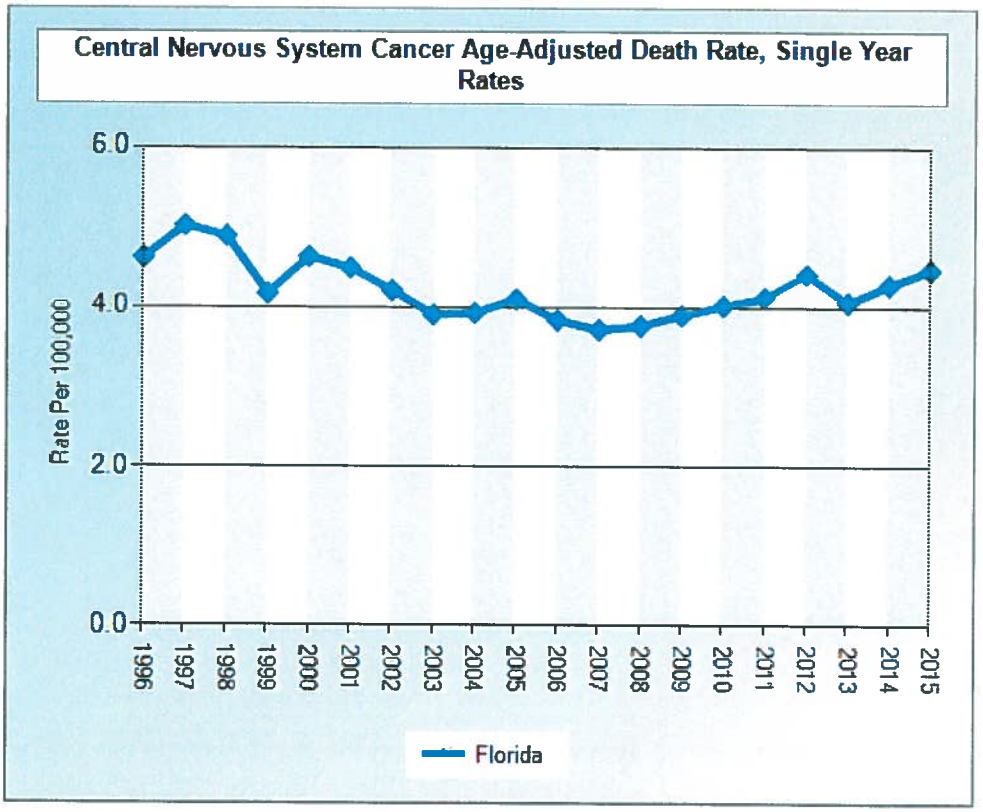



Data source: Florida Department of Health, Bureau of Vital Statistics

Brain/Central Nervous System Cancer is the growth of abnormal cells in the tissues of the brain and central nervous system. Cancerous brain and spinal cord tumors are the second most common cancers in children. Little is known about the causes of childhood and adult cancers of the brain and central nervous system. Several studies of environmental risk factors have presented inconsistent results. About 5% of brain tumors are due to hereditary factors. Risk factors are different for children than for adults. Established risk factors include exposure to therapeutic doses of ionizing radiation, rare hereditary syndromes and family history.

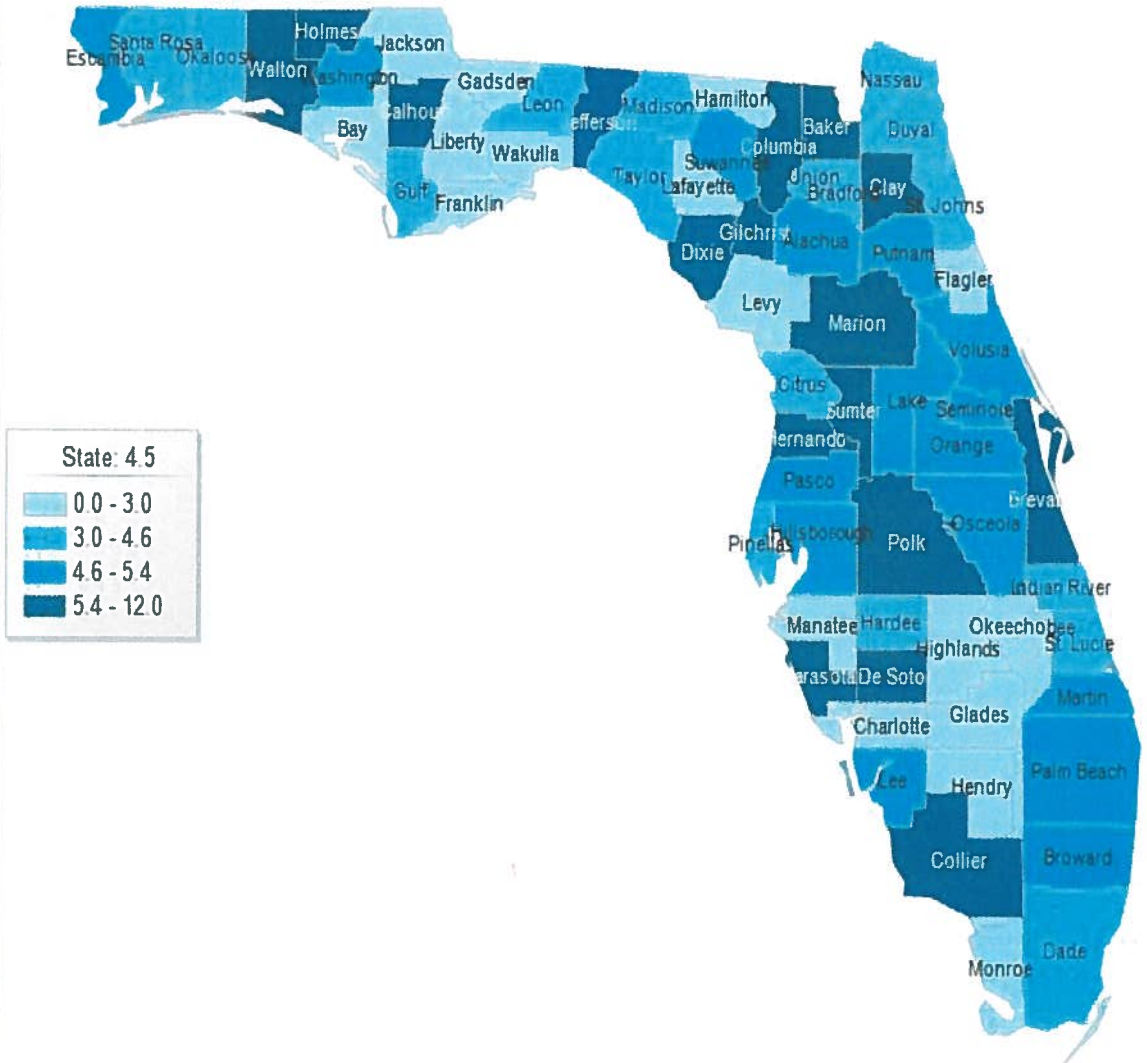
| Central Nervous System Cancer, Age-Adjusted Death Rate, Single Year Rates per 100,000, 2010-2015 | |
|---|---|
| Years | Rate |
| 2015 | 4.5 |
| 2014 | 4.3 |
| 2013 | 4.1 |
| 2012 | 4.4 |
| 2011 | 4.1 |
| 2010 | 4 |

| Central Nervous System Cancer, Age-Adjusted Death Rate, Single Year Rates by Age Group per 100,000, 2010-2015 | | | | |
|---|---|---|---|---|
| Years | (0-19 Years of Age) | (20-39 Years of Age) | (40-64 Years of Age) | (65+ Years of Age) |
| 2015 | 0.7 | 0.9 | 6.1 | 18.6 |
| 2014 | 0.7 | 1 | 5.9 | 17.1 |
| 2013 | 0.6 | 1 | 5.3 | 17 |
| 2012 | 0.6 | 1.1 | 6 | 17.8 |
| 2011 | 0.7 | 0.9 | 6 | 16.1 |
| 2010 | 0.6 | 0.9 | 5.3 | 16.5 |



Cancers of the brain occur in people of all ages but more frequently in two age groups; children under the age of 15 and adults over the age of 65. Central nervous system cancers death rates have not significantly changed in the last 20 years in Florida. There is no clear geographic pattern related to central nervous system cancer death rates.

**Central Nervous System Cancer Age-Adjusted Death Rate, Per 100,000, 2015**




Data source: Florida Department of Health, Bureau of Vital Statistics

Federal Funding Awarded to Florida Institutions for Cancer-related Research

It is evident cancer research efforts in Florida are improved through state and federal grant award funding. The Department's William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program (Bankhead-Coley) and the James and Esther King Biomedical Research Program (King) seek to provide research grant funding to proposals that demonstrate the greatest opportunity to attract federal research grants and private financial support. Annually, the Bankhead-Coley and King Funding Opportunity Announcements include Bridge grants as a mechanism of support to provide interim funding for promising investigator-initiated research projects that have been highly rated by national panels of peer reviewers in recent federal competitions but were not funded due to budgetary constraints. To be eligible for a Bridge grant, applicants must have submitted a multi-year, investigator-initiated research application to a federal agency and the applicant must have received a peer review summary statement indicating high scientific merit.

Florida cancer researchers have been successful in receiving federal research grants and are continually achieving more federal funding each year. In 2013, Florida ranked 16th in the nation in NIH funding. The state rose to 13th in the nation in 2014, and 12th in the nation in 2015.

The following charts indicate the cancer research federal funding awarded to Florida researchers, by funding institution, for 2015-2013.

## Federal Research Funding 2015

| State | NIH Funding | Rank | Total[1] (NIH, CDC, NSF, AHRQ) | Rank |
|---|---|---|---|---|
| California | $3,581,764,094 | 1 | $3,891,905,345 | 1 |
| Massachusetts | $2,519,342,334 | 2 | $2,579,487,932 | 3 |
| New York | $2,149,771,633 | 3 | $2,734,502,129 | 2 |
| Pennsylvania | $1,538,118,189 | 4 | $1,633,737,641 | 4 |
| North Carolina | $1,067,284,633 | 5 | $1,176,758,751 | 7 |
| Texas | $1,040,799,728 | 6 | $1,197,032,537 | 6 |
| Maryland | $984,919,207 | 7 | $1,548,145,413 | 5 |
| Washington | $862,176,970 | 8 | $1,010,349,539 | 8 |
| Illinois | $794,979,202 | 9 | $906,014,462 | 9 |
| Ohio | $694,751,046 | 10 | $774,600,329 | 10 |
| Michigan | $654,349,171 | 11 | $739,694,569 | 11 |
| **Florida** | **$527,733,701** | **12** | **$685,727,275** | **13** |

[1] www.report.nih.gov, https://taggs.hhs.gov/2015AnnualReport/Portfolios, http://dellweb.bfa.nsf.gov/AwdLst2/default.asp, www.researchamerica.org

| | | | | |
|---|---|---|---|---|
| Minnesota | $513,335,268 | 13 | $577,721,320 | 14 |
| Connecticut | $506,188,803 | 14 | $516,097,284 | 17 |
| Georgia | $497,568,909 | 15 | $695,114,170 | 12 |
| Tennessee | $483,022,887 | 16 | $528,240,269 | 16 |
| Missouri | $482,818,909 | 17 | $529,841,700 | 15 |
| Wisconsin | $415,365,292 | 18 | $467,334,387 | 18 |
| Colorado | $343,161,117 | 19 | $409,329,864 | 21 |
| Virginia | $296,219,739 | 20 | $416,191,484 | 20 |

## Federal Research Funding 2014

| State | NIH Funding | Rank | Total (NIH, CDC, NSF, AHRQ) | Rank |
|---|---|---|---|---|
| California | 3,410,496,236 | 1 | 3,785,519,397 | 1 |
| Massachusetts | 2,364,750,629 | 2 | 2,519,340,720 | 3 |
| New York | 2,069,300,604 | 3 | 2,667,579,462 | 2 |
| Pennsylvania | 1,496,869,899 | 4 | 1,621,491,499 | 4 |
| Maryland | 1,010,931,562 | 5 | 1,219,997,494 | 5 |
| North Carolina | 991,876,570 | 6 | 1,115,762,540 | 7 |
| Texas | 972,156,544 | 7 | 1,149,072,673 | 6 |
| Washington | 876,933,041 | 8 | 995,839,449 | 8 |
| Illinois | 710,197,186 | 9 | 860,727,544 | 9 |
| Ohio | 633,220,134 | 10 | 722,795,387 | 10 |
| Michigan | 570,661,279 | 11 | 684,649,598 | 11 |
| Minnesota | 496.534,123 | 12 | 572,226,044 | 14 |
| **Florida** | **472,980,811** | **13** | **629,812,193** | **12** |
| Missouri | 467,769,290 | 14 | 520,579,742 | 15 |
| Georgia | 466,527,650 | 15 | 625,030,177 | 13 |
| Connecticut | 464,422,776 | 16 | 512,141,722 | 17 |
| Tennessee | 444,845,210 | 17 | 513,935,064 | 16 |

| | | | | |
|---|---|---|---|---|
| Wisconsin | 383,027,428 | 18 | 445,295,108 | 18 |
| Colorado | 310,947,915 | 19 | 374,975,967 | 19 |
| Oregon | 301,075,374 | 20 | 355,554,759 | 20 |

## Federal Research Funding 2013

| State | NIH Funding | Rank | Total (NIH, CDC, NSF, AHRQ) | Rank |
|---|---|---|---|---|
| California | 3,334,417,000 | 1 | 4,985,551,000 | 1 |
| Massachusetts | 2,384,194,000 | 2 | 2,991,956,000 | 2 |
| New York | 1,946,868,000 | 3 | 2,839,882,000 | 3 |
| Maryland | 1,590,089,000 | 4 | 2,050,901,000 | 4 |
| Pennsylvania | 1,387,998,000 | 5 | 1,863,196,000 | 5 |
| North Carolina | 1,037,787,000 | 6 | 1,386,026,000 | 7 |
| Texas | 956,595,000 | 7 | 1,690,571,000 | 6 |
| Washington | 835,212,000 | 8 | 1,126,004,000 | 9 |
| Illinois | 760,095,000 | 9 | 1,322,208,000 | 8 |
| Ohio | 685,297,000 | 10 | 971,411,000 | 10 |
| Michigan | 575,889,000 | 11 | 954,657,000 | 11 |
| Minnesota | 493,986,000 | 12 | 689,927,000 | 15 |
| Tennessee | 456,096,000 | 13 | 632,924,000 | 17 |
| Georgia | 450,949,000 | 14 | 798,615,000 | 13 |
| Connecticut | 444,605,000 | 15 | 578,344,000 | 19 |
| **Florida** | **435,070,000** | **16** | **904,179,000** | **12** |
| Missouri | 409,220,000 | 17 | 561,028,000 | 20 |
| Wisconsin | 371,985,000 | 18 | 590,213,000 | 18 |
| Virginia | 319,864,000 | 19 | 651,724,000 | 16 |
| Colorado | 316,251,000 | 20 | 776,950,000 | 14 |

Description of Collaborative Grants and Interinstitutional Collaboration among Participating Cancer Centers

The description of the collaborative grants and interinstitutional collaboration among participating cancer centers was submitted to the Department by the Florida Academic Cancer Center Alliance. Attachment A includes the following information as outlined in statute:

- collaborative efforts focusing on grants and interinstitutional agreements among participating cancer centers
- a comparison of collaborative grants in proportion to the grant totals for each cancer center
- a catalogue of retreats and progress seed grants using state funds
- targets for collaboration in the future and reports on progress regarding such targets where appropriate


# Attachment A

## Florida Consortium of National Cancer Institute Centers Program

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**July 1, 2017**

## Collaborations among the Florida-based NCIs

The Florida Academic Cancer Center Alliance, consisting of the Moffitt Cancer Center (Moffitt), the UF Health Cancer Center (UF Health), and the Sylvester Comprehensive Cancer Center (Sylvester), was formed to obtain NCI designation for UF Health and Sylvester, sustain Comprehensive status for Moffitt, and to build collaborations between the centers. The three centers meet regularly at multiple leadership levels. The Center Directors meet four times a year (two in person) and the administrative leadership meets monthly by phone. At these meetings, the leaders discuss the scientific progress of each center, review pilot project proposals (described below), present ways to enhance collaboration, consider ideas for expanding the education and training of Florida's cancer research workforce, and discuss how the centers together can improve overall cancer care in the state.

Since 2016, the Centers, on a rotating basis, have hosted annual scientific retreats to nurture scientific collaborations and include presentations by pilot awardees as well as other areas of potential collaboration. The agenda for the 2016 and the 2017 meetings are provided (Attachment A) and described in more detail below.

Since 2015, Moffitt has collaborated with the other FACCA members on 49 unique publications (Attachment B). The UF Health Cancer Center and the Sylvester Comprehensive Cancer Center have collaborated on an additional 8 publications together (Attachment B).

Moffitt continues to be the state leader in obtaining NCI grant funding with $24.7 million (M) in 2016, making it among the top 30 in institutions funded by the NCI. Overall research funding from over 350 grants, contracts and clinical trials is over $80 million a year. NCI funding at the UF Health Cancer Center has consistently exceeded over $10 million annually. NCI funding continues to be on a positive trajectory, with the current NCI funding exceeding $11 million. Total direct peer-reviewed research funding is currently over $23 million. The overall cancer center research portfolio consists of 197 grants, contracts and clinical trials, with a current direct cost annual funding exceeding $26 million. NCI funding at Sylvester exceeds $7 million annually. Overall research funding from over 270 grants, contracts and clinical trials is over $27 million in annual direct costs.

While the alliance is still in its early stages, Moffitt has collaborated with Sylvester or UF Health on 10 externally funded awards including funding from the NCI and Florida Biomedical Research Program since 2015. In addition, Sylvester and UF Health have 1 collaborative grant through the Florida Department of Health.

To further enhance collaboration between the centers, a pilot program was developed. Since the fall of 2015, Moffitt has funded seven collaborative projects totaling $350,000 that match scientific strengths at Moffitt with strengths at the other two centers to foster team science. Sylvester has funded eight collaborative projects totaling $400,000 and UF Health has funded 9 projects totaling $450,000. The following table summarizes the collaborations between the three institutions by award year.

| PI (Institution) | Project title | Year |
|---|---|---|
| Egan, Kathleen, ScD (Moffitt);<br>Yaghjyan, Lusine, PhD (UF Health) | Gut microflora and estrogens: a new paradigm for breast cancer risk reduction | 2015 |
| Lynch, Conor, PhD (Moffitt);<br>Daaka, Yehia, PhD (UF Health);<br>Burnstein, Kerry, PhD (Sylvester) | Role of AVPR1 in metastatic castration resistant prostate cancer | 2015 |
| Permuth, Jenny, PhD & Malafa, Mokenge, MD (Moffitt);<br>Trevino, Jose, MD (UF Health);<br>Merchant, Nipun, MD (Sylvester) | The Florida pancreas cancer collaborative: a partnership dedicated to the prevention and early detection of pancreatic cancer | 2015 |
| O'Dell, Walter, PhD (UF Health);<br>Takita, Christine, MD (Sylvester) | Modeling the patterns of breast cancer early metastases | 2015 |

| | | |
|---|---|---|
| Chellappan, Srikumar, PhD (Moffitt);<br>Law, Brian, PhD (UF Health) | Targeting mitotic functions of TBK1 and Cdk2 to combat cancer | 2016 |
| List, Alan, MD & Wei, Sheng, PhD (Moffitt);<br>Hudson, Barry & Lippman, Marc (Sylvester) | RAGE signaling through the inflammasome: novel combined inflammatory therapeutic targets in cancer | 2016 |
| Smalley, Keiran, PhD (Moffitt);<br>Licht, Jonathon, MD (UF Health);<br>Harbour, William, MD (Sylvester) | Defining and targeting the epigenetic landscape of uveal melanoma | 2016 |
| Pal, Tuya, MD (Moffitt);<br>DeGennaro, Vincent, MD (UF Health);<br>Hurley, Judith, MD & George Sophia, PhD (Sylvester) | The effect of Immigration on the development of breast cancer in women of African descent | 2016 |
| Huang, Suming, PhD (UF Health);<br>Xu, Mingjiang, MD, PhD (Sylvester) | The role of HoxBlink INCRA in NPM1 mutation-mediated pathogens of myeloid malignancies | 2016 |
| Renne, Rolf, PhD (UF Health);<br>Mesri, Enrique, PhD (Sylvester) | Oncogenic role of KSHV micro RNAs in cell and animal models of Kaposi's sarcoma | 2016 |

A third funding cycle for collaborative projects recently closed on April 7, 2017. Twelve proposals were received involving collaborations among the three institutions. These proposals are currently under review with a funding decision expected by the end of June.

The 2015 projects will be concluding in July 2017 and the teams have submitted extramural grants and peer-reviewed publications or have them in preparation. The following is a summary of progress by the 2015 funded projects:

**A. Dr. Permuth (Moffitt), Dr. Merchant (Sylvester), & Dr. Trevino (UF Health)**

*Publications (FACCA PIs in Bold)*

1. **Permuth JB, Trevino J, Merchant N** and **Malafa M**. Partnering to advance early detection and prevention efforts for pancreatic cancer: the Florida Pancreas Collaborative. Future Oncol. 2016; 12(8):997-1000, PMID: 26863203.
2. **Permuth JB**, Choi J, Balarunathan Y, Kim J, Chen DT, Chen L, Orcutt S, Doepker MP, Gage K, Zhang G, Latifi K, Hoffe S, Jiang K, Coppola D, Centeno BA, Magliocco A, Li Q, **Trevino J, Merchant N**, Gillies R, **Malafa M**, On Behalf Of The Florida Pancreas Collaborative. Combining radiomic features with a miRNA classifier may improve prediction of malignant pathology for pancreatic intraductal papillary mucinous neoplasms. *Oncotarget.* 2016 Dec 27;7(52):85785-85797 doi: 10.18632/oncotarget.11768. PMID: 27589689
3. **Permuth JB**, Choi JW, Chen D, Jiang K, DeNicola G, Li J, Coppola D, Centeno BA, Magliocco A, Balagurunathan Y, **Merchant N, Trevino JG**, Jeong D. A pilot study of radiologic measures of abdominal adiposity: weighty contributors to early pancreatic carcinogenesis worth evaluating? *Can Bio & Med.* 2017 Feb 15;14(1):66-73*)*
4. **Permuth JB,** Chen D, Yoder SJ, Li J, Smith AT, Choi JW, Kim J, Balagurunathan Y, Jiang K, Coppola D, Centeno BA, Klapman J, Hodul P, Karreth F, **Trevino JG, Merchant N**, Magliocco, **Malafa MP**, Gillies R. Linc-ing Circulating Long Non-coding RNAs to the Diagnosis and Malignant Prediction of Intraductal Papillary Mucinous Neoplasms of the Pancreas. (in press, *Scientific Reports*)

*Grants* – The team has submitted four large-scale highly-ranked collaborative extramural grant submissions through three different sponsors:

1. A proposal to the American Cancer Society Research Scholar Mechanism, which was scored 'very good' but not funded;
2. Two R21 proposals to the National Cancer Institute (NCI). The initial submission scored in the 8th percentile with an impact score 23 and a re-submission was assigned to different reviewers and was scored in the 12th percentile with an impact score 27. It is currently being considered as an 'exception' by council because it aligns well with NCI's portfolio to fund research on recalcitrant cancers;
3. An infrastructure application to the 2017 Florida Biomedical Research/James and Esther King Research Program (92nd percentile which is equivalent to NCI's 8th percentile) but the proposal was not funded. The team plans to repurpose the proposal for anR01 mechanism for submission this summer.

**B. Dr. Lynch (Moffitt), Dr. Daaka (UF Health), & Dr. Burnstein (Sylvester)**

*Publications (FACCA PIs in Bold)*

1. Abstract: Arginine Vasopressin Receptor 1A as a Novel Therapeutic Target for Castration-Resistant Prostate Cancer. Ning Zhao, PhD, Stephanie Peacock, MD,PhD, Chen Hao Lo, MS, Meghan Rice, PhD, Laine Heidman, BS, Ann Greene, BS, Yushan Zhang, PhD, **Yehia Daaka, PhD, Conor Lynch, PhD, Kerry Burnstein, PhD**; 2017 Annual Meeting of the Endocrine Society

*Grants* – The team has submitted four proposals to four different sponsors:

1. Bankhead Coley – score 94.6%, *not funded*
2. DOD – score 1.4 (outstanding), *not funded*
3. NCI R01, *pending*
4. Prostate Cancer Foundation, *pending*

**C. Dr. Egan (Moffitt) & Dr. Yaghjyan (UF Health)**

*Publications* – A manuscript is currently in preparation.

*Grants* – The team has submitted one proposal and a second one is in preparation:

1. The team submitted an R21 application which received a 10$^{th}$ percentile ranking, though it was not selected for funding. Unfortunately, the revised application, reviewed by a different Study Section, received a lower priority score.
2. Planning is underway for an R01 application which will be a collaborative effort between investigators at Moffitt Cancer Center, UF Health, and Harvard Medical School (involving the Nurse' Health Study). The proposed application will examine: 1) the association of the gut microbiome with mammographic breast density; 2) associations of the gut microbiome with urinary estrogen metabolites; and 3) associations of alcohol consumption and BMI with gut microbiome. This submission is planned for the October 5, 2017 deadline.

**D. Dr. O'Dell (UF Health) & Dr. Takita (Sylvester)**

*Publications (FACCA PIs in Bold)*

1. Manuscript submitted to the *Journal of Medical Imaging*, currently in revision.
2. Radiation risk versus projected clinical benefit of surveillance imaging for early detection and treatment of breast cancer metastases. **O'Dell W, Takita C**, Casey-Sawicki K, Daily K, Heldermon C, Okunieff O. Oral Presentation, 22$^{nd}$ Annual Multidisciplinary Symposium on Breast Disease, Amelia Island, FL, February 9-12, 2017, selected for *The Breast Journal* Award, given to the top 3 abstracts at the symposium.
3. Abstract also submitted for presentation at the 2017 Annual Meeting of the American Society for Radiation Oncology (ASTRO), pending acceptance decision.

*Grants* – An NIH R01 in preparation, based on this work.

These pilot projects have provided the foundation for the annual scientific retreats (Attachment A), which are designed to build upon existing collaborations, leverage the strengths of each center, and promote areas of common interest for future collaborations. Attended by faculty from all three centers, each retreat has presented four areas to target for collaboration. Each topic is introduced by a Center Director. Then, a faculty member from each center provides a brief summary of their research in the area and as a group, potential collaborations are discussed. The following areas were the focus of the 2016 and 2017 meetings:

2016

- Viruses, bacteria and the microbiome
- Personalized medicine (with focus on immunotherapy)
- Community participatory research
- Aging and inflammation

2017

- Epigenetics
- Viral oncology
- Health Outcomes
- Drug development

While collaborations are not limited to these areas, they represent areas where each Center has expertise and could likely contribute. The retreats, combined with a robust pilot project program, have already been successful in obtaining

external funding, publishing new discoveries, and establishing long-term collaborations. While only a few years old, a strong foundation of collaboration has been established that will lead to more collaborative grants and publications in the coming years. Also, the collaboration has provided critical support for UF Health and Sylvester to expand their cancer centers with the goal of obtaining NCI designation in the near future. The Collaboration assisted Moffitt in competitively renewing their NCI designation as a Comprehensive Cancer Center in 2016. As collaborations increase and mature, Moffitt expects the additional collaborations will lead to greater success and position Moffitt well for its next renewal in 2021.

Through state funding, UF Health and Sylvester have provided support for the development of the OneFlorida Cancer Control Alliance, a statewide network established through an award from the Florida Department of Health to create programs designed to translate research findings into practice and bring the benefits of lab research and other clinical settings to more than 9 million patients in all of Florida's 67 counties (Attachment C). This network, funded by the Department of Health's James & Esther King Biomedical Research Program, has created and implemented tobacco cessation programs in doctors' offices around the state in a coordinated effort to prevent cancers and other cardiovascular diseases related to tobacco use, just one example of the network's impact on improving the health of Floridians. The statewide network is also dedicated to helping researchers and patients from underserved and vulnerable populations become involved in community-based research. This effort ensures treatments and programs serve the entire population of the state and are tailored to individual community needs.

***FACCA Retreat***
***Newman Alumni Center – March 3-4, 2016***
***6200 San Amaro Drive, Coral Gables, FL 33146***

**THURSDAY, MARCH 3, 2016**

| | |
|---|---|
| **10:30 a.m. – 12:00 p.m.** | **Retreat Registration** |
| | **Poster set-up** |
| | **Refreshments** |
| **12:00 p.m. – 12:45 p.m.** | **Lunch** |
| **12:45 p.m. – 1:05 p.m.** | **Opening Remarks**<br>Stephen D. Nimer, M.D.<br>Professor of Medicine<br>Director, Sylvester Comprehensive Cancer Center |
| **1:05 p.m. – 1:15 p.m.** | **FACCA Pilot Project Process**<br>Brian C. Springer, MHA<br>Vice President, Research Administration<br>Associate Center Director, Administration<br>H. Lee Moffitt Cancer Center & Research Institute |
| **1:15 p.m. – 1:35 p.m.** | **FACCA Pilot Project Awardees**<br>*"Gut microflora and estrogens: a new paradigm for breast cancer risk reduction"*<br>Kathleen Egan, Sc.D. [Moffitt]<br>Lusine Yaghjyan, Ph.D. [UF] |
| **1:35 p.m. – 1:45 p.m.** | **Discussion** |
| **1:45 p.m. – 2:05 p.m.** | **FACCA Pilot Project Awardees**<br>*"Role of AVPR1a in metastatic castration resistant prostate cancer"*<br>Conor Lynch, Ph.D. [Moffitt]<br>Yehia Daaka, Ph.D. [UF]<br>Kerry Burnstein, Ph.D. [SCCC] |
| **2:05 p.m. – 2:15 p.m.** | **Discussion** |
| **2:15 p.m. – 2:30 p.m.** | **Break** |
| **2:30 p.m. – 2:50 p.m.** | **FACCA Pilot Project Awardees**<br>*"Modeling the patterns of breast cancer early metastases"*<br>Walter O'Dell, Ph.D. [UF]<br>Cristiane Takita, M.D. [SCCC] |

***FACCA Retreat***
***Newman Alumni Center – March 3-4, 2016***
***6200 San Amaro Drive, Coral Gables, FL 33146***

| | |
|---|---|
| **2:50 p.m. – 3:00 p.m.** | **Discussion** |
| **3:00 p.m. – 3:20 p.m.** | **FACCA Pilot Project Awardees**<br>*"The Florida pancreas cancer collaborative: a partnership dedicated to the prevention and early detection of pancreatic cancer"*<br>Jenny Permuth, Ph.D. [Moffitt] |
| **3:20 p.m. – 3:30 p.m.** | **Discussion** |
| **3:30 p.m. – 4:30 p.m.** | **Topic 1: Viruses, Bacteria, and the Microbiome**<br>*Introduction by Jonathan Licht, M.D.*<br>*Director, University of Florida Health Cancer Center*<br>Christian Jobin, Ph.D. [UF]<br>Anna Giuliano, Ph.D. [Moffitt]<br>Sylvia Daunert, Ph.D. [SCCC] |
| **4:30 p.m. – 4:45 p.m.** | **Discussion** |
| **4:45 p.m. – 7:00 p.m.** | **Poster Session / Cocktails** |
| **7:00 p.m. – 8:00 p.m.** | **Seated Dinner** |
| **9:00 p.m.** | **Retrieve Posters** |

**FRIDAY, MARCH 4, 2016**

| | |
|---|---|
| **7:30 a.m.** | **Breakfast** |
| **7:45 a.m. – 8:00 a.m.** | **Opening Remarks**<br>Thomas Sellers, Ph.D., MPH<br>Director, H. Lee Moffitt Cancer Center & Research Institute |
| **8:00 a.m. – 9:00 a.m.** | **Topic 2: Personalized Medicine (Focused on Immuno-Oncology)**<br>*Introduction by Stephen D. Nimer, M.D.*<br>*Director, Sylvester Comprehensive Cancer Center*<br>Elias Sayour, M.D., Ph.D. [UF]<br>Keiran Smalley, Ph.D. [Moffitt]<br>Jonathan Trent, M.D., Ph.D. [SCCC] |

***FACCA Retreat***
***Newman Alumni Center – March 3-4, 2016***
***6200 San Amaro Drive, Coral Gables, FL 33146***

| | |
|---|---|
| **9:00 a.m. – 9:15 a.m.** | **Discussion** |
| **9:15 a.m. – 10:15 a.m.** | **Topic 3: Community Participatory Research**<br>*Introduction by Thomas Sellers, Ph.D., MPH*<br>*Director, H. Lee Moffitt Cancer Center & Research Institute*<br>Betsy Shenkman, Ph.D. [UF]<br>Cathy Meade, Ph.D. [Moffitt]<br>Erin Kobetz, Ph.D. [SCCC] |
| **10:15 a.m. – 10:30 a.m.** | **Discussion** |
| **10:30 a.m. – 11:30 a.m.** | **Topic 4: Aging and Inflammation**<br>*Introduction by Jonathan Licht, M.D.*<br>*Director, University of Florida Health Cancer Center*<br>Frederic J. Kaye, M.D. [UF]<br>Martine Extermann, M.D. [Moffitt]<br>Barry Hudson, Ph.D. [SCCC] |
| **11:30 a.m. – 11:45 a.m.** | **Discussion** |
| **11:45 a.m. – 12:00 p.m.** | **Closing Remarks**<br>Stephen D. Nimer, M.D.<br>Director, Sylvester Comprehensive Cancer Center<br>Jonathan Licht, M.D.<br>Director, University of Florida Health Cancer Center<br>Thomas Sellers, Ph.D., MPH<br>Director, H. Lee Moffitt Cancer Center & Research Institute |
| **12:00 p.m.** | **Adjourn** |
| **12:00 p.m.** | **Lunch** |

***Florida Academic Cancer Center Alliance (FACCA) Research Retreat II***
***UF Research & Academic Center at Lake Nona – April 18-19, 2017***
***6550 Sanger Road, Orlando, FL 32827***

## TUESDAY, APRIL 18, 2017

| | |
|---|---|
| **10:30 am-12:00 pm** | **Retreat Registration** (*Atrium*) |
| | **Poster Set-up** |
| **12:00 pm-12:45 pm** | **Lunch** (*Rm 131/132*) |
| **12:45 pm-1:00 pm** | **Opening Remarks** (*Auditorium*)<br>Jonathan Licht, MD [UF]<br>Thomas Sellers, PhD, MPH [Moffitt]<br>Stephen Nimer, MD [SCCC] |
| **1:00 pm-2:00 pm** | **Topic 1: Epigenetics**<br>Discussion Session w/faculty from each center<br>Maria Figueroa, MD [SCCC]<br>Jonathan Licht, MD [UF]<br>Florian Karreth, PhD [Moffitt] |
| **2:00 pm-2:10 pm** | **Discussion** |
| **2:10 pm-2:30 pm** | FACCA Pilot Project<br>*The role of HoxBlinc INCRA in NPM1 mutation-mediated pathogens of myeloid malignancies*<br>Suming Huang, PhD [UF]<br>Mingjiang Xu, MD, PhD [SCCC] |
| **2:30 pm-2:50 pm** | FACCA Pilot Project<br>*Defining and targeting the epigenetic landscape of uveal melanoma*<br>Keiran Smalley, PhD [Moffitt]<br>Jonathan Licht, MD [UF]<br>William Harbour, MD [SCCC] |
| **2:50 pm-3:00 pm** | **Discussion** |
| **3:00 pm-3:10 pm** | **Break** |
| **3:10 pm-4:10 pm** | **Topic 2: Viral Oncology**<br>Discussion Session w/faculty from each center<br>Noriyuki Kasahara, MD, PhD [SCCC]<br>Scott Tibbetts, PhD [UF]<br>Peter Forsyth, FACP, MA [Moffitt] |

## TUESDAY, APRIL 18, 2017 *continued*

**4:10 pm-4:20 pm** **Discussion**

**4:20 pm-4:40 pm**

FACCA Pilot Project
*Oncogenic role of KSHV micro RNAs in cell and animal models of Kaposi's sarcoma*
Enrique Mesri, PhD [SCCC]
Rolf Renne, PhD [UF]

**4:40 pm-4:50 pm** **Discussion**

**4:50 pm-6:15 pm** **Poster Session/Cocktails** (*Atrium*)

**5:30 pm-6:15 pm** **Topic Tables**

Topic 1: High-performance Bioinformatics for Cancer Research
Alberto Riva, PhD [UF] & Steven Eschrich, PhD [Moffitt]

Topic 2: Application of NGS in Epigenetics and noncoding RNA Research
Rolf Renne, PhD [UF] & Michael Kladde, PhD [UF]

Topic 3: Gnotobiotic Technology to Study Microbiota Role in Preclinical Cancer Model
Christian Jobin, PhD [UF] & Conor Lynch, PhD [Moffitt]

**6:15 pm** **Retrieve Posters**

**6:30 pm** **Seated Dinner** (*Rm 131/132*)

FACCA Pilot Project
*Gut microflora and estrogens: a new paradigm for breast cancer risk reduction*
Kathleen Egan, ScD [Moffitt]
Lusine Yaghjyan, PhD [UF]

FACCA Pilot Project
*Role of AVPR1a in metastatic castration resistant prostate cancer*
Conor Lynch, PhD [Moffitt]
Yehia Daaka, PhD [UF]
Kerry Burnstein, PhD [SCCC]

FACCA Pilot Project
*Modeling the patterns of breast cancer early metastases*
Walter O'Dell, PhD [UF]
Christine Takita, MD [SCCC]

FACCA Pilot Project
*The Florida pancreas cancer collaboration: a partnership dedicated to the prevention and early detection of pancreatic cancer*
Jenny Permuth, PhD [Moffitt]
Mokenge Malafa, MD [Moffitt]
Jose Trevino, MD [UF]
Nipun Merchant, MD [SCCC]

## WEDNESDAY, APRIL 19, 2017

| | |
|---|---|
| **7:15 am** | **Breakfast** (*Rm 131/132*) |
| **7:45 am-8:00 am** | **Opening Remarks** (*Auditorium*)<br>Thomas Sellers, PhD, MPH [Moffitt]<br>Stephen Nimer, MD [SCCC]<br>Jonathan Licht, MD [UF] |
| **8:00 am-9:00 am** | **Topic 3: Health Outcomes**<br>Discussion Session w/faculty from each center<br>Julia Seay, PhD [SCCC]<br>Jong Park, PhD [Moffitt]<br>Yi Guo, PhD [UF] |
| **9:00 am-9:10 am** | **Discussion** |
| **9:10 am-9:30 am** | FACCA Pilot Project<br>*The effect of Immigration on the development of breast cancer in women of African descent*<br>Susan Vadaparampil, PhD, MPH [Moffitt]<br>Vincent DeGennaro, MD [UF]<br>Judith Hurley, MD [SCCC]<br>Sophia George, PhD [SCCC] |
| **9:30 am-9:40 am** | **Discussion** |
| **9:40 am-9:50 am** | **Break** |
| **9:50 am-10:50 am** | **Topic 4: Drug Development**<br>Discussion Session w/faculty from each center<br>Chengguo (Chris) Xing, PhD [UF]<br>Said Sebti, PhD [Moffitt]<br>Shaun Brothers, PhD [SCCC] |
| **10:50 am-11:00 am** | **Discussion** |
| **11:00 am-11:20 am** | FACCA Pilot Project<br>*RAGE signaling through the inflammasome: novel combined inflammatory therapeutic targets in cancer*<br>Alan List, MD [Moffitt]<br>Sheng Wei, MD [Moffitt]<br>Barry Hudson, MD [SCCC]<br>Marc Lippman, PhD [SCCC] |
| **11:20 am-11:40 am** | FACCA Pilot Project<br>*Targeting mitotic functions of TBK1 and Cdk2 to combat cancer*<br>Srikumar Chellappan, PhD [Moffitt]<br>Brian Law, PhD [UF] |
| **11:40 am-11:50 am** | **Discussion** |

## WEDNESDAY, APRIL 19, 2017 *continued*

| | |
|---|---|
| **11:50 am-12:00 pm** | **Closing Remarks**<br>Stephen Nimer, MD [SCCC]<br>Thomas Sellers, PhD, MPH [Moffitt]<br>Jonathan Licht, MD [UF] |
| **12:00 pm** | **Adjourn** |

## Collaborative Publications with Moffitt Cancer Center, the University of Miami and the University of Florida since 2015


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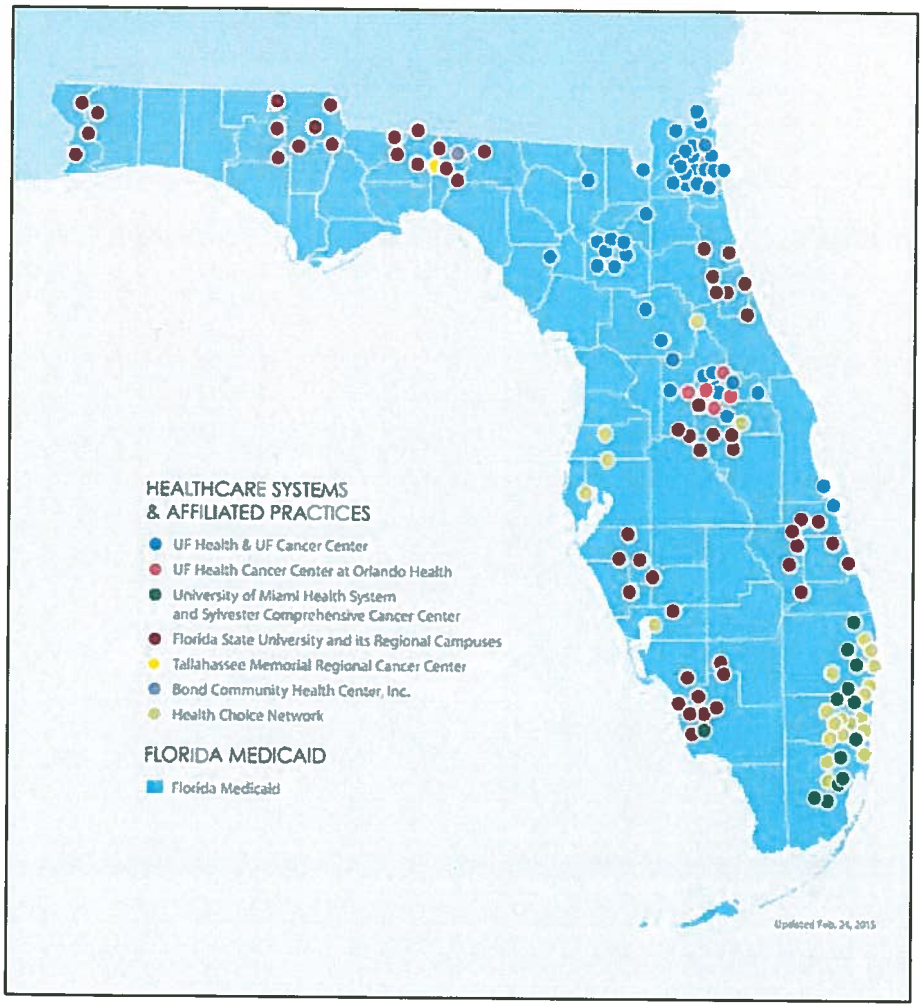
# OneFlorida Cancer Control Alliance

The OneFlorida Clinical Research Consortium formed the OneFlorida Cancer Control Alliance to strengthen statewide infrastructure and reduce health disparities in cardiovascular disease and cancer related to tobacco use. It is funded by a three-year, $1.6 million grant awarded to UF in 2014 by the Florida Department of Health's James and Esther King Biomedical Research Program.

The alliance involves the OneFlorida Clinical Research Consortium's academic and health care partners as well as Florida A&M University and Edward Waters College. The OneFlorida Cancer Control Alliance health care and community partners are:

- UF Health and the UF Health Cancer Center
- UF Health Cancer Center at Orlando Health
- University of Miami Health System and Sylvester Comprehensive Cancer Center
- Bond Community Health Center, Inc.
- Edward Waters College
- Florida A&M University
- Florida State University and Their Practice Partners
- Health Choice Network of Florida
- Tallahassee Memorial Regional Cancer Center
- Florida Department of Health
- Florida Health Equity Research Institute



The OneFlorida Cancer Control Alliance is pursuing work on two fronts to reduce tobacco-related health disparities in Florida. First, the alliance will enhance the consortium's infrastructure available to conduct tobacco-related cancer and cardiovascular disease research, particularly in primary care settings serving vulnerable populations. Second, the alliance will lead and facilitate pragmatic clinical trials and implementation science studies in real-world, primary care settings to increase health care provider capacity to follow evidence-based guidelines for tobacco-related risk factor screening and brief interventions.

## Research

The alliance will lead and facilitate research aligned with its goal to reduce tobacco-related health disparities in Florida, with an emphasis on pragmatic clinical trials and implementation science studies in primary care settings. The alliance will lead a pilot pragmatic clinical trial focused on implementing evidence-based tobacco cessation strategies in 60 urban and rural primary care practices serving vulnerable populations and will provide access to the alliance's network and infrastructure for Florida scientists with funded protocols that are approved to use OneFlorida resources.

## Infrastructure

The alliance's work is supported by and will help develop the OneFlorida Clinical Research Consortium's infrastructure cores, which provide the resources necessary to facilitate statewide clinical research across OneFlorida partners and collaborators. Specifically, the alliance will focus on enhancing the consortium's tools, data and training available to scientists and clinicians throughout Florida, including those at historically black colleges and universities, for conducting research in primary care settings on tobacco-related cancer and cardiovascular disease.

## Minority Education Program

The purpose of the OneFlorida Cancer Control Alliance's Minority Education Program is to promote diversity in cancer prevention and control research by providing developmental support for junior faculty who are members of underrepresented groups. The program's particular focus is on pragmatic clinical trials and implementation science research with the following racial and ethnic groups who have been shown to be underrepresented in biomedical research: African Americans, Hispanic Americans, American Indians, Alaska Natives, Native Hawaiians and other Pacific Islanders.

The Minority Education Program is a mentored research experience for junior faculty. Junior faculty members and one of their students will receive mentoring from a senior faculty member affiliated with the University of Florida or University of Miami Clinical & Translational Science Institutes (CTSIs) or Cancer Centers to conduct secondary data analyses that could lead to a pragmatic clinical trial or implementation science study in the area of cancer prevention and control. Pilot pragmatic clinical trials or implementation science studies are also supported through this mechanism. In addition, the junior faculty participate in two 3-credit online courses offered through the UF Department of Health Outcomes & Policy in the College of Medicine.

Participants are competitively selected and receive:

- Program funding
- Mentorship from a senior faculty member at the University of Florida or the University of Miami
- Support for study protocol and research coordination

The program accepts applicants from all five partner institutions annually.

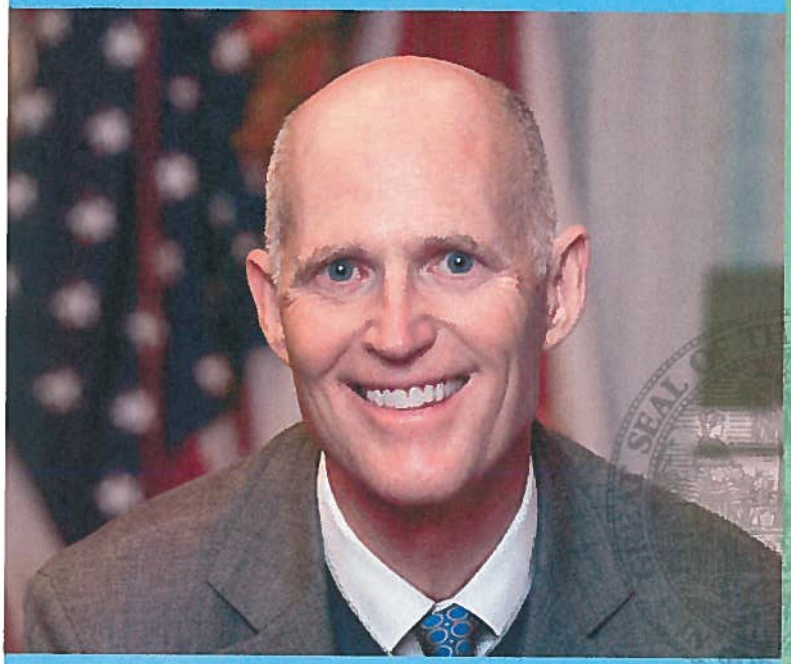
# CANCER POLICY UPDATES

# 2015–2022

Florida CANCER CONTROL & Research ADVISORY COUNCIL

A Road Map For Florida As A World Class Cancer Care And Biomedical Research Destination

## A MESSAGE FROM FLORIDA'S GOVERNOR



Dear Friends:
Florida families deserve the best cancer care possible. That's why I am proud to join your efforts to give hope to our families, friends, and neighbors affected by cancer.

Last year I signed legislation to establish the Florida Consortium of National Cancer Institute Center Program at the Florida Department of Health. The Consortium is designed to enhance the quality and competitiveness of cancer care and research in Florida. The Consortium will allocate $60 million each year to help Florida's Cancer Centers meet the rigorous scientific and research criteria required for the NCI designation. An additional investment of $20 million for peer-reviewed research grant funding was also included in our 2014-2015 Budget.

This $80 million investment for cancer centers will allow them to provide the most advanced care through innovative and collaborative research outcomes as a testament to Florida's commitment to providing world-class treatment to all cancerpatients. These efforts, along with the cancer plan development by the Florida Center Control and Advisory Council, will help ensure we're doing everything possible to provide the best outcome for Florida families. Florida's cancer centers provide patients with advanced treatment and support to beat this terrible disease. Our work will better equip Florida's cancer centers with the tools they need to expand cancer research and care for patients and their loved ones.

We remain committed to making Florida the best in the nation for cancer research and providing families with access to world-class treatment. Thank you for your dedication and leadership in the fight against cancer.

Sincerely,

**Rick Scott**
**Governor**

## FLORIDA'S SURGEON GENERAL

At the Florida Department of Health, our mission is to protect, promote and improve the health of all people in Florida through integrated state, county and community efforts. Cancer continues to be one of the leading causes of death in our state and deserves ongoing attention. Recently, the department has endeavored on a journey to promote the concept of health equity so that each person achieves the best health and quality of life possible. This includes addressing social determinants of health, such as access to healthy foods, increasing graduation rates, and decreasing violent crime in communities that are most challenged; improving these factors can reduce disparities in cancer morbidity and mortality in communities over time.

Our state health improvement plan and the department's strategic plan highlight several objectives to decrease cancer rates that align with the prioritized goals and strategies outlined in the Florida Cancer Control and Research Plan developed by the Florida Cancer Control and Research Council. Many activities aim to increase early cancer screening and detection, while others strive to increase physical activity and fruit and vegetable consumption. Through the department's Healthiest Weight Florida initiative we are partnering with numerous organizations to create environments that support healthy lifestyles which are protective against cancer as well as many other chronic diseases.

I am pleased to present the 2017 Florida Cancer Control and Research Plan, which provides a framework for reducing the burden of cancer by establishing innovative research initiatives, increasing access to care and expanding statewide data and surveillance. The plan seeks to reduce the immediate burden of cancer in Florida while also addressing long-term needs as we move closer to a cure. The Department is committed to supporting this important work through synergistic efforts and a focus on ongoing quality assurance and improvement.
Thank you for your continued dedication and support as we work together to make Florida a leader in cancer research, treatment and prevention, and the healthiest state in the nation.

**Celeste Philip, MD, MPH**
**State Surgeon General and Secretary**
**Florida Department of Health**

Florida CANCER CONTROL & Research ADVISORY COUNCIL

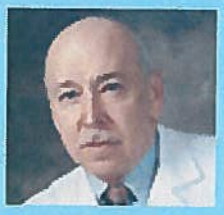
# Florida Cancer Control & Research Advisory Council Membership

Christopher Cogle, MD
Chair, University of Florida
Senate President's Appointee

Clement Gwede, Ph.D., MPH, RN,
FAAN, Vice Chair
Moffitt Cancer Center

Celeste Philip, MD, MPH
Florida's Surgeon General

Jessica Bahari-Kashani, MD
Florida Medical Association



Robert Cassell, MD, Ph.D.
Association of Community
Cancer Centers, Florida
Society of Clinical Oncology

Asher Chanan-Kahn, MD
Florida Hospital Association

Marti Coley Eubanks,
Director
Government Relations
Nemours Children Hospital

Lawrence Hochman, DO, FACRO
Florida Cancer Affiliates-Tampa
Florida Osteopathic
Medical Association

TBD
Speaker Pro-Tempore
House Speaker's Appointee

Duane Mitchell, MD, Ph.D.
University of Florida
Appointee

Theresa Morrison, Ph.D., CNS-BC
Florida Nurses Association

Amy Smith, MD
Arnold Palmer Hospital
for Children
Governor's Appointee

TBD
Senate President's
Appointee

Megan Wessel, MPH
American Cancer
Society

Mohammad Jahanzeb, MD, FACP
Sylvester Comprehensive
Cancer Center
University of Miami

# A LETTER FROM DR. COGLE

I go to work every day to cure cancer. My days are filled with untangling the knotted web of genetic mutations in my patients' cancer cells, teaching the next generation of doctors and scientists how to cure and heal, and growing commercial job opportunities for the invention of new drugs and lab tests.

When a state statute (1004.435) brings together a room full of cancer fighters like myself, it's easy to imagine the galvanized strength for one cause: reducing Florida's cancer burden.

I couldn't be more proud of our Council. Hundreds of volunteer-hours were dedicated to crafting an ambitious Florida Cancer Control and Research Plan of 5 goals and 15 objectives, creating nearly 150 work-tasks to accomplish these goals, and creating a dashboard system of metrics to keep the state on track. This is the Council's first report of the Florida Cancer Plan and our dashboard system, which illustrates both the progress and distance of reducing Florida's cancer burden.

Florida's constellation of cancer organizations aligned by the polestar of the Florida Cancer Control and Research Plan and harmonized by the Florida Department of Health's Comprehensive Cancer Control Program (FCCCP), have made tremendous strides in reducing cancer in Florida. All cancer organizations are commended.

But as we aspire to the vision of Florida as a destination for world-class healthy living, cancer care and research, our dashboard shows us that we have several opportunities for world-class health policy improvements and necessary financial investments.

With our growing momentum of successes and fulfillment of these opportunities, I'm confident we will soon set the pace for world-class cancer care and research while reducing Florida's cancer burden.

Christopher R. Cogle

**Christopher R. Cogle, M.D. Chairperson**

Florida Cancer Control and Research Advisory Council
Professor of Medicine University of Florida

# EXECUTIVE SUMMARY

The Florida Cancer Control and Research Advisory Cancer Council was established by state statute to advise the Board of Governors, the Legislature and the Surgeon General. The Cancer Council created a Florida Cancer Control and Research Plan with 5 goals, 15 objectives and nearly 150 work-tasks. This Plan paves the way to reduce Florida's cancer burden and establish Florida as a world-class destination for cancer care and research.

In regards to measuring Florida's cancer burden, critical investments in the state's cancer registry were made by the Legislature to maintain operations. The registry also initiated a pilot project to improve case capture in the outpatient cancer clinic setting. However, critical upgrades are needed to include not just diagnostic information, but also treatment and outcomes information. Cancer is a genetic disease. However, few molecular data are captured. Thus, further investments are needed to upgrade the cancer registry to enable capture of molecular cancer information and key screening results.

Regarding cancer prevention, we are already detecting significant reductions in cancers due to the work by Tobacco Free Florida, the Mary Brogan Breast and Cervical Cancer Screening Program and other prevention and early cancer detection programs (Figure 1). With cancer as the number one cause of death in Florida, the Cancer Council endorses these prevention and screening programs and call upon increased investments to bolster the downward tide.

One of the clearest opportunities for improvement in cancer prevention is increasing vaccination coverage for human papillomavirus (HPV). This virus causes cervical cancer in women and head & neck cancer in men and women. In fact, Florida and the US are about to face an epidemic of head & neck cancer due to HPV. Despite this clear indication and public health importance, Florida's vaccination rate is only 20-40%. The Cancer Council has prioritized this prevention measure for Florida and is working to increase this rate.

After years of work to advertise to the public the life-saving benefits of colonoscopy and educational sessions to Florida primary care providers, there is an increase in colonoscopy rates.

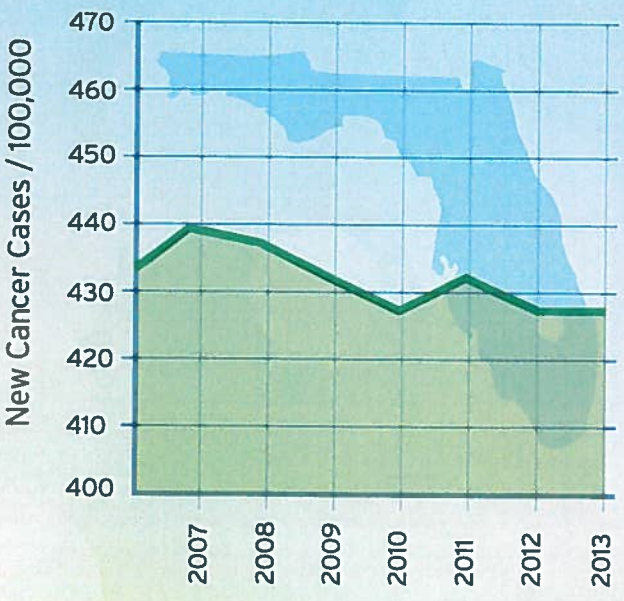
Towards improving cancer patient outcomes, the Cancer Council is working to improve Floridians' access to high quality cancer care and clinical trials. In this goal, the Cancer Council set ambitious targets to reduce patient mortality rates from the top 5 cancers in Florida: reduce lung cancer by 15%, breast cancer by 15%, prostate cancer by 20%, colon cancer by 25% and melanoma by 15%.

In terms of survivorship, the Cancer Council established a list of work tasks to be completed in the coming months that improve quality of life after a diagnosis of cancer.

Finally, the Cancer Council ardently supported increasing investments in cancer research and research infrastructure in Florida. Over the past year, the Cancer Council worked closely with the Biomedical Research Advisory Cancer Council to increase the visibility of Florida research, prioritize state funding to cancers with high mortality, and support highly meritorious scientific research teams in Florida. Sixteen grants were funded out of 201 applications to the Bankhead Coley and James & Esther King programs. The Cancer Council recognized that this level of investment covers a small fraction of highly meritorious grants and that a much larger investment is needed for Florida to achieve world-class designation for cancer research. The Cancer Council established plans to monitor cancer workforce and its pipeline to ensure adequate quantity and quality of oncology practitioners and researchers for Florida's growing population and industry growth.

## INCIDENCE OF CANCER IN FLORIDA

Figure 1



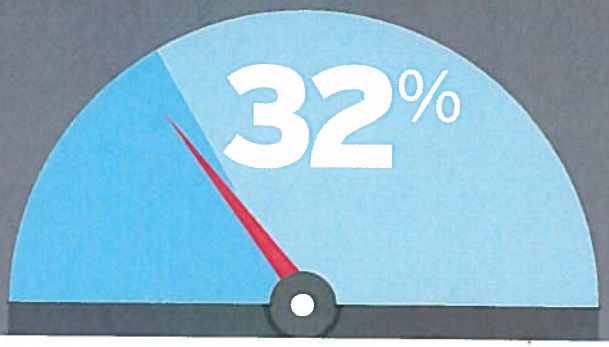

Source: FCDS

## INSIDE

**PG.6** The Burden of Cancer
**PG.8** The Best Defense is a Great Offense
**PG.9** Improving Patient Outcomes with Treatment
**PG.11** Beyond The Cancer Diagnosis
**PG.12** Florida as a Cancer Care and Research Destination
**PG.14** Appendix

# THE BURDEN OF CANCER

STATUS (%)




**GOAL 1:** EXPAND THE STATEWIDE DATA AND SURVEILLANCE PROGRAM (FCDS) TO FACILITATE ACCURATE AND TIMELY CANCER DIAGNOSIS COLLECTION AND REPORTING INCLUSIVE OF ALL FLORIDIANS

- Incorporate data from Florida-based department of veteran's affairs facilities by end of 2015
- Establish a strategic plan for incorporating all Florida-based ambulatory and hospital cancer cases in 2015

**GOAL 2:** SUPPORT THE DEVELOPMENT OF AN OUTCOMES-BASED STATEWIDE CANCER INTEGRATED DATA REPOSITORY TO FACILITATE ACCURATE IDENTIFICATION OF CANCER PATIENT TREATMENTS, OUTCOMES AND MIGRATION

- Establish a strategic plan for development, collection, management, and utilization of aggregate cancer patient outcomes-based and accurate ethnic/racial/demographic identifiers from throughout Florida in 2015
- Identify key partners for collation of this information (e.g., AHCA, Commission on Cancer, etc.) in 2015

**GOAL 3:** LINK KEY SCREENING, LABORATORY, AND MOLECULAR CANCER TEST RESULTS INTO THE FLORIDA CANCER INTEGRATED DATA REPOSITORY

- Establish a strategic plan for incorporating key screening, laboratory, and molecular cancer test results into the repository inclusive of public-private partnerships in 2015

## Cancer in a Diverse Florida

Florida is the nation's third most populous state with an estimated population of 19.9 million. From 2010 to 2014, Florida is ranked sixth among all states in terms of population growth with a population increase of 5.8% during this time.

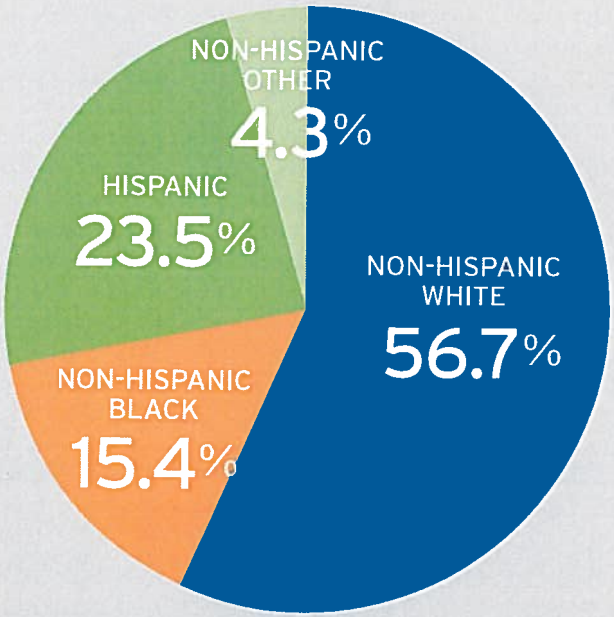
An estimated 2.1 million Florida residents live in rural areas. However, this varies greatly across geographic regions of the state. For example, over 65% of the population of Miami-Dade County is Hispanic.

Florida has the highest population of older adults in the U.S. with 18.6% of Florida residents over the age of 65. Of Florida residents ages five and older, more than one out of four (27.4%) speak a language other than English at home and one out of nine (11.5%) speak English less than "very well."

Approximately 87% of Florida residents ages 25 and older are high school graduates (or equivalent) and 27.2% have completed at least a bachelor's degree.

**In summary, Florida is a large and diverse state which closely resembles the continuously changing demographics of the entire nation.**

FLORIDA'S RACIAL/ETHIC COMPOSITION



# THE BURDEN OF CANCER

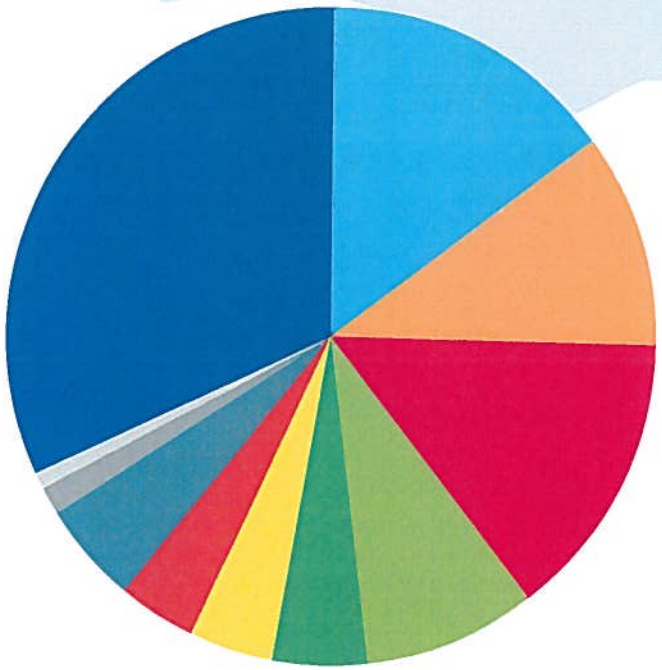
From the moment of detection through treatment and beyond, cancer represents one of the largest healthcare burdens on our Florida families. It affects the patient, caregivers, family, friends and other loved ones. For all involved, it is a journey that we believe can be either avoided or significantly improved. This document is a call-to-arms for state policy makers, healthcare providers and cancer stakeholders to band together and collaborate on making a difference, not just one patient at a time, but simultaneously for all cancer patients and caregivers in our great state.

Some of these recommendations can be accomplished quickly; others require more time to develop. However, the overarching goal is to reduce the burden of cancer for our Florida families and ensure that Florida becomes a destination for the highest-quality cancer care and research.

## The Impact of Cancer

Cancer represents the most common cause of death in Florida, leading to more than 43,000 dying each year. For the U.S. in general the trends are that lung and colorectal incidence rates are declining while incidence rates for liver, thyroid, and melanoma are increasing. In the U.S. most cancer mortality rates have decreased but liver and pancreatic deaths rates have slightly increased.

## CANCER TYPES IN FLORIDA



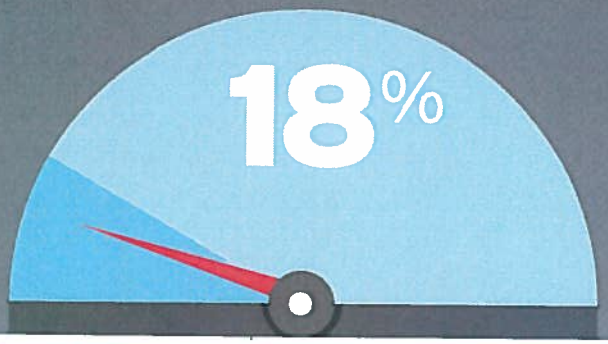
- Other (Leukemia, Pancreatic, etc.)
- Lung
- Breast
- Prostate
- Colorectal
- Bladder
- Melanoma
- Head & Neck
- Non-Hodgkin Lymphoma
- Ovarian
- Cervical

Source: FCDS 2013

Despite this clear burden of cancer on Floridians, the figures above represent an underestimate. Our statewide cancer registry, the Florida Cancer Data System (FCDS; see appendix), does not currently collect data on every Floridian with cancer. As an example, Floridians with cancer who receive care through the Department of Veteran's Affairs are not represented in these data. Likewise, patients diagnosed in ambulatory care centers are also not included. Additionally, what treatments were received by patients and how they are currently doing, is not consistently collected. For Florida to measure improvements in cancer care, identify new trends in disease burden, and establish effective policy, we must know the entire story.

# THE BEST DEFENSE IS A GREAT OFFENSE

STATUS (%)




## GOAL 1: DECREASE THE PROPORTION OF FLORIDIANS WHO USE TOBACCO PRODUCTS, WITH PARTICULAR EMPHASIS ON PREVENTION OF TOBACCO USE AMONGST YOUTH

- Endorse a comprehensive tobacco prevention and cessation program for Florida in 2015
- Collaborate with tobacco cessation stakeholders (e.g., Tobacco Free Florida) Quitline AHEC PHS Insurance
- Increase the number of committed never smokers among youth, ages 11-17, from 67.1% to 73.8% by 2020
- Increase the number of youth, age 11-17 who have been taught in any class about tobacco use during the current school year from 38.0% to 43.7% by 2020
- Reduce current cigarette use among youth, ages 11-17 from 4.3% to 3.6% by 2020
- Reduce current smoking rates among adults from 16.8% to 14.3%
- Increase the percentage of adult smokers making a quit attempt from 61.1% in 2014 to 67.2% by 2020

## GOAL 2: PROMOTE HEALTHY LIFESTYLES AND POLICIES FOR FLORIDIANS TO REDUCE THE RISK OF CANCER

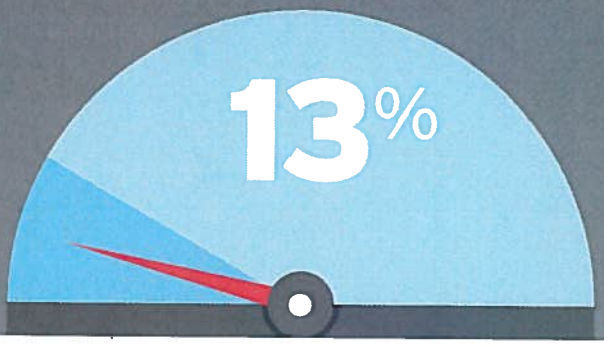
- Support education and policies aimed to reduce non-tobacco associated risk factors for cancer including certain infections, obesity, excessive ultraviolet light radiation, and Radon
- Increase the percentage of Florida adults at a healthy weight from 34.9% to 38.2% by 2017
- Increase the vaccination coverage level of 3 doses of human papillomavirus (HPV) vaccine for females AND males by age 13 to 15 years to 80% by 2020.
- Educate providers and the general public through at least two state-wide activities (in 2015) on the importance of provider vaccine recommendation to age appropriate persons, series completion and reminder systems

## GOAL 3: INCREASE THE PROPORTION OF FLORIDIANS WHO RECEIVE APPROPRIATE CANCER SCREENINGS

- Support education and policies aimed to reduce non-tobacco associated risk factors for cancer including certain infections, obesity, excessive ultraviolet light radiation, and Radon
- Endorse programs aimed to improve cancer screening methods or screening rates, including effective methods to screen high-risk populations of Floridians
- Increase the vaccination coverage level of 3 doses of human papillomavirus (HPV) vaccine for females AND males by age 13 to 15 years to 80% by 2020.
- Increase the percentage of women aged 21 to 65 who receive a Pap test in the last three years from 80.4% to 93% by 2020
- Increase the percentage of women aged 50 to 74 who receive a mammogram in the last two years from 76.8% to 81.1% by 2020
- Support the recommendation from the Florida Prostate Cancer Advisory Council that men aged 50 years and older (age 40 for men at high risk: African American men and men with a family history of prostate cancer) should be informed by their health care providers annually regarding the risks and benefits of PSA screening
- Promote the Human Papillomavirus vaccine for Florida's youth
- Support policies which limit out-of-pocket expenses for Floridians recommended for cancer screening services
- Support policies which limit out-of-pocket expenses for Floridians recommended for genetic testing and counseling based upon published guidelines, deemed at high risk for an inheritable cancer risk syndrome

# IMPROVING PATIENT OUTCOMES

STATUS (%)




## GOAL 1: SUPPORT POLICIES THAT WILL ENSURE HEALTH EQUITY FOR ALL CANCER PATIENTS AND THEIR CAREGIVERS

- Support oral therapy parity for cancer patients, regardless of coverage, as exempt from cost sharing purposes, including oral and intravenous cancer therapies and supportive care medications (similar to provision of services provided as part of hospice coverage)
- Recognize Florida provider and coverage networks which are inclusive of comprehensive cancer services available within Florida (e.g., at least one Florida hematopoietic cell transplant center is included in any provider network with cancer treatment coverage, genetic testing and counseling services, etc.)
- Partner with the Florida Health Equity Research Institute (HERI), Biomedical Research and Advisory Council (BRAC), and others to address the multi-level determinants of cancer-health disparities in Florida and reduce cancer morbidity and mortality in minority, medically-underserved, and rural communities
- Support policies to address access to care related to transportation needs to and from cancer treatments

## GOAL 2: IMPROVE FLORIDIAN'S ACCESS TO HIGH-QUALITY, MULTIDISCIPLINARY ONCOLOGY CARE

- Endorse standards of evidence-based high quality oncology care for Florida
- Undertake a needs assessment of county-based cancer burden from Commission on Cancer Accredited facility
- Support policies and programs which publicly report compliance with provision of high-quality cancer care (e.g., the Florida Cancer Centers of Excellence), particularly for childhood and rare (low incidence/high mortality) cancers
- Within 10 years, reduce mortality associated with the most common causes of cancer death in Floridians, including decreased deaths in lung cancer by 15%, breast cancer by 15%, prostate cancer by 20%, colon cancer by 25%, and melanoma by 15%
- Support navigators for multidisciplinary care provision in communities
- Support the development and policies of oncology Medical Homes

## GOAL 3: INCREASE THE NUMBER OF FLORIDIANS WITH ACCESS TO AND PARTICIPATION IN CANCER CLINICAL TRIALS

- Recognize proper implementation of clinical trials coverage provisions throughout all insurance and healthcare policies in Florida
- Support development of integrated statewide clinical trials network(s) between academic centers and community oncology practices to promote Florida-centric new treatment options for patients
- Support efforts to encourage patient referral to clinical trials
- Support efforts of NCI-Consortium (Florida Consortium of NCI Designated Centers) members to increase the number of therapeutic clinical trials offered in Florida and to increase the number of patients participating in these studies
- Support policies that increase cancer-related device and drug development in Florida

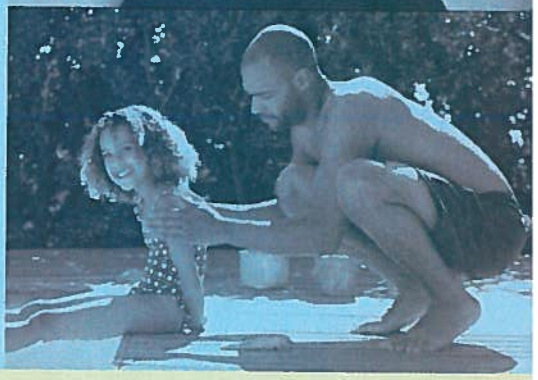
# IMPROVING PATIENT OUTCOMES

Many of the leading causes of cancer including tobacco use, obesity, viral infections, excessive ultraviolet light exposure, excessive alcohol consumption, and Radon exposure can be reduced or eliminated through awareness and behavior modification. These risk factors appear responsible for nearly 80% of the cancer diagnoses in the U.S.

While advancement has been made in some of these areas over the past few years, there is still a large need for improvement. The prevalence of smoking is on the decline among Florida adults and youth.

Prevention of cancer remains the most effective cancer treatment. For many cancers, early detection through cancer screening tests can identify cancers when otherwise undetectable and thus improve outcomes. Prevention through risk factor modification or carcinogenic exposure reduction and early detection through screening offers an opportunity to improve outcomes for Floridians and their families.

For many Floridians, cancer is a family affair, not just through the support of caregivers, but also due to genetic or other predispositions that may contribute. Identification of cancer predisposition in Floridians offers another opportunity to tailor risk factor modification, early detection, and cancer treatment to further improve the health of Floridians and their families. Early detection of cancer, specific to the needs of the individual, is the next best strategy after prevention.



## Recommended Health Screenings

| | |
|---|---|
| **BRCA-Related Cancer:** | Women who have family history of breast, ovarian, tubal, or peritoneal cancer |
| **Breast Cancer:** | Screening every 1-2 years starting at age 40 |
| **Cervical Cancer:** | Screening every 5 years |
| **Skin Cancer:** | Periodic skin exams are important |
| **Lung Cancer:** | Screenings for current or former smokers between the ages of 55-80 |
| **Colorectal Cancer:** | Initial screening for both men and women starting at age 50 |

## Florida

### Cancer Screening /Colorectal

**14%** Percentage of adults 50 years of age and older who received a stool blood test in the past year

**65.7%** Percentage of adults 50 years of age and older who received a sigmoidoscopy or colonoscopy in the past five years

### Cancer Screening /Cervical

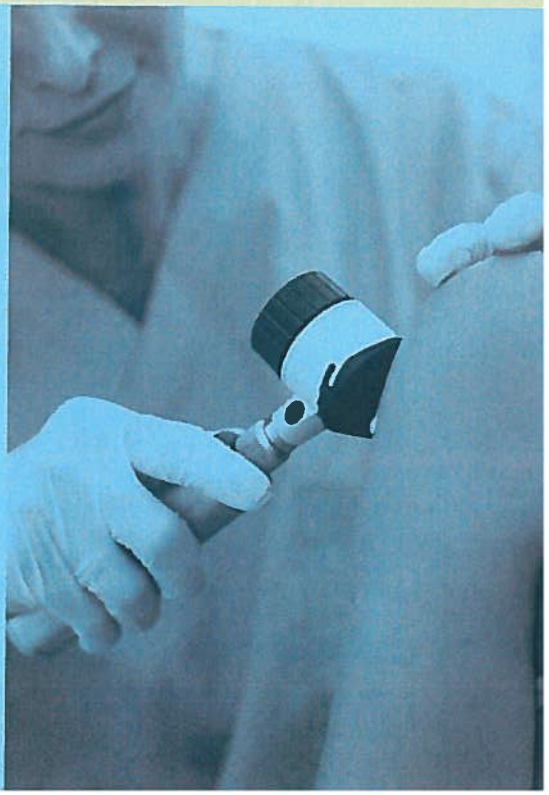
**79.7%** Percentage of women 18 years of age and older who received a Pap test in the past year

### Cancer Screening /Breast

**58.2%** Percentage of women aged 40 to 74 years who received a mammogram in the past year

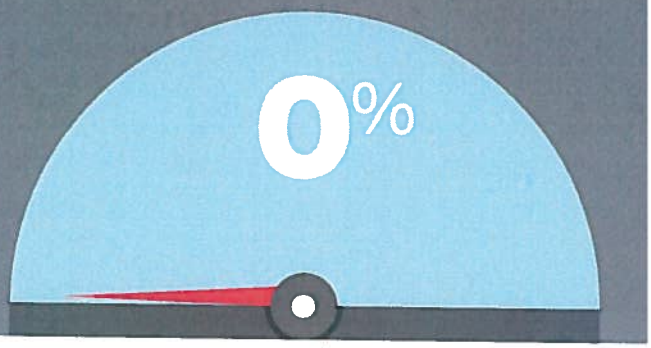
**54.3%** Percentage of women 18 years of age and older who had a clinical breast exam in the past year

Source: Florida BFRRS 2014 survey



# BEYOND THE CANCER DIAGNOSIS

In 2017, the Florida Cancer Control and Research Advisory Council will begin to execute the planned work tasks to improve cancer survivorship.




## GOAL 1: SUPPORT EDUCATION AND AWARENESS OF CANCER SURVIVOR NEEDS IN FLORIDA

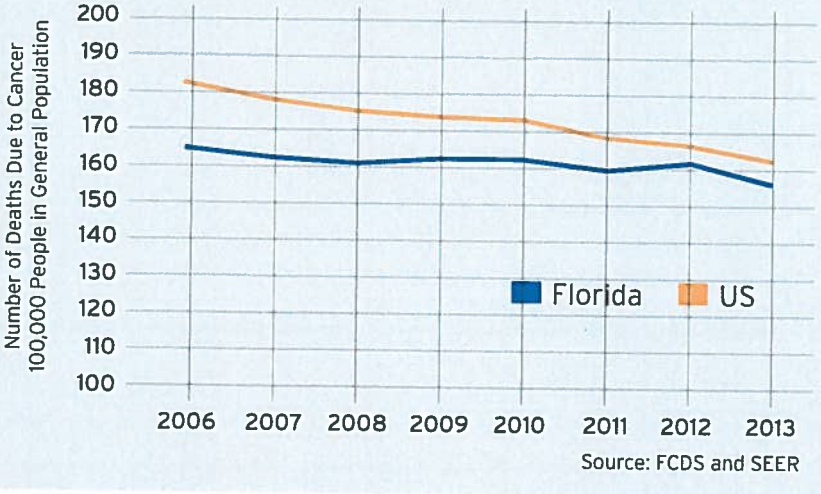
- Establish a definition of a cancer survivor for Florida
- Identify and endorse evidence-based high-quality standards for the care of cancer survivors
- Support Florida awareness of Cancer Survivor Day

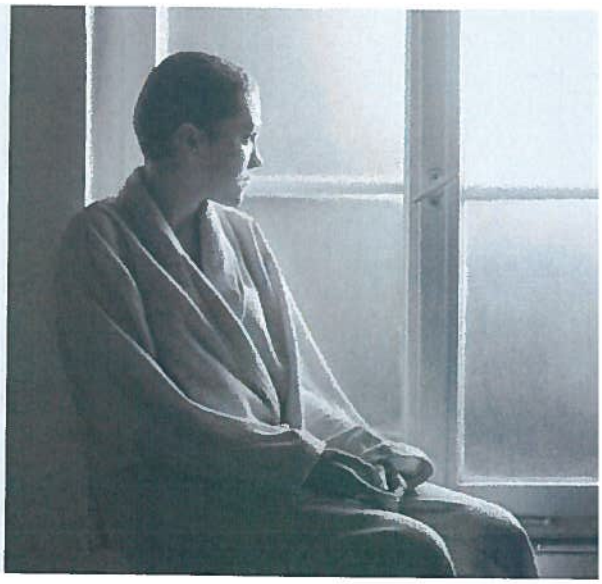
## GOAL 2: SUPPORT POLICIES THAT ENSURE ALL FLORIDIANS WITH CANCER (AND THEIR CAREGIVERS) HAVE ACCESS TO RESOURCES THAT PROVIDE QUALITY OF LIFE DURING AND AFTER THERAPY

- Identify and endorse supportive cancer patient care services and palliative care services (inclusive of caregiver support services) for Florida. In areas where there is debate on merit of services, support research to prove or refute value
- Recognize Florida provider and coverage networks which include comprehensive cancer support services available within Florida
- Support awareness and education of ways to live with cancer, focusing on quality of life and maintenance of independent functioning

## GOAL 3: SUPPORT POLICIES THAT ENSURE ALL FLORIDIANS WITH INCURABLE CANCER HAVE ACCESS TO RESOURCES THAT PROVIDE DIGNIFIED END OF LIFE CARE

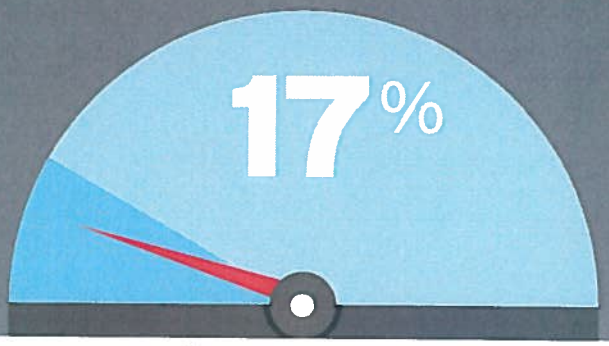
- Identify and endorse high quality evidence-based end-of-life medical care services for Florida
- Support patient and caregiver active decision making in use of hospice and other palliative care services
- Recognize Florida provider and coverage networks which include comprehensive cancer end-of-life services available within Florida



# FLORIDA AS A CANCER CARE AND RESEARCH DESTINATION

STATUS (%)




## GOAL 1: INVEST IN BIOMEDICAL RESEARCH – IN FLORIDA – FOR FLORIDIANS

- Coordinate the CCRAB Florida Cancer Plan priorities with the BRAC research agenda for Florida
- Increase and maintain continuous Biomedical research funding through the Bankhead-Coley and James and Esther King Biomedical Trust funds with a goal of further securing the reinvestment of federal tax dollars back to Florida for biomedical cancer research
- Focus research investment on new technology/device/therapy developments in Florida
- Continue to foster state policies that encourage biotechnology companies to headquarter in Florida
- Increase the number of Florida-based public-private partnerships in cancer research in next three years
- Increase visibility of successful public-private partnerships that target cancer
- Increase the visibility of cancer research discoveries from Florida researchers
- Increase the visibility of cancer care excellence from Florida cancer provider networks
- Support policies that promote sustainability of initial state Biomedical infrastructure investments
- Support NCI Consortium and Florida Cancer Centers of Excellence collaborative networking to facilitate team-based science
- Increase number of Florida-based NCI Designated Cancer Centers (Designated and Comprehensive) by 2020
- Work with BRAC to establish multi-PI capacity for research proposals by 2016

## GOAL 2: SUPPORT THE DEVELOPMENT OF A STATE BIOMEDICAL WORKFORCE PIPELINE (STEM K-12 AND BEYOND)

- Establish partnerships from stakeholders and the Florida Department of Education to solicit feedback on a needs assessment related to educating the next generation of biomedical researchers and cancer clinicians for Florida in 2015
- Determine how to commission a workforce/needs assessment for cancer and biomedical research for Florida
- Link Florida educational STEM programs with opportunities within the State University System and State College Partners
- Support biomedical cancer research training leading to PhD, MPH
- Support biomedical cancer clinical training inclusive of cancer-specific providers such as nursing, pharmacy, advanced practice providers (PA-C, ARNP) and physicians
- Support cancer biomedical research and clinical trainees that represent the communities served in Florida, inclusive of minority and disparate population

# FLORIDA AS A CANCER CARE AND RESEARCH DESTINATION

## GOAL 3: FACILITATE FLORIDA-BASED TELEMEDICINE FOR GENOMICS AND OTHER ADVANCED CANCER RESEARCH ANALYTICS AND HIGH-QUALITY CARE

- Develop a Cancer Medical Tourism plan for Florida in partnership with VISIT Florida and others by 2016
- Endorse a definition of telemedicine and support policies which promote the capacity for licensure to provide consultative services in genetics/genomics for cancer care in Florida
- Support policies which promote the ability to provide consultative services in Florida for cancer patients as part of medical tourism
- Support Florida-based medical, biotechnology and training programs for international cancer providers and investigators to ensure exposure to Florida cancer care and research systems and collaborative opportunities

## Appendix

The Florida Cancer Control and Research Advisory Council, also known as CCRAB, is the state council responsible for advising the Legislature, Governor and Surgeon General on how to reduce the cancer burden in Florida. We monitor cancer trends and disparities, evaluate and promote effective interventions to help in cancer prevention, screening and treatment. We also develop position papers on cancer-related legislation and state policy issues.

CCRAB was established in state statute in 1979, and is governed by Florida Statute 1004.435. The Council is housed at, and administratively supported by the H. Lee Moffitt Cancer Center and Research Institute, but operates as an independent group. Individual members are leaders in health care, education, cancer research and treatment, and Florida government, many of whom are cancer survivors. Membership also represents the totality of cancer stakeholder organizations statewide. The Council meets at least twice a year, has membership that is appointed as well as the Governor, President of the Senate, and Speaker of the House and by cancer stakeholder organizations. The group is overseen by a Chair and an Executive Committee. We greatly appreciate Moffitt Cancer Center's continuing support for the Council's operations and for allowing the Council to function as an independent advisory board.

Updated information can be obtained online at our website www.ccrab.org. For additional copies of this report, or any additional information about CCRAB and its activities, please contact the Council office.

## For More Information:

**CCRAB Website**
http://www.ccrab.org

**Florida Cancer Data Systems (FCDS)**
http://www.fcds.med.miami.edu/inc/statistics.shtml

**Florida Department of Health**
http://www.floridahealth.gov/

**Comprehensive Cancer Control Programs**
http://www.floridahealth.gov/diseases-and-conditions/cancer/cancer-control-florida.html

**Breast and Cervical Cancer Early Detection Program (BCCEDP)**
http://www.floridahealth.gov/diseases-and-conditions/cancer/breast-cancer/index.html & http://www.floridahealth.gov/diseases-and-conditions/cancer/cervical-cancer/index.html

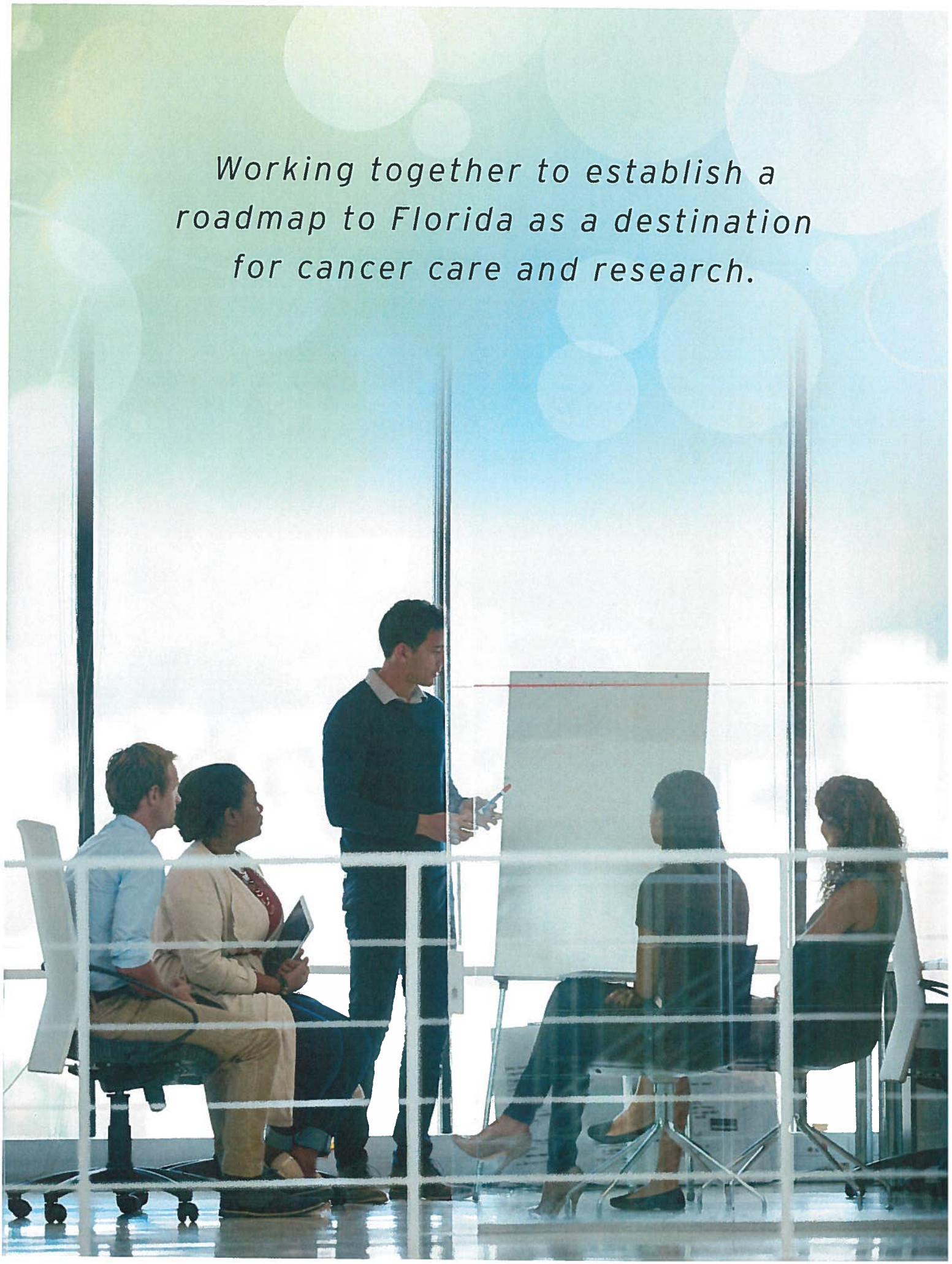
**Colorectal Cancer Control Program (CRCCP)**
http://www.floridahealth.gov/diseases-and-conditions/cancer/colon-cancer/index.html

**Florida's Health Equity Research Institute (HERI)**
http://www.flheri.org/

**Florida's Biomedical Research Advisory Council (BRAC)**
http://www.floridahealth.gov/provider-and-partner-resources/research/research-cancer-tobacco.html

**Prostate Cancer Advisory Council (PCAC)**
http://prostatecanceradvisorycouncil.org/

*Working together to establish a roadmap to Florida as a destination for cancer care and research.*



# THANK YOU TO OUR PARTNERS


## FOR MORE INFORMATION CONTACT:

**Merritt Martin**
State Legislative Affairs Director
Moffitt Cancer Center
merritt.martin@moffitt.org

**Laura Lenhart**
Public Affairs Strategist
Moffitt Cancer Center
laura.lenhart@moffitt.org