FLORIDA CANCER CONTROL AND RESEARCH ADVISORY COUNCIL (C-CRAB)

ANNUAL REPORT: 1992 ACTIVITIES

Sister Mary Clare Hughes, Past Chair
Warren E. Ross, M.D., Acting Chair
Dorothy F. Parker, M.H.S., Coordinator

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1992 C-CRAB ANNUAL REPORT

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FLORIDA CANCER CONTROL AND RESEARCH ADVISORY COUNCIL (C-CRAB)

1992 ANNUAL REPORT

SUMMARY OF ACTIVITIES

1. <u>Changes to the Statute</u>

During the 1992 legislative session, the statutory authority for Florida Cancer Control and Research Advisory Council (a.k.a. C-CRAB) was transferred from the Department of Health and Rehabilitative Services (HRS) to the H. Lee Moffitt Cancer Center and Research Institute, Inc., at the University of South Florida in Tampa.

A copy of the revised legislation can be found in **Attachment 1.**

The Statute, known as the Cancer Control and Research Act, was moved from section 385.201, which was part of the Chronic Disease chapter, to section 240.5121, under Post Secondary Education, reflecting its new location and association with the Board of Regents and the H. Lee Moffitt Cancer Center and Research Institute

Other changes in the statute in 1992 were:

1. C-CRAB now serves as an advisory body to the Board of Regents, in addition to the Legislature and the secretary of HRS.

2. The number of Council members increased from 28 to 30 by adding the following:

    a. one representative member from the College of Public Health of the University of South Florida;

    b. one representative from a statutory teaching hospital affiliated with a community based cancer center;

3. The name of the Papanicolaou Comprehensive Cancer Center was changed to the Sylvester Comprehensive Cancer Center at the University of Miami;

4. The number of members required for a quorum was increased from 14 to 16;

5. The requirement to produce a brochure on breast cancer treatment became conditional "if funds are specifically appropriated by the Legislature."

The Florida Cancer Control and Research Fund, Section 240.5121(6), allows for funds to be appropriated from the General Revenue Fund or any gifts, grants, or

funds from other sources. The Fund is to be used for awarding grants and contracts for cancer control and prevention, cancer education and training, cancer research, and all expenses incurred in connection with the administration of Section 240.5121. However, as in previous years, no funds were appropriated during 1992.

2. Transition from HRS to the Moffitt Cancer Center

The operation of C-CRAB was transferred from HRS to the H. Lee Moffitt Cancer Center as a Type IV transfer (which includes transfer of power, duties, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds). Dr. Richard Hopkins, State Epidemiologist at HRS, who has worked with C-CRAB and the Florida Cancer Plan, met with Dr. John Ruckdeschel, Center Director at the H. Lee Moffitt Cancer Center, in early May to discuss the transition. Sandy Wilkins forwarded all the files and materials prior to the end of her tenure as C-CRAB Staff Director, on May 22, 1992.

On October 6, 1992, a new Coordinator for C-CRAB was hired: Ms. Dorothy Parker (see **Attachment 2**. She is located at the H. Lee Moffitt Cancer Center, which provides operating expenses and support for her office. Ms. Parker can be reached at (813) 979-6734.

3. C-CRAB Chairperson

During 1992, Sister Mary Clare Hughes, representative from the Florida Hospital Association, and Chief Executive Officer of St. Vincent's Health System, served a two-year term as Chair of C-CRAB.

In November, a questionnaire was sent to C-CRAB members asking for nominees for her successor. Dr. Warren Ross, from the University of Florida College of Medicine, was nominated, and this choice was approved by C-CRAB's Executive Committee. A letter was forwarded to the Governor's Office recommending that Dr. Ross be appointed as the next Chair. Pending that decision, Dr. Ross is acting as Interim Chair. He has selected a new Executive Committee, and is moving ahead with plans for 1993 activities.

4. Membership (See **Attachment 3** for current membership list)

a. During 1992, the following members were appointed/reappointed (as of 2/14/92):
   1. Beth Bacon-Pituch, Department of Education
   2. Rita Bjork, general public
   3. Charles Eytel, M.D., American Cancer Society
   4. Daniel Finkelstein, D.O., Southeastern University of Health Sciences

5. W. Jarrard Goodwin, Jr., M.D., School of Medicine, University of Miami
6. Jack MacDonald, M.D., Florida Medical Association
7. James Orr, M.D., Florida Obstetric and Gynecology Society
8. John Witte, M.D., Dept. of Health and Rehabilitative Services

b. Two members resigned during 1992:
 1. Judith Vogt, general public
 2. William Mendenhall, M.D., Florida Radiological Association

c. The following members have been renominated for another term:
 1. Denis Cavanagh, M.D., College of Medicine, University of South Florida
 2. Jane Garcia, A.R.N.P., Florida Nurses Association
 3. Jeffrey Krischer, Ph.D., Florida Association of Pediatric Tumor Programs

d. Appointments for the following new nominations are being processed:
 1. Clarence H. Brown, III, M.D., Orlando Cancer Center
 2. Phillip Marty, Ph.D, College of Public Health, University of South Florida
 3. William Schiff, D.D.S., Florida Dental Association
 4. Frances Sykes, general public

e. Nominations are being sought for the following vacancies:
 1. Florida Radiological Society
 2. One general public representative

f. Legislative members
 1. The President of the Senate, Ander Crenshaw, appointed Senator Ginny Brown-Waite to replace Jeanne Malchon as the Senate representative on C-CRAB, as of January 7, 1993.
 2. The, Speaker of the House, Bo Johnson, appointed Representative Debby Sanderson to replace Lars Hafner as the House representative on C-CRAB, as of February 2, 1993..

5. C-CRAB Meetings

There were four meetings held during 1992: March 9th, April 30th, June 27th, and November 5th. A copy of the minutes from each of these meetings can be found in **Attachment 4.**

In addition, there was a meeting on January 22, 1992, for members of the Technical

6. Technical Advisory Groups

C-CRAB has formed four Technical Advisory Groups, which are composed of C-CRAB members as well as other professionals with expertise related to the Advisory Group's task. The Groups are:

1. Breast and Cervical Cancer
2. Smoking Cessation and Tobacco Issues
3. Emerging Issues
4. Access to State-of-the-Art Treatment

A list of the committee members, and minutes from their meetings, can be found in **Attachments 5-8**.

Each committee prepared a report which contains their recommendations in each area- - see **Attachment 9**. The recommendations were presented to C-CRAB, and approved at the April 30th and June 27th meetings (see minutes).

7. 1993 Florida Cancer Plan

The HRS Cancer Epidemiology Program, in consultation with C-CRAB, prepared the annual Florida Cancer Plan (see **Attachment 10**). It reflects the priorities identified by C-CRAB and its Technical Advisory Groups. C-CRAB membership formally approved the plan at its November 5th, 1992, meeting.

8. 10-Year Report from Florida Cancer Data System

The Florida Cancer Data System and the HRS Cancer Epidemiology Program are in the process of completing a ten-year report on cancer incidence in Florida. The report is not ready at this time, but is expected to be released by March, 1993. It will provide an detailed account of cancer incidence by site and county, and will be very useful for understanding the cancer experience in this state and for planning cancer control programs.

9. Plans for 1993

C-CRAB's priorities for 1993 are to finalize its Cancer Control Implementation Plan, and to submit a proposal to the legislature to appropriate funds for programs outlined in the Plan. The programs will address the two priorities for 1993: (1) breast and cervical cancer screening, and (2) smoking cessation.

C-CRAB will also work with the Agency for Health Care Administration and the Department of Health and Rehabilitation Services to integrate its plan into other state health plans.

ATTACHMENT 1

Cancer Control and Research Act
(Florida Statute 240.5121)

240.5121 Cancer control and research.—

(1) SHORT TITLE.—This section shall be known and may be cited as the "Cancer Control and Research Act."

(2) LEGISLATIVE INTENT.—It is the finding of the Legislature that:

(a) Advances in scientific knowledge have led to the development of preventive and therapeutic capabilities in the control of cancer. Such knowledge and therapy must be made available to all citizens of this state through educational and therapeutic programs.

(b) The present state of our knowledge concerning the prevalence, cause or associated factors, and treatment of cancer have resulted primarily from a vast federal investment into basic and clinical research, some of which is expended in this state. These research activities must continue, but programs must be established to extend this knowledge in preventive measures and patient treatment throughout the state.

(c) Research in cancer has implicated the environment as a causal factor for many types of cancer, i.e. sunshine, X rays, diet, smoking, etc., and programs are needed to further document such cause and effect relationships. Proven causes of cancer should be publicized and be the subject of educational programs for the prevention of cancer.

(d) An effective cancer control program would mobilize the scientific, educational, and medical resources that presently exist into an intense attack against this dread disease.

(3) DEFINITIONS.—The following words and phrases when used in this section have, unless the context clearly indicates otherwise, the meanings given to them in this subsection:

(a) "Cancer" means all malignant neoplasms, regardless of the tissue of origin, including lymphoma and leukemia.

(b) "Council" means the Florida Cancer Control and Research Advisory Council, which is an advisory body appointed to function on a continuing basis for the study of cancer and which recommends solutions and policy alternatives to the Board of Regents and the secretary and which is established by this section.

(c) "Department" means the Department of Health and Rehabilitative Services.

(d) "Fund" means the Florida Cancer Control and Research Fund established by this section.

(e) "Qualified nonprofit association" means any association, incorporated or unincorporated, that has received tax-exempt status from the Internal Revenue Service.

(f) "Secretary" means the Secretary of Health and Rehabilitative Services.

[1](4) FLORIDA CANCER CONTROL AND RESEARCH ADVISORY COUNCIL; CREATION; COMPOSITION.—

(a) There is created within the H. Lee Moffitt Cancer Center and Research Institute, Inc., the Florida Cancer Control and Research Advisory Council. The council shall consist of 30 members, which includes the chairperson, all of whom must be residents of this state. All members, except those appointed by the Speaker of the House of Representatives and the President of the Senate, must be appointed by the Governor. At least one of the members appointed by the Governor must be 60 years of age or older. One member must be a representative of the American Cancer Society; one member must be a representative of the Florida Tumor Registrars Association; one member must be a representative of the Sylvester Comprehensive Cancer Center of the University of Miami; one member must be a representative of the Department of Health and Rehabilitative Services;

one member must be a representative of the Florida Nurses Association; one member must be a representative of the Florida Osteopathic Medical Association; one member must be a representative of the American College of Surgeons; one member must be a representative of the School of Medicine of the University of Miami; one member must be a representative of the College of Medicine of the University of Florida; one member must be a representative of Southeastern College of Osteopathic Medicine; one member must be a representative of the College of Medicine of the University of South Florida; one member must be a representative of the College of Public Health of the University of South Florida; one member must be a representative of the Florida Society of Clinical Oncology; one member must be a representative of the Florida Obstetric and Gynecologic Society who has had training in the specialty of gynecologic oncology; one member must be a representative of the Florida Medical Association; one member must be a member of the Florida Pediatric Society; one member must be a representative of the Florida Radiological Society; one member must be a representative of the Florida Society of Pathologists; one member must be a representative of the H. Lee Moffitt Cancer Center and Research Institute, Inc.; three members must be representatives of the general public acting as consumer advocates; one member must be a member of the House of Representatives appointed by the Speaker of the House; one member must be a member of the Senate appointed by the President of the Senate; one member must be a representative of the Department of Education; one member must be a representative of the Florida Dental Association; one member must be a representative of the Florida Hospital Association; one member must be a representative of the Association of Community Cancer Centers; one member shall be a representative from a statutory teaching hospital affiliated with a community-based cancer center; and one member must be a representative of the Florida Association of Pediatric Tumor Programs, Inc.

(b) The terms of the members shall be 4 years from their respective dates of appointment.

(c) A chairperson shall be appointed by the Governor for a term of 2 years. The chairperson shall appoint an executive committee of no fewer than three persons to serve at the pleasure of the chairperson. This committee will prepare material for the council but make no final decisions.

(d) The council shall meet no less than semiannually at the call of the chairperson or, in his absence or incapacity, at the call of the secretary. Sixteen members constitute a quorum for the purpose of exercising all of the powers of the council. A vote of the majority of the members present is sufficient for all actions of the council.

(e) The council members shall serve without pay. Pursuant to the provisions of s. 112.061, the council members may be entitled to be reimbursed for per diem and travel expenses.

(f) No member of the council shall participate in any discussion or decision to recommend grants or contracts to any qualified nonprofit association or to any agency of this state or its political subdivisions with which the member is associated as a member of the governing body or as an employee or with which the member has entered into a contractual arrangement.

(g) The council may prescribe, amend, and repeal bylaws governing the manner in which the business of the council is conducted.

(h) The council shall advise the Board of Regents, the secretary, and the Legislature with respect to cancer control and research in this state.

(i) The council shall approve each year a program for cancer control and research to be known as the "Florida Cancer Plan" which shall be consistent with the State Health Plan developed by the Statewide Health Council and integrated and coordinated with existing programs in this state.

(j) The council shall formulate and recommend to the secretary a plan for the care and treatment of persons suffering from cancer and recommend the establishment of standard requirements for the organization, equipment, and conduct of cancer units or departments in hospitals and clinics in this state. The council may recommend to the secretary the designation of cancer units following a survey of the needs and facilities for treatment of cancer in the various localities throughout the state. The secretary shall consider the plan in developing departmental priorities and funding priorities and standards under chapter 395.

(k) The council is responsible for including in the Florida Cancer Plan recommendations for the coordination and integration of medical, nursing, paramedical, lay, and other plans concerned with cancer control and research. Committees shall be formed by the council so that the following areas will be established as entities for actions:

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

(l) In order to implement in whole or in part the Florida Cancer Plan, the council shall recommend to the Board of Regents or the secretary the awarding of grants and contracts to qualified profit or nonprofit associations or governmental agencies in order to plan, establish, or conduct programs in cancer control or prevention, cancer education and training, and cancer research.

(m) If funds are specifically appropriated by the Legislature, the council shall develop and prepare a standardized written summary, written in layman's terms and in language easily understood by the average adult patient, informing actual and high-risk breast cancer patients of the medically viable treatment alternatives available to them in the effective management of breast cancer; describing such treatment alternatives; and explaining the relative advantages, disadvantages, and

risks associated therewith. Such summary, upon its completion, shall be printed in the form of a pamphlet or booklet and made continuously available to physicians and surgeons in this state for their use in accordance with s. 458.324 and to osteopathic physicians in this state for their use in accordance with s. 459.0125. The council shall periodically update the pamphlet to reflect current standards of medical practice in the treatment of breast cancer. The council shall develop and implement an educational program, including distribution of the pamphlet or booklet developed under this paragraph, to inform citizen groups, associations, and voluntary organizations about early detection and treatment of breast cancer.

(n) The council shall have the responsibility to advise the Board of Regents and the secretary on methods of enforcing and implementing laws already enacted and concerned with cancer control, research, and education.

(o) The council may recommend to the Board of Regents or the secretary rules not inconsistent with law as it may deem necessary for the performance of its duties and the proper administration of this section.

(p) The council shall formulate and put into effect a continuing educational program for the prevention of cancer and its early diagnosis and disseminate to hospitals, cancer patients, and the public information concerning the proper treatment of cancer.

(q) The council shall be physically located at the H. Lee Moffitt Cancer Center and Research Institute, Inc., at the University of South Florida.

(r) On February 15 of each year, the council shall report to the Governor and to the Legislature.

(5) RESPONSIBILITIES OF THE BOARD OF REGENTS, THE H. LEE MOFFITT CANCER CENTER AND RESEARCH INSTITUTE, INC., AND THE SECRETARY.—

(a) The Board of Regents or the secretary, after consultation with the council, shall award grants and contracts to qualified nonprofit associations and governmental agencies in order to plan, establish, or conduct programs in cancer control and prevention, cancer education and training, and cancer research.

(b) The H. Lee Moffitt Cancer Center and Research Institute, Inc., shall provide such staff, information, and other assistance as reasonably necessary for the completion of the responsibilities of the council.

(c) The Board of Regents or the secretary, after consultation with the council, may adopt rules necessary for the implementation of this section.

(d) The secretary, after consultation with the council, shall make rules specifying to what extent and on what terms and conditions cancer patients of the state may receive financial aid for the diagnosis and treatment of cancer in any hospital or clinic selected. The department may furnish to citizens of this state who are afflicted with cancer financial aid to the extent of the appropriation provided for that purpose in a manner which in its opinion will afford the greatest benefit to those afflicted and may make arrangements with hospitals, laboratories, or clinics to afford proper care and treatment for cancer patients in this state.

(6) FLORIDA CANCER CONTROL AND RESEARCH FUND.—

(a) There is created the Florida Cancer Control and Research Fund consisting of funds appropriated therefor from the General Revenue Fund and any gifts, grants, or funds received from other sources.

(b) The fund shall be used exclusively for grants and contracts to qualified nonprofit associations or governmental agencies for the purpose of cancer control and prevention, cancer education and training, cancer research, and all expenses incurred in connection with the administration of this section and the programs funded through the grants and contracts authorized by the Board of Regents or the secretary.

History.—ss. 1, 2, 3, 4, 5, 6, 8, ch. 79-320; ss. 1, 4, ch. 82-46; ss. 1, 19, ch. 82-182; s. 1, ch. 83-234; ss. 2, 3, ch. 83-265; s. 1, ch. 84-222; s. 95, ch. 86-220; s. 7, ch. 87-172; ss. 2, 5, 6, ch. 89-93; s. 1, ch. 90-314; s. 5, ch. 91-429; s. 41, ch. 92-58.

[1]**Note.**—Repealed effective October 1, 1999, by s. 6, ch. 89-93, and scheduled for review pursuant to s. 11.611.

Note.—Former s. 381.3712; s. 385.201.

ATTACHMENT 2

C-CRAB Coordinator (Dorothy Parker) Bio-Sketch

BIO-SKETCH

DOROTHY F. PARKER

PROFESSIONAL EXPERIENCE

1992 - present	Coordinator, Florida Cancer Control and Research Advisory Board, at H. Lee Moffitt Cancer Center, Tampa, FL
1988 - 1992	Program Coordinator/Data Analyst, Department of Community and Family Health, College of Public Health, University of South Florida, Tampa, Florida
1987 - 1988	Statistician, Professional Foundation for Health Care, Tampa, Florida
1983 - 1987	Clinical Research Coordinator, Department of Medicine, Good Samaritan Hospital, Portland, Oregon
1978 - 1982	Health Analyst/Evaluator, Community Outreach Branch, Howard-Georgetown University Cancer Center, Washington, D.C.
1976 - 1978	Community Service Planner, Baltimore City Health Department, Baltimore, Maryland
1974 - 1975	Administrative Assistant, Ambulatory Rehabilitation Center, New England Deaconess Hospital, Boston, Massachusetts

EDUCATION

M.H.S.	Johns Hopkins School of Hygiene and Public Health (Health Planning), 1977
B.S.	Boston University (Health Science), 1974
Post-graduate Coursework:	University of Minnesota: Summer Session in Epidemiology, 1979 Portland State University: Multivariate Analysis, 1986 University of South Florida: (1) Program Development and Change Process, College of Public Health, 1989; (2) Geographic Information Systems, Dept. of Geography, 1992

PUBLICATIONS

ARTICLES

Dunn PM, Parker DF, Levinson W, Mullooly JP: **The Effect of Resident Involvement on Community Hospital Charges.** Journal of General Internal Medicine 4:115-20, 1989. Also in DRG Monitor, March, 1989

Levinson W, Dunn PM, Parker D, Kaufman K: **A Scale to Measure House Staff Members' Attitudes Towards Psychosocial Aspects of Patient Care.** Journal of Medical Education 63(7):562-3, 1988

Shepard MA, Parker D, DeClerque N: **The Under-reporting of Pressure Sores in Patients Transferred Between Hospital and Nursing Home.** Journal of the American Geriatrics Society 35(2):159-60, 1987

Jones SR, Parker DF, Liebow ES, et al.: **The Appropriateness of Antibiotic Therapy for Infections in Long-term Care Facilities.** American Journal of Medicine 83 (3):499-502, 1987

Levinson W, Shepard MA, Dunn PM, Parker DF: **Cardiopulmonary Resuscitation in Long-term Care Facilities: A Survey of Do-non-resuscitate Orders in Nursing Homes.** Journal of the American Geriatrics Society 35:1059-62, 1987

Parker DF, Levinson W, Mullooly JP, Frymark SL: **Using the Quality of Life Index in a Cancer Rehabilitation Program.** Journal of Psychosocial Oncology 7(3):47-62, 1989

Askey DA, Parker DF, Alexander D: **Clergy as Intermediary: An Approach to Cancer Control,** in Progress in Cancer Control IV: Research in the Cancer Centers. NY: A.R. Liss, 1983

Enterline JP, Parker DF, White JE: **Planning Applied Population-Based Cancer Control Programs: The Uses of Mortality and Morbidity Data,** in Issues in Cancer Screening and Communications. NY: A.R. Liss, 1982

Parker DF, Enterline JP, White JE: **Differences Between Black and White Responses to Health Promotion Mechanisms,** in Issues in Cancer Screening and Communications. NY: A.R. Liss, 1982

REPORTS

Key Maternal and Child Health Status Indicators (for the State of Florida and each of the 67 counties). Published by Healthy Beginnings Program, College of Public Health, University of South Florida, 1991 & 1992

Maternal and Child Health County Data Books. Published by Healthy Beginnings Program, College of Public Health, University of South Florida, 1989

Cancer of the Esophagus, Metropolitan Washington Regional Cancer Registry Report Series, Vol. 1 (co-authored with John Enterline, Martin Levy, et al.). Published by Howard University and the Government of the District of Columbia, 1982

The Distribution of Cancer Mortality in Washington, D.C., 1971-1976 (co-authored with Jack White). Published by the Cancer Coordinating Council for Metropolitan Washington, 1979

The Present State of the Metropolitan Washington Regional Cancer Registry (co-authored with John Enterline). Published by the Cancer Coordinating Council for Metropolitan Washington, 1978

ATTACHMENT 3

C-CRAB Membership List

FLORIDA CANCER CONTROL AND RESEARCH ADVISORY COUNCIL (C-CRAB)
MEMBERSHIP LIST
Revised 1/29/93

Position Number	Name & Address	Phone/Fax	Dates of Term	Representation
16	Elizabeth A. Bacon-Pituch Dept. of Education 325 W. Gaines St., Room 422 Tallahassee, FL 32399-0400	(904) 488-3586 FAX: (904) 488-6319	2/14/92- 12/31/95	Dept. of Education
23	Rita Bjork 1028B Green Pine Blvd. West Palm Beach, FL 33409	(407) 684-8879	2/14/92- 12/31/95	General Public
29	Clarence H. Brown, III, M.D. VP for Medical Affairs & Medical Director Orlando Cancer Center 85 W. Miller St. Orlando, FL 32806	(407) 648-3800 x1851 FAX: (407) 425-5203	Appointment in process	Orlando Cancer Center
25	The Honorable Virginia Brown-Waite Hernando Government Complex, Rm. 361 20 N. Main St. Brooksville, FL 34601	(904) 544-2344 or (800) 949-2483	Appointed 1/7/93	Florida Senate
3	Jean A. Byers, CTR 3160 Auburn Blvd. Ft. Lauderdale, FL 33312	Home: (305) 584-7671 Beeper: (305) 355-9140	3/14/90- 12/1/93	Florida Tumor Registrars Association
10	Denis Cavanagh, M.D. Harbourside Medical Tower 4 Columbia Dr., Suite 470 Tampa, FL 33606	(813) 254-7774 FAX: (813) 254-0940	1/16/89- 12/1/92 Renominated for another term	Univ. of South Florida, College of Medicine
1	Charles S. Eytel, M.D. 400 8th St. N. Naples, FL 33940	(813) 649-3311 FAX: (813) 649-3301	2/14/92- 12/1/95	American Cancer Society

1	Charles S. Eytel, M.D. 400 8th St. N. Naples, FL 33940	(813) 649-3311 FAX: (813) 649-3301	2/14/92- 12/1/95	American Cancer Society
2	Daniel M. Finkelstein, D.O. 1750 N.E. 167th St. North Miami Beach, FL 33162	(305) 949-4000 x1512 FAX: (305) 949-4000 x1598 or x 4404	2/14/92- 7/1/95	Southeastern University of Health Sciences
6	Jane D. Garcia, A.R.N.P. EMSA 100 N.W. 70th Ave. Ft. Lauderdale, FL 33317	(305) 584-1000 x7680	1/6/89- 12/1/92 Renominated for another term	Florida Nurses Association
9	W. Jarrard Goodwin, Jr., M.D. Dept. of Otolaryngology (D-48) University of Miami P.O. Box 016960 Miami, FL 33101	(305) 585-7995	2/14/92- 12/1/95	Univ. of Miami School of Medicine
27	Jerry L. Harris, M.D. P.O. Box 14389 Tallahassee, FL 32317	(904) 878-5143 FAX: (904) 942-6622	3/14/90- 12/1/93	Florida Society of Pathologists
18	Sister Mary Clare Hughes President & CEO St. Vincent's Health System 1801 Barrs St., Suite 5747 Jacksonville, FL 32203	(904) 387-7550 FAX: (904) 981-2900	3/14/90- 12/1/93	Florida Hospital Association
19	Herbert D. Kerman, M.D. Halifax Medical Center 303 N. Clyde Morris Blvd. Daytona Beach, FL 32015	(904) 254-4210 FAX: (904) 254-4383	12/20/90- 12/31/94	Association of Community Cancer Centers
20	Jeffrey P. Krischer, Ph.D. 4110 S.W. 34th St., Suite 22 Gainesville, FL 32608	(904) 392-5198 FAX: (904) 392-8162	Reappointment in process	Florida Association of Pediatric Tumor Programs

30	Phillip J. Marty, Ph.D. USF College of Public Health 13201 Bruce B Downs Blvd, MDC 56 Tampa, FL 33612-3805	(813) 974-6688 FAX: (813) 974-5172	Appointment in process	Univ. of South Florida, College of Public Health
12	Elisabeth S. McKeen, M.D. 1117 N. Olive Ave., #201 West Palm Beach, FL 33401	(407) 833-1773 FAX: (407) 833-1799	3/14/90-12/1/93	Florida Society of Clinical Oncology
7	Arnold I. Miller, D.O. Regional Oncology/Hematology Assoc. 802 West Oak St. Kissimmee, FL 34741	(407) 846-8441 FAX: (407) 933-8549	3/14/90-12/1/93	Osteopathic Medical Association
26	James W. Orr, M.D. Watson Clinic 1600 Lakeland Hills Blvd. Lakeland, FL 33804-5000	(813) 680-7578 FAX: (813) 680-7954	2/14/92-12/1/95	Florida Obstetric & Gynecologic Society
14	Paul A. Pitel, M.D. Chief, Hematology/Oncology Nemours Children's Clinic 807 Nira St. Jacksonville, FL 32207	(904) 390-3789 FAX: (904) 390-3790	6/20/89-12/1/92	Florida Pediatric Society
11	Warren E. Ross, M.D. [Acting Chair] Associate Dean University of Florida, College of Medicine Box J-215, JHMHC Gainesville, FL 32610-0215	(904) 392-5265 FAX: (904) 392-6482	6/8/90-12/1/93	Univ. of Florida College of Medicine
28	John C. Ruckdeschel, M.D. Center Director H. Lee Moffitt Cancer Center 12902 Magnolia Dr. Tampa, FL 33612	(813) 972-7265 FAX: (813) 979-3090	Appointment in process	H. Lee Moffitt Cancer Center & Research Institute
8	David H. Shapiro, M.D. 1260 S. Greenwood Ave., Suite E Clearwater, FL 34616	(813) 441-8142 FAX: (813) 441-1651	12/20/90-12/1/94	American College of Surgeons

28	John C. Ruckdeschel, M.D. Center Director H. Lee Moffitt Cancer Center 12902 Magnolia Dr. Tampa, FL 33612	(813) 972-7265 FAX: (813) 979-3090	Appointment in process	H. Lee Moffitt Cancer Center & Research Institute
8	David H. Shapiro, M.D. 1260 S. Greenwood Ave., Suite E Clearwater, FL 34616	(813) 441-8142 FAX: (813) 441-1651	12/20/90- 12/1/94	American College of Surgeons
17	William M. Schiff, D.D.S. Univ. of Miami School of Med. Dept. of Oral Maxillofacial Surgery Doctors Hospital, 5000 University Dr. Coral Gables, FL 33136	(305) 448-0348	Appointment in process	Florida Dental Association
22	Frances Sykes 13327 Lake George Pl. Tampa, FL 33618	(813) 961-5760	Appointment in process	General Public
4	Edward J. Trapido, Sc.D. Sylvester Comp. Cancer Center PO Box 016960 (D4-11) Miami, FL 33101	(305) 547-3356 FAX: (305) 548-4871	12/20/90- 12/1/94	Sylvester Comprehensive Cancer Center
5	John J. Witte, M.D., M.P.H. Assistant Health Officer Disease Control & AIDS Prevention 1317 Winewood Blvd. Tallahassee, FL 32399-0700	(904) 487-2542 FAX: (904) 488-3480	2/14/92- 12/31/95	Dept. of Health and Rehabilitative Services
15	VACANT			Florida Radiological Society
21	VACANT			General Public
24	VACANT			House of Representatives

ATTACHMENT 4

Minutes from C-CRAB Meetings:

January 22, 1992
March 9, 1992
April 30, 1992
June 27, 1992
November 5, 1992

MINUTES

C-CRAB EXECUTIVE COMMITTEE MEETING WITH THE TECHNICAL ADVISORY GROUP
January 22, 1992

Meeting called to order.

Members Present:

Sister Mary Clare Hughes, CEO
Richard Karl, M.D.
Clyde McCoy, Ph.D.
Jean Byers, CTR
Jo Beth Speyer, M.S.W.
Phillip Benson
Tanya Rooks
Martin Green
Ernest Feigenbaum, M.D.
Susan Smith
Leslie Crawford
Lisa Gorospe, RN
Vickie Pryor, RN
Marilyn Crowell
June Sheehan
Warren Ross, M.D.
Jerry Woelfel

Staff Present:

Richard S. Hopkins, M.D.
Gita Soltani, Ph.D.
Sandra Wilkins, M.A.
Doug Palin, M.S.
Raul Quimbo
Michelle Houle

Dr. McCoy started off with a brief description of the C-CRAB history. How it began? What the missions are? The Cancer Plan was designed to prioritize cancer in Florida and to address all types of cancer and find out what needs to be done.

D. Palin led a discussion regarding Inventory in Cancer Services. Told the group where to call to get certain kinds of information. Asked if there was a need for more types of directories.

T. Rooks from Health Promotion & Education said that we needed something that told what kind of services were offered to the community. The PRIDE survey is now complete. T. Rooks stressed the fact that even though it was just done it now had incomplete information, and needs to be updated regularly.

J.B. Speyer is currently rewriting the proposal criteria for licensed mammography units using ACR and NCI guidelines through telephone surveys. Wanted to know what the state criteria was.

D. Palin said is was mainly equipment related.

Dr. Hopkins announced that we were between Phase 1 and 2 in the DBI project. Said that Phase 3 would probably take 3 to 4 years. Wants a list of priorities for the Cancer Plan and who is going to carry out these tasks. He then began his slide presentation regarding the ideal breast cancer control process, mortality and incidence data. He also told Jo Beth that he would be very interested in combining the data done by the Cancer Information Service with the data received from FCDS.

Went over briefly the priorities of NCI, state of the art treatment, breast cancer, cervical cancer, and tobacco cessation. Explained to the group what Age adjusted meant as opposed to crude rates. Said his data was based on the 1970 Florida population. Stressed that since people lived longer these days it was more accurate to use current years instead of using 1940.

L. Crawford wanted to know if the doctors were ordering mammograms and the women were not following through.

V. Pryor discussed the gap in information because some doctors may feel that their patients can't afford the procedure therefore does not recommend that it be done.

P. Benson brought out that women might decide it was important enough to spend money on it if the doctors stressed it was necessary.

BREAK 10:15 a.m. - 10:30 a.m.

Dr. Hopkins went over definitions of In Situ, Local, Regional, Distant.

Dr. McCoy mentioned may be we could lower mortality by using more aggressive treatment.

L. Crawford brought up the relationship between estrogen replacement and the incidence rate.

Dr. Ross said that data was still unclear.

J.B. Speyer brought up a Swedish survey, said they offered different types of estrogen along with different doses administered.

Sister wanted to know how do we get outpatient data.

Dr. Hopkins said at the present time they were having a hard enough time running FCDS on the funds available. Said that more services could not be offered because of lack of money. A definite increase in the budget is needed.

Dr. Feigenbaum suggested getting data from insurance companies. Said the HMO's should be interested in participating. They could give us accurate data as to what types of tests and how many are being performed.

Dr. Ross said that during the Lawton Chiles era he was demanding lots of data.

Dr. Hopkins went over a recent survey done by Epidemiology. Results were that most hospitals would be willing to continue reporting cases to FCDS without reimbursement. Very few said they would not. Dr. Hopkins said this would help as far as FCDS's budget is concerned.

Dr. Feigenbaum stressed that if we produced data the counties could use it and it would help them gain funding from the legislature. Example: We have a high rate of a certain cancer, give us some money so we can research this and find out what the problem is.

S. Smith told how frustrating it was trying to analyze cases now in hospitals for lack of information. Hospitals records need to be more complete.

Dr. Crockett said we need a way of monitoring data and being able to do a follow up.

Dr. McCoy said that Medicare has a lot of potential.

Dr. Hopkins brought up the fact that there seems to be a pattern in cervical cancer in black women throughout the counties. See more in the Pan Handle.

Dr. Ross mentioned it could be Raydon exposure through streams.

V. Pryor said it could also be due to phosphate mining.

Dr. Hopkins went on to Lung cancer. Said he could make out no definite patterns.

J.B. Speyer wanted to know what counties have the highest amount of smoker.

M. Green said the PRIDE survey would be helpful but, there are many areas that the survey could not cover. Such as minor smoking behaviors.

P. Marty said information was available but difficult to compare.

LUNCH 12:00 p.m. - 1:15 p.m.

Sister started off with going over the current C-CRAB committee groups. Wanted to know if they should be updated. Also discussed the need to update sections in the Cancer Plan.

Dr. Hopkins wanted to know what kind of data should be offered. Disease specific needs was agreed upon. Said plan should just be a highlight that is backed up by other documentation.

J.B. Speyer wanted to know if this was going to be addressed by the Legislature. Said it needed to be simple and easy to follow.

Dr. Hopkins stressed that he only wanted one point raised per graph.

Whole group agreed that the Plan should be simple, accessible, people oriented, and widely distributed.

Dr. McCoy briefly went over who this should be mailed to: 28 organizations of C-CRAB, Legislatures, Public, CPHUs, ACS, FMA, Family Practice, Tumor Registrars, Hospitals. Explore all data and figure out who is responsible for distribution?

Dr. Hopkins brought up the fact that we did not do a good job marketing the current plan. Said that we did not get proper input from the public. Suggested using Public Hearings

Dr. Feigenbaum said we should encourage ACS do get involved.

Dr. Hopkins wanted to know if the data should be displayed by county, state districts, ACS districts, or area codes.

Dr. Crockett said the "real people" don't relate to the district level.

Group stressed that they would be more interested in data displayed by county.

Dr. Hopkins said he wants the dat displayed broke in groups no smaller than districts. County would be to specific. And this is supposed to be more of an overview.

A point was raised from local concerns: Where to you go for service? Need more specialist.

P. Marty announced that ACS is establishing INET for referral purposes and it will begin functioning soon.

Dr. McCoy brought a survey done by the Univ. of Miami for metro, urban, and rural staging. There was a problem with the size of counties, could not get an accurate scale population

Dr. Hopkins again brought up the prioritizing of the Plan. Should be organized around Breast/Cervical Cancer, Tobacco, Treatment, Other Cancer, Miscellaneous, Summary of all chapters. Plan should be brief not technical or clinical.

P. Benson said that going back & forth between county and district would be confusing and defeat the purpose of being simple. Maybe we should stick to districts. Might help to deal with bigger chunks.

P. Marty said that we would have support from ACS.

D. Palin stressed the fact that if we go on the road to find out what the public wants. We should keep in mind their observations and use their ideas, if not what is the point of asking.

Dr. McCoy said it would be impossible to go on the road without county data.

Dr. Feigenbaum introduced APEX said it had to do with community planning and action programs, assessment of local needs, organize public, endorsing projects, and setting goals for the future.

J.B. Speyer suggested using the Executive Summary as an Overview.

1. Overview
2. Cancer Plan
3. Technical reports (backup documentation)

Group then discussed committees. People chose which committees they would like to on.

1st Choice:

I. Breast and Cervical Cancer: McCoy, Speyer, Crawford, Boyack, Gorospe, Crowell, Smith

II. Tobacco: Byers, Green, Pryor, Benson, Marty

III. Access: Feigenbaum, Woelfel

IV. Miscellaneous: Crockett

2nd Choice:

I. Breast and Cervical Cancer: Feigenbaum, Byers, Pryor, Benson

II. Tobacco: Boyack, Crowell, Smith, Crockett

III. Access: McCoy, Speyer, Crawford, Gorospe

IV. Miscellaneous: Woelfel, Green, Marty

A Point was brought up that everyone should be involved in the Executive Summary. Also that Other Cancers should be included in the Plan.

Sister discussed ideas for the next meeting date. March 9 or March 12. No decision has been made yet. It was decided however to have a C-CRAB meeting from 10:00-12:00 break for lunch and meet with the TAG from 1:00-5:00.

Meeting adjourned. 3:00 p.m.

FLORIDA CANCER CONTROL AND RESEARCH ADVISORY COUNCIL (C-CRAB)

MINUTES

March 9, 1992

Meeting Site:
Emergency Medical Services
Building D, Main Conference Room
Tallahassee, Florida

MEMBERS PRESENT:

Sr. Mary Clare Hughes, Chairman
Beth Bacon-Pituch
Jean A. Byers, C.T.R.
Denis Cavanagh, M.D.
Charles Eytel, M.D.
Jane Garcia, A.R.N.P.
Jerry L. Harris, M.D.
Richard C. Karl, M.D.
Jeffrey Krischer, Ph.D.
Jack W. MacDonald, M.D.
Elizabeth McKeen, M.D.
James Orr, M.D.
Paul Pitel, M.D.
Edward Trapido, Sc.D.
John J. Witte, M.D.

MEMBERS ABSENT:

Kelli Crabb, J.D.
Daniel Finkelstein, D.O.
Rep. Lars Hafner
George Karr, D.D.S.
Herbert Kerman, M.D.
Sen. Jeanne Malchon
William Mendenhall, M.D.
Arnold I. Miller, D.O.
Clyde B. McCoy, Ph.D.
Warren E. Ross, M.D.
David Shapiro, M.D., F.A.C.S.

GUESTS:

John Carbonneau
Landis Crockett, M.D.
Lisa Gorospe, R.N.
Richard S. Hopkins, M.D., M.S.P.H.
Jill MacKinnon
Maurine Jones, Ph.D.
Vicki Pryor, R.N.
Sharon Reich
Jo Beth Speyer, M.S.W.

STAFF:

Gita Soltani, Ph.D.
Douglas Palin, M.S.
Sandra L. Wilkins, M.A.
Raul Quimbo, M.S.
Kriss Hensley, M.S.W.
Martin T. Green, Jr.
Terry Work
Priscilla Rollison
Michelle Houle

CALL TO ORDER: **SISTER MARY CLARE HUGHES, CHAIRMAN**

Sister Mary Clare called the meeting to order at 10:10 a.m.

OPENING REMARKS:

Sister Mary Clare, Chairman welcomed everyone to the meeting and asked that C-CRAB introduce themselves and tell what organization they represented.

The Chairman then introduced the C-CRAB's newest member, Beth Bacon-Pituch, representing the Department of Education.

HRS AND C-CRAB UPDATE:

The Chairman asked Dr. Witte to give an update on current HRS issues. Dr. Witte stated that the lack of funds continues to be the primary issue and said Dr. Hopkins will address FCDS as well as legislation that is rapidly moving through both houses of the legislature. He asked Dr. MacDonald to report on what is happening regarding the relocation of the C-CRAB to the H. Lee Moffitt Cancer Center and Research Institute.

Dr. MacDonald described the desire of Mr. Moffitt to relocate the C-CRAB to the Moffitt Center to help with the problems that have plagued the C-CRAB for the last 12 years; one being lack of funding the other being lack of defined support staff. Moffitt wants to assist in the growth and expansion of the C-CRAB. The relocation would place the C-CRAB under the Board of Regents and offer the C-CRAB a physical location at the H. Lee Moffitt Cancer Center and Research Institute. This is known as a two legislature initiative: This year we'll relocate by statute, and next year we'll create a source of funding. Dr. Mahan, Dr. Witte, and Dr. Hopkins, Dr. MacDonald and Jerry Woelfel, ACS, met just before a conference call between the Executive Committee Members. Dr. Mahan said he would have no specific objection to relocating the C-CRAB outside of HRS if the major emphasis remained on epidemiology, early detection, and prevention. Mr. Moffitt gave Dr. MacDonald the reassurance that these would remain the priorities of the C-CRAB. His only additional request was that a member representing the University of South Florida, College of Public Health be added to the C-CRAB. An amendment was tagged onto the HRS Reorganization Bill and has passed through several of the committees.

Dr. Witte discussed a call received from a member of the Senate HRS Committee saying that this legislation has been introduced into the senate and into the house. The amendment is in place for discussion and vote by the Legislature. The Moffitt Statute and the HRS reorganization bill are basically worded the same.

Dr. Hopkins pointed out that the C-CRAB serves in an advisory capacity to the Secretary of HRS on issues of cancer control and research. One consequence of this bill would be that the entity with the power to award contracts and grants would now belong to the Board of Regents.

MOTION: Dr. Trapido put forth a motion that the C-CRAB object to changes proposed in Amendment 016, House Bill 2379 and not recommend it's adoption.

Dr. Trapido felt it would be a disaster to move from one bureaucracy to another and pointed out that the goals of the Board of Regents is education not health. He stated that there are no guarantees that any money will be allocated simply because it is being moved to education and he was sure that everyone on this committee wishes that it could have been more active throughout the years, and was clearly due to lack of funding.

Dr. Crockett asked why you should you want to move the C-CRAB.

Dr. Trapido brought up the point that if the committee is moved elsewhere, people have to understand that the C-CRAB has always tried to maintain a non parochial chairmanship and kept it away from the medical schools. If it is going to be moved it should be done in an open way and let the four schools bid for it and not do it behind the scenes by a small group of people.

MOTION SECOND: Jeffrey Krischer seconded the motion.

Sister pointed out that nothing was known about this until after the last C-CRAB Executive Committee meeting held on January 21, 1992.

Dr. McKeen wanted to know just how much weight the C-CRAB could pull in opposing this bill.

Sister pointed out that C-CRAB is just an advisory group and does not have the weight of a legislative body.

Dr. MacDonald went into a brief summary of how this bill came about. The committee's lack of producing or doing something was one of the major problems. The American Cancer Society wanted to get Public Affairs involved. The Florida Cancer Plan is one component of the existence of the C-CRAB but that is not all it consists of. The American Cancer Society with their interests and Mr. Moffitt with his own independent interest began to realize that he could get the C-CRAB going in the right direction in formulating public policy by getting a vehicle properly funded to create an entity called the Florida Cancer Control and Research Advisory Council in a manner that is interchangeable to public policy for volunteer groups. Two things became evident, C-CRAB could never gain funding for support staff. Mr. Moffitt and the American Cancer Society took steps to get a dedicated staff person. Two years ago in a meeting Dr. Schiebler discussed that the C-CRAB was a fine organization and has a finely crafted statute and should be moved somewhere where it could receive some money. Someone asked where that somewhere would be? Give it a home and resources at the H. Lee Moffitt Cancer Center. Someone else said that was fine for one year but would they want to continue to do it for the next 25 years? Nothing else was said about it until recently with the introduction of this bill. The question asked by Jean Byers was what clout does the C-CRAB have? Dr. MacDonald said he thinks everyone has the number to their representative. You will find that they don't know anything about this and that they would not hang up if you told them no money is involved. Any input to the legislature would have to be on an individual basis.

Dr. Cavanagh brought up a story about Mr. Moffitt wanting to appoint a Cancer Center Director because he felt that the University of South Florida was not giving the center proper support. After a lot of back and forth between the school and the cancer center, Mr. Moffitt finally took the bull by the horns and went to Tallahassee to formulate a bill. As President of the medical staff, Dr. Cavanagh, in accordance with a faculty vote on the subject, Dr. Cavanagh opposed Mr. Moffitt. In the end, Mr. Moffitt still got his bill and the new Director of the Moffitt Cancer Center is working out very well. In view of his past experience, Dr. Cavanagh felt Mr. Moffitt may be right again and it may be a mistake to oppose this bill. Dr. Cavanagh said we should look at this in a different way: Mr. Moffitt is tired of looking at the C-CRAB sitting there for 12 years being ineffective, and this is his way of making the C-CRAB work. Just like appointing a Czar at the Moffitt Cancer Center was his way of making it work.

Dr. MacDonald spoke in opposition of the motion. He basically agreed with what Dr. Cavanagh had to say. We can look at this thing in all different ways. Mr. Moffitt clearly has two goals one is to enhance the success of the Cancer Center and the other is to get the C-CRAB funded.

Jeffrey Krischer spoke in favor of the motion due to his concern about the transition between education and health.

MOTION DEFEATED: Motion was voted upon and defeated.

Jean Byers asked how this would effect people the C-CRAB has come to depend on such as Dr. Hopkins.

Dr. Hopkins answered by saying that HRS will still be represented by Dr. Witte. The National Cancer Institute's Data Based Intervention Project has the mission to develop the Cancer Plan. That would not be changed. What would happen to the one staff position that supports C-CRAB is not clear right now.

Administratively there is no specific budget for C-CRAB so there is nothing to transfer to the Cancer Center. If the Moffitt Cancer Center had a vigorous administrator he could ask how much have we spent so far. I am not sure how this will fall out. To date there have been no allocations for C-CRAB the money has been taken out of the Cancer Registry.

Dr. MacDonald stated that that was the problem right there. You thought she worked for C-CRAB but she doesn't. Our position is that you don't really have a staff person, the politicians think we do. I think that reflects the frustration of many people who have come to the conclusion that C-CRAB should be moved somewhere else.

Dr. Hopkins stated that he understood that. Dr. MacDonald said earlier that Moffitt and ACS was responsible for getting a position to support the C-CRAB, and that's true, we are very grateful for that. As far as I can tell given the history of our budget there was never any match in appropriations. We are grateful for what they did do but it may not be quite as much as you think it is.

Dr. Witte stated there is another legislative issue that will directly effect the C-CRAB. The proposal of the Breast Cancer Task Force.

Dr. Hopkins said the bill was progressing in a steady fashion. The bill was introduced by Winnie Holland, lobbyist for the Florida Professional Women's Association, former employee of HRS. The Task Force would consist of about a dozen members. Charged with coming up with a report of ways to teach women about breast self exams and mammography. The American Cancer Society supports this bill. He feels that this is overlapping the responsibilities of the C-CRAB. The bill also requests that HRS provide the staff support for this Task Force. You are all familiar with the ability of a Task Force with no support staff. At a time when the government is as strapped for money as it is now, it seemed like a strange bill to him.

Dr. Cavanagh asked who the Task Force will answer to?

Dr. Hopkins said that the organizations that are to be represented on the Task Force are already on the C-CRAB with the exception of large and small businesses. The American Cancer Society gave a written statement to the Senate Health Care Committee that they would be willing to provide support staff to the Task Force.

DATA BASED INTERVENTION CO-OPERATIVE AGREEMENT UPDATE:

Dr. Soltani discussed the Co-Operative Agreement. The Data based intervention project which is funded by the National Cancer Institute. The goal of this program is to work with the Department and build a foundation for growing cancer control programs. The C-CRAB is helping prioritize cancer problems involving data intervention. NCI has six priorities. We were asked to pick at least four priorities to focus on. Florida will be focusing on Cessation and prevention of Tobacco Use, Breast Cancer Detection, Cervical Cancer Detection, and Access to State-of-the-Art Treatment. Environmental and occupational exposure are going to be covered under the Emerging Issues Committee. Florida already has a Cancer Plan and our goal is to help update the current plan. Phase One of DBI involves analyzing all available data. NCI does not fund surveys. DBI's goal is to use available data such as Florida Cancer Data System and Behavioral Risk Factor Surveillance System. The Florida DBI is in the process of going into Phase Two. Phase Three is the implementation of interventions. DBI does not pay for actual services it pays for coordination and evaluation of services. Phase Four consists of finding out what intervention works.

The Chairman asked Dr. Soltani to explain the relationship between the DBI study and C-CRAB.

C-CRAB is an advisory group for cancer control and prevention in Florida. The goal of DBI is to reduce cancer mortality and morbidity. DBI basically provides the resources to update the Cancer Plan.

What year is the DBI in?

Dr. Soltani responded that the DBI project is a seven year grant. We are in the transition between Phase One and Two. It was funded in December of 1990. It started late because of the HRS budgetary process. The DBI professional staff weren't hired until June of 1991.

The Chairman pointed out that the new draft of the Cancer Plan is due by June, 1992. And wanted to know when the data reports were due to NCI.

Dr. Soltani stated that data analysis is an ongoing process, it is not that clear cut as to our deadlines. We have to have the draft of the Cancer Plan by June, 1992.

Dr. Witte wanted to know if it was a requirement of the National Cancer Institute that the C-CRAB approve of the Cancer Plan.

Dr. Soltani answered yes.

DATA PRESENTATION/REVIEW:

Dr. Hopkins discussed that the objective of the committee meetings were to come up with a list of 4 or 5 top priority interventions. As far as possible, the priority areas should be based on available data. In some cases we must depend on clinical experience and real world knowledge. C-CRAB will then take those lists and combine them into one list and decide from that what the main priorities are. We would like to be able to say that all are in agreement that Intervention A is the one top priority and Intervention B is the second top priority, and Intervention C is the third top priority. That doesn't mean that the Florida Cancer Plan can not include 25 to 50 other activities that C-CRAB feels is important.

Dr. Hopkins shared overhead graphics (Attachment A) which depicted incidence and mortality rates of the most current data from Florida Cancer Data System for Breast & Cervical Cancer as well as treatment data from BRFSS.

A few highlights were:

1. Age specific incidence showed that breast cancer is steadily increasing in white women.
2. Older minority women get fewer mammograms.
3. Lower income women don't get mammograms.
4. Women over 40 who have not finished high school get fewer mammograms.
5. Diagnosis in the Local stage is rising. Meaning more cases are being found early on and are more treatable.
6. The reasons most women gave for not receiving mammograms are:
    a. The doctor did not recommend it.
    b. They did not think they needed it.
    c. Cost was not a factor.

Dr. Krischer asked if the BRFSS data could be used by others.

Dr. Hopkins said that he would be glad to share his BRFSS information with interested parties. He added there were problems getting record layouts and he certainly wouldn't burden anyone with data that they couldn't read.

FCDS BUDGET REPORT:

Doug Palin gave the members a brief summary on the FCDS budget. Due to increases in operational costs, inflation, a growing registry which means a growing data base and budget cuts, we find ourselves now in the position of reimbursing the hospitals for FY 1991-92 out of FY 1992-93 funds. A part of the

appropriations by registry law must be used for reimbursement of hospitals at a reasonable cost. Hospitals will have to be reimbursed by using next years funds causing a reduction in funds for FY 1992-93 operation. There has been a request made from our office for an emergency allocation of $200,000 to use for reimbursement for the hospitals. If we don't receive this funding we have very few options; one being to assume level funding and reimburse hospitals with what we have left. The other option would be to cease collecting any more cases and cleaning up and editing all the records we currently have. We could then use next years funds to close out the registry and have 10 years of registry data to work with in the future. If new funds are appropriated in the future we may be able to catch up or we may not. At the present time we have no expectation of increased funds. At this point we also have no indication of further reduction.

The Chair asked what was the standard reimbursement for hospitals?

Doug Palin answered that the standard fee is $3.00 per case.

Dr. Hopkins pointed out that there hasn't been any reimbursement since last July. We are only reimbursing once per year.

Dr. MacDonald said, So if they don't take next years budget further, there won't be any reimbursement for this coming July either.

Doug Palin, "Yes, and based on earlier estimates and funds reserved for the hospital registry the actual reimbursement cost will be short even with the $150,000. We either have to cut further into operational cost or reimburse at the rate of $2.35 per case. In other words we would be prorating the reimbursement fee.

The Chair asked Dr. Hopkins what we would do without a registry?

Dr. Hopkins replied that Doug Palin was correct in his assessment of the situation. In the reality budget we don't even claim the actual cost it takes to run the registry properly. So each year we try to run the registry with less and less money and go further in the hole. We have been paying the hospitals later and later and so we end up paying for this years cases with next year's funds. We have asked for an allocation of $200,000 to support the registry. Even with this money the registry will still be in the hole. To answer your question, many states function just fine without a registry. I prefer to have one available for a lot of reasons. It does make cancer control priorities much more reasonable, things are possible to plan based on actual data, therefore making it easier to gain appropriations.

The Chair asked Dr. Hopkins if there was any action that this council could take to help that would help in this situation or have they begun the budgetary process?

The legislature needs to hear from concerned citizens about the importance of cancer control. If they don't hear from people they won't take any action. One idea that we have talked about is that we amend the law that establishes that we have to reimburse the hospitals. Most states do not reimburse the hospitals for reporting and some states tax the hospitals to support the registry. From our point of view the $150,000-200,000 that we would save by not reimbursing the hospital would help us keep the registry functioning properly.

Jean Byers made a point that without the reimbursement it would make it very difficult for hospital registries to report. Many hospitals want to use the money they receive in updating the registry and the education of the registrars.

Dr. Hopkins stated that he was not happy with this idea of not reimbursing the hospital but it was one possible option the Department could take.

Doug Palin described the results of a hospital survey trying to get some feel for the hospitals response to this possibility. An overwhelming number of hospitals said that they would continue to report whether they were being reimbursed or not and few of them said yes, they would on a temporary basis to overcome this shortfall. There were not more than four that flat said, no. We also asked what other types of information we could supply regarding data analysis that would be more helpful to the registries. We received many good ideas.

Dr. Hopkins explained the process of getting this issue onto the Governor's Investment Budget. First we have to get approval of the issue by Dr. Witte to say yes this is a priority. He goes up to his level and talks to Dr. Mahan to get his approval. Then Dr. Mahan goes in front of the Executive Management Group (Medicaid, CYF, etc.) to get it approved by the Department to be on the Governor's Investment Budget. A request for up to 1.7 million dollars to support early detection of breast and cervical cancer through the county public health units did make it to the Governor's Investment Budget but the request for an enhanced registry did not make it into the Investment Budget. C-CRAB is an advisor to the Secretary. I don't think the Secretary thinks about the C-CRAB too much from day to day. Presumably one of the things the C-CRAB should do is advise the Secretary regarding cancer control. C-CRAB could opt to write a letter to the Secretary discussing their views on this issue.

The Chair asked if the C-CRAB wished to take any action regarding the registry? "I think, if I understood Dr. Hopkin's last comment, that we are the advisors of the Secretary. We could alert the Secretary by a letter that we are concerned about losing the funding or not receiving an increase for the registry."

MOTION: Jean Byers made a motion that the C-CRAB write a letter to the Secretary sharing the concerns of the C-CRAB regarding the need for increased appropriations for the Registry.

The motion was seconded.

No further discussion of the motion was needed.

MOTION: Passed unanimously.

12:10 to 1:15 Lunch

Sister Mary Clare, Chairman welcomed everyone to the second half of the meeting mentioning that a large group of advisors had joined the C-CRAB and asked that everyone introduce themselves and tell what organization they represented.

Dr. Hopkins discussed that the objective of the committee meetings were to come up with a list of 3 or 4 priority interventions. As far as possible, the priority areas should be based on available data though in some cases we must depend on clinical experience and real world knowledge. C-CRAB will then take those lists and combine them into one list and decide from that what the main priorities are. We would like to be able to say that all are in agreement that Intervention A is the one top priority and Intervention B is the second top priority, and Intervention C is the third top priority. That doesn't mean that the Florida Cancer Plan can not include 25 to 50 other activities that C-CRAB feels is important.

The meeting participants broke out into the following committees:

a. Committee on Breast & Cervical Cancer
b. Committee on Access to State of the Art Treatment
c. Committee on Smoking Cessation and Tobacco Issues
d. Committee on Emerging Issues

COMMITTEE REPORTS TO THE C-CRAB:

The participants reconvened in a joint meeting to present committee reports to the C-CRAB. See attached individual committee reports for details. However, the following is an abbreviated list of each committee's first round of priority areas:

Emerging Issues: 1) Colorectal Cancer, 2) Public Awareness, 3) Developing Leadership (who will speak for cancer control) (Attachment B)

Breast & Cervical Cancer: 1) Education of Professionals, 2) Public Education, 3) Universal Access to Screening, 4) Quality Assurance (Attachment C)

Access to State of the Art Treatment: Access to State-of-the-Art Treatment was defined as Access to Evolving Standards of Care. The chosen priorities for interventions are to address professional and public education to decrease the barriers to knowledge about the care and treatment of cancer. (Attachment D)

Smoking Cessation & Tobacco Issues: 1) Reduce Usage of Tobacco by Minors, 2) Reduce Prevalence of Tobacco, 3) Reduce Usage of Smokeless Tobacco. Next meeting date set for April 14, 1992. (Attachment E)

ANNOUNCEMENTS

Jill MacKinnon announced that the American Association of Central Cancer Registries (AACCR) will be holding their annual meeting in Key Biscayne for interested parties who would like to attend. Meeting dates will be April 27-29, 1992.

NEXT MEETING

It was decided that the C-CRAB should meet again before the end of April. It was agreed that they would give time for the Committees to meet first to become better prepared.

FLORIDA CANCER CONTROL AND RESEARCH ADVISORY COUNCIL (C-CRAB)
FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
1317 WINEWOOD BOULEVARD
BUILDING 2
TALLAHASSEE, FLORIDA 32399-0700
(904) 488-2905
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MINUTES for C-CRAB Meeting held on April 30, 1992

Meeting Site:
Moffitt Research Center
H. Lee Moffitt Cancer Center
12902 Magnolia Drive
Tampa, Florida 33682-0179

C-CRAB MEMBERS PRESENT:

Beth Bacon-Pituch
Dept. of Education
Rita Bjork
Public Member
Jean Byers, CTR
Florida Tumor Registrar's Association
Denis Cavanagh, M.D.
University of South Florida
Charles Eytel, M.D.
American Cancer Society
Daniel Finkelstein, D.O.
Southeastern University of Health Sciences
Jane Garcia, R.N.
Florida Nurses Association
Richard S. Hopkins, M.D., M.P.H.
State Epidemiologist (representing Dr. John Witte)
Richard Karl, M.D.
H. Lee Moffitt Cancer Center
Jeffrey Krischer, Ph.D.
Florida Association of Pediatric Tumor Programs
Jack W. MacDonald, M.D.
Florida Medical Association
Warren Ross, M.D., Associate Dean
University of Florida's Medical School
Edward Trapido, Sc.D.
Sylvester Comprehensive Cancer Center

OTHERS PRESENT

Mr. H. Lee Moffitt
Mr. Carl Bender
American Cancer Society
Ms. Dorothy Green
American Cancer Society
Carol Palomino, Government Relations Manager
H. Lee Moffitt Cancer Center and Research Institute
Dr. Jack Ruckdeschel, Center Director
H. Lee Moffitt Cancer Center and Research Institute
Jerry Woelfel
American Cancer Society

C-CRAB MEMBERS ABSENT:

Sister Mary Clare Hughes, CEO
St. Vincent's Health System
Kelli H. Crabb
General Public
W. Jarrard Goodwin, Jr., M.D.
University of Miami
Lars Hafner, The Honorable
House of Representatives
Jerry L. Harris, M.D.
Florida Society of Pathologists
George Karr, D.D.S.
Florida Dental Association
Herbert Kerman, M.D.
Assoc. of Comm. Cancer Ctrs.
Jeanne Malchon, Senator
Florida Senate
Elisabeth McKeen, M.D.
Fl. Soc. of Clinical Oncology
William Mendenhall, M.D.
Fl. Radiological Association
Arnold I. Miller, D.O.
Osteopathic Medical Assoc.
James W. Orr, M.D.
Fl. Obstetrics & Gyn. Society
Paul Pitel, M.D.
Florida Pediatric Society
David H. Shapiro, M.D.
American College of Surgeons

STAFF PRESENT:

Doug Palin
Kriss Hensley
Raul Quimbo
Sandra Wilkins

CALL TO ORDER:	JACK W. MACDONALD, M.D., VICE CHAIRMAN

Dr. Jack MacDonald called the meeting to order at 10:40 AM.

WELCOMING REMARKS:

Dr. MacDonald introduced H. Lee Moffitt who welcomed the C-CRAB to the Center and invited everyone to explore and visit the facility at their leisure and to make themselves comfortable. He expressed his interest in becoming a part of helping to develop resources to accomplish the goals and objectives of the C-CRAB. He stated that by working together we can develop some clear objectives about what we want to accomplish, take the best and market them to the legislature. His desire is to better articulate what the C-CRAB is all about as well as the need to develop revenue and resources. Mr. Moffitt asked the C-CRAB to view him as a resource. He offered his services as an advocate and would be pleased to promote pieces of the plan to the legislature in order to accomplish the C-CRAB's goals for cancer control in Florida.

In closing, Mr. Moffitt thanked everyone for being there and complimented the work of the C-CRAB.

Dr. MacDonald introduced Dr. Jack Ruckdeschel, the H. Lee Moffitt Cancer Center Director. Dr. Ruckdeschel welcomed everyone and invited them to relax and enjoy themselves while at the H. Lee Moffitt Cancer Center and Research Institute.

Dr. Ruckdeschel wanted everyone to know that he was not there to run things for the C-CRAB. The Center is investing enormous resources in the cancer control effort and is very interested in the C-CRAB's Cancer Plan. He wants to do whatever it takes to help get the process "jump-started".

On that note, Dr. MacDonald thanked Dr. Ruckdeschel for his opening remarks and requested that he return later to more specifically address the C-CRAB's transition and future.

Dr. MacDonald then asked that everyone in the room introduce themselves.

REVIEW OF THE MINUTES:

Dr. MacDonald called for the review of the March 9, 1992 meeting minutes. He asked for any additions, deletions or objections and, hearing no comments, ordered them enrolled as written. (Attachment 1)

FCDS BUDGET REPORT:

Dr. MacDonald then asked Richard Hopkins, M.D., State Epidemiologist, to address the funding status of the Statewide Cancer Registry, known as the Florida Cancer Data System (FCDS). Dr. Hopkins first explained that the FCDS is funded by the state legislature and is currently operated under contract by the University of Miami. He added that, at this moment, HRS is involved in a competitive bidding process for the renewal of the contract. He expressed concern about the stability and adequacy of the funding for the registry and stated that he is exploring alternative resources for the continued operation of the registry. The current legislative appropriation for the registry is about $200,000 less than is needed to operate the registry. He informed the C-CRAB that anyone concerned about this funding problem may express such concern to those in control of funds. The top management of HRS need to hear from outside individuals and groups that the registry is important.

There are several programs in other states which are functioning quite well and we should look at them carefully to see if we would like to adopt any one of them as a model.

To date, we have been locked in a circle: the C-CRAB asks for money to support cancer control and the legislature keeps responding to the C-CRAB that they need more information. In turn, nothing has happened - no funding is received and the C-CRAB remains frustrated.

Dr. Ruckdeschel suggested that one way to break the circle is to do something that will make things happen. To that end, he announced the Moffitt Cancer Center has $50,000 to add to a pot to prime the pump to get things started. In addition, Dr. Hopkins offered the possibility that if the chosen interventions meet NCI criteria for the DBI, the HRS DBI project might match that contribution. Perhaps other organizations will join us in setting up a one-time pool of money to demonstrate to the legislature how successful such projects might be. However, this would be a one-time fund raising effort from our constituents and a regular, dependable source of income must be made available if cancer control is to become successful.

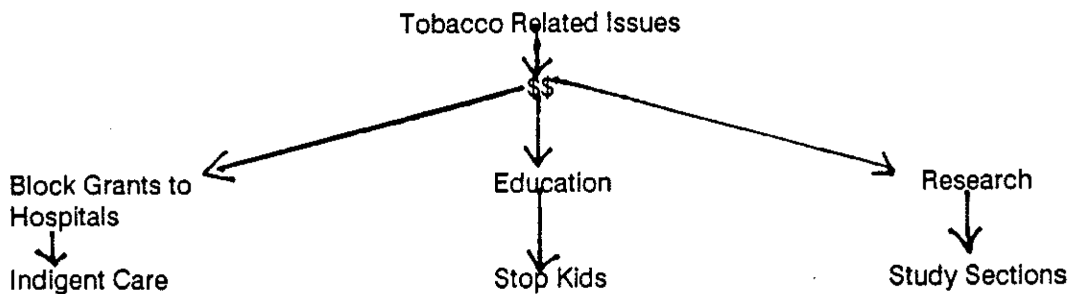
Dr. Ruckdeschel emphasized that there are good reasons for cancer centers being opened in the state and this is no time for fractious activity. The Moffitt Cancer Center is in favor of building collaboration among all the forces in the cancer control arena.

Dr. Ross expressed his concern that a RFP system in a state as large and diverse as Florida might not reach the people who need it. He suggested that we might look at another possible model which does not have to be considered mutually exclusive from the one Dr. Ruckdeschel presented. He mentioned Kentucky's program which had regional representatives out in the local areas to network and be in touch with what is needed.

Dr. Ruckdeschel agreed that community involvement from all areas will be important. He suggested that the RFP process flowing from the TAG(s) to the communities would be designed to stimulate grant applications from rural districts as well as urban areas. Grants would not be limited to scientific/technical proposals but would be open to less sophisticated programs considering implementing appropriate interventions in their communities. This system would provide the mechanism for accountability.

Dr. Ross indicated that C-CRAB needs to develop a mission statement before it can guide the cancer control activities in the state. The group agreed that this needs to be done.

Dr. Ruckdeschel mentioned that there are several good models that the C-CRAB might consider in selecting a process for developing cancer control activities but chose to cover the California program because he was personally familiar with it. California has a $ .25 tax on cigarettes which is distributed something like the following:



The California mass media campaign is funded under the education section.

The California cigarette tax was created by a public referendum and when the Governor wants to take the money for some other cause, it is more difficult because the constituency is much broader.

Lee Moffitt stated that he would be happy to be the legislative liaison to support whatever needs to be done to get a source of steady revenue.

Other possible sources might be suggested such as a sales tax on other services or products. Any other suggestions would be appreciated.

Dr. Ruckdeschel said that if the legislature doesn't support this after a few years, perhaps we (the C-CRAB) should pack up our marbles and go home.

A question arose as to how the staff transition to H. Lee Moffitt Cancer Center will be handled. Dr. MacDonald said that it will take a meeting with the current staff director, himself or the chairman and Carol Palomino of the Moffitt Cancer Center to decide the mechanics of the transition. The nuts and bolts of this will be left to the staff.

MOTION:

> Dr. Ross moved that C-CRAB adopt the concept that the C-CRAB is an advisory group that will make decisions regarding the flow and balance of funding for cancer control activities based on recommendations from a technical group that will do the work of evaluating proposals. The C-CRAB is not intended to actually manage the day to day activities of cancer control.

MOTION PASSED.

1:00 break for 1/2 hour lunch.

REVIEW OF ADVISORY COMMITTEE REPORTS:

The Committee on Access to State-of-the-Art Treatment Report was given by Dr. Charles Eytel. Dr. Eytel read through the report (Attachment 2) stating that the committee chose promoting the American College of Surgeons (ACoS) Cancer Program Standards for Cancer Care as the highest priority. The second priority is to help promote third party payment of cancer care. The third priority was encouraging both physician and public education in terms of treatment options and care.

After Dr. Eytel's report was completed, Dr. Hopkins asked that Council consider each in terms of how they should be prioritized. In addition, he asked them to consider how this information may be the beginning of a list of initiatives in terms of appropriateness and their fit into the priorities.

At the end of Dr. Eytel's presentation, Dr. MacDonald asked if there were any questions. Discussion ensued and it was agreed that the ACoS standards would be a great benefit to patients if they were embraced by an increased number of hospitals in the state of Florida.

The report was accepted as presented.

The Committee on Smoking Cessation and Tobacco Issues Report (Attachment 3) was presented by Jean Byers, C.T.R. Jean first announced the names of her committee members. She then stated that the group decided the main problem is one of perception. Tobacco is not looked upon as the killer it really is. She presented the report and discussed each aspect thoroughly. Jean reported that the committee had reviewed the California initiative and it would support a similar proposed tax on tobacco to fund cancer control activities in Florida and would like to see the C-CRAB carefully consider that option.

MOTION:

> Dr. Ross made a motion that this committee adopt the vehicle of increasing taxes on tobacco products (or some other product or service) as a formal mechanism for financing cancer control.

MOTION SECONDED. Discussion about the motion took place. No objection was raised

MOTION PASSED

It was made clear that this motion is not intended to be restrictive to the future decision-making of the C-CRAB, but is generic to show support for the concept of gaining consistent funding through a tax process.

The report was accepted as presented.

The Breast and Cervical Cancer Committee Report (Attachment 4) was presented by Dr. Cavanagh. Though no means for preventing breast cancer has been found, secondary prevention by means of early detection is very practical and may lead to either a cure or longer survival than does detection at later stages.

Dr. Cavanagh outlined eight objectives for the prevention and early detection of breast and cervical cancer.

Dr. Hopkins raised the question of choosing between the eight objectives/interventions as a matter of public health importance. How would the group prioritize their selections? He said the C-CRAB must ask themselves, "If I had to make a choice, how would I do that?" It is important that the C-CRAB consider these questions because within the next few months such decisions will have to be made and included in the updated Florida Cancer Plan.

The report was accepted as presented.

The Committee on Emerging Issues Report (Attachment 5) was given by Raul Quimbo. He stated that the committee is asking the C-CRAB to give direction as to which cancers that they presented to the C-CRAB on March 9, 1992, should be considered a priority. Discussion ensued regarding new data about the flexible sigmoidoscopy as an effective screening tool and this may be considered a professional and public education issue. It was also pointed out that inherited colon cancer is much more common than previously thought. In view of this and other emerging data, the C-CRAB asked the committee to come back with some data supporting colorectal, prostate and melanoma cancers.

The committee report was accepted as presented.

Dr. MacDonald asked that the committee staff put the information in a uniform format which will aid the C-CRAB in considering the material. It was stated that the C-CRAB needs a list to prioritize as well as orientation on the procedsses involved in prioritization.

The group confirmed that the C-CRAB needs to adopt a mission statement which will be the basis from which all decisions regarding activities and budget.

Dr. MacDonald asked if there were any new business. Hearing none, he suggested that the next meeting should be on a Friday afternoon or a Saturday.

The meeting adjourned a 2:45 PM

FLORIDA CANCER CONTROL AND RESEARCH ADVISORY COUNCIL (C-CRAB)

MINUTES

Tallahassee Memorial Regional Medical Center Auditorium
June 27, 1992

Members Present:
Sister Mary Clare Hughes, Chairman
Carl Bender (sub. for Dr. Eytel)
Jean Byers, CTR
Denis Cavanagh, M.D.
Daniel Finkelstein, D.O.
Jack Ruckdeschel, M.D. (sub. for Dr. Karl)
Jo Beth Speyer (sub. for Dr. Goodwin)
Dr. Tepperman (sub. for Dr. Krischer)
Edward Trapido, Sc.D.
John J. Witte, M.D,

Members Absent:
Beth Bacon-Pituch
Rita Bjork
Kelli Crabb
Jane Garcia, A.R.N.P.
Rep. Lars Hafner
Jerry Harris, M.D.
George Karr, D.D.S.
Herbert Kerman, M.D.
Jack MacDonald, M.D.
Sen. Jeanne Malchon
Elisabeth McKeen, M.D.
William Mendenhall, M.D.
Arnold Miller, D.O.
James Orr, M.D.
Paul Pitel, M.D.
Warren Ross, M.D.
David Shapiro, M.D.

Guests:
Clyde B. McCoy, Ph.D.
Marie Cowart
Carol Palomino

Staff:
Douglas Palin
Raul Quimbo
Kriss Hensley
Martin Green
Michelle Houle

The meeting was called to order at 10:35 a.m. by Sister Mary Clare Hughes, Chairperson.

The Chairperson began the meeting by asking the members if it was acceptable to allow representatives of absent C-CRAB members to participate as active and voting members. Dr. Tepperman represented Dr. Krischer with the Florida Association of Pediatric Tumor Programs, Carl Bender represented Dr. Eytel with the American Cancer Society, Jo Beth Speyer represented Dr. Goodwin with the University of Miami and Dr. Ruckdeschel represented Dr. Karl with the H. Lee Moffitt Cancer Center and Research Institute.

MINUTES OF THE LAST MEETING:

MOTION: A motion was made that it be the wish of the body to accept these representatives.

The motion carried with no objections.

Chairperson's Remarks: Today we hope to accomplish two things; the first being the prioritization of the Advisory Committees' Recommendations; and second, discuss the updating of the current Cancer Plan.

MOTION: The approval of the minutes of April 30, 1992 was moved and seconded.

Dr. Cavanagh asked that, Page 7, line 37, 'from which' should be deleted and "for" should be inserted in its place.

The motion to approve was passed with the correction proposed by Dr. Cavanagh.

The Chairperson informed the Council that she sent Sandra Wilkins a Waterford Crystal shell in the name of the C-CRAB to thank her for her wonderful services.

HRS UPDATE:

Dr. Witte began the update of HRS issues by noting the current budget crisis. The Governor is pushing for his Investment Budget, but the Legislature passed the Reality Budget which the Governor vetoed. The Tallahassee Democrat reported that some compromises had been made. On Friday afternoon the Governor sent a letter to state employees suggesting they should be prepared if there was no state budget on July 1, 1992. (A copy of the letter was shared with the members of the group.) The letter said that he would like for employees to continue to work on a voluntary basis and that he would do everything in his power to assure that they would be paid. It appears that a compromise is being negotiated to solve this problem.

Carol Palomino, speaking as a legislative liaison, stated that it was anyone's game and anything could happen at this point in time. There are many dedicated people working hard to try and come to a compromise.

Dr. Witte further reported that the contract for the Cancer Registry was awarded to the University of Miami's School of Medicine. Two proposals were submitted, one from the University of Miami's School of Medicine and the other from the University of South Florida's College of Public Health. Four highly qualified outside evaluators reviewed the proposals and ranked Miami as the best qualified provider. With budget times getting tougher and tougher, HRS is now beginning to reimburse hospitals at half the normal $3.00 rate per case. HRS is currently borrowing from future funds to pay the hospitals. Dr. Witte asked Doug Palin to comment on the requests that have been made.

The Cancer Epidemiology Section sent out a letter and survey to the hospitals earlier this year advising them of the possibility of no reimbursement or a reduced rate of reimbursement for cases reported and asking for input from the hospitals and. Through the Federal Preventative Block Grant Fund, HRS requested a one-time allocation of $200,000.00 to help with registry costs during this coming year until HRS can get an increase for FY 1993-94. HRS Disease Control has submitted a legislative budget request of $440,000.00 for registry operation and hospital reimbursement.

Dr. Witte added that even if the Governor's Investment Budget passes for FY 1992-93, it does not allow for any additional funding for the reimbursement of hospitals.

HRS Family Health Services has also submitted a legislative budget request for 1993-94 for community based early detection and treatment of breast and cervical cancer. Cancer Epidemiology has provided data to help them with this request.

The legislative budget request consists of 15 million dollars in general revenue to support HRS County Public Health Units (CPHUs)in developing community partnerships with volunteer organizations and medical care providers in the provision of screening services for early detection and control of breast and cervical cancer. 'f,~is request will fund projects in all 15 districts and will serve approximately 200,000 women.

Dr. Witte emphasized that this is what the State Health Office has recommended to the Secretary of HRS. The recommendation will then be finalized and sent to the Governor for consideration. The Governor will then incorporate them into his budget proposal.

The Cancer Epidemiology Section will continue to keep the C-CRAB updated on current issues within the HRS.

Dr. Trapido asked Dr. Witte to clarify the relationship between the State Health Office and Family Health Services.

Dr. Witte responded by saying that there are several Assistant State Health Officers who are in charge of certain programs under the State Health Office. Dr. Witte is the Assistant State Health Officer for Disease Control and AIDS Prevention and Dr. Leslie Beitsch is the Assistant State Health Officer for Family Health Services which is basically a hands-on program working directly with the CPHUs and the community. Some of the programs under the Office of Family Health Services are Family Planning Program, Women Infants and Children (WIC), Health Program Policy and Development, and Dental Health Services

COMMITTEE REPORTS: (Attachment 1)

Committee on Smoking Cessation and Tobacco Issues

Jean Byers discussed some issues raised at the last Committee on Smoking Cessation and Tobacco Issues Meeting concerning the possibility of encouraging the passage of a Children's Access to Tobacco Law to the Legislature. Such a law would make Florida the first state in the United States that would require tobacco retailers to obtain a permit to sell tobacco products. During this special session, the Legislature passed and sent to the Governor, a bill that would require retailers to obtain this permit. Failure to abide by the restrictions of this statute could mean the imposition of penalties including the loss of the permit to sell tobacco. The fees provide funds for 32 positions at the Department of Business Regulation to enforce the law and set up sting operations state-wide.

Dr. Witte reported that the Governor had signed the *bill* and that it would basically be similar to the law that pertains to the sale of alcohol. If the retailers sell to minors they would be in danger of losing their license.

Committee on Breast and Cervical Cancer

Dr. Cavanagh reported that the Committee on Breast and Cervical Cancer produced their committee report and then HRS staff summarized all of the recommendations. Dr. Cavanagh and Kriss Hensley brief y discussed their report and submitted a summary to the C-CRAB.

Committed on Access to State-of-the-Art Treatment and Care

The Committee on Access to State-of-the-Art Treatment and Care submitted their recommendations.

Committee on Emerging Issues

The Committee on Emerging Issues also submitted their recommendations.

Jo Beth Speyer strongly encouraged the department to call on the Cancer Information Service (CIS). She would like the CIS to become a resource for public education and activities. CIS should be part of all of the committee reports as a source of support. The federal government is providing a great deal of money to pay for CIS services. It has a growing number of staff and, hopefully, there will soon be a branch based in Tallahassee.

PRIORITIZATION WORKSHOP:

The Chairperson introduced the facilitator for the prioritization workshop, a charter member of the C-CRAB, Clyde B. McCoy, Ph.D., from the University of Miami, School of Medicine.

Dr. McCoy: One of the functions and duties of the C-CRAB, mandated by the legislation, is to approve the Florida Cancer Plan. In the beginning, the plan was handled almost exclusively by individual members. The first cancer plan was very general and consisted of every critical cancer issue within the state. Through the years the Plan has progressed significantly. The Florida Cancer Data System along with the Cancer Information Service and other data sources are now available to the C-CRAB.

The C-CRAB also has priorities from past cancer plans so that we can continue past efforts. The C-CRAB expressed some concern about the lack of availability of resources and began to seek funding. Several ways to gain funding were tried. including going directly to the Legislature through the HRS legislation appropriation process. Sandra Wilkins worked closely with the C-CRAB and was able to produce a very unique Cancer P~an. The C-CRAB then became a very active participant with the National Cancer Institute's Data-Based Intervention Project in HRS.

The C-CRAB is at a point where it will decide priority objectives in the cancer plan. The Technical Advisory Committees have summarized the issues of concern and have submitted three to five

recommendations to address these concerns. It should be noted that recommendation number three from the Committee on Smoking Cessation and Tobacco Issues has been accomplished and should be deleted from consideration.

It was pointed out by Dr. Ruckdeschel that the C-CRAB has been more successful making recommendations that do not require resources or do not have to go through the appropriations committee of the Legislature.

Dr. McCoy began the workshop by discussing the Hanlon Method of Prioritization. This consists of taking all 18 recommendations and ranking them using the overall priority rating (OPR) formula, where the following criteria are considered:

A) Size of the problem,
B) Seriousness of the problem,
C) Estimated effectiveness of the solution and
D) PEARL factors (propriety, economic feasibility, acceptability, resource availability, legality).

The overall priority rating formula is expressed in the following manner:

$$(OPR) = \frac{(A+B)C}{3} \times D$$

Discussions began on the pros and cons of using the methodology.

Dr. Harris was concerned that there may be a conflict between what we personally, think are high cancer control priorities and what we, as professionals, think might be the most effective thing to do for cancer control over the next year or two. Is there a way to evaluate which areas need the most help at the present time. Are there critical areas that are already being addressed by other organizations that would make it possible for the C-CRAB to focus on other critical areas.

There was discussion concerning which prioritization method should be used and whether to prioritize all 18 recommendations or whether to prioritize the 4 major areas. and either accept the recommendations within these areas as they are or prioritize them again.

Dr. Witte was concerned about the deciding on priorities without any input from the absent members.

Dr. McCoy pointed out that this prioritization exercise is only an intermediate step. The outcome of this workshop will be sent to all members who are not present so that they can also voice their opinions. Then the final product would be produced. It is very important to have a consensus of priorities.

Dr. Ruckdeschel felt it would be to tedious to take all 18 recommendations and score them according to the methodology. He felt that the members could choose five to six top priorities and then use the methodology to rank those recommendations.

Dr. Harris disagreed with the way the Breast and Cervical Cancer Summary was prioritized. He

felt that Access to Screening and Care should be the top priority.

Dr. Cavanagh suggested that he and Dr. Harris should go back and use the prioritization method for the Breast and Cervical Cancer Summaries and see which priorities ranked highest.

At the April 30th meeting, in Tampa, there was considerable discussion concerning the cigarette tax. When the Committee on Smoking Cessation and Tobacco Issues recommended it as a ballot initiative, they felt that this should be a priority area. (Page 6 of Minutes)

The members decided to break for lunch and come back and prioritize all 18 recommendations as a group.

AFTERNOON SESSION:

The C-CRAB began to list the top priorities they felt should be addressed.

There were eight recommendations chosen to be considered as top priorities:

Access to Screening & Care for Breast Cancer
Access to Screening & Care for Cervical Cancer
Reduction of Smoking Prevalence
Initiation of State Ballot Initiative
Public Education about Breast Cancer
Professional Education about Breast Cancer
Public Education about Cervical Cancer
Professional Education about Cervical Cancer

The members voted and narrowed the recommendations down to four choices.

Access to Screening & Care for Breast Cancer (10 votes)
Access to Screening & Care for Cervical Cancer (10 votes)
Smoking Prevalence (3 votes)
State Ballot Initiative (7 votes)

The members then voted that the State Ballot Initiative be broken out of the eight and used as an implementation tool to support Smoking Prevalence.

Dr. Ruckdeschel proposed that Access to Screening and Care for Breast Cancer be combined with Access to Screening and Care for Cervical Cancer. The issues for access are; cost, availability, transportation and fear of procedures, identical for both problems. Whatever options are chosen for implementation will be equally effective for both areas.

Dr. Cavanagh agreed with Dr. Ruckdeschel's proposal.

Dr. Trapido disagreed with combining the priorities. He felt programs dealing with the two cancers would be targeting different age groups and possibly even different types of physicians; it would

have very different impacts on the state of Florida in terms of number of cases; and access to screening procedures for cervical cancer are much more readily available than screening procedures for breast cancer.

Dr. Ruckdeschel countered this objection by saying that the majority of the 'public' in this issue are folks who are going to a doctor at a CPHU or other community based clinic for diagnosis and treatment. Clinics deal with all ages and should be encouraged to perform as many services at one time.

Dr. Witte pointed out that there are almost no available onsite mammography units in the county public health units and the federally funded primary care centers.

Dr. Ruckdeschel emphasized that physicians will not readily provide cancer prevention information because they are not being reimbursed for their time, stating that patients are also not willing to pay out of pocket for cancer prevention information that is not covered by their insurance. The C-CRAB ought to be addressing issues on how reimbursement can obtained for physicians providing cancer prevention information.

MOTION: Combine the recommendations for Access to Screening and Care for Breast Cancer with Access to Screening and Care for Cervical Cancer.

A discussion followed which resulted in giving equal priority to the recommendations:

Access to Screening and Care for Breast and Cervical Cancer
Smoking Prevalence

In addition to the two top priority initiatives recommended, the C-CRAB voted to include three implementation recommendations:

1. That a tobacco or health ballot initiative be placed on the 1994 ballot to create and fund tobacco prevention and intervention programs, activities, research and care for medically indigent. patients with tobacco-related diseases.

2. The C-CRAB will create a committee to study and recommend measures to improve access to screening and care for cancer patients, especially these who are uninsured or under insured.

3. That an evaluation component be included in the recommended initiatives to ensure that progress is made on their implementation. (A strong feeling that outcomes, i.e., reduction of mortality or incidence figures, are not what should be measured but that there appeared to be a strong desire for process objectives, i.e., number of mammographies, etc.)

Jo Beth Speyer, speaking as a member of the Committee on Access to State of the Art Treatment and Care, commented that she felt the Committee would have no objections of the C-CRAB's choice of top priorities.

1992 CANCER PLAN:

The Chairperson asked for comments and recommendations on writing the current cancer plan.

Jean Byers asked where this left the old plan. She suggested that this could be as priority initiatives for next year instead of re-writing the plan?

Jo Beth Speyer felt we could put together an executive summary for the Legislature using today's accomplishments as an Addendum to the Plan.

Carol Palomino then produced a draft statement of the Mission of the C-CRAB, as authorized by Dr. Ruckdeschel, and asked for input and changes to make this Statement more accurate. (Attachment 2)

The Chairperson recommended that the H. Lee Moffitt Cancer Center check the Mission Statement against the statute to insure that it is in compliance with the legislative mandate.

Dr. Finkelstein made a correction in the first sentence to read "persons who suffer from cancer" instead of "persons who suffer from more advanced cancer'. The change was agreed on by all members present.

Dr. Trapido made the argument that the words "in those who are at risk of developing cancer" and "in those who have developed cancer" limits the population that the mission applies to.

Dr. Tepperman felt that the wording of the Mission Statement should be flexible enough so that C-CRAB's role is not limited to certain areas.

The approval of the Mission Statement was tabled pending input and approval from all members.

Meeting was adjourned at 2:50 p.m.

Revised 11/13/92
D. Parker, Coordinator

FLORIDA CANCER CONTROL AND RESEARCH ADVISORY COUNCIL (C-CRAB)

DRAFT MINUTES FOR MEETING HELD ON NOVEMBER 5, 1992

MEETING SITE:
Administrative Board Room
H. Lee Moffitt Cancer Center
12902 Magnolia Dr.
Tampa, FL 33612

C-CRAB MEMBERS PRESENT:

Elizabeth Bacon-Pituch
Dept. of Education
Clarence Brown. M.D.
Orlando Cancer Center
Jean Byers, C.T.R.
FL Tumor Registrars' Assn.
Denis Cavanagh, M.D.
Univ. of South Florida
Don Webster for Dr. Eytel
American Cancer Society
Jane Garcia, R.N.
FL Nurses Assn.
Jo Beth Speyer for Dr. Goodwin
Univ. of Miami
Jerry Harris, M.D.
FL Society of Pathologists
Richard Karl, M.D.
H. Lee Moffitt Cancer Center
George Karr, D.D.S.
FL Dental Association
Jeffrey Krischer, Ph.D.
FL Assn. of Pediatric Tumor Programs
Phil Marty, Ph.D.
Univ. of South Florida, College of Public Health
Ed Trapido, Ph.D.
Sylvester Comprehensive Cancer Center
John Witte, M.D.
Health and Rehabilitative Services

C-CRAB MEMBERS ABSENT:

Sister Mary Clare Hughes, Chair
St. Vincent Health System
Rita Bjork
General Public
Kelli Crabb
General Public
Daniel Finkelstein, D.O.
Southeastern Univ. of Health Sciences
Lars Hafner
FL House of Representatives
Herbert Kerman, M.D.
Assn. of Comm. Cancer Centers
Jeanne Malchon
FL Senate
Jack MacDonald, M.D.
FL Medical Assn.
Elisabeth McKeen, M.D.
FL Society of Clinical Oncology
Arnold Miller, D.O.
Osteopathic Medical Assn.
James Orr, M.D.
FL OB/GYN Society
Paul Pitel, M.D.
FL Pediatric Society
Warren Ross, M.D.
Univ. of Florida, School of Medicine
David Shapiro, M.D.
American College of Surgeons

Guests:
Abe Lopman, Orlando Cancer Center
Marcia Nenno, American Cancer Society
Nina Entrekin, American Cancer Society
Dorothy Green, American Cancer Society
Bill Buckley, Dept. of Health and Rehabilitative Services
Jim Studnicki, Ph.D., Univ. of South Florida, College of Public Health
Jan Marshburn, Univ. of South Florida, College of Public Health
Jack Ruckdeschel, M.D., H. Lee Moffitt Cancer Center
Anne Goff, H. Lee Moffitt Cancer Center
Brenda Medero, H. Lee Moffitt Cancer Center

Staff: Dorothy Parker, C-CRAB Coordinator

Call to Order & Introductions

Dr. Jack MacDonald was scheduled to chair the meeting, but he was unable to attend due to the cancellation of his flight (inclement weather in Tallahassee). Therefore, Dr. Denis Cavanagh was asked to chair the meeting.

Dr. Cavanagh called the meeting to order shortly after 10:00 a.m. He asked for everyone to introduce themselves. Dr. Ruckdeschel welcomed everyone to the Moffitt Cancer Center, and introduced Dorothy Parker, who was recently hired as the C-CRAB Coordinator. Ms. Parker started on October 5th, and will be based at the Moffitt Cancer Center. During the last month, Ms. Parker visited several C-CRAB members and the former C-CRAB staff at HRS to get their perspectives on the history of C-CRAB, and to explore ideas for future activities.

Approval of Minutes from Last Meeting

There were three corrections to the minutes from the June 27th meeting: (1) the date at the top of the first page should read "June 27" instead of "July 27"; (2) Carol Palomino is a legislative "liaison" from the H. Lee Moffitt Cancer Center, not a legislative "lobbyist" (page 2, line 25); and (3) the reference to the Breast Cancer Summary on page 5, line 26, should read "Breast and Cervix Summary" to reflect the dual focus of C-CRAB's priorities.

> ***ACTION:*** A motion was made to accept the minutes with these changes. The motion was passed unanimously.

Approval of 1993 Florida Cancer Plan

A draft copy of the 1993 Florida Cancer Plan, prepared by HRS, was mailed to members prior to the meeting (originally scheduled for October 9th). Dr. Witte asked if there were any changes, but there were none.

> ***ACTION:*** A motion was made to approve the plan. The motion was passed unanimously.

Update on the 10-Year Cancer Registry Report

Mr. Buckley from HRS explained that they are in the process of preparing an incidence report using data from the Florida Cancer Data System (FCDS) from 1981-1990. The format will be similar to the 7-year report that was released in 1991. It will include incidence numbers and rates for 38 major sites, with commentary on the less frequently occurring sites, as well as time trends. The first draft is expected to be released in January, 1993, and should be available for inclusion in the C-CRAB annual report, which is due February 1, 1993.

Update on Data Based Intervention Research Project (DBIR)

Dr. Witte and Mr. Buckley presented the revised DBIR 1993 Implementation Plan, which was distributed at the meeting (an earlier version was previously mailed to C-CRAB members). Mr. Buckley asked for approval of the plan so it can be sent to NCI by November 12, 1992.

Mr. Buckley explained the three proposed strategies: (1) district-level projects, developed and implemented in conjunction with the 15 Health and Social Services Councils (HSSC), where half the districts would receive DBIR staff interventions and half would receive no interventions; (2) funding for design and evaluation of community interventions to reduce morbidity and mortality through early interventions; and (3) legislator education in cancer control issues, e.g., cigarette tax increase, and insurance coverage for Pap tests (C-CRAB would play an role in this). The 10-year cancer registry report will be a source of baseline data for these projects.

Dr. Krischer asked about the status of the formation of the HSSCs, and suggested working with the three cancer centers which already have population-based catchment areas. Dr. Witte responded that HRS is in the process of reorganizing from 11 to 15 districts, and the formation of HSSCs will follow. The HSSCs can work with the cancer centers in their district.

Mr. Buckley mentioned that funding for design and evaluation projects (not implementation) would be limited - possibly to only $60,000 over two years.

> ***ACTION:*** A motion was made to approve the DBIR 1993 Implementation Plan. The motion passed unanimously.

Legislative Initiatives

1. Mandated insurance coverage of Pap smears

   Dr. Witte reported that a legislative initiative to mandate insurance coverage of Pap smears is not on HRS's legislative agenda for the upcoming session. Therefore, he asked that C-CRAB and/or its constituent organizations promote the initiative.

   Dr. Cavanagh expressed his concern about follow-up for women with positive Pap smears, and how treatment would be funded. Dr. Trapido also emphasized the importance of the referral issue. Mr. Webster and others replied that this initiative dealt only with commercial insurance coverage; therefore, insured women would most likely have resources to pay for treatment.

   It was agreed that C-CRAB would support this initiative because it falls within previously-determined priority areas. It was suggested that the legislation be modeled

after, and perhaps attached to, the mammography legislation (Florida Statue 627.6613).

Dr. Karr mentioned that this may not be good year to introduce additional insurance legislation because of the major insurance package passed in 1991, but the group felt that it was already a priority issue for C-CRAB.

Mr. Webster said that the ACS would be interested in supporting this initiative, and that he would bring the issue to its Public Issues Committee, although they do not have a scheduled meeting until January. Other members of C-CRAB could be designated to work with ACS on this (although no one was named). It was suggested that Dr. MacDonald get the support of the Florida Medical Association. The Florida Dental Association has already established its legislative priorities, but Dr. Karr suggested they might tie it in to their insurance legislation.

> ***ACTION:*** Dr. Marty moved that C-CRAB: (1) support the principle of insurance coverage for Pap smears; (2) work on legislation that would require such coverage, preferably in the upcoming legislative session; and (3) model it after or link it to the mammography legislation. The motion was approved.

Forming an ad-hoc committee on this issue was not thought to be necessary; ACS can call on people informally for assistance.

2. Revisions to the Clean Indoor Air Act

Dr. Witte and Mr. Buckley reported that HRS would not be proposing revisions to the Clean Indoor Air Act at this time. The Tri-Agency Coalition (Florida chapters of the American Cancer Society, American Heart Association, and American Lung Association) felt it was too early, and HRS is still working the definition of terms in the legislation. Jean Byers asked about shopping malls; Mr. Buckley replied that this was one of the issues being addressed.

Dr. Witte will be asked to report on the status of this at the next meeting.

3. Cigarette excise tax

a. HRS proposal for a 1¢ increase: Dr. Witte described the HRS legislative proposal for a 1¢ excise tax increase, with revenues going for cancer control; 85% - or approximately $12 million - for the Cancer Control and Research Fund for C-CRAB programs and operations, and 15% - approximately $2 million - to the FCDS. Dr. Trapido asked for an explanation their mechanism for submitting legislative proposals. Dr. Witte explained that it has already gone to the Secretary of HRS, and will then go to the Governor.

b. ACS proposal for a $1 increase: Mr. Webster described the ACS proposal for a $1 per pack tax. This has been presented to the Tri-Agency Coalition, which may support it. Their main interest is to use the higher price to reduce consumption, especially among teenagers. Based on the Canadian experience, a 10% increase in the price of cigarettes results in a 4% reduction in consumption among adults, and a 14% reduction among teens. Mr. Webster distributed a handout with other background information to justify their proposal.

Discussion of proposals: Dr. Brown asked about linking the tax to a percentage of the cost of cigarettes rather than a specific dollar amount. He pointed out that the current tax is actually a lower percentage of the cost than it was in the past.

The question was raised about using a ballot referendum to raise the tax rather than legislation. Jean Byers and others stated that the Technical Advisory Group on smoking already explored that idea, and found the process to be lengthy, cumbersome, and unlikely to be successful. Furthermore, if the referendum fails, there is little chance of getting a tax increase through the legislature at a later date. Dr. Karr felt that ACS has probably researched this issue and has reasons for suggesting a legislative initiative over a referendum.

There was much discussion about whether or not to earmark tax revenues for cancer or health programs. Dr. Trapido mentioned the experience in 1989 when a 5 cent per pack tax was passed, earmarked for cancer programs. However, at the last minute, the legislature voted to put it all into general revenue. Others reminded the group that there would be the risk of having all the revenue from the $1 increase go to non-health programs.

Reference was made to the experience in California where tax revenues were earmarked for cancer programs, primarily education and some for research. Ms. Speyer suggested that C-CRAB look closely at their experience.

Dr. Cavanagh suggested supporting the $1 tax with 25¢ going to cancer control programs, as mentioned by Dr. Ruckdeschel at a previous C-CRAB meeting. Dr. Marty suggested that some part of the money from a cigarette tax should be allocated for such programs, and Dr. Trapido agreed. Jean Byers reminded the group that C-CRAB has already recommended the allocation of some money from a cigarette tax for cancer control programs, pointing out that if C-CRAB decides to accept the ACS plan with no earmarking, the issue would need to come up for another vote.

C-CRAB's legislative representatives should be helpful in this issue. However, we will have to wait until new legislative representatives to C-CRAB are nominated by

the new President of the Senate and the Speaker of the House.

Dr. Krischer proposed that there are really two separate issues: (1) increasing cost to decrease consumption; and (2) raising funds for cancer control.

> ***ACTION:*** Dr. Krischer moved to support the ACS plan in principle (separate from the funding issue).

Dr. Trapido said he did not support separating the two issues; that there was no point in separating funding from the cancer plan. Dr. Krischer pointed out that providing disincentives to smoking is also part of the plan.

There was some discussion about the influence of the tobacco lobby, although Dr. Witte thought that their influence was decreasing. Nevertheless, it will have to be dealt with.

Dr. Cavanagh pointed out that it might be better to use the California example, rather than the Canadian, one as a model, since Florida has more in common with California.

> ***ACTION:*** The motion to support the ACS plan was approved unanimously.

Dr. Trapido said that there was no need for a separate motion to approve funding that would go to the cancer control fund because that had already been recommended by C-CRAB. He then moved to amend the motion to reflect support of the HRS 1¢ increase. Dr. Witte reiterated that 85% would go to C-CRAB and 15% to the registry.

It was suggested that rather than pick an arbitrary figure, the amount could be based on how much money C-CRAB needs to implement programs. Dr. Cavanagh said that a C-CRAB plan with dollar amounts for specific programs was on the afternoon agenda, and that Ms. Parker would calculate out how much those programs would cost.

It was decided to break for lunch at this point.

After lunch, the discussion continued. It was suggested that C-CRAB should endorse a tax of "at least one cent" to accommodate both proposals. Another suggestion was to endorse the ACS proposal as a deterrent and to say up front that C-CRAB would like some amount (e.g., $14 million) for cancer control programs.

A strategy for working out the details of how the cigarette tax increase will be handled in the legislature needs to be determined. Ms. Parker will call upon C-CRAB members who have an interest in and experience with this issue for further action prior to the next meeting, and will report on their activities at that time.

C-CRAB Implementation Plan

Ms. Parker presented a draft C-CRAB Implementation Plan that she compiled from materials from ACS, HRS, and previous reports from C-CRAB's TAGs. The purpose of this plan is, in anticipation of funding, to implement programs that address the priorities established by C-CRAB, i.e., smoking cessation, and breast and cervical cancer screening.

The remainder of the meeting was devoted to discussion of this plan. The results of the discussion will be reflected in a revision of the plan, which will be distributed to all C-CRAB members for further comment by early December. The goal is to have a plan that can be taken to the legislature in the upcoming session that contains proposed programs with their estimated costs.

Mr. Webster suggested using the format that is used with other legislative plans that summarizes dollars requested on a cover sheet, with backup documentation following. Dr. Witte also suggested Ms. Parker look at the format of legislative reports that present a statement of need, then the cost involved.

There was a discussion of the cost of programs; it was suggested to look at other states' efforts, e.g., California and Texas. Dr. Karr cautioned to carefully plan programs; he reported that the Florida Dental Association ran a media campaign last year on periodontal disease and smoking that was purchased from California. It cost $4 million and was only aired during non-prime time hours, thus was not very effective. Dr. Harris proposed feasibility studies before embarking on programs, with careful planning and justification.

It was also suggested that C-CRAB should develop an alternative strategy in the event that there is no money to fund any of the proposed programs.

Administrative Issues

Since discussion of the C-CRAB Implementation Plan went on longer than expected, the items on the agenda regarding administrative issues were not discussed. These include the process for nominating a new chairperson, C-CRAB stationery, revision of by-laws, and scheduling the next C-CRAB meeting. Ms. Parker will speak by phone, or arrange a conference call, with members of the Executive Committee to address these issues.

In addition, Ms. Parker will tally the responses to the questionnaire distributed to members at the meeting that addresses some of these issues. A questionnaire will be mailed to members who did not attend the meeting to obtain their opinions.

The meeting was adjourned at 3:00 p.m.

ATTACHMENT 5

Committee on Breast and Cervical Cancer

Membership List

Minutes from Meetings: 3/9/92 and 4/15/92

Data on Breast and Cervical Cancer in Florida

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BREAST and CERVICAL CANCER COMMITTEE
Minutes
April 15, 1992

Members Present

Denis Cavanagh, M.D., Co-Chairman
Jerry Harris, M.D.
Marvin Dewar, M.D.
Maurine Jones, Ph.D.
Jane Garcia, R.N.
Leslie Crawford, M.S.W.
Susan Smith, C.T.R.
Terry Work
Priscilla Rollison
Kriss Hensley, M.S.W.

Members Absent

Warren Ross, M.D., Chairman
David Shapiro, M.D.
Ed Trapido, Sc.D.
Lisa Gorospe, R.N.
Nina Entrekin
Marilyn Crowell, M.P.H.

The meeting was called to order by Dr. Cavanagh with an introduction of each member.

The first order of business was to approve the minutes from the March 9, 1992 Breast and Cervical Cancer Committee meeting. Except for the misspelling of Dr. Dewar's name, the minutes were approved without changes.

Next, Dr. Cavanagh presented a fourteen page draft he had prepared for the committee's review. The document spelled out the four agreed upon objectives for both breast cancer control as well as the four objectives for cervical cancer control. In addition, the paper justified the need for a detailed statewide cancer plan for breast and cervical cancer screening and treatment.

Dr. Cavanagh suggested to the committee that they might go through the draft, line by line, and make any changes and/or recommendations. The members agreed. The rest of the meeting was spent doing just that.

The Basic Outline of the Draft of the Statewide Cancer Plan for Breast and Cervical Cancer Screening and Treatment is as follows:

OBJECTIVES
(in priority order)

BREAST CANCER:

Objective 1: Public Education
Objective 2: Professional Education
Objective 3: Universal Access to Screening and Care
Objective 4: Quality Assurance of Mammograms

Intervention strategies for each objective are in the process of being developed.

CERVICAL CANCER:

Objective 1: Public Education
Objective 2: Professional Education
Objective 3: Universal Access to Screening and Care
Objective 4: Quality Assurance of Cytology

Intervention strategies for each objective are in the process of being developed.

At the conclusion of the meeting the consensus of the group was that a great deal had been accomplished, with much credit going to Dr. Cavanagh for the outstanding draft he submitted for the committee's review.

The committee decided that HRS staff would incorporate the changes in the draft as well as insert intervention strategies for each of the objectives. It was agreed that the strategies from the Pennsylvania "Recommendations for a Statewide Plan for the Early Detection of Breast Cancer", October, 1991 would be used.

Upon completion of the integrated draft, HRS staff would forward copies to each committee member and ask that any changes be phoned in to the staff. It is anticipated that a final draft will be presented to the C-CRAB at their next meeting in Tampa on April 30, 1992.

The meeting was adjourned at 3:00 PM.

BREAST and CERVICAL CANCER COMMITTEE
Minutes
March 9, 1992

Members Present

Denis Cavanagh, M.D., Co-Chairman
Jerry Harris, M.D.
Ed Trapido, Sc.D.
Nancy Boyack, B.S.
Maurine Jones, Ph.D.
Terry Work
Marilyn Crowell, M.P.H.
Jane Garcia, R.N.
Susan Smith, C.T.R.
Lisa Gorospe, R.N.
Kriss Hensley, M.S.W.

Members Absent

Warren Ross, M.D., Chairman
Marvin DeWar, M.D.
David Shapiro, M.D.
Leslie Crawford
Nina Entrekin

The meeting was called to order by Dr. Denis Cavanagh with an introduction of each member.

Dr. Cavanagh began by saying that he originally had thought it might be a good idea to break the committee out into two subcommittees, one on breast cancer and the other on cervical cancer. He said that he wasn't so sure about that idea, on second thought. The committee agreed that they would prefer to stay together.

The next order of business was to review the agenda.

I. It was decided by majority vote to adopt the sample meeting rules provided to the committee.

II. Although a sample guide for establishing public health priorities was provided, the group elected to bypass such an effort and to move on to the task at hand.

III. The committee was in agreement that, after review of state and national goals and objectives, something can indeed be done to decrease the severity of these diseases. Further, it was articulated that primary prevention is not going to give us the greatest return on investment but rather a secondary prevention approach would have the greatest impact.

IV. Data in the committee packets were reviewed. One item which received quite a bit of attention was a Behavioral Risk Factor Survey (BRFS) question relating to why women aged 40 and over do not have a mammogram. Although it is evident that the question has validity problems, concern was expressed that the question revealed that doctors are not recommending mammography according to ACS guidelines. Additionally from the BRFS was a question asking " Whose idea was it to have a mammogram? " Most often it was the

idea of the physician. This lends credibility to the belief that physicians have a marked impact on whether or not a woman receives mammography.

Other pieces of data reviewed included Maryland's Ideal Cancer Control Process for both breast and cervix; crude and adjusted cervical cancer incidence and mortality rates for Florida 1981-1987; as well as an unpublished article on Screening for Breast Cancer in Florida Women (Hopkins/Hensley).

The ensuing discussion covered breast cancer and the reasons why some women do not have mammograms (a) discomfort (b) embarrassment (c) lack of availability (d) not being referred by physician. The committee discussed who the women in need were and how best to target them as well as their health care provider.

V. The committee readily agreed upon two objectives for breast cancer. Those were 1.) professional education and 2.) public education. The committee was more divided when it come to a third objective. Both quality control and access to care were considered critical components of breast cancer control. With some discussion the committee agreed that quality control was already being addressed by other professional organizations such as the American College of Obstetricians and Gynecologists (ACOG), the American College of Radiology (ACR) and Health Care Financing Administration (HCFA). Given that, the committee concluded that access to care would be the third objective.

There was little time left to discuss interventions for the three objectives. A general intervention strategy was formulated for professional education. The committee was in agreement with the concept of education programs with emphasis on breast screening by self-breast exam, physical exam and mammography.

Before adjourning, the committee recommended that the same objectives for breast cancer also be adopted for cervical cancer.

Agenda items VI and VII were not completed. It was decided that a follow-up committee meeting needed to be held before the next C-CRAB meeting. The committee meeting was tentatively scheduled to be held in Tallahassee at a time yet to be specified.

ATTACHMENT 6

Committee on Smoking Cessation and Tobacco Issues

Membership List

Minutes from meeting: 3/9/92

Report on Smoking-Attributable Mortality, Morbidity
and Economic Cost Estimates for Florida, 1988

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**RECOMMENDATIONS OF
THE C-CRAB TECHNICAL ADVISORY GROUP
SMOKING CESSATION AND TOBACCO ISSUES COMMITTEE**
April 14, 1992

GOAL: To significantly reduce incidence of tobacco related cancers in Florida.

RATIONALE: In Florida, annual tobacco related mortality exceeds all mortality associated with cocaine and crack, heroin, drunk driving, homicide, suicide, and AIDS combined. Yet progressive anti-tobacco legislation rarely becomes law, and tobacco education initiatives and programs are woefully underfunded. A recent bill intended to strengthen the Florida Clean Indoor Air Act took three years to pass through the legislature and be signed into law. The modest improvements in this bill will have little noticeable effect on the lives of most Floridians. This committee concludes that legislators, educators, health care professionals, and the general public are well aware of the dangers associated with tobacco abuse, yet public perceptions, attitudes and actions do not reflect the seriousness of the tobacco problem.

OBJECTIVES:
1. Reduce the current cigarette smoking prevalence from 24.6% to 15% by the year 2000 in accordance with the federal government's Healthy People 2000 Report.
2. Reduce the initiation of smoking by school aged children from 25% to 15% by the year 2000.
3. Reduce the total number of cigarette packs sold in Florida by 15% by the year 2000.
4. Increase the availability of affordable smoking cessation programs and methods.

1992-1994 SMOKING CESSATION AND TOBACCO ISSUES PRIORITIES:

I. Change the attitudes of Floridians with regard to tobacco use through a statewide informational campaign.

A. TARGET: Youth

ACTIVITIES: Distribution of existing tobacco prevention messages directed at the youth market, and development of educational materials to supplement Florida's Smoke Free Class of 2000 project.

TIME-FRAME: Using existing materials, availability would be immediate. Based on the California model, a major public information campaign could be launched in early 1995.

METHODOLOGY: Professionally produced tobacco prevention messages are available without charge from the California

Department of Health Services' Tobacco Education Media Campaign. The cost of adding a logo recognizing Florida specific organizations would be minimal. Small talent fees would be required to meet California actor's guild requirements. If used as public service announcements the only additional cost would be for reproduction. If used as paid advertising, costs would be substantial. Additional funds could be used to produce Florida specific and regional messages.

COST: Cost for Smoke Free Class of 2000 materials would depend upon recommendations from the Tri-Agency Coalition on Smoking or Health. Costs associated with an influential media campaign are discussed above.

FUNDING: Based on the California model, a ballot initiative would provide funding for such activities in the near future. In the interim, grants and endowments are available and should be exploited.

B. TARGET: Women of Childbearing age

ACTIVITIES: Distribution of existing tobacco prevention and intervention video messages directed at women and the family members through HRS county public health units. Make these existing tobacco prevention and intervention videos available to specific health care specialists, hospitals, and other health care professionals. Distribute existing Cancer Society smoking cessation referral materials to HRS County Public Health Units, Obstetricians and Gynecologists.

METHODOLOGY: Tobacco prevention and intervention videos are presently available. Distribution to 67 HRS County Public Health Units would require the purchase of viewers for each county, in addition to video reproduction costs.

TIME-FRAME: Videos are currently available. Implementation dependent upon funding.

FUNDING: Following the California model, a ballot initiative could provide funding for such activities in the near future. In the interim, grants and endowments are available and should be exploited.

C. TARGET: Health Professionals

ACTIVITIES: Development of a one page, camera ready information sheet conveying positive tobacco prevention and intervention messages. This camera ready copy would be distributed to all Florida health care professional groups for reproduction in their newsletters and journals. Yearly mailings from the Department of Professional Regulation and

the Department of Health and Rehabilitative Services to each licensed health professional in Florida would help to emphasize the importance of physicians and health care providers in tobacco intervention.

METHODOLOGY: Utilization of the HRS Public Information Office and the DOE Graphics Department for the development of professional and attractive copy would keep costs expenses low. Producing camera ready copies and mailing costs would be the primary expenses.

FUNDING: Because of the importance of changing the attitudes of health professionals we would recommend that the expenses be partially absorbed by HRS. A proposal to the Tri-Agency Coalition on Smoking or Health may also provide the necessary funds.

D. TARGET: General Public

ACTIVITIES: A public information campaign based on the California model should be implemented. This campaign should utilize television, radio, print, and outdoor advertising.

METHODOLOGY: Professionally produced tobacco prevention and intervention messages are available from the California Department of Health Serv ces. As described under the youth target additional funding would be required for development and production of educational posters, outdoor advertising, television and radio advertising purchased in targeted markets, and print advertising.

FUNDING: Following the California model, a ballot initiative could provide funding for such activities in the next few years. In the interim, grants and endowments are available and should be exploited.

II. **Sponsor a state ballot initiative to create a tobacco products surtax fund. This fund would be used for tobacco prevention and intervention activities, research, and care for medically indigent patients with tobacco related diseases.**

ACTIVITIES: Draft a constitutional amendment and initiate a petition drive to place it on the November 8, 1994 ballot.

METHODOLOGY: A grass roots effort would be required to raise money and garner petition signatures. Publicity to promote support for the ballot initiative would be the primary cost. The American Cancer Society, American Heart Association, American Lung Association, local anti-tobacco

groups and coalitions, and other pro-health organizations should be encouraged to participate in this effort.

TIME-FRAME: The initiative petition should be in final form and petitions delivered to county supervisors of elections by April 9, 1994. The initiative must be certified by the Florida Department of State Division of Elections by July 8, 1994.

FUNDING: Solicit contributions from major health care organizations and the concerned public to promote the initiative.

III. Support passage of public health legislation requiring tobacco retailer permitting to eliminate children's access to retail tobacco products.

ACTIVITIES: Initiate the passage by ballot initiative of Florida's Children's' Access to Tobacco Products Control Act with permitting requirements in tact should be passed into a law.

METHODOLOGY: Members of C-CRAB should be provided with information packets as prepared by Senator Frankel's office along with a request to share these packets with the organizations they represent.

TIME-FRAME: dependent upon actions of legislature in the next special session.

COST Cost would include packet reproduction and mailing expenses.

FUNDING: The American Lung Association can be petitioned to reproduce and mail packets to C-CRAB members.

EVALUATION:

1. Monitor Percentage of Adult Smokers.
   a. Establish a 1991 baseline from the Florida Behavioral Risk Factor Surveillance System survey.
   b. Monitor annually to determine effects of tobacco intervention/prevention activities.

2. Monitor Percentage of Teen Smokers.
   a. Establish a 1991 base line considering trends indicated in the Florida Youth Risk Behavior Survey.
   b. Encourage the Department of Education to conduct this survey on a yearly basis to determine effects of tobacco prevention and intervention activities. The Department of Health and Rehabilitative Services and the member organizations of C-CRAB should provide technical support

to DOE in the preparation of this survey.

3. Monitor the Quantity of Tobacco Products Sold in Florida.
   a. Information regarding amount of packages (including smokeless tobacco) sold in Florida is provided by the Department of Business Regulations, Division of Alcohol and Tobacco. This data is available by the year or month, statewide or by county.
   b. Monitor yearly reports to determine effects of tobacco intervention/prevention activities.

4. Availability of smoking cessation programs and methods.
   a. Request that the American Cancer Society update the current smoking cessation referral guide annually. Local coalitions, the American Cancer Society, American Heart Association, American Lung Association, and HRS county public health units should be encouraged to help validate the current guide and add programs which have not been listed.
   b. Monitor number of programs by county annually to evaluate the effects of attitude changing activities.

MEETING MINUTES
C-CRAB TECHNICAL ADVISORY GROUP
COMMITTEE ON SMOKING CESSATION AND TOBACCO ISSUES
MARCH 9, 1992

I. The Chair called the meeting to order at 1:45 p.m.

<u>Members Present</u>

Jean Byers, C.T.R.
Chairman

Elisabeth McKeen, M.D.
Co-Chairman

Beth Bacon-Pituch,
Florida Department
of Education

Vickie Pryor, R.N.
HRS Nursing Consultant

Philip Benson
HRS Health Educator

Martin T. Green, Jr.
Committee Staff
HRS Tobacco Issues Contact

<u>Members Absent</u>

Rep. Lars Hafner (D)
St. Petersburg

George Karr, D.D.S.

Phillip Marty, Ph.D
USF College of Public Health

Arnold Miller, D.O.
Regional Oncology/Hematology

II. The following meeting rules were adopted:

1. This committee will function in an advisory capacity.

2. Decisions will be reached by a consensus (or majority vote) of those in attendance.

3. Meetings will take place as deemed necessary by the Chairman and Co-chairman.

4. At every meeting, the committee will set the date and plan the agenda for the next meeting.

5. DBI staff will write all reports and may be considered as a coordinating team and technical consultants. In addition to the DBI staff, other staff of HRS state health offices will be present as needed.

6. The Co-chairman will take minutes. The committee staff will transcribe minutes, answer questions, assist the Chairman in coordinating the meetings or telephone conferences, preparing the agendas, handouts, and making

sure that members are kept informed on occasions when they are unable to attend the meetings.

7. Each committee should develop a timeline for completion of their work by June 1992.

III. State and national goals were reviewed by the committee.

IV. Copies of the Florida Youth Risk Behavior Survey Report were presented to the committee by Beth Bacon-Pituch, and the data on youth smoking behavior was discussed.

V. The following tobacco issues were discussed:

1. Children's Access to Tobacco. Martin Green provided an update on the Florida Sale of Tobacco Products to Children Control Act. The bill had been weakened, but was progressing through the legislative process.

2. Smoking Cessation. The committee discussed health care provider intervention and the economic barriers to smoking cessation assistance.

3. Nonsmokers' Exposure to Tobacco Smoke. Martin Green briefed the committee on the Florida Clean Indoor Air Act and proposed legislative revisions.

4. Tobacco Taxes. The committee discussed the feasibility of a ballot initiative to reduce consumption and garner funds for tobacco education through a tobacco tax.

   The committee reviewed the California initiative which provided funds for a multi-media anti-tobacco campaign and other health related services through a ballot initiative.

VI. Findings of the Committee:

1. Smoking cessation should be an important part of a comprehensive plan. However, due to the highly addictive nature of nicotine, prevention is the key to significantly lowering smoking rates and reducing tobacco-related cancers.

2. The Florida Children's Access to Tobacco Products Control Act is an important first step to preventing

nicotine addiction, but further legislation is necessary.

3. Educators, legislators, health care professionals, children, and the general public as a whole are aware of the health hazards of tobacco abuse. Further educational efforts are important, but will serve only to reinforce existing knowledge. Public perceptions and attitudes about smoking should be changed before the problem will be addressed in a serious way by legislators and public health professionals.

VII. Primary Interventions Recommended by the Smoking Cessation and Tobacco Issues Committee:

1. The committee agreed that funding for a state-wide anti-tobacco information campaign was necessary to inform children, pregnant women, health professionals, the legislature, and the general public about the addictive nature of tobacco abuse. This campaign would draw more attention to the tobacco abuse problem in Florida by influencing public perceptions and attitudes about smoking.

   The campaign would use public service announcements and paid advertising in the television, radio, print, and outdoor mediums. Targeted audiences will include all smokers, pregnant women, children, and legislators/policy-makers.

   Such a campaign would clear the way for more progressive legislation on tobacco issues, emphasize the importance of intervention by health care providers, and foster a public perception of smoking as a deadly addiction rather than a bad habit.

   It was agreed that Martin Green and Phil Benson would investigate alternative funding sources for this campaign.

2. The committee decided that an Office on Smoking and Health should be established at HRS. Such an office would coordinate state health office anti-tobacco efforts, monitor Florida Clean Indoor Air Act compliance, provide smoking cessation referrals, and act as a clearinghouse for the most up-to-date information on smoking and health. Such an office could provide a much needed focal point for state and local anti-tobacco efforts.

3. Florida should stop sales of tobacco products to children by passig of a tobacco retail permitting law. Such a law should be designed to impose administrative penalties against retailers who sell tobacco products to minors (See 1992 Legislature HB2375 and SB300).

VIII. It was decided by the committee that the primary goals of the Florida Cancer Plan's tobacco component should be as follows:

1. Reduce the cigarette smoking prevalence from 24.6 percent in 1991 to no more than 15 percent by the year 2000.

2. Reduce the initiation of smoking by middle and high school aged children from 25 percent to no more than 15 percent by the year 2000.

3. Reduce the total number of cigarette packs sold in Florida by 15 percent by the year 2000.

4. Eliminate barriers to smoking cessation and increase the availability of low-cost smoking cessation programs.

5. Ultimately eliminate all tobacco abuse and tobacco-related cancers in Florida.

IX. Data to be used to measure the success of the campaign:

1. Percentage of Smokers. This can be measured by the Florida Behavioral Risk Factor Surveillance System.

2. Percentage of teen smokers. This estimate can be monitored by the DOE Florida Youth Risk Behavior Survey Report.

3. Number of packs sold. This data is available through the DBS Division of Alcohol and Tobacco and is available statewide or by county, and yearly or by the month.

4. Costs associated with obtaining smoking cessation assistance, such as nicotine gum and transdermal patches, and the availability of low-cost smoking cessation classes and programs.

X. By the recommendation of the Chair and by the approval of the committee members present, the next meeting of the

C-CRAB Technical Advisory Group Smoking Cessation and Tobacco Issues Committee will be held in Tallahassee, Florida, on April 14, 1992 at 10:00 a.m. Committee staff will make arrangements for this meeting.

XII. The Chair adjourned the meeting at 3:55 p.m.

SMOKING-ATTRIBUTABLE MORTALITY, MORBIDITY AND ECONOMIC COST ESTIMATES FOR FLORIDA, 1988

The following smoking-attributable mortality, morbidity, and economic cost estimates were calculated by the HRS Health Promotion and Education Program using the SAMMEC II computer software program. SAMMEC II is a spreadsheet provided to Florida by the Office on Smoking and Health. It operates within Lotus 1-2-3 to estimate the disease impact of smoking on a population. Using mortality data, economic cost data, and smoking prevalence data, SAMMEC II estimates the economic and human costs of Florida's number one preventable cause of death; smoking.

In 1988, the total smoking-attributable economic costs for tobacco-related mortality and morbidity in Florida is estimated to be **$2,503,750,280**. It is also estimated that **28,105** Floridians died as a result of tobacco related disease.

DIRECT COSTS **$761,583,117**
Medical costs for the prevention and detection of diseases linked to cigarette smoking and for the treatment and rehabilitation of smokers.

MORTALITY COSTS **$1,445,048,302**
Productivity losses, measured as earnings losses, due to premature death from smoking-related diseases and associated medical conditions.

MORBIDITY COSTS **$297,118,861**
Productivity losses due to disability days and work loss days from nonfatal smoking-related diseases.

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TOTAL COSTS **$2,503,750,280**

TOP 5 FATAL TOBACCO-RELATED DISEASES IN FLORIDA, 1988

Disease	Fatalities
ALL HEART DISEASE	9950
LUNG CANCER	7864
CHRONIC AIRWAYS OBSTRUCTION	3090
STROKE	1539
BRONCHITIS/EMPHYSEMA	1083
OTHER DISEASES	4579
TOTAL	28,105

DEATH BY AGE GROUP IN FLORIDA 1988 ESTIMATES

Age	No. of Deaths
< 1	72
1-19	49
20-24	8
25-29	12
30-34	10
35-39	177
40-44	319
45-49	658
50-54	1044
55-59	1884
60-64	3328
65-69	3487
70-74	4323
75-79	4515
80-84	3871
85+	4346

YEARS OF POTENTIAL LIFE LOST (YPLL) IN FLORIDA ALL AGES, 1988 ESTIMATES

DISEASE	YPLL
ALL CANCERS	140,572
ALL HEART DISEASE	154,413
ALL RESPIRATORY DISEASES	56,826
PERINATAL CONDITIONS	5,444
OTHER DIAGNOSES	6,974
TOTAL YEARS OF LIFE LOST DUE TO SMOKING-RELATED DISEASES IN FLORIDA IN 1988	364,229

Above estimates provided by the HRS Cancer Epidemiology Program and the SAMMEC II Computer Software Program.

CIGARETTE CONSUMPTION BY MINORS IN THE U.S AND FLORIDA

MINORS SMOKING BEHAVIOR, U.S.

AGE	SMOKED DURING PRECEDING 30 DAYS	SMOKED DURING PRECEDING WEEK
12	2.4 %	0.7 %
13	5.2 %	2.5 %
14	10.4 %	7.1 %
15	16.0 %	11.8 %
16	19.0 %	13.7 %
17	23.8 %	17.9 %
18	30.6 %	25.4 %

Source: Teenage Attitudes and Practices Survey (TAPS), 1989. Conducted by the National Institute on Drug Abuse.

MINORS SMOKING BEHAVIOR, FLORIDA

GRADE LEVEL	TOTAL USE
7TH	17.9 %
8TH	24.7 %
9TH	30.8 %
10TH	30.4 %
11TH	30.5 %
12TH	32.3 %
JrHS	21.3 %
SrHS	30.9 %
TOTAL	27.6 %

SOURCE: Florida State-Wide Survey of Adolescent Drug Use, conducted by the Governor's Drug-Free Communities Program in the fall of 1990.

GROSS SALES OF CIGARETTES TO MINORS

NATIONAL:

Minors consume an estimated 947 million packs of cigarettes, spending annually over $1.23 billion. (Source: "Who profits from Tobacco Sales to Children", Journal of the American Medical Association, May 23-30, 1990,).

It is estimated that 3.3% of all cigarettes sold in the U.S. are purchased by minors.

FLORIDA:

Smokers in Florida consumed **1,296,892,789** packs of cigarettes in fiscal year 1990-91.

Utilizing the national estimate, minors in Florida purchased 42,797,462 packs of cigarettes statewide in FY 1990-91. At a cost of approximately $2.17 per pack, this comes out to $92,870,492.54 spent by minors on cigarettes.

For the counties listed below, the following figures would represent the approximate number of packs sold to minors, and the dollar amount spent on cigarettes by minors in fiscal year 1990-91.

COUNTY	TOTAL PACKS SOLD	ESTIMATED # OF PACKS PURCHASED BY MINORS (3.3%)	ESTIMATED AMOUNT SPENT BY MINORS ON CIGARETTES ($2.17)
BROWARD	93,090,357	3,071,982	$6,666,200.94
DADE	141,536,245	4,670,696	$10,135,410.32
DUVAL	74,938,221	2,472,961	$5,366,325.37
PALM BEACH	81,111,113	2,676,667	$5,808,367.39
PINELLAS	98,424,235	3,248,000	$7,048,160.00
POLK	48,585,755	1,603,330	$3,479,226.10

SOURCE: Florida Department of Business Regulation's Division of Alcoholic Beverages and Tobacco. Estimates by the HRS Cancer Epidemiology Program.

The Florida State-Wide Survey of Adolescent Drug Use sample included 130,000 students from across the state. This survey found that, "In Florida it is illegal for minors to purchase or smoke cigarettes, but this law is difficult to enforce and

cigarettes are generally available to minors without fear of penalty." This survey also revealed the following:

Seventeen percent of junior and senior high school students reported first use of cigarettes under the age of 12 years.

Seventeen percent of junior high and 15.9 percent of senior high students reported smoking cigarettes an eleven years or younger.

The most common ages of first use of cigarettes by senior high students were reported in the range of 12 to 15 years with 24.5 percent of these students reporting using cigarettes during this period.

TOBACCO ADVERTISING

Between 1975 and 1983 the amount of money spent to promote cigarettes increased from $490 million to $1.9 billion.

To replace smokers who quit or die prematurely, the industry must attract approximately two million new smokers per year. Most of these replacement smokers are children or adolescents. Approximately 60 percent of smokers start by the age of 13 and fully 90 percent before the age of 20. These statistics translate into the need for more than 5000 children and teenagers to begin smoking every day simply to maintain the current size of the smoking population. ("Tobacco Advertising and Consumption: "Evidence of a Causal Relationship", Journal of Public Health Policy, Winter, 1987).

RJR Nabisco spent $636.1 million on advertising in 1990, making it 13th out of the top 100 advertisers. ("100 leading National Advertisers," Advertising Age, September 25, 1991).

ATTACHMENT 7

Committee on Emerging Issues

Membership List

Summary of Discussions: 3/9/92

Report on Colorectal Cancer in Florida

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Summary of Discussions of the Committee on Emerging Issues

Date: March 9, 1992
Site: EMS Conference Rm. (Rm. 115)
Tallahassee, Fl.

Present:
Richard Karl, M.D., Chairman
John Carbonneau
Landis Crockett, M.D.
Richard Parham
Paul Pitel, M.D.
Sharon Reich

Staff:
Raul Quimbo
Gita Soltani, Ph.D.

Absent:
Cindy Becker
Cathy Clay, M.P.H.
Kelly Crabb, J.D.
Jeff Krischer, Ph.D.
Gary Lyman, Ph.D.
Clyde McCoy, Ph.D.
William Mendenhall, M.D.
John Witte, M.D., M.P.H.

The committee chairman guided the group into identifying what cancer site(s) the committee should focus on by asking a series of questions. The first question posed was: "How serious is the cancer when compared with other cancers?". The committee compared the incidence and mortality rates of each cancer site. The members decided that because of their lower incidence and mortality rates, bladder, testicular, and the childhood cancers should be of lower pririties than colorectal, prostate, and melanoma cancers.

The next question posed was: "In which of the remaining cancer sites would intervention, especially early screening and detection, be most effective in reducing incidence and mortality?". The group decided that there was insufficient evidence on the value of screening for melanoma cancer. In the case of ovarian cancer, the symptoms of the cancer do not become apparent until it is in the advanced stage, hence efforts directed towards early detection have limited value.

For prostate cancer, the consensus of the committee was that there is no sufficient evidence in favor of or against screening. The committee decided that it should focus on colorectal cancer because efforts aimed at early detection of the cancer hold potential for success. The committee noted the recently published

finding that sigmoidoscopy is effective in reducing mortality due to colorectal cancer.

The committee then decided to request CCRAB to make a determination on whether CCRAB feels colorectal cancer deserves equal, if not greater, focus in the Cancer Plan as breast, cervix, and lung cancers. Should the CCRAB feel that colorectal cancer deserves equal focus, the committee will meet to discuss possible interventions aimed at reducing incidence and mortality of colorectal cancer in Florida.

The committee then discussed issues pertinent to cancer prevention and control in Florida. Of concern was the lack of implementing capacity to follow the stages of cancer data analysis and cancer prevention and control planning. The committee compared this to a lack of an "effector arm" that will "get the job done". The committee felt that there is currently no identifiable leader who speaks out for cancer prevention and control, galvanizes public opinion, and coordinates efforts between the government, the medical community, the policy makers, and the "grassroots".

The committee also felt that there was a need to incorporate efforts aimed at developing strong public awareness of the value of early detection of cancer. The Cancer Plan should incorporate the use of the mass media and person-to-person contact in promoting such awareness.

REQUESTED ACTIONS FROM THE C-CRAB.

A. The Committee on Emerging Issues is asking advise from C-CRAB to make a determination on whether colorectal cancer in Florida should be given equal concern as breast, cervix, and lung cancer. If so then, the committee will meet to identify possible interventions aimed at reducing incidence and mortality of colorectal cancer in Florida.

B. The Committee on Emerging Issues strongly reccomends that developing strong public awareness of the value of early detection of cancer should be a major goal of the State Cancer Plan.

COLORECTAL CANCER
(SUMMARY)

Florida hospitals reported 73,831 cases of colorectal cancer during 1981-89 (an average of 8,203 new cases every year). White males and females represented the great majority (94.7%) of the colorectal cancers reported. The age adjusted incidence rate for whites (45.48) is higher than for non-whites (32.7) (Table 1). Colorectal cancer is the second leading cause of cancer among women after lung and breast cancer. This is the third most common type of cancer among males after lung and prostate cancer.

There were a total of 35,059 deaths during 1981-90 from colorectal cancer (an average of 3505 per year). The majority of deaths were white males and females (93%), however the age adjusted mortality rate was the same for whites and non-whites (18.5). Colorectal cancer is the second most common cause of death following lung cancer.

Incidence rates have shown a slight decrease in trend with some year to year fluctuation. Overall, the age adjusted incidence rates have been declining during 1981-89 at -.51 cases per year per 100,000 population. The risk of colorectal cancer increases greatly after age 50 [1] (Attachment 1, 7 Year Overview).

The mortality rates have been steadily declining during 1981-1990 (figure #2). On average, the rate of deline in age adjusted mortality rate has been -.31 cases per year per 100,000 population.

Colorectal cancer has the lowest overall rate of survival after the cancer of ovary (table 2). If detected at the local stage the rate of survival is 88%. The survival rate decreases by 31% at the regional stage and declines to only 6% at the distant stage. The rate of survival from colorectal cancer among whites is significantly higher than that of blacks (table 3).

The statewide age adjusted mortality rate (19.6) for the period 1953-1987 is lower than the U.S. rate (22.38). None of the counties have higher than expected value or rates that are statistically significant.

<u>Risk Factors</u>[1]

Family history
Familial Polyposis Coli (or cancer family syndrome)
Personal history of endometrial
ovarian or breast cancer
History of longstanding ulcerative colitis

Adenomatous polyps
Previous colorectal cancer
Diets high in fat or low in Fiber

Screening

There are three different tests for detecting colorectal cancer: digital rectal examination, fecal occult blood testing, and sigmoidoscopy. Studies presented by The U.S. Preventive Services Task Force are inconclusive about the effectiveness of screening asymptomtic individuals using these tests[1]. This task force neither recommends nor discourages the use of fecal occult blood testing or sigmoidoscopy in screening of asymptomatic persons without risk factors for colorectal cancer. The digital rectal exam is designed to detect prostate cancer in men as well as rectal cancer in both men and women. The U.S. Preventive Services finds the digital rectal exam ineffective in detecting colorectal cancer (See attached: Screening for Colorectal Cancer, Efficacy of Screenign Tests P.47) Task Force The American Cancer Society (ACS) recommends annual digital rectal exam for asymptomatic persons age 40-50 who are at average risk. For persons 50 years of age and over in addition to yearly digital rectal examination, ACS recommends annual stool blood test and annual sigmoidoscopy every 3 to 5 years.[2]

1 Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions, Report of the U.S. Preventive Services Task Force, 1989, Baltimore: William and Wilkins.

2 Fink, Diane J., Group Vice President for Cancer control American Cancer Society (ACS), Californida Division Inc., Guidlines for the Cancer Related Checkup: Recommendations and Rationale, Atlanta: American Cancer Society, 1991.

ATTACHMENT 8

Committee on Access to State of the Art Treatment

Membership List

Minutes from Meeting: 3/9/92

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MINUTES

COMMITTEE ON ACCESS TO STATE OF THE ART TREATMENT
MARCH 9, 1992

PRESENT
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Charles Eytel, M.D., Co-Chairman
Janet Barber, Ph.D.
Gary Freeman, M.S.
Jill MacKinnon
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ABSENT
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Herbert Kerman, M.D.
Senator Jeanne Malchon
Jean Malecki, M.D., M.P.H.
Steve Whitaker
Jerry Woefel

STAFF
Doug Palin

INTRODUCTIONS

Introductions were made all around with each giving their agency and specializations. Dr. MacDonald briefly discussed the agenda and the decision making process. It appeared that decisions would be made by consensus.

A rather long discussion took place as to the definition of "State-of-the-Art Treatment. It was decided that diagnosis and pre-malignant disease would be ignored for purposes of this committee. It was suggested that "Access" could be defined by dollars and education.

Does this mean that a directory of services should be kept in every county? It was not felt that a voluminous directory in every locale was the answer to the question.

Ms. Speyer volunteered that the Cancer Information Service has available information of referral services. She also pointed out that CIS has computer access to the Physician's Data Query (PDQ) for those who have questions on the latest proven treatments for cancer.

The committee generally felt that "State of the Art" was too all-inclusive; that it included the latest innovations and clinical trials which might not be proven over time. Instead, the committee decided to redefine the title of its task, ie., Access to State of the Art Treatment to Standard of Practice for cancer treatment.

The Standard of Practice was defined as that treatment which could offer, consistently, the best outcome for the malignancy in the present stage of development of the tumor.

The State of the Art, ie., Standard of Practice was then discussed. The concept was visualized as a three-legged stool (familiar to some of us one-time dairy farmers) where the legs were Technology, Dollars and Knowledge.

The technology is not within the control of this committee and, anyway, the machines are there. Dollars are a structural barrier, also not within the purview or the ability of this committee to make more than a cursory recommendation. The subject of knowledge became the main theme of this committee.

The first discussions dealt with knowledge on the part of the cancer patient and the general public. Patients should ask for second opinions before committing to any particular treatment. Public Information and Public Education are the means by which to increase knowldge of the choices which patients must make about their treatment. Awareness! was repeatedly emphasized.

One measure of state of the art would be a comparison of hospitals by means of whether or not they had American College of Surgeons (ACoS) Cancer Programs. There was general consensus that the ACoS program could be used as the standard of care.

It was proposed that there is an equally compelling need for physician education with regard to the "Standards of Care" and the location and availability of specific treatments.

Access is the key. We should look at barriers to knowledge. Some of these barriers were mentioned such as:

knowledge
transportation
language
denial
religion
cultural

The charge of this committee is to identify and recommend ways to remove the barriers.

The Chronic Disease Workshops sponsored by HRS, the USF School of Public Health and the Moffitt Center was discussed as a effective effort to provide professional education to medical professionals in and out of the county health departments.

It was the consensus of the committee that its work would be site based by the most important sites already, for most part, selected by the CCRAB, listed below in priority order. Considerations in the prioritization of the sites were impact of the disease, treatability, availability of methods of early diagnosis, possibility of having an impact.

1. BREAST CANCER

a. Enhance physician, nurses, health educator's roles as patient advocates.

b. Encourage patients to ask for second opinions.

2. COLON/RECTUM

3. CERVICAL

a. Barrier example: Latino reluctance with male physicians

4. LYMPHOMAS(HODGKIN'S & NON-HODGKINS)/LEUKEMIA

a.

5. PROSTATE

a. New, preliminary data shows it may be effectively screened. Coming.

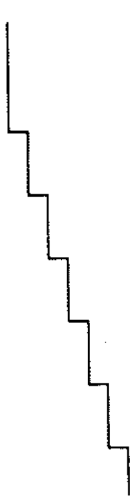
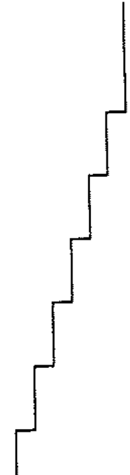
6. OVARY

The chairman briefly reviewed the discussion prior to returning to report to the CCRAB.

REPORT TO THE CCRAB - CHAIRMAN, DR. MACDONALD

Access to State of the Art Treatment was translated to Access to Evolving Standards of Care.

THREE ROADS TO CARE

DOLLARS [$]	**TECHNOLOGY**	**KNOWLEDGE**
		

ACCESS TO CARE

1. **Technology** was not seen as a major factor for attention by the committee.
2. **Dollars [$]** are a structural barrier not amenable to actions by the CCRAB.
3. **Barriers to Knowledge**

   Professional (All health care providers)

   Public

The problem of Barriers to Knowledge must be addressed with Education. The Committee focused on sites on which an impact can be named:

1. Female Breast
2. Colon and Rectum
3. Cervix
4. Lymphomas/Leukemia
5. Prostate
6. Ovary

A future meeting will address recommended interventions in the area of professional and public information.

ATTACHMENT 9

Summary of C-CRAB's Advisory Committee's Recommendations

SUMMARIES OF THE C-CRAB ADVISORY COMMITTEES' RECOMMENDATIONS

(Note: Data analysis is continuing. As a result, these recommendations are subject to changes or refinements. The C-CRAB members will be furnished a copy of the changes, should there be any, before the prioritization workshop.)

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SMOKING CESSATION AND TOBACCO ISSUES

In Florida, annual tobacco related mortality exceeds all mortality associated with cocaine and crack, heroin, drunk driving, homicide, suicide, and AIDS combined. Tobacco abuse is clearly Florida's number one drug problem. The Florida Department of Health and Rehabilitative Services estimates that smoking attributable economic costs in Florida exceeded two-billion dollars in 1989 alone.

The Smoking Cessation and Tobacco Issues Committee concludes that legislators, educators, health care professionals, and the general public are well aware of the dangers associated with tobacco abuse. Unfortunately, public perceptions, attitudes and actions do not reflect the seriousness of the tobacco problem.

Therefore, in order to reduce tobacco initiation and use (and the disease that it causes), it is necessary to change the attitudes of Floridians with regard to tobacco abuse through a statewide informational campaign; designed not just to heighten awareness, but to change attitudes about the smoking problem among decision-makers, health care professionals, and the general public.

I. SMOKING PREVALENCE

Problem:
According to the 1991 Behavioral Risk Factor Surveillance System, approximately 24.6 percent of Florida adults smoke, yet smoking cessation and prevention activities are not funded at the state level.

The C-CRAB recommends that an intensive media campaign based on the California model be conducted in Florida. This campaign should be designed to change attitudes and perceptions about tobacco abuse among decision-makers, health care professionals, and the general public. The percentage of addicted persons in Florida should be reduced from 24.6 percent to 15 percent by the year 2000 in accordance with the federal government's Healthy People 2000 Report.

II. STATE BALLOT INITIATIVE

Problem:
A recent bill intended to strengthen the Florida Clean Indoor Air Act took three years to pass through the legislature and be signed into law. Unfortunately, the modest improvements in this bill will have little noticeable effect on most Floridians. Additionally, none of the revenue generated by Florida's 33 cent per pack cigarette tax is used to fund tobacco prevention and cessation activities or Clean Indoor Air Act enforcement. Progressive anti-tobacco legislation rarely becomes law through the Federal Government or the state legislatures. Tobacco education initiatives and programs in Florida are woefully underfunded or nonexistent.

The C-CRAB recommends that a tobacco or health ballot initiative be placed on the 1994 ballot. This initiative would create and fund tobacco prevention and intervention programs, activities, research, and care for medically indigent patients with tobacco-related diseases.

III. YOUTH SMOKING INITIATION

Problem:
According to the Florida Youth Risk Behavior Survey Report of 1992, 72 percent of all students surveyed reported that they tried smoking cigarettes. An additional 10 percent believed that they would try smoking in the next 12 months. Additionally, 27 percent of all students surveyed reported that they have smoked regularly (at least one cigarette a day for 30 days) during their lifetime.

The C-CRAB recommends that the Florida Legislature pass public health legislation requiring tobacco retailers to obtain a permit to sell tobacco products. With statewide implementation and enforcement, tobacco retail permitting would reduce or eliminate children's access to retail tobacco products. Along with media messages targeted at Florida's young people, initiation of smoking by school aged children should be reduced from 25% to 15% by the year 2000.

IV. BARRIERS TO SMOKING CESSATION

Problem:
The drug nicotine is easily available to all Floridians, including children, in the form of inexpensive tobacco products. Yet to obtain the same drug for use in nicotine replacement therapy, a doctor's office visit and expensive prescriptions are necessary. Further, the costs of smoking-cessation classes and services are out of reach of most lower-income smokers. These barriers to smoking cessation prevent many Floridians from obtaining the smoking-cessation assistance they desire.

The C-CRAB recommends that affordable smoking cessation programs and drugs be made available to every Floridian through the HRS County public health units. Health maintenance organizations and insurance companies should be encouraged to defray the preventative costs of nicotine replacement therapy.

BREAST CANCER

In the United States at this time, breast cancer accounts for approximately 30% of all newly diagnosed female cancers and 18% of all female cancer deaths. Crude incidence rates have increased about 3% per year since 1980, going from 84.4/100,000 in 1980 to 109.5/100,000 in 1988.

Incidence rates are increasing partly because of earlier diagnosis through screening and partly because of increased longevity of the population. Mortality has been fairly stable over the past 30 years. Since not enough is known about the cause of breast cancer, primary preventive measures are not successful at this time. However, secondary prevention through screening asymptomatic women has been shown to be effective, especially when screening programs are directed at high-risk groups. The ethnic makeup of the high-risk group differs somewhat by state, therefore targeting should be based on the data available in each state.

Breast cancer is the most common malignancy and the second highest cause of cancer mortality among women. There will be an estimated 180,000 new cases diagnosed and 46,000 deaths attributed to the disease in 1992. At current incidence rates, one of every nine American women will develop breast cancer during her lifetime. According to the American Cancer Society projection in *Cancer Facts and Figures-1992*, which is based on the SEER projection, there will be 11,200 new cases of breast cancer in Florida women in 1992 and 2,900 women will die of this disease. The American Cancer Society and the National Cancer Institute recommend regular clinical examination of the breast for all women. Screening mammography should begin at age 40, followed by annual or biennial mammograms from ages 40 to 49 and annual mammograms beginning at age 50. Clinicians should carry out regular breast examinations for all women over age 20.

I. PUBLIC EDUCATION

Problem:
According to the 1990 Behavioral Risk Factor Survey (BRFS), a substantial minority of Florida women in the target age group for mammography are not receiving regular mammograms. Women not receiving mammograms are widely distributed by age, race, education, income, and geography, but are concentrated among minority women, those without a high-school education, and those with low income. Overall, 55.8% of Florida women aged 40 and over reported receiving a mammogram in the past two years. One-third, or 33.4% , reported they had never received a mammogram. This represents approximately 1,100,000 women in the age group for whom regular screening mammography is recommended who have never had a mammogram. Of Florida women aged 40 and older, 90.9% that they had ever had a breast exam by a physician or assistant. 65.9% reported that they had had one in the previous year, almost 40% (representing over 800,000 women) reported they had not had a mammogram in the previous year. Of women who reported they had a breast exam in the last year, 31.3% reported they had not had a film in the previous two years.

The C-CRAB recommends that the Secretary of HRS, the legislature and the private sector cooperate to support the development and implementation of effective public education programs that will result in changes in knowledge, attitudes and behaviors of women, to increase their likelihood of receiving mammograms as recommended. Such programs should include older minority women as a primary target group.

II. PROFESSIONAL EDUCATION

Problem:
A substantial number of Florida women in the target age group for mammography are not receiving regular mammograms. Over one-third of women age 40 and over have never had a mammogram. Women not receiving mammograms are widely distributed by age, race, education, income, and geography, but are concentrated among minority women, those without a high-school education, and those with lower incomes. Physicians are often not recommending mammograms for women who are covered by national recommendations, and 40% of women (40 years of age and older) who have had a breast examination by a physician in the last year have not had a mammogram in that same period. (1990 BRFS)

Because primary health care providers play such a crucial role in providing long term preventive care, professional education which stresses breast cancer education, screening and treatment should be promoted.

The C-CRAB recommends that the Florida Medical Association and the American Cancer Society cooperate to support the development and implementation of effective provider education programs that will result in increasing the likelihood that providers will carry out clinical breast examinations and recommend mammograms. Screening mammography should begin at age 40, followed by annual or biennial mammograms from ages 40-49 and annual mammograms beginning at age 50 . Clinicians should carry out regular breast examinations for all women over age 20 as well as encourage women to practice monthly self-breast exams. Such programs should include family practitioners as a target group.

III. ACCESS TO SCREENING AND CARE

Problem:

Although cost and lack of insurance are not the major barriers to mammography, they are more often cited by low-income women as reasons they did not have a mammogram than by higher-income women. The group most likely to have had a mammogram in the last two years (57.3%), and least likely to have never had one (30.9%), were the women aged 50 to 59. White non-Hispanic women were more likely to have had a mammogram in the last two years (56.3%) and less likely to have never had a mammogram (34.9%) than either White Hispanic women or Black women. When age and race/ethnicity were examined together, there was little variation by age among the White non-Hispanic women, but for both Hispanic White women and Black women those aged 60 and over were notably less likely to have had a mammogram in the last two years (32.4 and 38.7% respectively). The percent local at diagnosis is higher in non-Hispanic whites (about 56%) than in Hispanic whites (about 50%) or non whites (about 39%). For local stage disease, urban groups were least likely to get surgery alone (69.7%), rural most likely (79.6%); urban most likely to get combined treatment (27.4% vs 16.0%). Mixed group values are intermediate. (FCDS 1989). For local stage disease, women 80+ are most likely to get surgery alone (85.2%) vs under 50 (68.7%). Youngest women are most likely to get combined therapy (21.4%) vs oldest (10.9%). For those women diagnosed with regional disease, 61% of those 80+ got surgery alone, vs 42.7% of women under 50. 31.7% vs 49.2% for combined. (FCDS 1987-89). All these points are evidence for access to screening and care being a problem.

Universal access to breast cancer screening should be available at a reasonable cost and be reimbursable by third-party payers. Special efforts must be made for screening in the low-income and minority populations.

The C-CRAB recommends that the Department of Health and Rehabilitative Services, American Cancer Society, Florida Medical Association and American College of Radiology cooperate to support interventions that will assure that all women aged 40 and over can obtain screening mammography, follow-up diagnostic tests, and needed treatment regardless of ability to pay.

IV. QUALITY ASSURANCE OF MAMMOGRAMS

Problem:
After the proliferation of dedicated mammography units, there was a time when it was believed by professionals and the public alike that all was well with mammography; image quality was thought to be consistently good and breast doses consistently low. However, in 1985 to 1987, research dispelled that false sense of security. Quality assurance is clearly tied to the training of radiologists and must be considered if screening centers are to function efficiently. The Mammography Accreditation Program recently established by the American College of Radiology, grants accreditation on the basis of image quality, image dose, the adequacy of facilities, equipment and the training of professional and technical personnel. Of the 578 state licensed mammography units, 187 or 32.4% are ACR certified.

Quality assurance is an essential feature of any breast cancer screening program, therefore, all women should be referred to units which meet or exceed standards of the American College of Radiology (ACR).

The C-CRAB recommends that the Department of Health and Rehabilitative Services, American Cancer Society and Florida Medical Association cooperate to assure that all licensed mammography facilities in the state meet or exceed standards of the ACR.

CERVICAL CANCER

In the United States it is estimated that there will be 13,500 new cases of invasive cancer of the cervix, and approximately 4,500 women will die from the disease in 1992. The five-year survival rate is about 90% for women with localized invasive cervical cancer, but only about 40% when the disease has spread beyond the site of origin. Nationwide, in 1989, there were approximately 600,000 cases of cervical intraepithelial neoplasia, including 50,000 cases of carcinoma-in-situ. If these cases can be found and treated, almost all can be cured, and deaths from invasive squamous carcinoma could be essentially eliminated. As recently as 1987, invasive cancer of the cervix caused 36,000 hospitalizations, and 44,000 years of potential life lost before the age of 65, so this disease still presents a significant problem. In 1986 the cervical cancer age-adjusted death rate was 3.0/100,000 women in this state. With an effective cervical cancer screening program, the age-adjusted death rate could be reduced by approximately twenty-five percent by the year 2000. This is an achievable goal and the reduction in death-rate could be much greater with effective cervical cancer screening programs. These programs would be particularly effective if they could pick up the estimated 30,000 cases of cervical intraepithelial neoplasia and 2,400 cases of carcinoma-in-situ of the cervix before these women develop the invasive stage of the disease. All of these women could be treated with relatively simple and inexpensive means. Unfortunately, we still see an average of 744 cases of invasive cervical cancer per year in the state of Florida.

I. PUBLIC EDUCATION

Problem:
According to the HRS Cancer Epidemiology-Florida Cancer Data System report *Cancer In Florida, Seven Year Overview (1981-87)*, in white women the crude incidence rate was 12/100,000, and the age-adjusted rate 9.2/100,000. On the other hand, in black women the crude incidence rate was 18.7/100,000 and the age-adjusted rate 21/100,000. This emphasizes the need for special efforts to screen black women in this state. Women who are least likely to get Papanicolaou smears regularly should be targeted, e.g., white Hispanic women who were less likely (40.8%) to have had a Papanicolaou smear than blacks (14.4%) in the last five years. Women under 24 (22.2%) and over 65 (26%) years of age were least likely to have had a Papanicolaou smear in the last five years. Women with educational attainment to the 8th Grade or less, and women with an annual income of less than $15,000 per year, also were less likely to have had a Papanicolaou smear within the last five years. These are women whom we should be making special efforts to reach.

The C-CRAB recommends that the Secretary of HRS, the Legislature and the private sector cooperate to support the development and implementation of effective public education programs that will result in changes in knowledge, attitudes and behaviors of women, to increase their likelihood of receiving pap smears as recommended as well as preventive measures that a woman can take to reduce her risk for cervical cancer.

II. PROFESSIONAL EDUCATION

Problem:
According to the 1989 Florida Point In Time Survey (PITS), 72% of females 18 and older have had a pap smear within the previous 24 months. Only 43.7% of white-Hispanic women 18 and older have had a pap smear within the same time period. For the age category 18-49, white non-Hispanics were most likely to have been screened within the previous 2 years (86.6%) followed by Blacks with 76.4%. White non-Hispanic women were the least likely to have had a pap smear within the last 24 months (40.9%). For those women who had a checkup within the previous two years, 94.8% in the age category 18-49 also had a pap smear. As age increases, screening decreases. For women aged 50-59, 85% reported having had a pap smear. Seventy-four percent (73.8%) of women aged 60-69 had a pap smear within the previous two years. The age categories 70-79 and 80+ were the least likely to have been screened with 66.3% and 56.6% respectively.

Because primary health care providers play such a crucial role in providing long term preventive care, professional education which stresses cervical cancer education, screening and treatment should be promoted.

The C-CRAB recommends that the Florida Medical Association and the American Cancer Society cooperate to support the development and implementation of effective provider education programs that will result in increasing the likelihood that providers will recommend screening and use a variety of provider interventions to educate, motivate or remind patients about adhering to recommended screening guidelines.

III. ACCESS TO SCREENING AND CARE

Problem:
According to the 1989 Point in Time (PIT) Survey, white-Hispanic women are the least likely to have had a pap smear in the previous five years (53.5%) vs 83.3% for white non-Hispanics and 87.1% for Blacks. Additionally, for those females 60 years of age and above, white-Hispanic women were again the least likely to have had a pap smear in the previous five years (60.6%) as compared to white non-Hispanics with 73.3% and Blacks with 83.9%. Based on 1989 FCDS stage at diagnosis for cervical cancer, non-white women had the highest rates, both crude and age-adjusted, for invasive cervical cancer. Non-white women aged 40 and above have higher age-specific rates for both regional and distant stage cervical cancer when compared to white females.

Universal access to cervical cancer screening should be available at a reasonable cost and be reimbursable by third-party payers. Special efforts must be made for screening in high-risk populations.

The C-CRAB recommends that the Department of Health and Rehabilitative Services, American Cancer Society, Florida Medical Association, and the American Society of Clinical Pathologists cooperate to support interventions that will assure that all sexually active women obtain pap smears, follow-up diagnostic tests, and needed treatment regardless of ability to pay.

IV. QUALITY ASSURANCE OF CYTOLOGY

Problem:
Accuracy and the level of false negatives in Pap testing are affected by errors in sampling and cytological evaluation. Studies show that the false negative rate for cervical cytology varies from 10 to 40 percent (World Health Organization, 1986). Specimen adequacy can be improved through standardization of sample collection and preparation. The National Committee for Clinical Laboratory Standards (NCCLS) is in the process of developing such consensus guidelines. The Bethesda System (TBS) for cytopathology reports has introduced uniformity to diagnostic assessment and terminology. The Bethesda System terminology has received broad support from numerous professional societies and had gained widespread acceptance in laboratory practice. A survey of the practice characteristics of over 250 cytopathology laboratories conducted by the College of American Pathologists (CAP) six months after publication of TBS, indicated that over 70% of the responding laboratories were either using TBS or would soon convert. However, support for TBS has not been unanimous. A survey performed by the Society of Gynecologic Oncologists in August, 1990, revealed that 63% of the respondents agreed with TBS, while 26% disagreed.

The C-CRAB recommends that the Department of Health and Rehabilitative Services, the Florida Society of Pathologists and the Florida Medical Association cooperate to assure that all licensed cytopathology laboratories meet or exceed the standards of the College of American Pathologists.

ACCESS TO STATE OF THE ART OF TREATMENT AND CARE

The three critical issues concerning access to state of the art treatment and care are quality of treatment and care, financial assistance for treatment, and utilization of community resources.

The National Cancer Institute (NCI) endorses the application of multidisciplinary expertise in planning treatment and care for some cancer types. The American College of Surgeons (ACoS) has developed standards for cancer patient treatment and care in which prospective multidisciplinary patient-oriented cancer conferences are required.

Among colon cancer patients in 1988 and 1989 in Florida, a significantly higher proportion of cancer patients is treated with adjuvant chemotherapy in ACoS certified hospitals than NonACoS hospitals. Of the 317 hospitals in Florida, only 49 are ACoS certified. Many are in the southern half of the state.

Sixteen (16) counties do not have ACoS approved cancer program hospitals, and are not located near counties that have an ACoS hospital. Analysis of the 1989 colon cancer treatment patterns reveals that 96.9% of the patients who were residents of counties where an ACoS hospital was located were treated in that county. Only 33.7% of the colon cancer patients who were residents of counties next to one which has an ACoS hospital were treated in a county with an ACoS hospital. Only 15% of patients who were residents of counties located farther away were treated in counties with an ACoS hospital. The data shows that colon cancer patients tend to stay in their county of residence for treatment. The data is suggestive that distance is an important factor in determining where a cancer patient gets treatment.

About 60,000 new cases of cancer are diagnosed in Florida every year. Cancer is the leading cause of death among persons aged 25 to 64. About 2.2 million, or one in five Floridians has no health insurance. By 1995, it is estimated that the number of uninsured Floridians will be 3.3 million. Forty-two percent (42%) of all people with incomes below the official poverty level of $12,708 (family of 4) are uninsured. In the meantime, the per capita health cost has been rising. In 1980, the annual per capita health care cost was about $960. In 1990, it had risen to $2,430. By the year 2000, it is projected to be $5,520.

Sections 408.004 to 408.006 of the Florida Health Care Act of 1992 mandates the development of a State Health Plan that addresses the issues of health care availability, health care cost containment, health care insurance; and health regulation by 1994.

Most Florida communities are served by local ACS units. These local units provide public health information about cancer, transportation assistance to treatment centers, and support group sessions to help the victims cope with the disease. Local ACS units vary in resources and consequently types of local support to cancer victims that they offer.

Local cancer units do not know all the cancer victims in their service area. Cancer victims are expected to initiate contact with these local units before they can be assisted. Not all cancer victims make such initial contact.

Thus, not all cancer victims avail themselves of assistance and support services offered by the local ACS. Currently, there is no estimate on the number of patients who are not utilizing cancer related resources which are available in their local communities.

The following problem areas are identified to address the issues of quality of treatment and care, financial assistance for treatment, and utilization of community resources.

I. QUALITY TREATMENT AND CARE

Problem:
There is geographical imbalance in the distribution of ACoS hospitals. Some counties in the Florida panhandle are located far from a county with an ACoS hospital.

The C-CRAB recommends that the Florida Hospitals Association encourage their eligible members to adopt ACoS standards for cancer treatment. Priority attention should be given to increasing the number of these hospitals in the Florida panhandle from to serve patients in counties which do not currently have an ACos approved hospital nor are located next to county which has an ACoS approved hospital.

II. PROFESSIONAL EDUCATION

Problem:
Analysis of the 1989 treatment patterns for colon cancer revealed that surgery adjuvant chemotherapy is less frequently administered in non ACoS hospitals and in rural counties where no ACoS approved program hospital is located. Analysis of breast cancer treatment patters also show that a higher percentage of patients in urban counties was treated with combined treatments than rural counties. Adjuvant chemotherapies are relatively easy to adopt since they often do not require extensive training and do not involve the purchase of expensive equipments. These findings suggest that proven medical technologies are not being adequately disseminated to health professionals in rural areas. At the same time, the findings also suggest that medical expertise that is not present in rural areas should be made more accessible to rural health practitioners to assist in planning treatment procedures.

The C-CRAB encourages ACoS hospitals, in cooperation with other health education organizations such as A.H.E.C. (Area Health Education Centers), to be more active in promoting the use of proven medical technologies. In addition, the C-CRAB also recommends that ACoS hospitals develop and implement a system where non-affiliated physicians can make use of the multidisciplinary expertise that is available to ACoS hospitals in development cancer treating protocols.

III. AFFORDABLE CANCER TREATMENT

Problem:
Every year, there are approximately 12,000 Floridians who develop cancer and who have no health insurance. The number of insured Floridians whose insurance will not sustain them for prolonged cancer treatment is unknown.

The C-CRAB recommends that the HRS Cancer Program, the Florida Department of Elderly Affairs, and the ACS work together to document the lack of access to treatment among cancer victims in Florida due to financial reasons and submit the findings to the planning body responsible for developing the Florida Health Plan.

IV. UTLIZATION OF COMMUNITY RESOURCES

Problem:
According to local ACS officials many cancer victims are not aware nor do they avail themselves of local community resources which may help them cope with the disease.

The C-CRAB recommends that physicians should encourage cancer victims to get in touch with local cancer support groups as the ACS and other support groups such as the CIS for informational and other types of assistance that may be available in the local community.

EMERGING ISSUES

The two most prominent emerging issuses in colorectal cancer control and surveilance are prevention and financial assistance for treatment. Colorectal cancer is the second most common cause of cancer deaths among Americans. Approximately 160,000 new cases and 61,000 deaths occur due to this cancer every year. In Florida approximately 8,200 new cases and 3,500 deaths are reported every year. White males and females represent the great majority of the colorectal cancers reported (94.7%). The age adjusted incidence for persons of the white race is 44.7 per 100,000 persons. The age adjusted incidence rate for persons of the nonwhite race is 32.7 per 100,000 persons. The mortality rates are the same for both races (18.5 per 100,000 person).

Studies indicate that early detection of colorectal cancer increases the chance of survival. If detected at the local stage, the five year survival rate is 88%. The five year survival rate decreases to 57 % when the cancer is detected at the regional stage and only 6% when it is detected at the distant stage. The effectiveness of screening for colorectal cancer remains controversial. The American Cancer Society (ACS) recommends annual digital examination for persons over age 40 and annual stool testing beginning age 50. In addition, they recommend sigmoidoscopy every 3 to 5 years beginning at age 50. Other studies argue that there is no sufficient evidence for or against screening efforts especially fecal occult blood testing or sigmoidoscopy. There is general agreement that it is clinically prudent to screen for colorectal cancer among persons aged 50 years or older with known risk factors for colorectal cancer.

The standard procedure for treating colorectal cancer is surgical resection of the primary tumor and the regional mesenteric lymph nodes. Surgery with chemotherapy has shown promising results in reducing the risk of recurrence and the overall death rate. Adjuvant chemotherapy with 5-FU (flourouracil) combined with levamisole, administered to patients with colon cancer in Duke's stage C (equivalent to FCDS regional stage), has been reported to reduce the risk of recurrence of the disease by 44%, and reduce the overall death rate by 33%. Regional stage colorectal cancer comprises 38.2% of 77,162 colorectal cancers reported to the FCDS (Florida Cancer Data System) from 1981 to 1989.

I. PUBLIC EDUCATION

Problem:
Florida has a significantly older population than other states with almost 1/3 of the total number of residents being 50 years old or older. More than 96% percent all colorectal cancer reported belong to this age group. Almost 97% of all deaths due to colorectal cancer are in this age group. While no data is available on how many have of persons age 50 and above have risk factors for cancer other than old age, the age specific incidence rate of colorectal cancer doubles every seven years. The age specific mortality rates follow the same trend.

The C-CRAB recommends that the Secretary of the HRS, the legislature and the American Cancer Society cooperate to support the development and implementation of effective public education programs that will enable the public to determine if they are of high risk of developing colorectal cancer to increase the likelihood of detecting colorectal cancer at an early stage.

II. NUTRITION

Problem:
Increased risk of colorectal cancer has been significantly associated with saturated fat consumption. Analysis of the 1990 Behavior Risk Factor Survey reveals that a higher percentage of black Floridians rarely or never remove the skin when they eat chicken, eat fried chicken and fried fish, and use whole milk and use lard frying.

The C-CRAB recommends that the HRS, the American Cancer Society, and the Fla. Department of Education cooperate to support the development and implementation of effective public education programs that will enable the public to change dietary behaviors towards reducing fat intake and increasing the consumption of fruits and vegetables. Changing the dietary behaviors of blacks should be a primary component of such program.

III. ADOPTION OF PROVEN MEDICAL TECHNOLOGIES

Problem:
In 1988, the GAO reported that despite results of clinical studies conducted as early as 1978 that showed improved chances of survival as a result of adjuvant chemotherapy, only 6% of the colon cancer patients who were included in the 1985 SEER (Surveillance, Epidemiology, and End Results) Cancer Registry database received adjuvant chemotherapy. In Florida in 1989, only 9.3% of all patients given treatment, and only 10.6% of all the patients with colon cancer in regional stage who received treatment were given adjuvant chemotherapy.

The C-CRAB recommends that the Florida Hospital Association and the Florida Medical Association support a study on why the adoption of proven medical innovations in Florida is slow and not more widespread, and what steps could be taken to facilitate more rapid adoption of proven medical innovation. A primary focus of this study should be on improved treatment protocols for colorectal cancer.

ATTACHMENT 10

1993 Florida Cancer Plan

1993 FLORIDA CANCER PLAN

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EXECUTIVE SUMMARY

The 1993 Florida Cancer Plan is the result of analysis of cancer incidence, mortality, risk factors and other appropriate data for the period 1981 through 1989. These analyses were conducted by the Florida Department of Health and Rehabilitative Services (HRS) under the Data Based Intervention Research (DBIR) for Public Health Agencies Cooperative Agreement from the National Cancer Institute (NCI). On the recommendation of the Florida Cancer Control Research and Advisory Council (C-CRAB), HRS determined that the 1993 priorities for cancer prevention and control efforts will be directed to the co-equal issues of:

Reducing Smoking Prevalence
and
Access to Screening and Care for Breast and Cervical Cancer

The data and analyses used to determine these priorities are contained in the body and appendices of the 1993 Florida Cancer Plan.

The 1993 Florida Cancer Plan consists of four sections:

Section one, the introduction, provides the rationale for the focus of the plan, terminology and a description of the data sources upon which the analyses are based.

Section two discusses the incidence and prevalence of cigarette use in Florida. This section examines the economic costs, incidence and mortality of smoking related cancers. It presents the definition of the problem addressed in the 1993 Plan, strategies for considering the problem and methodologies for evaluating the effectiveness of interventions for the prevention and cessation of cigarette smoking.

Sections three and four address the incidence, morbidity and mortality of breast and cervical cancer in Florida. They discuss screening for these cancers and the demographic data related to access to screening and care. They also define the problems to be considered, the strategies to be used and the methodologies for evaluating the effectiveness of interventions.

Strategic interventions will focus on:

- Focus public and legislative awareness on the magnitude of the health and social issues attributable to smoking, breast cancer and cervical cancer.
- Focus public and legislative awareness on the long and short term benefits of prevention and control efforts directed at smoking, breast cancer and cervical cancer.

- Focus public and legislative awareness on the economic, geographic, cultural and institutional barriers to universal access to screening and care as well as the reduction of smoking prevalence.

- Utilize existing regional and local institutions to attain the priority objective of the plan.

To facilitate the development of appropriate interventions the Department will:

- Prepare a comprehensive descriptive analysis of cancer in Florida for the period of 1981-1990. These data will serve as the primary data source for determination of appropriate interventions.

- Prepare "cancer briefs" for legislators and other opinion leaders to focus attention on the cancer prevention and control needs defined in the 10 year analysis.

- Propose legislative initiatives which will:

  Fund the Cancer Prevention and Control Fund through an increase in the cigarette tax.

  Require health insurance coverage of Papanicolaou tests at intervals consistent with NCI recommendations.

  Clarify the Florida Clean Indoor Air Act (FCIAA) to facilitate a smoke free environment for Floridians.

HRS, with the advice of the C-CRAB, will implement the 1993 Florida Cancer Plan with emphasis on populations with incidence, prevalence, morbidity or mortality higher than the state mean. Focused interventions will be conducted by HRS and other agencies.

These interventions will:

- define statewide prevention and access initiatives.

- define local prevention and access initiatives.

Each initiative:

- will address specific needs defined by available data.

- will be evaluated on health status or health behavior indicators as measures of success.

- outcome will be used to focus and refine future interventions.

As data and experience are gained through the data driven intervention process, the Florida Cancer Control and Prevention Plan will be incrementally revised to identify additional priorities, strategies and interventions designed to achieve the goals of the federal government's Healthy People 2000 Plan.

Proposals and inquiries will be solicited through the Department and C-CRAB membership. Projects will be selected on the basis of:

- The criteria defined in the 1993 Florida Cancer Plan.
- Consistency with the conditions of the DBIR grant award.
- Consistency with the Department's Agency Functional Plan.

Selection will be made, on a noncompetitive basis, by the Department based on the above current statutes.

INTRODUCTION

This Florida Cancer Plan focuses on development of programs for the control of smoking-related cancers and on female breast and cervical cancers, consistent with the recommendations of the C-CRAB. Such programs offer significant opportunities for long-range reduction of cancer morbidity and mortality through the use of early detection and prevention techniques.

The "Florida Cancer Plan" was originally published in 1990 by HRS. The Plan was developed with the extensive consultation and approval of the C-CRAB. The C-CRAB was first appointed by the Governor in 1980 by authority of the Cancer Control and Research Act of 1979. Its members represent the health professions, cancer organizations, the Legislature, the universities and medical schools and state government, with three members representing the general public as consumer advocates.

Also in 1990, HRS was awarded a National Cancer Institute Cooperative Agreement to carry out Data Based Intervention Research for Public Health Agencies (DBIR). The project was to use various available data bases relating to cancer to plan and initiate prevention and control activities.

During Phase I of the project, appropriate data bases were identified, evaluated and analyzed to provide the basis for the definition and prioritization of the cancer problems in the state and to identify available resources. It is believed that an effective plan to resolve problems of cancer control must be data driven. However, the existing "Florida Cancer Plan" is not primarily data driven. Rather, it is the product of the experience and observations of members of the C-CRAB and other selected experts in the field. It was the first phase of a Florida Cancer Plan which served as a beginning for an effective comprehensive plan for cancer control developed over a five year period. It was intended to undergo periodic review and revision to reflect strategies appropriate for the time, the measure of progress, the level of need and also to serve as a point of departure for this data driven plan.

During Phase II of the project, the Florida Cancer Plan was revised to focus on the priority areas of concern as identified and prioritized by the C-CRAB. It focuses on two areas (1) smoking-related cancers and (2) female breast and cervical cancers. These cancers offer significant opportunities for long-range reduction of morbidity and mortality through the use of early detection and prevention techniques.

TERMINOLOGY

Age-Adjusted Rates: The sum of the weighted age-specific rates. The direct method of adjustment was used to produce the age-adjusted rates for this report. Valid comparisons between age-adjusted rates can be made, provided the same standard population and age group have been used in the calculation of the rates. The United States 1970 standard million population is used for this plan.

Cancer Incidence: A measure of the number of new cases of cancer occurring in a particular population in a given period of time. Incidence rates in this report are numbers of cases occurring in one year per 100,000 persons in the population. For breast and cervical cancer, the rates are calculated per 100,000 females.

Cancer Mortality: A measure of the number of deaths attributable to cancer in a particular population in a given period of time. Mortality rates are expressed in terms of numbers of deaths per 100,000 persons.

Crude Rate: The measure of disease occurrence calculated for a whole population. For example, the crude cancer incidence rate for Florida during 1990 would be the proportion of cases diagnosed during 1990 to the average population of Florida in 1990.

Prevalence: A measure of the proportion of the population that has a disease or condition at a specific point in time.

Screening: Designed to identify groups of persons who are most likely to have cancer. More intensive diagnostic study of individuals in these groups can result in early detection of cancer and development of plans for treatment or behavior change.

Stage: A measure of the stage of disease at the time the cancer is first diagnosed. The groupings are general enough so that nearly every case can, with careful consideration, fit into one of them. These stage categories are defined as follows:

> In situ: A tumor that fulfills all of the microscopic criteria for malignancy, except for invasion.
> Local: A tumor that appears to be confined entirely to the organ of origin.
> Regional: A tumor that has extended beyond the limits of the organ of origin directly into surrounding organs or tissues or into regional lymph nodes by way of the lymphatic system.
> Distant: A tumor that has spread to parts of the body remote from the primary site of the tumor.

Surveillance: Activities which gather and analyze population-wide information on cancer occurrences and deaths, as well as behaviors and environmental factors which present possible risks for cancer.

The Bethesda System (TBS): Used for reporting cervical/vaginal cytologic diagnoses. TBS (1) provides uniform diagnostic terminology to facilitate unambiguous communication between the laboratory and the clinician; (2) incorporates specimen adequacy evaluation as an integral part of the report, and (3) eliminates Papanicolaou class numbers. TBS has 3 basic elements: (1) statement of specimen; (2) general categorization; and (3) descriptive diagnoses.

DATA SOURCES

Behavior Risk Factor Surveillance System (BRFSS): Personal Behavior Data. Florida takes part in the Behavioral Risk Factor Surveillance System, funded by the Centers for Disease Control (CDC). BRFSS uses telephone interviews to ask a variety of questions relating to preventable risk factors for the leading causes of deaths, including cancer. Each month in Florida approximately 187 telephone interviews are conducted in a randomly selected statewide sample. Due to the relatively small numbers of people interviewed, no county specific data can be analyzed at this time. Only a few questions can be added to the CDC questionnaire each year limiting the ability to address areas of specific interest to cancer control.

Florida Cancer Data System (FCDS): Incidence Data. All Florida licensed hospitals report to HRS each cancer case admitted for diagnosis and treatment. These reports are collected, stored and analyzed at the FCDS central office in the Sylvester Comprehensive Cancer Center (SCCC) at the University of Miami. This data system provides information for analysis of cancer incidence and stage of diagnosis. The information is used by the C-CRAB to set priorities and evaluate interventions. The most serious limitations of the FCDS data are (1) only initial treatment is recorded, (2) no follow-up is obtained therefore, no direct measure of survival is available and (3) since the FCDS is a hospital-based registry, there is an undetermined number of cases treated in physicians offices, free-standing radiotherapy clinics, ambulatory surgical centers, that are lost.

Florida Youth Risk Behavior Survey Report (YRBSR): Personal Behavior Data. Florida also participates in the CDC-funded Youth Risk Behavior Survey. Similar to the BRFSS, YRBSR is a random sample conducted in 60 schools in 28 of Florida's school districts. The population base for this survey is active students, dropouts are not included there by imposing a serious limitation in applying the results to the general youth population.

Office of Vital Statistics: Mortality Data. When a Florida resident dies, a death certificate is filed with the county health department and then forwarded to the state vital records program, which maintains records of all deaths. Each year the HRS Cancer Epidemiology program receives a data file of all cancer deaths. This data file is analyzed and used to identify problems and to plan programs.

Point In Time Survey (PITS): Personal Behavior Data. PITS data were analyzed in 1989 on demographics, level of physical and recreational activities, diet, cigarette smoking, intake of alcoholic beverages and preventive health practices in order to identify persons who are at high risk for cardiovascular disease. Although these data were collected for cardiovascular diseases, they contain a great deal of risk factor data which pertain to cancer. The PITS was limited to Leon county so the applicability of these data to the state as a whole is questionable.

Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC II): Smoking-Attributable Mortality Data. SAMMEC II is a CDC-funded computer software packet which collects estimates of the disease impact of smoking on the population. Using mortality data, economic cost data, and smoking prevalence data for large populations to make calculations appropriate for each population. SAMMEC II is produced by the CDC Office on Smoking and Health, Centers for Chronic Disease Prevention and Health Promotion.

SMOKING CESSATION AND TOBACCO ISSUES OVERVIEW

United States

According to the U.S. Surgeon General's Office, smoking is responsible for one of every six deaths in the United States, and remains the single most important preventable cause of death in our society. Smoking is responsible for over 80 percent of all lung cancer deaths nationally and is associated with cancers of the lip, oral cavity, pharynx, esophagus, stomach, pancreas, larynx, trachea, bronchus, cervix, bladder and kidney.

Florida

In Florida, annual tobacco related mortality exceeds all mortality associated with drug abuse, drunk driving, homicide, suicide, and AIDS combined. Tobacco abuse is clearly Florida's number one drug problem. HRS estimates that smoking attributable economic costs in Florida exceeded two-billion dollars in 1989 alone.

Prevalence Rates

Like the rest of the nation, Florida's smoking prevalence is slowly declining (Florida is at 23.57 percent compared to 22.59 nationally, as of October 1991). But the economic and health consequences of today's dependent smokers, and the new young smokers being recruited, will not be felt until well into the next century.

An additional indicator of the smoking problem is tobacco consumption. In 1989, Floridians and visitors consumed 1.4 billion packs of cigarettes at a combined cost of almost three billion dollars. This equates to over 100 packs of per resident.

Mortality Rates

Through the use of the CDC SAMMEC II Software Program (Smoking-Attributable Mortality, Morbidity, and Economic Costs), it is estimated that 26,498 Floridians died as a result of tobacco abuse in the year 1989 alone. Of these deaths, 10,336 were attributed to cancer, at a cost to the state of an estimated $652,767,329, including direct costs of medical care, indirect costs resulting form losses of output due to morbidity and premature mortality, nonhealth sector direct and indirect costs, social costs and decreased quality of life, and rippling effects of cost increases throughout the economy. The breakdown of deaths by specific diagnoses is as follows:

Lung	8,202	Bladder	295
Lip, Oral Cavity	509	Kidney	200
Esophagus	492	Larynx	196
Pancreas	359	Uterine Cervix	83

Problem

Future tobacco-related mortality and morbidity in Florida will be directly linked to current smoking prevalence. Approximately 23.6 percent of Florida adults smoke and 72.0 percent of all high school students have tried smoking cigarettes. An additional 10.0 percent believed that they would try smoking in the next 12 months. Of all students, 27.0 percent smoke regularly (at least one cigarette a day for 30 days).

Goal

To reduce the disease related to tobacco use.

Objectives

1. Reduce the percentage of tobacco addicted persons in Florida from 23.6 percent in 1991 to 15.0 percent by the year 2000 in accordance with the federal government's Healthy People 2000 Report.

2. Reduce the initiation of smoking by school aged children from 25.0 percent in 1991 to 15.0 percent by the year 2000.

3 Increase availability of affordable nicotine replacement therapy and smoking cessation assistance.

4. Reduce consumption of cigarettes by 25.0 percent.

Strategies

1. As Florida's public health authority, the HRS State Health Office will take the initiative in organizing a broad-based Anti-Tobacco Coalition (ATC), with the objective of meeting or surpassing the national goals outlined in the Federal Government's Healthy People 2000 report and in this Cancer Plan. Under the leadership of Florida's State Health Officer, the Healthy Communities/Healthy People Program is being implemented which draws upon volunteer organizations, medical professional associations, educators, business organizations and other interested parties to act on problems in concert with the Legislature and the Florida Tri-Agency Coalition on Smoking or Health. Such a coalition would bring greater focus to the tobacco problem in the state and help clear the way for the progressive anti-tobacco initiatives outlined in this plan.

2. An intensive media campaign with the goal of reducing overall prevalence, consumption, and initiation, must be conducted in Florida. This campaign would be based on the successful California model. Such a campaign would be designed to change attitudes and perceptions about tobacco abuse among decision-makers,

health care professionals and the general public. Like the California model, the Florida Campaign would be region specific, and should follow four simultaneous strategies:

(a) Strive to raise the priority of smoking as a public health issue.
(b) Improve the ability of communities to affect change in smoking barriers.
(c) Strive to increase the influence of the existing legal and socioeconomic factors that discourage tobacco use and encourage smoking cessation.
(d) Strengthen social norms and values that discourage tobacco use.

Evaluation

Ongoing surveillance will be conducted using the Behavioral Risk Factor Surveillance Survey, the Youth Risk Factor Surveillance Survey and cigarette tax data.

Responsible Agencies

The HRS and the C-CRAB would be responsible for outlining goals and strategies; the state ACT and community organizations would be responsible for implementation; and HRS would be responsible for evaluation of the plan.

Conclusion

In order to reduce the smoking prevalence which leads to death and disease, it is necessary to change the attitudes of Floridians with regard to tobacco abuse through a statewide information campaign. Such a campaign should be designed not only to heighten awareness, but also to influence perceptions of the smoking problem among decision-makers, health care professionals, as well as the general public. Professionals in the fields of education, health care, public health, law enforcement, trade unions, as well as in Florida's regulatory agencies and in the legislature, must be educated to take action to address the tobacco problem in our state.

For tobacco prevention and education programs to be effective, they must be sustained by adequate funding. For this kind of intervention to be shown to be effective it must demonstrate measurable reductions in smoking prevalence and tobacco consumption, and increases in the availability of smoking-cessation assistance, as well as in funding for progressive anti-tobacco initiatives at the state level.

BREAST CANCER OVERVIEW

United States

Breast cancer is the most common malignancy and the second highest cause of cancer mortality among women in the nation. There will be an estimated 180,000 new cases diagnosed and 46,000 deaths attributed to the disease in 1992. At current incidence rates, one of every nine American women will develop breast cancer during her lifetime.
Breast cancer accounts for approximately 30 percent of all newly diagnosed female cancers and 18 percent of all female cancer deaths. Crude incidence rates have increased about 3 percent per year since 1980, going from 84.4/100,000 in 1980 to 109.5/100,000 in 1988.

The increase in incidence rates is attributable in part to earlier diagnosis through screening. Increased longevity of the population also plays a part. Mortality has been fairly stable over the past 30 years.

Florida

Incidence Rates

Based on data from the Florida Cancer Data System (FCDS) for the period 1981-1989, the crude incidence of breast cancer has risen from 149.1 to 163.5 cases per 100,000 women aged 20 and over. The absolute number of breast cancer cases increased from 5,914 in 1981 to 9,125 in 1990, in part because of the rise in the population of women in Florida, as well as an increase in the average age of women, during that period.

Stage of Diagnosis

The increase in breast cancer rates has been confined to cases that were in situ or local stage at diagnosis. The incidence rates for cases diagnosed at regional or distant stages have decreased, and the absolute numbers of cases diagnosed at a distant stage have decreased as well.

Number of Deaths and Death Rates

The absolute number of breast cancer deaths increased from 1,876 in 1981 to 2,646 in 1990. The crude mortality rate for breast cancer has risen from 35.4/100,000 in 1981 to 38.8/100,000 in 1990.
Risk Factors

All women are at risk for getting breast cancer, including those with no family history of disease. Eighty percent of women who develop breast cancer have no family history of it. The two main factors are being a women and getting older.

Risk Factors

- Being female
- Advancing age
- Family history of breast cancer
- History of breast cancer in one breast
- Higher socioeconomic status
- Personal history of fibrocystic disease
- Personal history of ovarian or endometrial cancer
- Living in an urban area
- Being white
- Never having been pregnant
- Having had no full-term pregnancies before age 30
- Early onset of menopause
- Late menopause
- Early onset of menarche

Breast Cancer Screening

Guidelines for Breast Cancer Screening:

The following ACS guidelines (1989) are intended for women under 40 years of age who are asymptomatic:

Women should learn and practice monthly breast self-examination
A clinical breast examination should be performed at a minimum of every three years

Women Between 40-49 Years of Age:

Monthly breast self-examination
A clinical breast examination on an annual basis
A mammogram every one to two years

For Women 50 Years of Age and Older:

Monthly breast self-examination
An annual clinical breast examination
Mammogram every year

ACCESS TO SCREENING AND CARE

Problem

A substantial minority (37.6%) of Florida women in the recommended age group for screening, females 40 and older, are not receiving regular mammograms. Women not receiving mammograms are widely distributed by age, race, education, income and geography, but are concentrated among minority women, those without a high-school education, and those with low income.

Based on the results of the BRFSS, approximately 1,100,000 in the age group for whom regular screening is recommended, have never had a mammogram. Despite the fact that screening is indicated based on guidelines set by ACS and NCI, physicians are often not recommending mammograms. Additionally, 40 percent of women aged 40 and older who have had a clinical breast exam by a physician in the last year have not had a mammogram in the same period.

Although cost and lack of insurance are not the major barriers to mammography, they are more often cited by low-income women as reasons they did not have a mammogram than by higher-income women.

Goal

Universal access to breast cancer screening and appropriate follow-up diagnosis and treatment should be available at a reasonable cost be made available to all who need it, regardless of ability to pay. Special efforts must be made for screening in the low-income and minority populations.

Objective

1. Increase to at least 60 percent the proportion of women aged 50 and older who have reported having received a clinical breast examination and a mammogram within the preceding 1 to 2 years.

2. Increase to 80 percent the proportion of women aged 40 and older who have reported ever having received a clinical breast examination and a mammogram.

Strategy

The Breast and Cervical Cancer Committee of the Florida C-CRAB will develop measures which are designed to provide universal access to screening and care for breast cancer. These strategies for 1993 will address the access-related issues of:

- Economic: Providing no cost or low cost mammograms increase screening. Incentives, such as redeemable coupons (vouchers), can enhance mammography usage. Cost is a barrier to some women, and its significance may increase if more women understood the need for regular mammography.

- Geographic: Lack of transportation as well as inconvenient location of mammography centers are barriers. In addition, hours of operation that do not include evening and weekend mammography screening can decrease access.

- Institutional: Absence of physician referral is a major reason why many women do not have mammograms. This is particularly true for the elder (65+) population. Physicians should be used as primary channels to reach, educate and influence women to have regular mammograms. Adherence to screening guidelines should be strongly promoted.

- Cultural: A major barrier in Hispanic women is culture-based embarrassment. This barrier may vary depending upon the length of time in the U.S., country of origin and acculturation The inability to speak and/or read English also presents a significant problem.

  For Black women, fear of pain has been identified as a major barrier to ever having had a mammogram. Lack of knowledge of the mammogram procedure is also a barrier.

  In the elder population, multi-sensory interventions can increase screening behavior. Visual messages should use large type and be brief. Auditory messages should be of high quality sound.

  Women generally understand that mammography detects breast cancer early and that early detection is beneficial, but they do not necessarily perceive their own vulnerability to breast cancer and do not see themselves at risk if they have no symptoms or family history of the disease.

  Trained peers can be effective educators for informing women in their population of the risks of breast cancer and the value of regular mammography. Level of reading skill should be taken into account and screening messages should fit the audience.

The C-CRAB recognizes that interventions through public education, professional education and access to state-of-the-art care all have an important place in control of breast cancer, but believes that assuring access to early detection is of the highest priority.
Responsible Agencies

HRS, in consultation with the C-CRAB, will set priorities and develop strategies for achieving universal access to screening and treatment for breast cancer.

The HRS District Planning Councils, which include broad representation from each district, will advise both HRS and the C-CRAB as to the appropriateness of planned interventions and will oversee the integration of interventions into the community continuum of care.

Evaluation

For geographically specific interventions, process objectives will be established which will measure changes in access to screening and follow-up diagnosis and treatment, particularly as they relate to high-risk populations. Medicaid billing information as well as similar health care utilization data will be used to assess changes in screening and treatment activity.

HRS is responsible for the ongoing surveillance of behavior data using the BRFSS. These data are used and will continue to be used to monitor the impact objectives concerning reported changes in mammography and clinical breast examination screening behaviors.

Additionally, the HRS will use the FCDS to evaluate the outcome objectives of long-range changes in stage at diagnosis for breast cancer.

Conclusion

Although breast cancer incidence rates are increasing, earlier detection and improved treatment have kept mortality fairly stable over the past 30 years. Since not enough is known about the cause of breast cancer, primary preventive measures are not successful at this time. However, secondary prevention through screening asymptomatic women shows great promise, especially when screening programs are directed at high-risk groups.

Public health agencies, voluntary organizations and others attempting to increase screening for breast cancer through mammography in their communities, should ensure that the outreach components of their program are addressed to the groups of women who are least likely to have been screened as recommended. This would include Hispanic and Black women, particularly those over the age of 60. Special attention should also be given to low-income and low-education groups, regardless of their race or ethnicity.

CERVICAL CANCER OVERVIEW

United States

In 1992 it is estimated that there will be 13,500 new cases of invasive cancer of the cervix in the United States, and approximately 4,400 will die from the disease. The five-year survival rate is about 90 percent for women with localized invasive cervical cancer, but only about 40 percent when the disease has spread beyond the site of origin. In 1989, there were approximately 600,000 cases of cervical intraepithelial neoplasia (CIN), including 50,000 cases of carcinoma-in-situ (CIS). If patients with CIS and CIN can be found and treated, almost all can be cured, and deaths from invasive squamous carcinoma of the cervix could be essentially eliminated.

Florida

Incidence Rates

According to the cervical cancer data in FCDS for 1989, the absolute number of cervical cancer cases reported in white women was 675 and 151 in Black women. The crude incidence rate in white women was 12.0/100,000 and the age-adjusted rate was 9.1/100,000. Conversely, in Black women the crude incidence rate was 14.8/100,000 and the age-adjusted rate was 15.7/100,000.

Stage of Diagnosis

Based on 1989 FCDS data, Black women had the highest rates, both crude and age-adjusted, for invasive cervical cancer. Black women aged 40 and above have higher age-specific rates for both regional and distant stage cervical cancer when compared to white females.

Number of Deaths and Death Rates

The absolute number of cervical cancer deaths increased from 244 in 1981 to 267 in 1990. For the period 1981-1990, the average annual age-adjusted mortality rate for Black women was 8.8/100,000 and 2.5/100,000 for white women.

Risk Factors

- Early age of sexual intercourse
- Multiple sex partners
- Inadequate screening
- Genital warts of certain types
- Cigarette smoking
- Lower socioeconomic status
- Non-white race

Cervical Cancer Screening

The principal screening test for cervical cancer is the Papanicolaou smear. A Pap smear is recommended annually for all women who are sexually active, or have reached age 18. Less frequent screening can be done at the discretion of a physician once three or more annual Pap smears have been normal.

ACCESS TO SCREENING AND CARE

Problem

According to the 1989 Point In Time Survey (PITS), white-Hispanic women are the least likely to have had a Pap smear in the previous five years (53.5 percent vs 83.3 percent for white non-Hispanics and 87.1 percent for Blacks). Additionally, for those females 60 years of age and above, white-Hispanic women were again the least likely to have had a Pap smear in the previous five years (60.6 percent) as compared with white non-Hispanic with 73.3 percent and Blacks with 83.9 percent.

Women with educational attainment to the 8th Grade or less, and women with an annual income of less than $15,000 per year, also were less likely to have had a Pap smear within the last five years. We should be making special efforts to reach these women.

Goal

Universal access to cervical cancer screening should be made available at a reasonable cost and be reimbursable by third-party payers. Special efforts must be made for screening high-risk populations.

Objective

1. Increase to at least 85 percent the proportion of women who reported having received a Pap test within the preceding 1 to 3 years.
2. Increase to at least 95 percent the proportion of women aged 18 and older who have reported ever having received a Pap test.

Strategy

The Breast and Cervical Cancer Committee of the Florida C-CRAB will develop measures which are designed to provide universal access to screening and care for cervical cancer. These strategies for 1993 will address the access-related issues of:

Economic: The cost of obtaining a Pap smear can be a barrier, particularly among women of low income.

Geographic: Convenient access and transportation to a medical facility which performs Pap tests can increase screening.

Institutional: Lack of physician initiative is a major reason why many women do not have Pap smears. Cultural insensitivity from medical professionals, particularly as it relates to Hispanic women, can be a barrier to Pap screening.

Cultural: Culture-based attitudes held by some Hispanic women, pose a significant barrier to Pap smear testing. Barrier attitudes include embarrassment at having a stranger view the genitals, concern that finding illness will make a patient a burden on others and belief that sexual matters are private. In addition, some patients, motivated by "simpatia", may appear to agree with screening advice and to understand issues of treatment, but may withhold questions to avoid appearing disrespectful.

For Black women, barriers include lack of perception of risk, fear and embarrassment, and lack of knowledge of the procedure.

A major reason why many women do not obtain Pap smears is not realizing the importance of the test. Additionally, many American women hold vague or conflicting ideas about the appropriate timing for Pap screening, perhaps because they receive mixed messages on the subject.

The C-CRAB recognizes that interventions through public education, professional education and access to state-of-the-art care all have an important place in control of cervical cancer, but believes that <u>assuring access to early detection is of the highest priority</u>.

Responsible Agencies

HRS, in consultation with the C-CRAB, will set priorities and develop strategies for achieving universal access to screening and treatment for cervical cancer.

The HRS District Planning Councils, which include broad representation from each district, will advise both HRS and the C-CRAB as to the appropriateness of planned interventions and will oversee their integration of interventions into the community continuum of care.

Evaluation

For geographically specific interventions, process objectives will be established which will measure changes in access to screening and follow-up diagnosis and treatment, particularly as they relate to high-risk populations. Medicaid billing information as well as similar health care utilization data will be used to assess changes in screening and treatment activity.

HRS is responsible for the ongoing surveillance of behavior data using the BRFSS and the PITS. These data are used and will continue to be used to monitor the impact objectives concerning reported changes in pap smear screening behavior.

Additionally, the HRS will use the FCDS to evaluate the outcome objectives of long-range changes in stage at diagnosis for cervical cancer.

Conclusion

Cervical cancer ranks eleventh as a cause of female cancer deaths, accounting for three percent. Even though it is not a major cause of death in this country, it represents an important opportunity for a reduction in cancer mortality because the Pap smear, like the mammogram, is an established screening tool.

Unfortunately, we still see an average of 744 cases of invasive cervical cancer per year in the state of Florida. Women who are least likely to get Pap smears regularly and consequently, most likely to develop invasive disease, should be targeted, especially white-Hispanic women and Black women.

If a woman has access to the Pap smear, follows the recommended guidelines for screening, and the smear is used properly, invasive cancer of the cervix could become an almost entirely preventable disease.