Florida Cancer Control
& Research Advisory Council

General Membership Meeting

Friday, May 18, 2018
10:00 a.m. to 3:00 p.m.
Moffitt McKinley Outpatient Cancer Center

Florida Cancer Control
& Research Advisory Council

Mission Statement

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

Florida Cancer Control & Research Advisory Council

General Membership Meeting Agenda

Friday, May 18, 2018
10:00 a.m. – 3:00 p.m.
Moffitt McKinley Outpatient Center – Gruden Huddle Room
10920 McKinley Drive, Tampa, 33612

WebEx: https://moffitt.webex.com/moffitt/j.php?MTID=m5224f6700973c07bd5467ee2df68ffef
Audio: 1-415-655-0001
Meeting number (access code): 312 725 480#

10:00 a.m.	**Welcome, Introductions & Mission Moment**	*Dr. Chris Cogle*
10:10 a.m.	**Approval of Minutes from September 29, 2017 Meeting**	*Dr. Chris Cogle & Council*
10:15 a.m.	**State of the State on Cancer**	*Drs. Chris Cogle & Clement Gwede*
11:00 a.m.	**Florida Department of Health Updates**	*Dr. Celeste Philip & DOH Team*
11:45 a.m.	**Florida Academic Cancer Center Alliance (FACCA) Update**	*Merritt Martin*
11:50 a.m.	**2018 Legislative Session Update**	*Heather Youmans & Representative Grant*
12:15 p.m.	***Break***	
12:30 p.m.	**Working Lunch – Presentation by Kelly Sittig, Executive Director, Iowa Cancer Consortium**	*Kelly Sittig*
1:45 p.m.	**Florida Cancer Data Systems Update**	*Tara Hylton & Gary Levin*
2:15 p.m.	**Biomedical Research Advisory Council (BRAC) Update**	*Dr. Danny Armstrong*
2:45 p.m.	**CCRAB Membership Update**	*Dr. Chris Cogle*
2:55 p.m.	**Next CCRAB Meeting**	*Dr. Chris Cogle*
3:00 p.m.	**Adjourn**	*Dr. Chris Cogle*

Florida Cancer Control & Research Advisory Council

Florida Cancer Control & Research Advisory Council Membership

(May, 2018)

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

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

Celeste Philip, MD, MPH
Florida's Surgeon General

Jessica Bahari-Kashani, MD
Florida Medical Association

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

Asher Chanan-Khan, MD
Florida Hospital Association

Representative Jamie Grant
House Speaker's Appointee

Lawrence Hochman, DO, FACRO
Florida Osteopathic Medical Association

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

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

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

Megan Wessel, MPH
American Cancer Society

Senator Dana Young
Senate President's Appointee

TBD
Florida Nurses Association

TBD
House Speaker's Appointee

MINUTES

FLORIDA CANCER CONTROL AND RESEARCH ADVISORY COUNCIL
GENERAL MEMBERSHIP MEETING
Friday, September 29, 2017, 10:00 a.m. to 3:00 p.m.
Moffitt Cancer Center, Stabile Research Building Board of Trustees Room

Council Members Present

- Jessica Bahari-Kashani, MD - Florida Medical Association
- Robert Cassell, MD, PhD - Association of Community Cancer Centers
- Christopher R. Cogle, MD - University of Florida Shands Cancer Center - Senate President's Appointee *(Chair)*
- Clement Gwede, PhD, MPH, RN, FAAN - Moffitt Cancer Center *(Vice Chair)*
- Duane Mitchell, MD, PhD - University of Florida Shands Cancer Center
- Celeste Philip, MD, MPH - Florida's Surgeon General for Health, Florida Department of Health
- Megan Wessel, MPH - American Cancer Society
- Senator Dana Young - Senate President's Appointee

Council Members Not Present

- Asher Chana-Kahn, MD - Florida Hospital Association (By Phone)
- Lawrence Hochman, DO, FACRO - Florida Osteopathic Medical Association (By Phone)
- Erin Kobetz, PhD - Sylvester Comprehensive Cancer Center University of Miami (By Phone)
- Amy Smith, MD - Arnold Palmer Hospital for Children - Governor's Appointee (By Phone)
- Marti Coley Eubanks - Nemours Children's Hospital - House Speaker's Appointee
- Theresa Morrison, PhD, MSN, CNS-BC, RN - Florida Nurses Association

Others Present

- Daniel Armstrong, PhD, Chair, Florida Biomedical Research Advisory Council
- Paul Hull, ACS CAN
- Matt Jordan, ACS CAN
- Merritt Martin, Moffitt Cancer Center
- Bobbie McKee, PhD, Moffitt Cancer Center
- Lisa Richardson, MD, MPH CDC
- Thomas Stringer, MD, FACS, Chair, Florida Prostate Cancer Advisory Council
- Sandra Stonecypher, Moffitt Cancer Center
- Jamie Wilson, Moffitt Cancer Center
- Marian Banzhaf, Florida Department of Health (By Phone)
- Felicia Dickey, Florida Department of Health (By Phone)
- Tara Hylton - Florida Department of Health (By Phone)
- Gary Levin, Florida Department of Health (By Phone)
- Sam Mooneyhan, Florida Department of Health (By Phone)
- Melissa Murray Jordan, Florida Department of Health (By Phone)
- Kelly O'Dare, PhD, Florida Department of Health (By Phone)
- Ken Peach, Florida Department of Health (By Phone)
- Gregg Smith, Florida Department of Health (By Phone)
- Heather Youmans, ACS CAN (By Phone)

Welcome
Dr. Chris Cogle began by welcoming members and guests, taking a moment to reaffirm the Council's mission to advise the state on ways to reduce cancer burden, and reviewing the day's agenda.

Approval of Minutes
Dr. Cogle led the motion to review and approve the minutes from the May 12, 2017 meeting. Drs. Mitchell and Bahari-Kashani motioned to approve the minutes. The Council concurred.

CCRAB September 2017 Introduction
Dr. Cogle presented a Power Point reviewing the mission of CCRAB, and updated the Council on the top five causes of death nationally and in Florida, metrics on cancer deaths and incidences in Florida. There was discussion regarding incidence and Florida's cancer burden.

Florida Cancer Plan Progress Report
Dr. Cogle began the discussion of topics within the Cancer Plan Dashboard. He explained that several goals had been selected for this agenda item, while additional goals will be addressed during other portions of the agenda. Then, several goals will be the focus at the next meeting.

Theme #1: The Burden of Cancer
Goal 3: Link key screening, laboratory, and molecular cancer test results into the Florida cancer integrated data repository

Dr. Gwede discussed the workgroup of DOH/FCDS key partners referenced in the dashboard update, and the possibility of a CCRAB member serving on this workgroup. Dr. Philip said she felt that it would be possible. Tyra Hylton provided an update on task force/workgroup members, and explained that they would soon have a better idea of the timeline for meeting. She also explained that many of the individuals selected had relationships with other institutions. Drs. Mitchell and Kobetz mentioned looking at additional individuals to represent their institutions.

Theme #2: The Best Defense is a Great Offense
Goal 3: Increase the proportion of Floridians who receive appropriate cancer screenings

Megan Wessel pointed to the progress in colorectal cancer screening within the FQHC population, but also explained that the loophole with screening and treatment is still an issue given that insurers may not cover the screening if it results in being coded as diagnostic. Additionally, Ms. Wessel said, to increase screening rates, hospitals are working internally and externally, and local partnerships work on identifying colonoscopies needed, donated, and utilized. Dr. Richardson said studies have shown that colonoscopy capacity is sufficient in many areas, but might not be utilized by those who need them. There was discussion regarding return rates for mailed tests. Dr. Kobetz informed the group of Miami's success with return rates.

There was discussion regarding the proportion of women below 200% FPL receiving screening mammograms and Pap smears via the Mary Brogan Breast and Cervical Program. Dr. Philip pointed out that the proportion of women actually being served may be higher, as the Mary Brogan data do not include screenings at FQHCs or other local clinic providers. The DOH will work on trying to get these data captured. Drs. Cogle and Gwede offered to assist DOH staff to obtain a more precise number for the population being served.

There was discussion regarding the PCAC recommendations. Dr. Stringer said that once the new USPSTF guidelines are finalized, PCAC will incorporate them into their recommendations. He also explained that urologists are seeing increases in the number of high risk prostate cancer diagnoses. Dr. Gwede asked if aligning guidelines could be a potential action item to consider, and Dr. Stringer said that there are numerous guidelines. Ms. Wessel said that the CCRAB role has historically been to not endorse particular guidelines, but rather encourage patients to be informed decision makers based on conversations with their doctor. Drs. Hochman and Cassell mentioned that it is also important to make sure that the physicians are informed. Dr. Armstrong said there could be opportunities for Florida investigators to get involved with improving screening methods to identify high risk cancers.

Florida DOH Update by Dr. Celeste Philip

Dr. Philip thanked Dr. Cogle for initiating a meeting with DOH staff over the summer, and invited the staff participating via phone to join her in giving updates on DOH cancer program work.

Tara Hylton and Gary Levin gave an update on CDC funding received to capture screening data in the cancer registry. In October, they expect additional details from the CDC on what will be required for this pilot program. Ms. Hylton provided an overview of demographic characteristics based on preliminary analysis of new information from the VA. There was discussion regarding the potential for duplicates in registries due to patients using VA facilities in multiple states. A federal-level requirement for the VA to report into cancer registries would help improve data quality, as missing cases would be accounted for and variation reduced.

Marian Banzhaf discussed the lung cancer screening pilot program in Florida. She explained that they are working on incorporating cessation into the program, and reviewed the criteria. The scope of work and invitation to negotiate will be published. Dr. Cogle asked how many groups they thought they'd be able to fund. She said they want to look at areas with higher incidence.

Melissa Murray Jordan gave an update on the Cancer Centers of Excellence Designation. She discussed criteria, the application process, and feedback. No applications were submitted for the spring 2017 cycle.

Dr. Philip said the Telehealth Advisory Council is close to finalizing recommendations, and asked if CCRAB members had suggestions they would like her to take back to ACHA. Dr. Cogle said it was important to ensure that all cancer patients have access to telehealth. He asked to make sure that the Originating Site requirement for reimbursement not be restricted to the physical proximity of the provider; instead, the patient be allowed to be in a remote setting from the health provider during the telehealth encounter. Dr. Philip said they would not advocate for anything that restricts access. Dr. Cogle also pointed out that since Florida has not joined the Interstate Medical Licensure Act, nurses instead of physicians may be better positioned to lead telehealth efforts in Florida, as nurses will be able to use their licenses in other states as opposed to Florida doctors.

Dr. Cassell asked to be added to the DOH Cancer Stakeholder newsletter distribution list. Sam Mooneyhan said he is happy to add everyone.

CDC Division of Cancer Prevention and Control Presentation by Dr. Lisa Richardson
Dr. Lisa Richardson, Director of the CDC's Division of Cancer Prevention and Control delivered a presentation regarding the Division's work.

Florida Consortium of National Cancer Institute Centers Program Report
Dr. Cogle invited anyone who had reviewed the 2017 Florida Consortium of National Cancer Institute Centers Program Report to provide feedback to DOH. Dr. Philip and Melissa Murry Jordan provided an overview of what is included in the report. Dr. Cogle suggested that the report could emphasize how state investments help institutions achieve and maintain NCI designation rather than just highlighting research projects. Dr. Gwede thought including an executive summary might help to synthesize. There was discussion regarding the challenge of making the distinction between the funds to help achieve NCI designation versus funds for state biomedical research programs. Moving forward, DOH may be able to give the three institutions the opportunity to contribute to an executive summary for the next report, which is required every three years. The next report to the DOH is due in 2020.

Florida Biomedical Research Advisory Council Update by Dr. Daniel Armstrong
Dr. Armstrong gave an update on the BRAC's cancer research programs' application number and funding rates. He explained that there are still a large number of with high meritorious scores going unfunded. The proposals that are funded have showed a great return on investment in terms of publications, patents, additional funding, etc. Dr. Armstrong also said the $25 million state Zika initiative could have an impact on cancer, as it lays out a model. There was discussion about possibilities for proposals that the BRAC is not able to fund going on to receive funding from another source, such as partnering with the private sector.

American Cancer Society Cancer Action Network Update
Mr. Matt Jordan gave an update on ACS CAN's legislative priorities for the year, which include funding for the Mary Brogan Breast and Cervical Cancer Screening Program, the state's biomedical research programs, and the tobacco education and cessation program. Mr. Paul Hull highlighted the great progress Florida's cancer research programs have made since they were established. There was discussion regarding Tobacco Free Florida funding, spending, and return on investment. The DOH will provide information on the tobacco program's spending and effectiveness. Florida's investment is still far below what the CDC recommends for tobacco prevention and education funding in the state.

There was discussion regarding hurricane impact. Ms. Wessel provided information on the challenges that cancer patients and oncologists in Puerto Rico are facing, such as lack of access to medications and preauthorization needed for treatment.

CCRAB Annual Report due February 2018
Dr. Cogle asked for input on what others thought might be necessary or useful to make the CCRAB Annual Report, which is due in February 2018, more of a resource. A suggestion was to consider programs externally funded at DOH, and show productivity towards meeting needs and making progress. Senator Young suggested that giving legislators a one pager and offering to follow up with full report would be more useful for legislators, and would save money on printing. There was discussion over state budget issues as they are faced with hurricane costs.

Next CCRAB Meeting
Dr. Cogle stated that the next CCRAB meeting will be May.

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

Dr. Cogle thanked everyone for participating. The meeting adjourned at 3:00 p.m. on September 29, 2017.

STATE OF THE STATE ON CANCER

Florida Cancer Plan 2015-2020

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

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

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

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

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

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

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

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

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

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

CCRAB Newsletter

SPRING 2018

1. Florida Cancer Plan Breast Cancer Screening Goal

Our 2015-2020 Florida Cancer Plan goal for breast cancer screening is to increase the percentage of women aged 50 to 74 who receive a mammogram in the last two years from 76.8% to 81.1% by 2020. We are excited to announce that we have crossed this threshold for the first time. According to the most recent Behavioral Risk Factor Surveillance System (BRFSS) data, 81.6% of women in this age group received a mammogram in the past two years. This important accomplishment follows years of efforts by community groups, clinics, hospitals, cancer centers, the CDC, and the Mary Brogan Breast and Cervical Cancer Early Detection Program administered by the Florida Department of Health.

2. Florida Biomedical Research Program Grants for Cancer and Tobacco-Related Diseases

The Florida Department of Health has awarded a total of 25 projects worth $18.2 million through the Bankhead-Coley Cancer Research Program (11), the James and Esther King Biomedical Research Program (9), and the Live Like Bella Pediatric Cancer Research Initiative (5). This continued support is necessary to achieve our Florida Cancer Plan goals. At the upcoming CCRAB meeting, we will discuss the details including the number of highly meritorious applications that were unfunded due to lack of funds. For more information, please see the following press releases: www.floridahealth.gov/newsroom/2018/02/022618-cancer-research-funding-2018.html www.floridahealth.gov/newsroom/2018/03/030818-live-like-bella-2018.html

3. Constitution Revision Commission Update

Florida's Constitution Revision Commission (CRC) voted for 20 proposals grouped into 8 measures to be placed on the general election ballot this November. Each ballot measure must pass with at least 60-percent approval. Proposal 94 affecting Tobacco Free Florida was withdrawn due to compelling opposition and lack of support. The only remaining health-related proposal is Proposal 65, which would prohibit the use of vapor-generating electronic devices in enclosed indoor workplaces. More information about the 8 measures approved by the CRC can be found at: www.flcrc.gov/Media/PressReleases/Show/1099

4. Next CCRAB Meeting: Friday, May 18, 2018 at Moffitt Cancer Center

The next CCRAB meeting will be held on Friday, May 18th from 10:00 a.m. to 3:00 p.m. at the Moffitt McKinley Outpatient Center. Special guest presenter Kelly Sittig, Executive Director of the Iowa Cancer Consortium, will share Iowa's comprehensive cancer control program, which includes a 2018-2022 Iowa State Cancer Plan and measurable programs to achieve their objectives. Kelly's participation in our CCRAB meeting and presentation will directly impact our work in Florida to reduce our cancer burden.

CCRAB

Florida Cancer Control
& Research Advisory Council

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

CCRAB Website Traffic

Data from February 15, 2018 to May 10, 2018

	WEBPAGE LINK	TOTAL NUMBER OF TIMES PAGES & POSTS VIEWED
ALL PAGES & POSTS VIEWED ON CCRAB WEBSITE	http://www.ccrab.org	1,658
NEWS POST WITH 2018 CCRAB ANNUAL REPORT	http://www.ccrab.org/2018/2/ccrab-annual-report	155
PUBLICATIONS PAGE (ANNUAL REPORTS & CANCER PLAN)	http://ccrab.org/publications	182

FLORIDA DOH UPDATES

Cancer Center of Excellence Award

Annual Report

December 15, 2017

Rick Scott
Governor

Celeste Philip, MD, MPH
Surgeon General and Secretary of Health

2016-2017 Annual Report - Table of Contents

Cancer Center of Excellence Award Program Overview

The designation of a hospital, treatment center, or other organization as a Cancer Center of Excellence is intended to recognize organizations that demonstrate excellence in patient-centered coordinated care for persons undergoing cancer treatment and therapy in Florida. The goals of the Cancer Center of Excellence Award program (section 381.925, Florida Statutes) are to encourage excellence in cancer care in Florida, attract and retain the best cancer care professionals to the state, and help Florida organizations be recognized nationally as a preferred destination for quality cancer care. Cancer institutions that meet the criteria as a Cancer Center of Excellence, receive the award for a three year period. After the three-year period, recipients have the opportunity to seek re-designation.

By December 15 of each year, the Department reports the following information to the President of the Senate and the Speaker of the House of Representatives, as required by Florida Statute:

- The number of applications received
- The number of award recipients by application cycle
- A list of award recipients
- Recommendations to strengthen the program

The Joint Committee (committee) comprises members from the Florida Cancer Control and Research Advisory Council and the Florida Biomedical Research Advisory Council. The committee developed and reviews the rigorous performance measures, a rating system, and a rating standard that must be achieved to document and distinguish a cancer center that excels in providing quality, comprehensive, and patient-centered coordinated care. As required, the committee meets every three years and did so in the fall of 2016. The committee unanimously approved the recommended changes. These changes were incorporated into the original designation and re-designation manual and performance measures.

Application Cycles

2017

The Department conducted two application cycles in 2017 for new applicants. The first application cycle was conducted from March 15 to May 10, 2017 and the second cycle was

conducted from September 13 to November 13, 2017. There were no applications submitted for either of these cycles.

In 2017, the first re-designation application cycle was conducted for the Cancer Center of Excellence Award. The re-designation application cycle was conducted in the summer of 2017. All four Cancer Centers of Excellence Award recipients applied for the continued designation. The four current recipients are:

- H. Lee Moffitt Cancer Center and Research Institute
- Mayo Clinic Florida
- University of Miami Sylvester Comprehensive Cancer Center
- University of Florida Health Cancer Center, which includes Shands Hospital and Proton Therapy Institute, and Orlando Health's Orlando Regional Medical Center

Through the application process and subsequent peer review, it was determined that all four centers should be re-designated as Cancer Centers of Excellence in Florida. This award is recognized through 2020.

2016

The Department conducted two application cycles in 2016, the first cycle from February 1, 2016 to March 25, 2016 and the second cycle from July 1, 2016 to August 26, 2016. There were no applications submitted for either of these cycles.

2015

The Department conducted two application cycles in 2015, the first cycle from February 9, 2015 to March 27, 2015 and the second cycle from July 1, 2015 to August 21, 2015. There were no applications submitted for either of these cycles, and therefore no award recipients.

2014

The Department conducted two application cycles in 2014, the first cycle from February 3, 2014 to March 21, 2014 and the second cycle from July 1, 2014 to August 22, 2014. The program received nine applications resulting in four organizations receiving the award. The four recipients are the same recipients listed above.

Application and Review Process

Organizations seeking designation as a Cancer Center of Excellence submit an application and then undergo a review process approved by the committee. The application and review process involves the following steps:

- Organizations submit applications during one of the two application cycles offered each year.
- Staff review applications to confirm information is sufficient for evaluators. These evaluators determine whether the organization meets performance measures.
- Organizations may be asked to submit revised applications with additional information.
- A team of five independent evaluators review written materials. Evaluators are vetted and determined to be free from conflicts of interest.
- Two evaluation team members may, as necessary, conduct an onsite evaluation to verify submitted application documentation.
- Applicants are provided a draft evaluation report, including observations made during the site visit if applicable, and are allowed to respond with corrections and improvement plans, if needed.
- Each member of the evaluation team reviews the draft evaluation report, the organization's response if applicable, and reports to the State Surgeon General those applicants that achieved or exceeded performance measures and met all requirements of the rating system approved by the committee.
- The State Surgeon General notifies the Governor regarding providers that are eligible to receive designation as a Cancer Center of Excellence.

Re-designation Application and Review Process

For the re-designation award, the performance measures and manual updated by the committee in 2016 were utilized. The measures required for initial application are the same measures that were used in the re-designation application. During the peer review, the re-designation application was compared to the original application to ensure the current

designees are continually enhancing their programs to reflect best practices and advances in cancer treatment and care from the perspective of quality, comprehensive, and patient-centered coordinated care.

The application and review process involves the following steps:

- All Cancer Centers of Excellence Award recipients submitted an application for re-designation. The application was based on the revised performance measures as recommended by the committee.

- Applications received an administrative review and peer review.

- Peer reviewers determined if the performance measures were met. If needed, additional information was requested of the applicants to make a final award determination.

- Recommendations on the re-designation awards were forwarded to the State Surgeon General.

- The State Surgeon General notified the Governor regarding the providers that are eligible to the receive the re-designation as a Cancer Center of Excellence.

Recommendations to Strengthen the Program

In 2016, the committee reviewed and revised the performance measures and standards. No new applications have been submitted since 2014 even with the following revised performance measures and standards.

- A rationale statement was added to the Introduction that emphasizes that one purpose of the Cancer Centers of Excellence Program is to support efforts to obtain and sustain National Cancer Institute designation of Florida programs as Comprehensive Cancer Centers.

- A substantive change was recommended related to the requirement for research participation. Centers will now be required to "(a) have evidence of active involvement in clinical research, (b) evidence of national impact in one of six designated research areas, and (c) evidence of research in at least one other designated research area." This change

was proposed to address concerns of non-academic community hospitals/centers related to the type and scope of research involvement required.

- Additionally, revisions included documenting the level of researcher experience. Wording was revised to state that the organization should demonstrate biomedical researcher training to support the transition of new investigators to independent investigators.

- Also revised was “documentation of institutional or extramural support that has been targeted toward career growth for early career investigators during the last three years.” Once again, the focus is to demonstrate intentional effort to develop researcher capabilities.

The committee identified the need to increase awareness of the award which is critical to the success of the program. In response, the Florida Cancer Control and Research Advisory Council Florida Cancer Plan includes strategies to promote the award. Cancer plan is found at: http://ccrab.org/publications

Rule 64D-3.034

64D-3.034 Cancer Reporting.

(1) Reporting Requirements:

(a) Each facility and laboratory licensed under Chapters 395 and 483, and Section 408.07(20), F.S., respectively and practitioners licensed under Chapters 458, 459, 464, F.S., are required to report to the Florida Cancer Data System as required by Section 385.202, F.S., within six (6) months of each diagnosis and within six (6) months of the date of each treatment.

(b) Each facility shall submit each cancer case report electronically. Those facilities with fewer than 35 cancers annually requiring abstracting may submit paper copies or portions of the medical record, provided the copies contain all of the required information as per paragraph (1)(c).

(c) The data items, coding schemes, definitions, record layouts and reporting procedures are to follow the guidance provided in the Florida Cancer Data System Data Acquisition Manual (2005, or current year edition), incorporated by reference, available at: http://fcds.med.miami.edu/inc/downloads.shtml.

(2) Not withstanding subsection (1), each facility, center and laboratory that reports cancer cases to the Florida Cancer Data System shall make its records available for on-site review by the Department or its authorized representatives.

Rulemaking Authority 381.0011(2), 381.003(2), 381.0031(8), 384.33, 385.202(5), 392.66 FS. Law Implemented 381.0011, 381.003, 381.0031, 384.25, 385.202, 392.53 FS. History–New 11-20-06.

FLORIDA ACADEMIC CANCER CENTER ALLIANCE

About

Introduction

Cancer inflicts a devastating toll on Florida residents. Florida ranks second in the nation in terms of cancer incidence and mortality, with 117,000 newly diagnosed cases each year, and as the state's population continues to rise, projections suggest that it will become No. 1. Cancer is the second leading cause of death in Florida, second only to cardiovascular disease, and it surpasses heart disease, stroke and unintentional injuries in terms of potential life years lost. Moreover, cancer constitutes an economic burden on Floridians with approximately $4 billion in hospital charges for in-patient hospital care in which cancer is the primary diagnosis.

Mission

The **Florida Academic Cancer Center Alliance** was created to address this challenge to the state. Our goal is to expedite innovation in the area of cancer research throughout the State of Florida and maximize state investments in biomedical technology and research. The alliance encourages and promotes collaborative research conducted by researchers at its partnering institutions — the Moffitt Cancer Center, Sylvester Comprehensive Cancer Center and UF Health Cancer Center — and supports workshops and meetings to encourage the exchange of information and networking among researchers. The alliance accepts applications and awards grants for a wide variety of cancer-related research by researchers located at one of the three partnering institutions, and all alliance-funded research will be conducted by Florida-based scientists and will reflect our mission to attract and expand the state's research capabilities to address the public health challenges of cancer.

Goals

The goals of the Florida Academic Cancer Center Alliance are to:

- Support broadly based, multidisciplinary research programs with well-defined major objectives or themes;
- Create synergies and collaborations between UF, UM and Moffitt cancer researchers;
- Stimulate applications for future program-type federal or national extramural funding;
- Address research questions that can only be accomplished through collaborations, networks and consortia.

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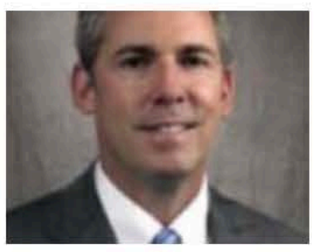
Directors

The Florida Academic Cancer Center Alliance co-directors at the three partner institutions provide executive-level coordination for the alliance, fostering trans-state research collaborations to promote excellence in cancer research for Florida's residents.



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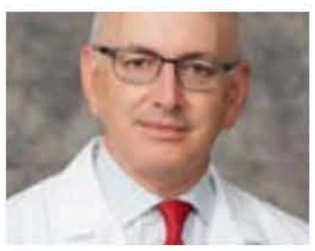

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MOFFITT CANCER CENTER

SYLVESTER COMPREHENSIVE CANCER CENTER
UNIVERSITY OF MIAMI HEALTH SYSTEM

UFHealth CANCER CENTER

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2018 LEGISLATIVE SESSION UPDATE

2018 Florida Legislative Priorities & Session Outcomes

The American Cancer Society Cancer Action Network (ACS CAN), Florida Division, works to achieve our advocacy goals by using a focused legislative agenda. ACS CAN develops an agenda that defines the annual priority initiatives, appropriations requests, and other issues that support our overall mission to save lives and diminish suffering caused from cancer. The following is a synopsis of the 2018 Legislative Session's cancer-related policy outcomes and appropriations in Florida.

2018 TOP LEGISLATIVE PRIORITIES IN FLORIDA		
LEGISLATIVE ISSUE & POSITION	**2017 LEGISLATIVE OUTCOME**	**IMPACT**
BREAST AND CERVICAL CANCER SCREENING The Mary Brogan Breast and Cervical Cancer Early Detection Program provides lifesaving cancer screenings for medically underserved women between the ages of 50 and 64 who have incomes below 200% of the federal poverty level. For 2018, ACS CAN asked that the state fund the program at approximately $2.6 million – half of the Centers for Disease Controls current investment in Florida.	House and Senate budget negotiators approved total state funding of **$1.83 million** in recurring revenue. While this is a decrease in overall funding from the previous budget year, it is a major increase in recurring dollars of $1.53 million.	➢ Investing recurring dollars to enhance this screening program for medically underserved women means that Florida is guaranteeing that funding will be included in next year's base budget. ➢ More than 15,000 women were screened with the dollars allocated during the last budget year. This significant increase in recurring funding will allow for the program to more adaquetley plan for the longterm success of the program, which will benefit the target population.
BIOMEDICAL RESEARCH It is vital that Florida supports measures that will increase the state's capacity for research and treatment, especially those measures that generate a substantial investment in the state's research infrastructure. For Fiscal Year 2018-19, we asked that both the James and Esther King Biomedical Research Program and the Bankhead-Coley Cancer Research Program would be funded at $15 million each and that, as prescribed by law, program funding allocations would be determined on a peer-reviewed, competitive grant basis.	Funding for the King Program came in at **$10 million** for the upcoming year. The Bankhead-Coley Program received **$13 million** which is an increase of $1 million over the previous fiscal year. $3 million of that funding is earmarked for pediatric cancer research. In addition, several other institutions engaged in cancer research in Florida received substantial legislative appropriations, continuing the state's investment to help more Florida based cancer centers become certified by the National Cancer Institute (NCI).	➢ A total of **$27 million** was allocated specifically for biomedical research with an additional **$62.3 million** provided to Florida-based cancer centers to help either preserve or attain their NCI designation. In sum, a total of **$89.3 million** was invested in cancer treatment and research.
TOBACCO PREVENTION & EDUCATION ACS CAN supports the continued, full implementation of Article X, Section 27 of the Florida Constitution. Funding allocated for the Tobacco Prevention and Education Program should be approximately $70 million for Fiscal Year 2018-19 and should be allocated based on the *CDC's Best Practices.*	The Legislature approved more than **$70 million** in funding for the Comprehensive Statewide Tobacco Prevention and Education Program. The dollars distributed within the larger program were generally consistent with the *CDC's Guidelines and Best Practices for Tobacco Control.*	➢ That amount constitutes a **$1.4 million** increase over last year's budget. ➢ Language included in the budget requires that all contracts funded through the program include performance measures and outcomes that are consistent with the CDC's Best Practices

OTHER SUBSTANTIVE ISSUES		
LEGISLATIVE ISSUE & POSITION	**2017 LEGISLATIVE OUTCOME**	**IMPACT**
Controlled Substance Prescribing The CDC has reported that Florida ranked fourth in the United States for total opioid overdose deaths in 2015. The 3,228 opioid-related deaths that occurred in Florida in 2015 represents a 23% increase from 2014, and equates to almost nine opioid-related deaths every day.	SB 8 by Benaquisto limits the prescribing of a schedule II controlled substance for the treatment of acute pain to a 3-day supply or a 7-day supply if deemed medically necessary. Excluded from these limits are pain related to cancer, terminal illness, palliative care and serious traumatic injury. The bill also requires physicians and pharmacist to check the prescription drug monitoring program before prescribing or dispensing a controlled substance, unless the controlled substance is a non-opioid schedule V or the medicine is prescribed to a child under 16.	Patients suffering from cancer are exempt from this law. The state provided $53.5 million in funding to help deal with the opioid crisis. Additionally, the bill provides an additional $1 million for improvements to the PDMP, enabling it to interface with electronic health records.

APPROPRIATIONS

The $88.7 billion budget for 2018-19 adopted during the legislative session included approximately $179 million for the fight against cancer. That amount constitutes an almost $4 million increase in associated funding from the prior budget year.

In total, cancer-related funding from the legislature included:

Mary Brogan Breast & Cervical Cancer Early Detection Program	$	1,838,235
Comprehensive Statewide Tobacco Prevention and Education	$	70,072,275
Biomedical Research		
James and Esther King Biomedical Research Program	$	10,000,000
William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program	$	10,000,000
Pediatric Cancer Research	$	3,000,000
Statewide Brain Tumor Registry Program - McKnight Brain Institute	$	500,000
Torrey Pines Institute	$	1,500,000
Endowed Cancer Research Chair		
Mayo Clinic Cancer Center of Jacksonville	$	2,000,000
Florida Consortium of National Cancer Institute Centers Program	$	62,228,743
Live Like Bella Childhood Cancer Foundation	$	600,000
Minority Health Initiatives	$	3,134,044
La Liga - League Against Cancer	$	1,150,000
Sylvester Comprehensive Cancer Center - Firefighters Cancer Research	$	1,000,000
Moffitt Cancer Center and Research Institute – Education	$	10,576,930
Coalition for Medicinal Cannabis Research & Education – Moffitt Cancer Center and Research Institute	$	150,000
TOTAL CANCER-RELATED ISSUES AND ACS CAN PRIORITIES	**$**	**178,750,227**

IOWA CANCER CONSORTIUM

2018-2022 Iowa Cancer Plan

Each year, an estimated 17,400 Iowans are diagnosed with cancer and 6,200 lose their lives. Cancer remains the second-leading cause of death in Iowa.[1]

Cancer is complicated, and there is no one answer to addressing it in Iowa. Researchers, public health advocates, health care providers - all Iowans - need come come together to make the biggest change and the most improvement.

The 2018-2022 Iowa Cancer Plan provides Iowans the direction and framework to do just that.

WHAT IS THE IOWA CANCER PLAN?

The 2018-2022 Iowa Cancer Plan serves as an evidence-based roadmap for comprehensive cancer control efforts in Iowa for the next five years. It is meant to help provide direction and guide all Iowans involved in cancer to work together towards accomplishing the same goals.

The plan identifies five priorities that must be addressed in order to reduce the burden of cancer in Iowa:

THE IOWA CANCER PLAN'S FIVE PRIORITIES

1 PREVENTION

Prevent cancer from occurring whenever possible.

2 SCREENING

Detect cancer at its earliest stages.

3 TREATMENT

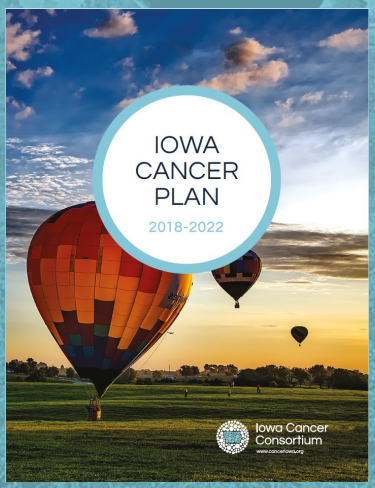
Improve the accessibility, availability and quality of cancer treatment services and programs.

4 QUALITY OF LIFE

Ensure the highest possible **quality of life** for all Iowans affected by cancer.

5 HEALTH EQUITY

Identify and eliminate cancer **health disparities**.



View the 2018-2022 Iowa Cancer Plan at www.canceriowa.org/iowacancerplan.

[1] Iowa Cancer Registry. 2017 Cancer in Iowa.

WHO SHOULD USE THE IOWA CANCER PLAN?

The Iowa Cancer Plan was created for all Iowans to use as a guide for **cancer control** and prevention work across the state. A diverse network of partnerships among individuals and organizations is essential for achieving the goals outlined within the plan. Having a variety of partners, such as the following, will strengthen efforts.

- Cancer Survivors
- Caregivers
- Businesses and employers
- Legislators
- Community-based organizations and volunteers
- Educators
- Faith-based organizations
- Government agencies
- Healthcare organizations and systems
- Media
- Payers and insurance providers
- Physicians and helathcare providers
- Professional organizations
- Public health departments
- Public policy advocates
- Schools and universities
- Researchers
- *All Iowans.*

THE IOWA CANCER CONSORTIUM'S ROLE

The Iowa Cancer Consortium is a statewide nonprofit coalition of health care providers, public health professionals, caregivers, researchers, cancer survivors, volunteers and advocates working together to reduce the burden of cancer in Iowa.

The Consortium envisions an Iowa where cancer is not a burden. Our mission is to reduce cancer incidence and mortality in Iowa through collaborative efforts that provide services and programs directed towards comprehensive cancer prevention and control.

To view the 2018-2022 Iowa Cancer Plan, visit www.canceriowa.org/iowacancerplan

"People in advocacy, people in research, people in public health and families need to work together...and need to understand differences and similarities. That's what's going to help us give [cancer] a voice."

Pamela Codd
Iowa City, Iowa
Caregiver and Advocate who lost her 5-year-old son, Dashiell to cancer

To view Pamela's story visit www.canceriowa.org/stories

The 2018-2022 Iowa Cancer Plan

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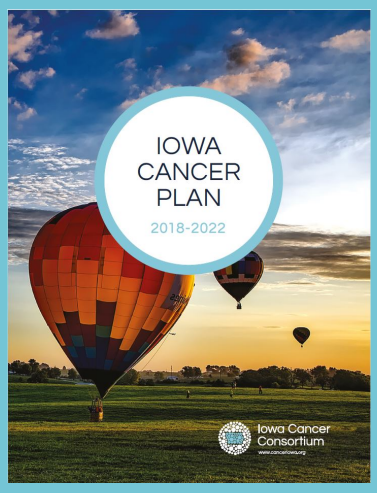

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- Government agencies
- Healthcare organizations and systems
- Media
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- Physicians and helathcare providers
- Professional organizations
- Public health departments
- Public policy advocates
- Schools and universities
- Researchers

And all Iowans.

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To view the 2018-2022 Iowa Cancer Plan, visit www.canceriowa.org/iowacancerplan

IOWA CANCER PLAN

2018-2022

Iowa Cancer Consortium

www.canceriowa.org

Iowa Cancer Consortium

George Weiner, M.D.
President, Board of Directors,
Iowa Cancer Consortium

Dear people of Iowa,

As President of the Iowa Cancer Consortium Board of Directors, it is my honor and pleasure to introduce the 2018-2022 Iowa Cancer Plan. This is the fourth such plan developed by the Consortium beginning with our first plan presented to the State of Iowa in 2003.

We have made significant progress in some areas of cancer control in Iowa based on initiatives that were outlined in the prior cancer control plans. Deaths from the most common cancers - lung, colorectal, breast and prostate cancer - have dropped steadily (albeit not fast enough). There is increasing acceptance of the importance of tobacco cessation, physical fitness, screening for cancers including colorectal and breast cancer, HPV vaccination and testing for radon as ways to reduce the burden of cancer.

Yet, there is still much to be done. There are still too many preventable deaths from cancer in Iowa. We could reduce the death rate from cancer in Iowa by over one-third if we fully applied what we already know about cancer control. Some populations in Iowa have a particularly high burden of cancer, and there is more that can and should be done to address these cancer disparities. In addition, cancer research is progressing at an unprecedented rate, and we need to continue to invest in cancer research in our state. This research will provide new tools that will help reduce the burden of cancer even further through improved prevention, early detection and therapy.

This cancer plan was developed over many months by dedicated teams of experts with a broad variety of backgrounds, including public health professionals, social scientists, epidemiologists, cancer researchers, oncologists, other cancer clinicians and patient advocates.

We owe it to the people of Iowa to do everything we can to work together to further reduce the burden of cancer now and for future generations. This plan describes how.

Sincerely,

George Weiner, M.D.
President, Board of Directors, Iowa Cancer Consortium

Dear Iowans,

Development of a plan and engaging key partners is key to successful community-based interventions which focus on improving health of Iowans. For 17 years, the Iowa Cancer Consortium has led Iowa's efforts in understanding cancer's impact on Iowans, as well as the identification of interventions which reduce the impact of cancer on our residents.

As the second leading cause of death among Iowans, cancer is a significant public health issue for our state. Successful interventions require the engagement of community-based resources, healthcare providers, families, and numerous other partners.

And we have proven strategies that reduce the burden of cancer. For example, we know that avoiding tobacco use reduces cancer risk. Having regular cancer screenings can help find precancerous changes and cancers at their earliest stages when prevention and treatment can be easier and more effective. Research also suggests that getting exercise, eating fruits and vegetables, and receiving certain vaccinations also are proven strategies which not only improve health generally, but are associated with reduced cancer risk.

The development of the Iowa Cancer Plan assists public policymakers, community-based organizations, healthcare providers, and all Iowans to harness energies to focus on effective strategies ranging the continuum from prevention through treatment and survivorship. Strong partnerships and a continued investment in cancer control and prevention will ensure a future where cancer is no longer a burden for Iowans. I commend this plan to Iowans impacted and interested in reducing cancer's burden. A community informed is a community armed with the tools necessary to make Iowa the healthiest state in the country.

Sincerely,

Gerd W. Clabaugh, MPA
Director, Iowa Department of Public Health

Dear Iowans,

I want Iowa to be the healthiest state in the nation. Key to that goal is combating the second-leading cause of death in Iowa, cancer. The Iowa Cancer Plan is a diverse and collaborative effort to establish Iowa's vision to combating cancer over the next five years.

It is important we have a comprehensive cancer control plan in place, however let us not lose sight of the thousands of Iowans whose lives have been taken by cancer. Their stories sometimes are heart wrenching and always moving. Throughout this plan, you will find stories of Iowans who have been affected by cancer.

The Iowa Cancer Plan, newly revised for 2018-2022, is a guide for cancer control practices across the state. It is also a tool for you as an Iowan. Because we are all changed by cancer, we must all work together to conquer it. You can do so much:

- Share the stories and information within this plan.
- Share your own story.
- Participate in cancer control in any way you can.
- Join the Iowa Cancer Consortium.
- Advocate for resources and encourage partnerships in the fight against cancer.

I commend the Iowa Cancer Consortium, its partners, and the passionate individuals and organizations on their collaborative efforts to reduce the burden of cancer for all Iowans. To ensure a healthier future for all Iowans, we must continue to hear one another's stories, tell our own, and most importantly, work together to conquer cancer.

Sincerely,

Kim Reynolds
Governor of Iowa

PLEASE NOTE:

Items in bold are defined in the glossary on page 39.

TABLE OF CONTENTS

The 2018-2022 Iowa Cancer Plan is dedicated to the people of Iowa whose lives have been touched by cancer. These Iowans are the faces of cancer in Iowa and inspire a collaborative effort to reduce the burden of cancer in our state.

This plan was created in a spirit of collaboration, and is the result of the work and input of many Iowans. We would like to extend a very sincere thank you to the following people for their passion and efforts in creating the 2018-2022 Iowa Cancer Plan:

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Michele West, PhD, University of Iowa Department of Epidemiology, Iowa Cancer Registry

The generous individuals who shared their cancer stories

Meg Beshey, Fort Dodge

David McCluskey, West Des Moines

Pamela Codd, Iowa City

Cathy Ketton, Niisha and ShanQuiesha Robinson, Waterloo

Jill Lightfoot, Bettendorf

Paula Schnack, Oakland

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Norm Van Klompenburg, MSW, Treasurer, Community Volunteer

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Kelly Rollins

Meagan Schorr, MPH, CHES

Lindsay Schultz

Kelly Wells Sittig, CCPH

Introduction to the Iowa Cancer Consortium

The Iowa Cancer Consortium is a statewide nonprofit coalition of health care providers, public health professionals, caregivers, researchers, cancer survivors, volunteers and advocates working together to reduce the burden of cancer in Iowa.

WHAT DOES THE CONSORTIUM DO?

There is a role at the Iowa Cancer Consortium for every Iowan. Learn more at www.canceriowa.org/membership.

- Establishes and grows partnerships between individuals and organizations, enhancing partners' abilities to address cancer issues.
- Provides a neutral setting for agencies competing for the same funding and patient base to work together to reduce duplication of efforts and advance common **cancer control** issues.
- Leverages state and federal funds to the fullest extent by using the expertise of volunteers and members.
- Provides capacity building opportunities, resources and support for **cancer control** work.
- Provides funding through a competitive grant process to programs and projects that advance priorities in the Iowa Cancer Plan.

The Iowa Cancer Consortium envisions an Iowa where cancer is not a burden. Our mission is to reduce cancer **incidence** and **mortality** in Iowa through collaborative efforts that provide services and programs directed towards comprehensive cancer prevention and control.

Above all, the Iowa Cancer Consortium is collaborative. We connect new and sometimes unlikely partners who want to make bigger impacts with their work and resources. We create partnerships that strengthen cancer prevention, screening, treatment and **quality of life** for all Iowans.

EIGHT TRAITS GUIDE THE WORK AND PARTNERSHIPS OF THE IOWA CANCER CONSORTIUM

1 The Iowa Cancer Consortium is *empowering.*

It connects stakeholders with tools, resources, knowledge and partnerships to help them succeed in their **cancer control** work

2 The Iowa Cancer Consortium is *credible.*

It recognizes that advances in cancer prevention, screening, treatment and **quality of life** are made through scientific research. It connects partners with reliable sources of information to help them succeed. It helps the public find accurate cancer information.

3 The Iowa Cancer Consortium is *open and engaging.*

It is approachable and seeks partners with diverse ideas and talents. There is a role at the Iowa Cancer Consortium for every Iowan.

4 The Iowa Cancer Consortium is *passionate.*

It is personally and professionally driven to make cancer less of a burden on families, friends, neighbors, coworkers and all Iowans.

5 The Iowa Cancer Consortium is *compassionate.*

It recognizes that every person experiences cancer differently and has a unique story to tell. It believes every cancer story has value.

6 The Iowa Cancer Consortium is *innovative.*

It thinks creatively to solve problems. It embraces new technologies and new ideas, and it helps its partners do the same.

7 The Iowa Cancer Consortium is *professional.*

It takes its work seriously and acknowledges the value of partners' contributions. It seeks input from a variety of stakeholders, and is balanced in its decisions and actions. It is competent and capable and understands the complexities of cancer and cancer issues.

8 The Iowa Cancer Consortium is *equitable.*

It believes that access to cancer services and outcomes should not depend on **race**, **creed**, color, national origin, age, sex, disability, **sexual orientation**, **gender** identity or any other classification.

As a leader in **cancer control**, the Iowa Cancer Consortium offers the state's cancer stakeholders access to resources, expertise, and non-competitive collaboration across traditional boundaries for a bigger impact in cancer prevention, early detection, treatment and **quality of life**.[1]

Introduction to the 2018-2022 Iowa Cancer Plan

Each year, an estimated 17,400 Iowans are diagnosed with cancer and 6,200 lose their lives. Cancer remains the second-leading cause of death in Iowa.[2]

All Iowans have a role in reducing the state's **cancer burden**. The 2018-2022 Iowa Cancer Plan serves as a roadmap for comprehensive **cancer control** efforts in Iowa for the next five years. It is meant to help provide direction and guide all Iowans involved in cancer to work together towards accomplishing the same goals. The Iowa Cancer Plan identifies five priorities that must be addressed in order to reduce the burden of cancer in Iowa.

THE IOWA CANCER PLAN'S FIVE PRIORITIES

1. **PREVENTION**
   Prevent cancer from occurring whenever possible.
2. **SCREENING**
   Detect cancer at its earliest stages.
3. **TREATMENT**
   Improve the accessibility, availability and quality of cancer treatment services and programs.
4. **QUALITY OF LIFE**
   Ensure the highest possible **quality of life** for all Iowans affected by cancer.
5. **HEALTH EQUITY**
   Identify and eliminate cancer **health disparities**.

The plan is organized by goals, actions and targets. Goals are measurable aims that address one or more of the above priorities. Under each goal there are actions, or activities that help accomplish a specific goal. At the end of each goal are data targets. These targets are data benchmarks that are used to measure and evaluate progress towards the outlined goals. Throughout the plan, specific actions are outlined that address policy, systems and environments.

These approaches are needed for long-term, sustainable improvements in comprehensive **cancer control**.

Iowa Cancer Plan terms defined:

PRIORITY
Major issue to be addressed in order to reduce the burden of cancer in Iowa.

GOAL
A measurable aim that addresses one or more priorities.

ACTIONS
Activities that help accomplish a specific goal.

DATA TARGETS
Data benchmarks used to measure and evaluate progress.

Who Should Use the Iowa Cancer Plan?

The Iowa Cancer Plan was created for all Iowans to use as a guide for **cancer control** and prevention work across the state. A diverse network of partnerships among individuals and organizations is essential for achieving the goals outlined within the plan. Having a variety of partners, such as the following, will strengthen efforts.

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- Faith-based organizations
- Government agencies
- Health-care organizations and systems
- Media
- Payers and insurance providers
- Physicians and health-care providers
- Professional organizations
- Public health departments
- Public policy advocates
- Schools and universities
- Researchers
- All Iowans

Read on to learn more about how Iowans can get involved in implementing the Iowa Cancer Plan.

A Picture of Iowa's Cancer Incidence and Mortality Rates Over Time

The state of **cancer control** is constantly changing. The graph below depicts how cancer **incidence** and **mortality** in Iowa have changed over time. At the same time, the 2018-2022 Iowa Cancer Plan is a continuation of plans from previous years. Some of the content within this version of the Iowa Cancer Plan will be reminiscent of previous versions. While this plan does not address every issue and need existing in comprehensive **cancer control** in Iowa, the priorities, goals and actions have been determined by the Iowa Cancer Consortium and its partners to be the leading evidence-based methods to reduce the burden of cancer in Iowa.

This graph provides a visual overview of the burden of various cancers in Iowa over time. The blue columns represent the number of new cases diagnosed in Iowa each year (**incidence**) and red columns represent the number of cancer deaths in Iowa each year (**mortality**).

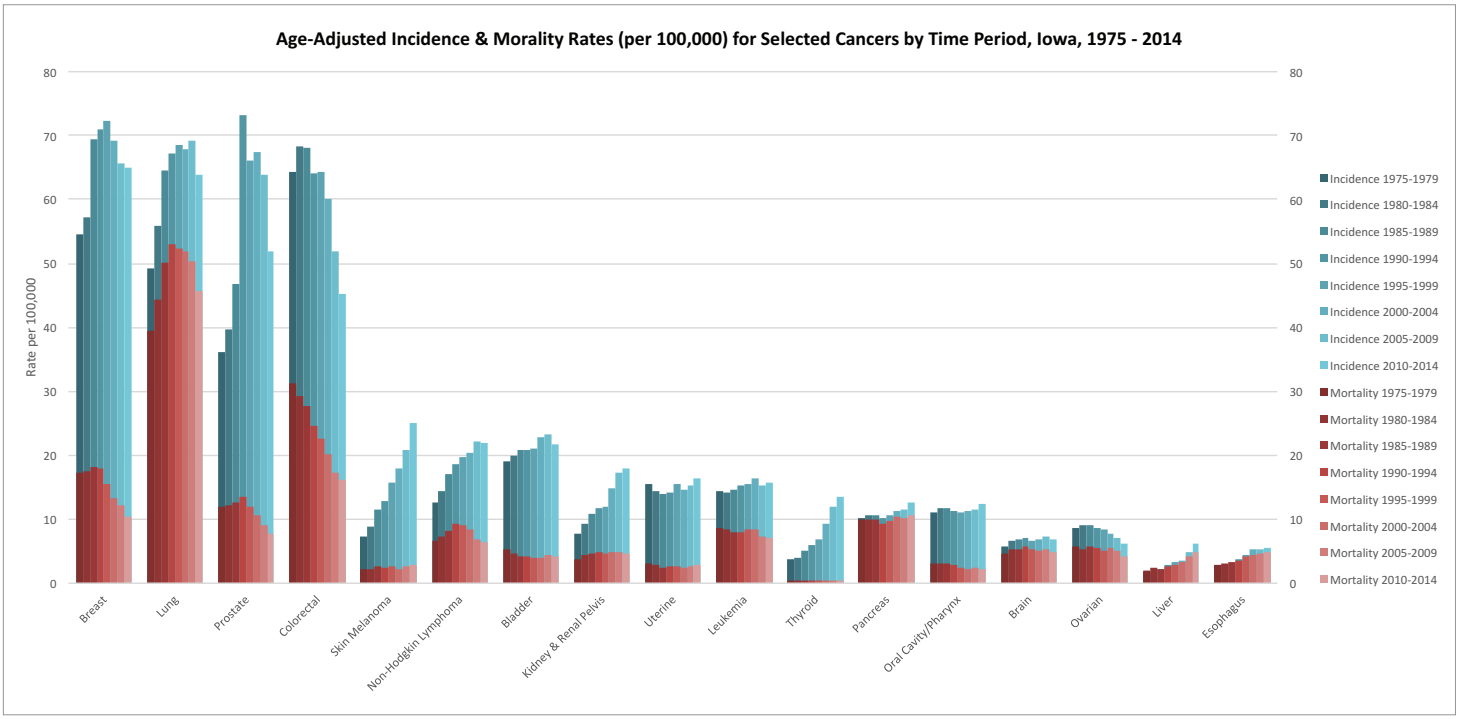


Figure 1. **Age-Adjusted Incidence** & **Mortality** Rates (per 100,000) for Selected Cancers by Time Period, Iowa, 1975-2014 [3]

Iowa Incidence and Mortality Baselines and Targets for 2022

For the clearest picture of changes in cancer **incidence** and **mortality** over time, **Surveillance, Epidemiology and End Results** Program (SEER) data from 2012-2014 was used to establish baselines.

Researchers at the Iowa Cancer Registry analyzed data from previous years to predict cancer incidence and mortality in 2022 if no **interventions** are implemented. However, because of the priorities, goals and actions outlined in the Iowa Cancer Plan, further reduction in incidence and mortality is expected. Incidence targets were set using a percent reduction from projected 2022 rates. Mortality targets were set based on Healthy People 2020 recommendations.[4] These adjustments are reflected in the 2022 data targets included in the chart below.

Please note that the rates in this table are **age-adjusted** to the 2000 U.S. Standard population per 100,000 population.

	INCIDENCE		MORTALITY	
Cancer Type	2012-2014 Baseline	2022 Target	2012-2014 Baseline	2022 Target
All Cancer Sites	459.5	402.0	167.3	153.9
Late Stage Female Breast	39.1	29.3	19.3	19.0
Colorectal	44.8	33.9	15.6	13.7
Cervical	7.3	3.6	2.0	1.8
Lung	63.2	49.1	45.3	41.7
Liver	6.2*	7.3*	4.8	4.4
Prostate	01.9	88.7	19.6	18.0
Skin Melanoma	25.3*	27.5*	2.9	2.7

Table 1. Iowa Cancer Plan **incidence** and **mortality** targets[3]

*Skin melanoma and liver cancer **incidence** has been on an upward trend. While the 2022 target is higher than the baseline, it is a reduction of the projected 2022 rate.

2018-2022 Iowa Cancer Plan Priorities

1 PREVENTION

Many cancers in Iowa can be prevented. The **National Cancer Institute** estimates that almost one third of cancers in the United States are linked to obesity, lack of physical activity and/or poor nutrition.[5] Cancers caused by tobacco and **secondhand smoke**, excessive alcohol consumption and certain viruses are highly preventable.

Behaviors that are known to reduce the risk of developing cancer include:

- Avoiding tobacco use and **secondhand smoke**.
- Getting the recommended amount of exercise.
- Eating a variety of fruits and vegetables.
- Limiting alcohol consumption.
- Completing the **human papillomavirus** (HPV) and hepatitis B vaccination series.
- Wearing sunscreen and sun protective clothing.
- Testing for **radon** and fixing indoor radon problems if needed.

Gail Orcutt, radon-induced lung cancer survivor and cancer prevention champion.

In Iowa, rates of melanoma, breast and colorectal cancers continue to be higher than the national average. Cancers such as liver, lung and pancreatic have been on the rise in recent years. Fortunately there are proven actions that individuals, organizations and communities can take to reduce the risk of these and other types of cancers from occurring. The 2018-2022 Iowa Cancer Plan includes goals with actions that, if accomplished, are proven to lower the likelihood of certain cancers occurring.

2 SCREENING

When cancer is detected at its earliest stages, cancer treatment is often more effective and survival is more likely.

Evidence-based screening methods do not exist for all cancers. But for those that have an associated evidence-based screening method – breast, cervical, colorectal and lung – screening is a critical part of reducing the number of deaths from cancer. For example, a study published in the journal Cancer has reported that if 80% of the eligible population were to be screened for colorectal cancer by 2018, more than 200,000 lives could be saved nationwide.[7]

In some cases, screening tests detect cells that are not yet cancer, but that have the potential to become cancer. For example, the Pap test can detect pre-cancerous cells in the cervix. If pre-cancerous cells are found, they can be treated, stopping cervical cancer before it starts.

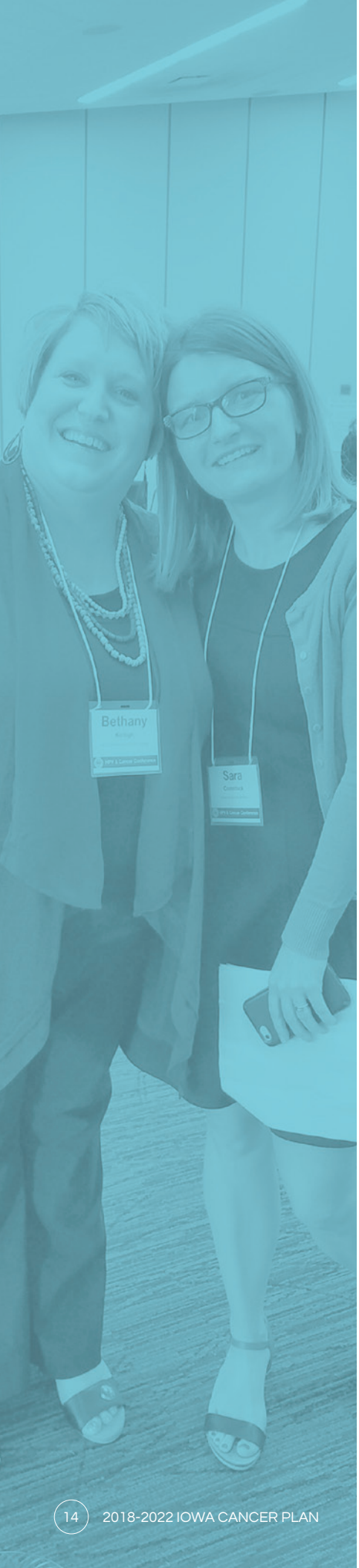
Many approaches are necessary for screening rates to go up and death rates to go down:

- More education is needed so that Iowans better understand cancer screening guidelines and opportunities.
- Iowans need access to a **medical home**, so they can make informed and personal decisions along with a trusted medical provider.
- Iowans need access to screening services. Barriers to health care must be addressed at a systematic and policy level.
- Screening services must be offered in inclusive, supportive and safe settings.
- When screening tests detect cancer, patients must be able to easily and readily access cancer treatment.

Making decisions about screening can be overwhelming and confusing. Multiple well-respected organizations, such as the **American Cancer Society** and the United States Preventive Services Task Force, publish screening guidelines to help individuals make decisions. Ultimately, Iowans should work with a medical provider to determine which screening methods are best for them and when screening should occur.

Many cancers do not yet have an evidence-based screening method. For those that don't, support for research to develop effective screening tests is critical.

This plan addresses individual, provider, community, clinical, policy and system approaches to increasing the early detection of cancer in the state. Components of all of these are needed to truly improve cancer **incidence** and **mortality** in Iowa.



3 TREATMENT

When cancer is found, an individual's survival and **quality of life** can depend on the availability of timely, quality treatment.

Iowans face a number of barriers to accessing lifesaving cancer treatment, including:

- Access to adequate health insurance.
- Transportation to medical facilities where quality care is available, especially in rural parts of the state.
- Financial insecurity.
- Barriers related to culture, language and/or identity.
- Competing basic needs and priorities.
- Overall availability of a qualified cancer workforce.
- Lack of awareness or understanding of the benefits of clinical trials.

Cancer research at all phases – including clinical trials – must be adequately supported so that new, emerging and more effective treatment methods are developed and utilized.

Additionally, **quality of life interventions** such as physical activity and nutrition programs can enhance and should be considered a crucial part of cancer treatment.

This plan addresses identified barriers to quality cancer treatment at the community and system levels, and recognizes the wide range of partners who must work collaboratively on a comprehensive approach to caring for Iowans.

4 QUALITY OF LIFE

Scientific advances in screening and treatment have allowed those diagnosed with cancer to live longer than ever before. In the United States, more than half of those who receive a cancer diagnosis will be alive in five years.[8]

Iowa's population is growing older. An estimated 15.8% of the state's total population was age 65 or older in 2014, and that percentage continues to rise.[9] As the size of the older population increases, so will the number of cancer diagnoses, patients and survivors.

Iowans face unique challenges following a cancer diagnosis. Treating cancer can cause a variety of short- and long-term effects that can impact not only the patient, but also those close to them.

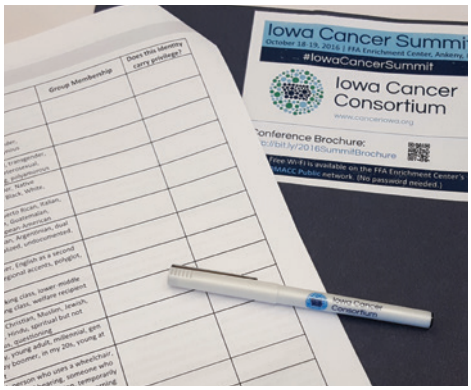
Additionally, research and advances in treatment have led to increased rates of survival for childhood, adolescent and young adult cancers. These populations face unique challenges as survivors, because less is known about **late effects** of treatment.[71]

In cancer, **survivorship** covers physical, **psychosocial** and economic issues, from diagnosis until the end of life. Survivorship experiences differ based on a person's unique experience. Survivorship can include:

- Issues with accessing health care and follow-up treatment.
- Changes in frequency of cancer screening.
- Late and long-term effects of treatment.
- Wellness support and services.
- Subsequent cancers.
- **Palliative care**.
- Hospice.
- Family members, friends and caregivers are also a part of the **survivorship** experience.

This plan addresses quality-of-life issues throughout a person's experience with cancer. Much of the burden of cancer is based on an individual's physical and **psychosocial** state. These populations face unique challenges as survivors.

5 HEALTH EQUITY



As demographics change in the United States and Iowa, so does the opportunity for every person to attain the highest level of health. Iowans face significant differences in access to and utilization of health care and health services.[10] Many of these differences can be attributed to the social determinants of health, which are the conditions in the environment in which people are born, live, work and age. Differences in the social determinants of health and **quality of life** lead to **health disparities**.[11] Addressing **health disparities** can improve health and reduce the burden of cancer in Iowa.

Health disparities based on many different factors can be found throughout Iowa. Some of the most prominent include:

- Disparities based on geographic location. According to the United States Census Bureau 35.8% of Iowa can be considered rural.[12] Iowans living in rural parts of the state can face access issues based on lack of transportation and insufficient workforce. Additionally, there are 94 medically underserved areas/populations in Iowa.[13] Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) identify geographic areas and populations with a lack of access to primary care services.
- Disparities based on cultural and/or language. By 2050, racial and ethnic minorities are predicted to make up the majority of the U.S. population.[14] Iowa's population is changing, as well. Between 2000 and 2014 the Hispanic population in Iowa increased more than 110%. Similarly, the Asian population increased more than 88% and the Black population increased more than 71%.[15] To ensure equitable health for all Iowans, health education, preventive services, health care, public health and other health services must be available and delivered in culturally and linguistically appropriate ways.
- Disparities based on **gender identity** and **sexual orientation**. The specific preventive and health care needs of members of the lesbian, gay, bisexual, transgender and queer (LGBTQ) community have overwhelmingly been overlooked in the past. Yet, we now know that members of this community are at an increased risk for many types of cancer. For example, LGBTQ people smoke cigarettes at a rate that is 68% higher than the rest of the population.[16] Additionally, LGBTQ people face continued discrimination and stigma within health care settings.

The examples above are not exhaustive. Iowans may face **health disparities** due to their racial or ethnic group; religion; socioeconomic status; gender; age; mental health, ability status; **sexual orientation** or **gender identity**; geographic location; or other characteristics historically linked to discrimination or exclusion.[9] These inequities will continue to increase if the underlying social determinants of health are not addressed.

The Iowa Cancer Consortium and its partners believe every Iowan should have the same opportunity to access and receive appropriate quality cancer services. By addressing disparities every goal and action will have a greater and more equitable effect.

Goal 1

Increase collaboration among organizations, coalitions, businesses and individuals to maximize cancer control resources and efforts.

ACTIONS

- **A** Engage traditional and non-traditional partners in coordinated **cancer control** efforts.
- **B** Increase resource sharing between **cancer control** partners.
- **C** Encourage all **cancer control** partners in Iowa to use the Iowa Cancer Plan for planning, funding and advocacy.
- **D** Coordinate with partners to ensure the use of consistent and accurate **cancer control** messages.
- **E** Increase collaborative efforts among county public health departments.
- **F** Increase the number and diversity of Iowans engaged in collaborative work through the Iowa Cancer Consortium.

DATA TARGETS

Increase the number of Iowa counties that are represented within the Iowa Cancer Consortium membership.

(Source: Iowa Cancer Consortium Wild Apricot Membership Database)

2017 BASELINE	2020 GOAL
51 COUNTIES	99 COUNTIES

Increase the number of organizational Iowa Cancer Consortium members.

(Source: Iowa Cancer Consortium Wild Apricot Membership Database)

2017 BASELINE	2020 GOAL
44 MEMBERS	55 MEMBERS

Increase the number of individual Iowa Cancer Consortium members.

(Source: Iowa Cancer Consortium Wild Apricot Membership Database)

2017 BASELINE	2020 GOAL
156 MEMBERS	250 MEMBERS

People in advocacy, people in research, people in public health and families need to work together…and need to understand differences and similarities. That's what's going to help us give [cancer] a voice.

Pamela Codd
Mother of Dashiell Codd
Caregiver and Advocate
Iowa City, Iowa

To view Pamela's story visit www.canceriowa.org/stories

Goal 2

Decrease tobacco and nicotine use and exposure.

ACTIONS

- **A** Educate the public, including parents, teachers, students, retailers and local leaders on the dangers of tobacco and nicotine products.
- **B** Educate policy makers on the costs of tobacco and nicotine use, including loss of employee productivity and health care related expenses.
- **C** Raise the minimum legal sale age of tobacco products to 21 years old.
- **D** Increase referrals to and participation in evidenced-based tobacco cessation services* for all tobacco users, including **cancer survivors**.
- **E** Increase the number of health care organizations using provider reminder systems to advise tobacco users to quit using tobacco.
- **F** Collaborate with local Tobacco Community Partnerships to further tobacco prevention, cessation and control efforts.[17]
- **G** Require that nicotine delivery devices, including **e-cigarettes**, be held to the same advertising, promotion and sponsorship standards as all other tobacco and nicotine products.
- **H** Increase the tax on tobacco products.
- **I** Maintain or increase funding to the Iowa Department of Public Health (IDPH) Division of Tobacco Use Prevention and Control to CDC-recommended levels for Iowa.[18,19]
- **J** Eliminate the casino exemption in the **Smokefree Air Act**.
- **K** Increase the number of school districts, colleges/universities, workplaces, housing units and parks that implement comprehensive tobacco and nicotine-free policies.[20]
- **L** Advocate for policy that prohibits smoking in cars when minors are present.
- **M** Increase the number of insurance plans covering evidence-based cessation services, **Nicotine Replacement Therapy** (NRT) and counseling.

QUITLINE IOWA

1 800 QUIT NOW | 1 800 784 8669

*An example of an evidence-based tobacco cessation service is Quitline, which uses 2A's and an R when implementing tobacco **interventions**.

1. **A**sk about tobacco use.
2. **A**dvise patients to quit.
3. **R**efer patients to Quitline Iowa.

For more information about Quitline Iowa, visit www.quitlineiowa.org or call 1-800-QUIT NOW

DATA TARGETS

Decrease tobacco use among adults.

Percent of Current Smokers, All **Races**, Both Sexes, Ages 18+ (Source: BRFSS 2016[21])

16.7% → 15.0%

2016 BASELINE — 2022 GOAL

Decrease youth tobacco initiation.

Percentage of 11th grade students who have ever smoked tobacco or used any tobacco products (not including electronic cigarettes). (Source: Iowa Youth Survey 2016[22])

19.0% → 17.0%

2016 BASELINE — 2022 GOAL

Increase adult cessation attempts.

Percent of Current Smokers Trying to Quit for a Day or More, All **Races**, Both Sexes, Ages 18+ (Source: BRFSS 2016[21])

52.5% → 57.8%

2016 BASELINE — 2022 GOAL

Decrease the **age-adjusted incidence** per 100,000 for lung cancer.

(Source: State Health Registry of Iowa[3])

63.2 → 49.1

2012-14 BASELINE — 2022 GOAL

Decrease tobacco use among youth.

11th grade overall tobacco use rate including cigarettes, smokeless, cigars, pipes, and water pipes. (Source: Iowa Youth Survey 2016[22])

10.0% → 9.0%

2016 BASELINE — 2022 GOAL

Increase the portion of Iowans who don't allow smoking inside their homes.

Which statement best describes the rules about smoking inside your home? 1. Smoking is not allowed anywhere inside your home. (Source: BRFSS 2016[21])

85.4% → 93.9%

2016 BASELINE — 2022 GOAL

Increase the proportion of Iowans reporting no hours of exposure to **secondhand smoke**.

In a typical week at work, how many hours would you say that you are in a room or car with smoke from someone else's cigarettes, cigars, or pipe? Zero hours. (Source: BRFSS 2016[21])

57.9% → 63.7%

2016 BASELINE — 2022 GOAL

Decrease the **age-adjusted mortality** per 100,000 for lung cancer.

(Source: State Health Registry of Iowa[3])

45.3 → 41.7

2012-14 BASELINE — 2022 GOAL

Goal 3

Increase efforts that support healthy eating, physical activity and healthy weight status.[23]

ACTIONS

- **A** Increase access to and availability of healthy food and beverage choices in public locations and private businesses, including grocery stores, convenience stores, schools, restaurants and workplaces.
- **B** Require public and private venues including restaurants to label all food and drink products with nutritional information.
- **C** Increase awareness and educate policy makers about **food swamps** and **food deserts** and their contribution to obesity.
- **D** Implement policies that increase access to healthy food and decrease access to unhealthy food.
- **E** Establish workplace and community policies that support breastfeeding.
- **F** Improve community design and infrastructure to create environments that support increased physical activity.
- **G** Support initiatives that increase opportunities for physical activity in schools and workplaces.
- **H** Increase access to overweight and obesity screening and educate providers on the associated risk factors.
- **I** Engage providers and patients in healthy weight management and best practices, including the role of nutrition and physical activity as part of cancer prevention, treatment and care.
- **J** Support third-party reimbursement for primary care treatment of overweight and obesity from medical providers, registered dieticians and other qualified health care providers.

DATA TARGETS

Decrease proportion of adults who are overweight or obese.

Overweight or obese Iowans (body mass index greater than or equal to 25.0 kg/m2), All **Races**, Both Sexes, Ages 18+ (Source: BRFSS 2016[21])

2016 BASELINE	2020 GOAL
68.7%	61.8%

Increase proportion of adults getting recommended levels of physical activity.

Iowans Getting Recommended Level of Physical Activity, All **Races**, Both Sexes, Ages 18+. Recommended physical activity was defined as either regular physical activity 30 or more minutes per day for 5 or more days per week or vigorous activity 20 or more minutes per day for 3 or more days per week. (Source: BRFSS 2015[24])

2015 BASELINE	2020 GOAL
48.8%	53.7%

Decrease proportion of adults who are obese.

Obese (body mass index greater than or equal to 30.0 kg/m2), All **Race**s, Both Sexes, Ages 18+ (Source: BRFSS 2016[21])

2016 BASELINE	2020 GOAL
32.0%	28.8%

Increase level of reported fruit and vegetable consumption among adults.

Percentage of Iowans Who Consumed Five or More Fruits/Vegetables per Day, All **Races**, Both Sexes, Ages 18+ (Source: BRFSS 2015[24])

2015 BASELINE	2020 GOAL
13.5%	14.9%

Goal 4

Decrease excessive alcohol consumption.

ACTIONS

- **A** Increase education and awareness of the relationship between alcohol and cancer.
- **B** Increase screening and treatment for **chronic heavy drinking**.[25]
- **C** Maintain limits on hours of alcohol sale in on premise settings such as bars and restaurants.[26]
- **D** Encourage the regulation of **alcohol outlet density**.[27]

DATA TARGETS

Decrease the percentage of adults in Iowa who are heavy drinkers.

The percentage of adults in Iowa who are heavy drinkers (defined as an average of greater than 14 drinks per week for men and seven drinks per week for women). (Source: BRFSS 2015[24])

5.9%	5.3%
2016 BASELINE	2020 GOAL

Decrease the percentage of adults in Iowa who report at least one binge drinking episode in the past 30 days.

The percentage of adults in Iowa who reported at least one binge drinking episode (defined as when a man drinks more than five drinks or a woman drinks more than four drinks on one occasion) in the past 30 days. (Source: BRFSS 2015[24])

19.8%	17.8%
2016 BASELINE	2020 GOAL

Decrease alcohol use among youth.

Percentage of 11th grade students who have ever used alcohol. (Source: Iowa Youth Survey 2016[22])

48.0%	43.2%
2016 BASELINE	2020 GOAL

Decrease youth alcohol initiation.

Percentage of 11th grade students currently using alcohol. (Source: Iowa Youth Survey 2016[22])

21.0%	18.9%
2016 BASELINE	2020 GOAL

Goal 5

Increase vaccination completion rates for all vaccines proven to reduce the risk of cancer.

ACTIONS

- **A** Increase hepatitis B vaccination among high-risk populations.[28, 29]
- **B** Maintain or increase hepatitis B vaccination rates in children.[30]
- **C** Increase access and coverage to the **human papillomavirus** (HPV) vaccination series for populations recommended by the **Advisory Committee on Immunization Practices**.[31, 32]
- **D** Implement health care system strategies and office-based reminder systems to increase the number of patients who initiate and complete the HPV vaccination series.
- **E** Increase public awareness of vaccines proven to reduce the risk of cancer.
- **F** Support and collaborate with the Iowa Department of Public Health (IDPH) Immunization Program to increase reporting of all vaccines proven to reduce the risk of cancer in the **Immunization Registry Information System** (IRIS).
- **G** Add the HPV vaccine to physician-recommended vaccines at wellness checkups for recommended populations.
- **H** Collaborate with school- and university-based clinics to offer the HPV vaccine.
- **I** Encourage providers to strongly recommend the HPV vaccine as a cancer prevention vaccine.
- **J** Reduce missed clinical opportunities to recommend and administer the HPV vaccine.

DATA TARGETS

Increase routine vaccination coverage levels for adolescent boys and girls aged 13 to15.

Percentage of boys and girls aged 13-15 in the IRIS system that have up-to-date 3-1-2-1-2 coverage. (Source: Iowa Immunization Program Annual Report 2016[33])

58.0%	63.8%
2016 BASELINE	2022 GOAL

Increase number of adolescents vaccinated against hepatitis B.

Percentage of adolescent boys and girls aged 13-15 in the IRIS system who have completed the Hepatitis B vaccine doses. (Source: Iowa Immunization Program Annual Report 2016[33])

89.0%	97.9%
2016 BASELINE	2022 GOAL

Increase number of children aged 2 years vaccinated against hepatitis B.

Percentage of boys and girls aged two in the IRIS system who have completed the Hepatitis B vaccine doses. (Source: Iowa Immunization Program Annual Report 2016[33])

87.0%	95.7%
2016 BASELINE	2022 GOAL

Increase number of boys and girls aged 13 to 15 vaccinated against HPV.

Percentage of adolescent boys and girls aged 13-15 in the IRIS system who have completed the HPV vaccine doses. (Source: Iowa Immunization Program Annual Report 2016[33])

27.0%	29.7%
2016 BASELINE	2022 GOAL

Goal 6

Increase protective behaviors from sun/ ultraviolet (UV) exposure.

ACTIONS

- **A** Increase awareness of the harms of ultraviolet exposure.
- **B** Increase availability of sunscreen at outdoor events.
- **C** Increase targeted skin cancer education for Iowans who work outside.
- **D** Decrease the use of tanning beds.
- **E** Increase public education about the harms of exposure to ultraviolet light from tanning beds.
- **F** Increase the number of schools that educate children about the risks of sun/ultraviolet exposure using evidence-based programs.
- **G** Advocate for prohibiting the use of tanning beds for all Iowans under the age of 18.
- **H** Promote policies that advance sun/ ultraviolet safety measures such as the use of sunglasses, hats, sun shades, trees, and/or other protective means.

The American Cancer Society recommends taking the following steps to stay safe in the sun:

- Cover up.
- Use a broad-spectrum sunscreen with an SPF 30 or higher.
- Seek shade.
- Avoid tanning bed and sunlamps.

For more information on sun safety visit: https://www.cancer.org/healthy/be-safe-in-sun.html

DATA TARGETS

Decrease the **age-adjusted incidence** per 100,000 for skin melanoma.

Skin Melanoma **incidence** has been on an upward trend. While the 2022 target is higher than the baseline, it is a reduction of the projected 2022 rate. (See Table 1) (Source: State Health Registry of Iowa[3])

2012-2014 BASELINE	2022 GOAL
24.9	27.5

Decrease the **age-adjusted mortality** per 100,000 for skin melanoma.

(Source: State Health Registry of Iowa[3])

2012-2014 BASELINE	2022 GOAL
2.9	2.7

Decrease the percentage of high school students who use an indoor tanning device such as a sunlamp, sunbed or tanning booth one or more times during the past 12 months.

Baseline and targets are not included because this data is not currently collected in Iowa. (Source: Youth Risk Behavior Survey)

2018 BASELINE	2022 GOAL
TBD%	TBD%

Decrease the percentage of high school students who most of the time or always wear sunscreen with an SPF 15 or higher when they are outside for more than one hour.

Baseline and targets are not included because this data is not currently collected in Iowa. (Source: Youth Risk Behavior Survey)

2018 BASELINE	2022 GOAL
TBD%	TBD%

To view Paula's story visit
www.canceriowa.org/stories

I use my story to talk to kids and teens about sun-safety and tanning bed dangers. Melanoma is highly treatable if caught in its earliest stages. In our small town, you can ask anyone if they've been to the dermatologist in the past year and they'll say 'yes.'

Paula Schnack
Cancer Survivor
Oakland, Iowa

Goal 7

Decrease exposure to radon and other environmental substances linked to cancer.

ACTIONS

- **A** Increase the percentage of Iowans who test their homes for **radon** and mitigate when needed.*
- **B** Educate the public, health care providers, public health officials, schools, property owners and managers and policy makers about **radon** and other environmental substances linked to cancer.
- **C** Collaborate with cities and housing departments to develop initiatives that provide financial assistance for **radon** testing and mitigation.
- **D** Develop and support cross-sector initiatives that increase home **radon** testing and mitigation.
- **E** Require **radon** testing and mitigation in schools, multi-housing units, rental housing and new construction.
- **F** Require newly constructed homes and buildings to be built using **passive radon control methods** according to the **2015 International Residential Building Code**.[34]
- **G** Support research and funding to increase the evidence for environmental cancer risks.[35]
- **H** Support initiatives that reduce environmental exposures to substances or chemicals linked to cancer.

*EPA strongly recommends that you fix your home if your test shows 4 picocuries (pCi/L) or more. If your test shows between 2 and 4 pCi/L, consider fixing.[36]

DATA TARGETS

Decrease the **age-adjusted incidence** per 100,000 for lung cancer.

(Source: State Health Registry of Iowa[3])

63.2	49.1
2012-2014 BASELINE	2022 GOAL

Decrease the **age-adjusted mortality** per 100,000 for lung cancer.

(Source: State Health Registry of Iowa[3])

45.3	41.7
2016 BASELINE	2022 GOAL

Increase the percent of households who have tested for **radon** gas.

(Source: TBD)

TBD%	TBD%
2016 BASELINE	2022 GOAL

Increase the number of home mitigations performed by certified contractors.

(Source: TBD)

TBD	TBD
2016 BASELINE	2022 GOAL

My mom never really said the C word… we knew what she had because she had a lumpectomy, but we didn't know her family history at all. When Shae found out she had breast cancer, one of the things she was upset about was not knowing her family history… we need to make sure everyone knows their family history.

Cathy Ketton Founder of Splash of Color Cancer Support Group and mother of Niisha and ShanQuiesha Robinson breast cancer survivors and advocates. Waterloo, Iowa

To view Cathy, Niisha and ShanQuiesha's story visit: www.canceriowa.org/stories

Goal 8

Increase access to cancer risk assessment and genetic counseling services.

ACTIONS

- **A** Increase education and awareness of **genetic counseling** and testing and their roles in providing information on cancer risk management, screening and treatment.
- **B** Encourage health insurance plans to cover **cancer risk assessment** and **genetic counseling** services.
- **C** Encourage providers to discuss family history with patients to inform better screening recommendations and determine if **genetic counseling** is appropriate.
- **D** Increase advocacy and funding for cancer genetic research.
- **E** Advocate for an increased focus on genetic/genomic education for providers through initial training and continued education.
- **F** Promote **Advanced Genetics Nursing-Board Certified** (AGN-BC) and Certified Genetic Counselor (CGC) credentialing to increase access to providers trained in cancer **genetic counseling**.
- **G** Advocate for the licensing of genetic counselors in Iowa.

DATA TARGETS

Increase the number of licensed Genetic Counselors in Iowa.

Currently the state of Iowa does not license genetic counselors; the target established is based on the number of certified genetic counselors at time of print. (Source: National Society of Genetic Counselors[37])

0 COUNSELORS	19 COUNSELORS
2016 BASELINE	2020 GOAL

Goal 9

Increase understanding of and adherence to recommended cancer screening guidelines.

ACTIONS

- **A** Educate the public about the importance of cancer screening guidelines.*
- **B** Increase screening rates among populations who are eligible.
- **C** Increase access to recommended cancer screenings.
- **D** Encourage workplaces to educate employees about regular cancer screenings.
- **E** Promote and support programs that provide free or low-cost recommended screenings to people who are **uninsured** or **underinsured**.
- **F** Encourage providers, clinics and systems to use evidence-based strategies, such as system-based patient reminder tools, to increase cancer screenings.

* Two sources of evidence-based cancer screening guidelines are:

1. The **American Cancer Society**
   www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html
2. **The United States Preventive Services Taskforce**[72]
   www.uspreventiveservicestaskforce.org/BrowseRec/Index

DATA TARGETS

Increase the percent of women between 50-74 years of age who have had a mammogram in the past two years.

(Source: BRFSS 2016[21])

2016 BASELINE	2022 GOAL
77.6%	85.4%

Increase the percent of people age 50-75 years of age who had a colorectal screening test.

Proportion of people 50-75 years of age with stool test in past year OR colonoscopy within past 10 years OR sigmoidoscopy within past five years. (Source: BFRSS 2016[21])

2016 BASELINE	2022 GOAL
68.6%	80.0%

Increase the percent of women age 21 years and older who had a Pap test within the past three years.

Proportion of women 21 years of age and older who have had a Pap test in past three years. (Source: BFRSS 2016[21])

2016 BASELINE	2022 GOAL
81.6%	89.8%

I've had people tell me they're not going to get a colonoscopy. If you knew somebody who has died from [colorectal cancer] and you know they could have been screened…all of a sudden that prep is not such a big deal… because it can literally change your life.

David McCluskey
Cancer Survivor
West Des Moines, Iowa

To view David's story visit www.canceriowa.org/stories

Goal 10

Increase access to quality cancer care and services.

ACTIONS

- **A** Increase availability of culturally and linguistically appropriate cancer education materials.
- **B** Increase access to transportation and lodging resources available to cancer patients and their families.
- **C** Increase available clinical hours for cancer screenings, treatment and other services.
- **D** Increase availability of **telemedicine** services and infrastructure.
- **E** Increase access to genetic tumor testing to identify the most appropriate treatment for patients.
- **F** Increase availability of targeted therapy treatment options.
- **G** Provide free or reduced-cost cancer services for **underinsured** or **uninsured** Iowans.
- **H** Increase patient access to copay and financial counseling assistance.
- **I** Increase in-person translation services available to all patients and families requesting them.

DATA TARGETS

Increase the percentage of survivors living 5 years after their initial cancer diagnosis.

Percentage of people who survived at least 5 years after their cancer diagnosis, Iowa, 2007-2010 (Source: State Health Registry[3])

2007-10 BASELINE	2022 GOAL
66.4%	73.0%

Maintain the number of American College of Surgeons approved cancer programs in Iowa.

(Source: American College of Surgeons Commission on Cancer[38])

2016 BASELINE	2022 GOAL
14 PROGRAMS	14 PROGRAMS

Decrease the percentage of Iowans with no health insurance.

(Source: U.S. Bureau of the Census, Health Insurance Coverage in the United States: 2015 Current Population Reports. 2016[39])

2015 BASELINE	2022 GOAL
5%	0%

See table 1 for more **incidence** and **mortality** data targets.

I had to travel three and a half hours for treatment. We had to plan trips [to the hospital] as smart as we could. It takes a lot out of you and those expenses add up.

Meg Beshey
Cancer Survivor
Fort Dodge, Iowa

To view Meg's story visit www.canceriowa.org/stories

Goal 11

Increase the number of oncology and other health care providers trained and practicing in Iowa.

ACTIONS

- **A** Advocate for competitive salaries in Iowa for oncology and other health care providers involved in **cancer control**.
- **B** Support continuing education opportunities for oncology and other health care providers involved in **cancer control**.
- **C** Increase the number of research scientists, including basic researchers and other professionals involved in population science research.
- **D** Increase the number of health systems that reimburse tuition for health care providers practicing in Iowa.
- **E** Increase the number of oncology and other health care providers in **cancer control** who move to Iowa to practice.
- **F** Support self-care practices for health care providers, including resiliency training and physical and mental well-being.

DATA TARGETS

Increase the number of community health workers, cancer patient navigators and cancer care coordinators in the workforce.

(Source: TBD)

Goal 12

Increase awareness of and participation in cancer research, including clinical trials, focused on cancer prevention, early detection and treatment.

*Several groups in Iowa including the NCI Community Oncology Program (NCORP) and The University of Iowa Holden Comprehensive Cancer Center participate in the NCI's **National Clinical Trials Network** (NCTN). Population-based and observational clinical research studies are also being conducted across the state of Iowa. Data from some of these studies allows for monitoring the burden of cancer in the state.

In addition to the activities above, the Holden Comprehensive Cancer Center does basic cancer research and conducts first-in-human clinical trials.

This research was valuable in identifying the **cancer control** priorities described in this plan.

For more information on the NCTN, visit www.cancer.gov/research/areas/clinical-trials/nctn

For more information on NCORP, visit www.ncorp.cancer.gov

For more information on NCI-designated cancer centers, visit www.cancer.gov/research/nci-role/cancer-centers

ACTIONS

- **A** Support all phases of cancer research across the state including laboratory research, clinical trials and population research.*
- **B** Expand reach of community oncology practices clinical research programs through increasing the reach of NCI clinical trial networks.
- **C** Link clinical research efforts of Iowa's NCI-designated Holden Comprehensive Cancer Center at the University of Iowa with collaborating practices throughout the state for access to emerging treatment and **interventions** offered through clinical trials.
- **D** Develop and disseminate education campaigns to inform the public about research, including clinical trials.
- **E** Create a statewide clinical trials database.
- **F** Increase accessibility of cancer clinical trials to all cancer patients.
- **G** Support policies and systems changes that expand access to and use of cancer clinical trials.
- **H** Build or sustain **coalitions** with key stakeholders to enhance support for cancer research and the availability of cancer clinical trials.
- **I** Increase collaboration between researchers to better translate research findings into practice.

DATA TARGETS

Increase the number of open cancer clinical trials in Iowa.

(Source: ClinicalTrials.gov[41]
Search Criteria: TBD
Condition/Disease: Cancer
Country: United States
State: Iowa
Find a study to participate in)

253 TRIALS	278 TRIALS
2016 BASELINE	2022 GOAL

Number of Cancer Centers in Iowa reporting open clinical trials and number patients participating in clinical trials to a statewide clinical trials database.[38, 40]

(Source: TBD)

0 CENTERS	14 CENTERS
2016 BASELINE	2022 GOAL

Goal 13

Increase access to and awareness of quality-of-life services available to cancer patients during and after cancer treatment.

ACTIONS

- **A** Increase financial assistance programs and resources for cancer patients, families and caregivers.
- **B** Educate health care providers on financial resources available to patients.
- **C** Educate the public and providers on the benefits of advance care plans.
- **D** Educate health care providers, patients, caregivers and the community on the benefits of **hospice care**.
- **E** Educate health care providers, patients, caregivers and the community on the benefits of starting **palliative care** at the time of a cancer diagnosis.
- **F** Encourage payers to provide coverage for transportation and mental health care for cancer patients, families and caregivers.
- **G** Increase access to **palliative care** services for all cancer patients and increase access to hospice services for patients facing end of life.
- **H** Increase awareness and use of **survivorship care plans**.
- **I** Increase patient and caregiver awareness of and access to **psychosocial**, wellness, financial, sexual, spiritual, rehabilitation and community-based support services.
- **J** Train health care providers on how to communicate difficult information, including end-of-life conversations.
- **K** Educate health care providers on the importance of early and regular conversations with patients on goals of care, including patients' cultural preferences.
- **L** Educate health care providers, patients, families and communities on the specific and unique needs of **cancer survivors**, including sexual health, physical activity, nutrition, fertility, depression and anxiety.
- **M** Encourage providers to recognize and address unique needs of childhood, adolescent and young adult cancer population including **survivorship**, late effects of treatment, employment, education and financial barriers.
- **N** Implement best practices for transition from active cancer treatment to post-treatment care and hospice services.
- **O** Increase resources and support for the unique needs of caregivers.

DATA TARGETS

Increase the number of Iowa hospitals with a **palliative care** program.

(Source: Center to Advance Palliative Care 2015, America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals.[42])

2015 BASELINE	2022 GOAL
B	A

Maintain the state grade for pain policies.

(Source: Pain & Policy Studies Group 2013, Achieving Balance in State Pain Policy: A Progress Report Card[43])

2015 BASELINE	2022 GOAL
A	A

It's hard to have to realize that the person who had been your foundation and had been taking care of you your whole life; now you have to do that for them. But it's something I was so glad I was able to do for my mom.

Jill Lightfoot
Caregiver and Physician
Bettendorf, Iowa

To view Jill's story visit
www.canceriowa.org/stories

Goal 14

Improve the health equity of cancer control interventions and services.

ACTIONS

- **A** Identify and change institutional and structural systems that promote or reinforce activities, behaviors, attitudes and/or biases that contribute to inequitable cancer outcomes.
- **B** Promote the use of evidence-based strategies and activities to reduce bias, discrimination and racism in health care settings.
- **C** Support initiatives that provide training and education about the impact of discrimination and racism on Iowans navigating health care, including topics related to **cultural humility**, privilege and power dynamics.
- **D** Increase representation and engagement of marginalized people in the development and implementation of **cancer control** activities.
- **E** Increase the number of culturally specific health care settings.[44]
- **F** Increase the use of health literate practices in all **cancer control** activities.[45]
- **G** Address social determinants of health in project and **intervention** planning.

DATA TARGETS

Increase number of Iowa Cancer Consortium member organizations who predominately serve minority populations to inform culturally-specific **cancer control** and prevention activities.[46]

(Source: Iowa Cancer Consortium Wild Apricot Membership Database)

Goal 15

Increase access to cancer-related data, and educate Iowans on ways to apply data to cancer control activities.

ACTIONS

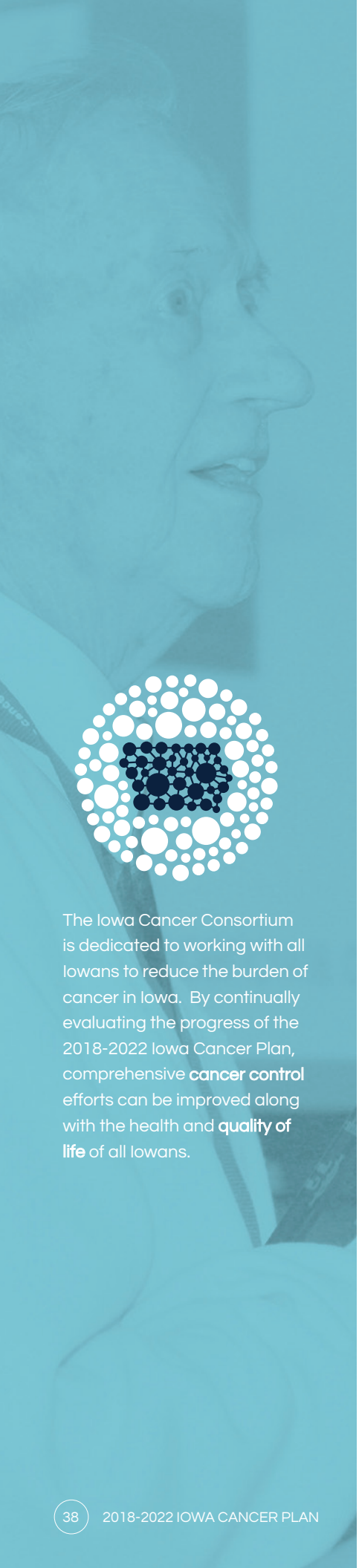
- A Promote analysis of current data-collection systems to better identify existing data gaps and disparities within Iowa communities.
- B Encourage data sharing across organizations that track risk factors and diseases linked to cancer.
- C Educate **cancer control** partners on available data sources and methods of interpreting data to inform **cancer control** programs and initiatives.
- D Standardize the collection and reporting of **race**, ethnicity, preferred language and country of origin for cancer-related datasets.[47]
- E Engage under-represented communities in identifying critical data gaps.[30]

DATA TARGETS

Number of Iowa Cancer Plan goals that have meaningful measures of success.

(Source: Iowa Cancer Plan 2018-2022)

14 GOALS	15 GOALS
2017 BASELINE	2022 GOAL



The Iowa Cancer Consortium is dedicated to working with all Iowans to reduce the burden of cancer in Iowa. By continually evaluating the progress of the 2018-2022 Iowa Cancer Plan, comprehensive **cancer control** efforts can be improved along with the health and **quality of life** of all Iowans.

Evaluation Plan

The Iowa Cancer Consortium, along with its partners, recognize that evaluation is an important part of measuring progress towards reducing the burden of cancer.

The Consortium has developed a five year evaluation plan to measure the impact of the 2018-2022 Iowa Cancer Plan. The data targets within the plan provide a simple way of evaluating progress. However, some goals have no associated data measure, which creates a unique challenge in measuring progress. Targets for these goals have been created that call for the identification, collection and reporting of data that can be used as baselines in the future.

The Iowa Cancer Plan will be evaluated following guidelines recommended in the CDC's Comprehensive **Cancer Control** Branch Program Evaluation Toolkit which outlines three main focus areas:

- Partnerships: the quality, contributions and impacts of your comprehensive **cancer control coalition**.
- Plan: the quality and implementation of the statewide comprehensive **cancer control** plan.
- Program: the extent to which **interventions** outlined in your comprehensive **cancer control** plan are executed and yield intended results.[48]

Glossary

2015 INTERNATIONAL RESIDENTIAL BUILDING CODE: Created by The International Code Council to set standards and codes used to construct residential and commercial buildings. This document outlines **radon mitigation** standards, primarily for new building construction.[26] For more information, visit: https://up.codes/viewer/general/int_residential_code_2015/chapter/F#F

AGE-ADJUSTED: Also known as age standardization. It is a technique used to allow populations to be compared when the ages of populations being compared are different.

ADVANCE CARE PLANNING: Making decisions about the care a person would prefer if they were eventually unable to speak for themselves. These decisions are based on personal values, preferences and discussions. For more information, visit https://www.nhpco.org/advance-care-planning.

ADVANCED GENETICS NURSING-BOARD CERTIFIED (AGN-BC): Credentials given to licensed professional nurses with special education and training in genetics.

ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP): A group of medical and public health experts who develop recommendations on the use of vaccines in the United States. The recommendations stand as public health guidance for safe use of vaccines and related biological products.[50] For more information, visit https://www.cdc.gov/vaccines/acip/about.html.

ALCOHOL OUTLET DENSITY: Applying licensing or zoning regulations to reduce the number of businesses who can sell alcohol in a given area.

AMERICAN CANCER SOCIETY: A global grassroots organization of 2 million volunteers whose mission is to save lives, celebrate lives, and lead the fight for a world without cancer.[51] To learn more visit www.cancer.org

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS): "The nation's premier system of health-related telephone surveys that collect state data about United States residents regarding their health-related risk behaviors, chronic health conditions and use of preventive services."[52] For more information, visit https://www.cdc.gov/brfss/index.html.

CANCER BURDEN: A measure of the **incidence** of cancer within the population and an estimate of the financial, emotional or social impact it creates.

CANCER CARE PLAN: A plan of professional clinical activities developed to describe the treatment regimen and arrangements for a person with cancer.

CANCER CONTINUUM: Also called the **Cancer Control** Continuum. The term describes the delivery of care throughout prevention, detection/screening, diagnosis, treatment, **survivorship** and end of life. An individual may move forward and back along the continuum several times before staying in survivorship or progressing to end of life.

CANCER CONTROL: A public health approach aimed at reducing the burden of cancer in a population. This is done using evidence-based and cost-effective **intervention**s throughout the **cancer continuum** to ultimately reduce suffering to patients and their families.

CANCER RISK ASSESSMENT: Usually divided into two major categories: assessment of familial or genetic risk and assessment of environmental factors that may be causally related to cancer. Evaluation of familial risk should include both maternal and paternal lineages, with specific attention to cancers that co-exist in known hereditary cancer syndromes. Evaluation of environmental factors should focus on assessment of known modifiable factors, such as smoking, obesity, diet and physical activity.[53]

CANCER SURVIVOR: Anyone affected by cancer, including the individual diagnosed, family, friends and caregivers.

COALITION: A group or groups of people who have joined together for a common purpose.

CHRONIC HEAVY DRINKING: Having more than four drinks on any day for men and more than three drinks on any given day for women. It is also defined as greater than 14 drinks per week for men and seven drinks per week for women.[18] For more information, visit https://www.rethinkingdrinking.niaaa.nih.gov/How-much-is-too-much/Is-your-drinking-pattern-risky/Whats-At-Risk-Or-Heavy-Drinking.aspx

CLINICAL TRIAL: A type of research study that tests how well new medical approaches work in people. These studies test new methods of screening, prevention, diagnosis or treatment of a disease.

COMPLETE STREETS: Streets designed to enable safe access for all users. They may include bike lanes, sidewalks, bus lanes, frequent and safe crossing opportunities and median islands.

CREED: A system of religious beliefs.

CULTURAL HUMILITY: "Ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]."[54] For more information, visit http://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility.aspx.

E-CIGARETTES: Electrical devices that mimic the act of smoking tobacco and create an inhaled mist. Also known as electronic cigarettes, they are marketed as a smoking-cessation tool, but may have negative health effects.

EVIDENCE-BASED PUBLIC HEALTH: The development, implementation and evaluation of effective programs and policies in public health. This is done through the application of principles of scientific reasoning. Evidence-based public health includes the appropriate use of behavioral science theory and program planning models.

FOOD DESERT: Areas in the country where there is limited access to affordable and nutritious foods.

FOOD SWAMP: A place where unhealthy foods are readily available and there is a disproportionate amount of advertising for unhealthy foods.

GENDER IDENTITY: One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.[55] For more information, visit http://www.hrc.org/resources/sexual-orientation-and-gender-identity-terminology-and-definitions.

GENETIC COUNSELING: A communication process between a specially trained health professional and a person concerned about the genetic risk of disease. The person's family and personal medical history may be discussed, and counseling may lead to **genetic testing**.[56]

GENETIC TESTING: "The use of a laboratory test to look for genetic variations associated with a disease. The results of a genetic test can be used to confirm or rule out a suspected genetic disease or to determine the likelihood of a person passing on a mutation to their offspring." [57]

HEALTH DISPARITIES: "A particular type of health difference that is closely linked with social, economic and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; **sexual orientation** or **gender identity**; geographic location; or other characteristics historically linked to discrimination or exclusion." For more information, visit https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities.

HEALTH EQUITY: "The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices and the elimination of health and health care disparities."[42] For more information visit https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities.

HEALTH LITERACY: "The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."[30] For more information, visit: https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication

HEALTH POLICY: Decisions, plans and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people.[59] For more information, visit http://www.who.int/topics/health_policy/en/.

HOSPICE CARE: Providing humane and compassionate care focusing on the **quality of life** rather than the length of life, it includes care for people in the last phases of incurable disease so that they may live as fully and comfortably as possible.[60] For more information, visit https://www.cancer.org/treatment/finding-and-paying-for-treatment/choosing-your-treatment-team/hospice-care/what-is-hospice-care.html.

HUMAN PAPILLOMAVIRUS (HPV): There are more than 100 types of HPV that can infect the genital areas, mouths, and throats of males and females. Nearly all cervical cancers are caused by HPV.

IMMUNIZATION REGISTRY INFORMATION SYSTEM (IRIS): A computerized tracking program that documents immunizations for children, adolescents and adults who are seen in a variety of public and private health care provider sites throughout the state. The IRIS program is able to document individual immunizations, track vaccine usage and vaccine distribution.[61] For more information, visit https://idph.iowa.gov/immtb/immunization/iris

INCIDENCE: The occurrence, rate or frequency of disease.

INTERVENTION: An action taken to improve a situation. In this plan, intervention usually refers to an action taken by public health or health care professionals to improve health.

LATE EFFECTS: Health problems that occur months or years after cancer treatment is completed.[71] For more information, visit https://www.cancer.gov/types/childhood-cancers/late-effects-pdq.

MEDICAL HOME: An approach to providing comprehensive primary care. It is a health care setting that facilitates partnerships between patients, physicians and caregivers. Also known as a Patient-Centered Medical Home.

MISSED CLINICAL OPPORTUNITY: "A clinical encounter where the patient received at least one adolescent vaccination, but not another."[62] For more information, visit http://www.sciencedirect.com/science/article/pii/S240585211630012X.

MORTALITY: "The relative frequency of deaths in a specific population."[63]

NATIONAL CANCER INSTITUTE (NCI): The National Cancer Institute is part of the National Institutes of Health (NIH), which is part of the federal government. NCI offers many services for **cancer survivor**s including the Cancer Information Service.

NATIONAL CLINICAL TRIALS NETWORK (NCTN): Previously known as the NCI **Clinical Trials** Cooperative Group Program, the NCTN is a **National Cancer Institute** (NCI) program that gives funds and other support to cancer research organizations to conduct cancer clinical trials. The NCTN helps these organizations develop new clinical trials and manage their regulatory, financial, membership, and scientific committees. It also helps with statistics and data management, Institutional Review Boards (IRBs), and patient tissue sample collection and storage. This support allows researchers to conduct trials that focus on specific cancers and patient populations and new treatment methods.[64] For more information, visit https://www.cancer.gov/research/areas/clinical-trials/nctn.

NCI COMMUNITY ONCOLOGY RESEARCH PROGRAM (NCORP): A national network of cancer care investigators, providers, academia and other organizations that brings cancer prevention clinical trials and cancer care delivery research (CCDR) to people in their communities.[65] For more information, visit https://ncorp.cancer.gov/

NCI-DESIGNATED COMPREHENSIVE CANCER CENTER: A designation given to a cancer center from the **National Cancer Institute**'s Cancer Centers Program. NCI-Designated Cancer Centers are recognized for their scientific leadership, resources, and the depth and breadth of their research in basic, clinical and/or population science. Comprehensive Cancer Centers demonstrate an added depth and breadth of research, as well as substantial transdisciplinary research that bridges these scientific areas.[66] For more information, visit https://www.cancer.gov/research/nci-role/cancer-centers

NICOTINE REPLACEMENT THERAPY (NRT): The use of chewing gum, patches, sprays, inhalers or lozenges that contain nicotine, but do not contain other harmful chemicals in tobacco. NRT helps tobacco users quit using tobacco and can help relieve some withdrawal symptoms associated with efforts to quit using tobacco.

PALLIATIVE CARE: Care given to improve the **quality of life** of patients who have a serious or life-threatening disease. The goal of palliative care is to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment. Also called comfort care, supportive care and **symptom management**.

PASSIVE RADON CONTROL METHODS: Typically installed during the construction of new homes, a passive **radon** control system is a vent pipe extending from the sub-slab gravel up through the roof. It uses natural pressure differentials and air currents to mitigate radon.

PSYCHOSOCIAL: Describes the psychological, social and spiritual aspects of human activity.

QUALITY OF LIFE: The overall enjoyment of life, including an individual's sense of wellbeing and ability to carry out various activities.

QUITLINE IOWA: A statewide toll-free evidence-based smoking-cessation hotline.[67] For more information, call 1-800-QUIT-NOW (1-800-784-8669), or visit https://www.quitlineiowa.org/.

RACE: A socially constructed classification of humans into groups based on physical traits, ancestry, genetics, social relations or the relations between those groups.

RADON: A radioactive gas found in outdoor and indoor air at various concentrations. It is the second leading cause of lung cancer after smoking and the number-one leading cause of lung cancer among non-smokers.

RADON MITIGATION: Any process or action that is done to reduce radon levels in a building or home.

SECONDHAND SMOKE: A mixture of two forms of smoke that come from burning tobacco: side stream smoke and mainstream smoke. Side stream smoke comes from the end of a lighted cigar, pipe, or cigarette. Mainstream smoke is exhaled by a smoker.

SEXUAL ORIENTATION: An inherent or fixed emotional, romantic or sexual attraction to other people.[39] For more information, visit http://www.hrc.org/resources/sexual-orientation-and-gender-identity-terminology-and-definitions.

SMOKEFREE AIR ACT: In 2008, the Iowa legislature passed a law to protect employees and the general public from **secondhand smoke**. The act prohibits smoking in almost all public places, enclosed areas within places of employment, and some outdoor areas. For more information, visit https://smokefreeair.iowa.gov/.

SMOKING CESSATION: Discontinuing the practice of smoking.

SURVEILLANCE, EPIDEMIOLOGY AND END RESULTS (SEER): A **National Cancer Institute** (NCI) cancer statistics program that provides information on cancer data in an effort to reduce the **cancer burden** among the United States population. For more information, visit https://seer.cancer.gov/[69]

SURVIVORSHIP: In cancer, survivorship covers the physical, **psychosocial** and economic issues of cancer, from diagnosis until the end of life. It focuses on the health and life of a person with cancer beyond the diagnosis and treatment phases. Survivorship includes issues related to the ability to get health care and follow-up treatment, late effects or long-term effects of treatment, second cancers and **quality of life**. Family members, friends, and caregivers are also part of the survivorship experience.

SURVIVORSHIP CARE PLAN: The **survivorship** care plan describes any ongoing issues that need to be addressed, and describes the cancer care the patient received. In other words, the Survivorship Care Plan includes the treatment plan and treatment summary, as well as information on follow-up care and ongoing concerns.[70] For more information, visit https://www.journeyforward.org/what-is-cancer-survivorship-care-planning.

SYMPTOM MANAGEMENT: Care given to improve the **quality of life** of patients who have a serious or life-threatening disease. The goal of symptom management is to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment. Also called comfort care, **palliative care** and supportive care.

TELEMEDICINE: The use of telecommunications technology to diagnose and treat patients remotely.

UNDERINSURED: Having inadequate health insurance coverage.

UNINSURED: Not covered by health insurance.

UNITED STATES PREVENTIVE SERVICES TASKFORCE (USPSTF): An independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive service.[72] For more information, visit https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/index.html

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Iowa Cancer
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of Public Health

CCRAB MEMBERSHIP UPDATE

FLORIDA CCRAB MEMBERSHIP

(AS OF MAY, 2018)

NAME	APPOINTED BY/REPRESENTATIVE OF	TERM YEARS
Jessica Bahari-Kashani, MD	Florida Medical Association	2014 - 2018
Robert Cassell, MD, Ph.D.	Association of Community Cancer Centers	2014 - 2018
Asher Chanan-Khan, MD	Florida Hospital Association	2014 - 2018
Christopher Cogle, MD	Senate President	2014 - 2018
Representative Jamie Grant	House Speaker	2017 - 2021
Clement Gwede, Ph.D., MPH, RN	Moffitt Cancer Center	2016 - 2020
Lawrence Hochman, DO, FACRO, MHSA	Florida Osteopathic Medical Association	2014 - 2018
Erin Kobetz, Ph.D., MPH	Sylvester Comprehensive Cancer Center University of Miami	2014 - 2018
Duane Mitchell, MD, Ph.D.	University of Florida Shands Cancer Center	2016 - 2020
Celeste Philip, MD, MPH	N/A (Surgeon General)	N/A
Amy Smith, MD	Governor	2014 - 2018
Megan Wessel, MPH	American Cancer Society	2014 - 2018
Senator Dana Young	Senate President	2017 - 2021
Marti Coley Eubanks	House Speaker	2014 - 4/20/2018
Theresa Morrison, Ph.D., MSN, CNS-BC, RN	Florida Nurses Association	2014 - 5/2/2018