



# CANCER CENTER SUMMIT REPORT

A Strategic Look at Cancer Centers and Colorectal Cancer Screening



Washington, DC

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# INTRODUCTION

On October 2nd, 2017, in Washington, DC, the American Cancer Society (ACS) and the National Colorectal Cancer Roundtable (NCCRT) hosted a Cancer Center Summit: A Strategic Look at Cancer Centers and Colorectal Cancer Screening. The purpose of the meeting was to convene representatives from key national and local organizations, including leaders from the National Cancer Institute (NCI), the Centers for Disease Control and Prevention (CDC), and several NCI-designated cancer centers to explore how to leverage the expertise and community presence of cancer centers in the effort to increase CRC screening rates.

**The specific meeting objectives were to:**

- ▶ *Document centers of screening excellence that have leveraged their position as community leaders to increase CRC screening rates for the surrounding community;*
- ▶ *Explore how those cancer centers became leaders in increasing CRC screening rates;*
- ▶ *Identify cancer center best practices for advancing CRC screening;*
- ▶ *Understand cancer center barriers to focusing on CRC screening as a priority issue;*
- ▶ *Identify strategies to overcome barriers so that cancer centers can leverage their role in the community to achieve higher CRC screening rates; and*
- ▶ *Begin the process of developing a strategic plan to spur cancer center action in this area.*

## NCCRT

**The National Colorectal Cancer Roundtable (NCCRT)** works with its member organizations to produce tools and resources and promote collaborations that help to reduce duplication of effort.

The NCCRT also hosts intensive work sessions such as this summit to inform the creation of new strategies, tools, resources, and collaborations.

The work sessions are critical to advancing the NCCRT mission of increasing colorectal cancer (CRC) screening rates.

Cancer centers vary tremendously in their size, their scope, and resources. Some are awash in flexible philanthropy funding, and some have almost none. They vary in the extent of relationships with community-based healthcare settings where screening takes place, which is a central issue today.

In addition, cancer centers are not evenly-distributed geographically across the US, meaning that many communities do not have proximity to cancer center resources and services. Community outreach and engagement has become an important part of the cancer center application for federal funding.

In recent years, cancer center supplements have been funded to support work within the cancer center catchment areas focusing on topics such as increasing HPV vaccination rates and improving smoking cessation services for cancer.

# BARRIERS, NEEDS AND OPPORTUNITIES

## PRE-MEETING SURVEY RESULTS

Prior to the summit, participants took part in a 12-question survey about the role of cancer centers in promoting CRC screening. Responses were received from 24 participants representing 17 groups. Question types were check-all-that-apply or were open-ended.

### What are the roles cancer centers can play in supporting CRC screening in communities?

#### Survey Responses

Promote their knowledge of evidence-based interventions to increase CRC screening and reduce disparities. Share best practices with both healthcare organizations and provider groups.

Collaborate with local health systems and community stakeholders (ACS, gastroenterologists (GIs), Federally Qualified Health Centers (FQHCs), comprehensive cancer coalitions (CCCs), primary care), including those who serve the underserved. Be at the table and ENGAGED. Be present in the community.

Serve as a safety net. Provide accessible facilities for screening, including for underserved. Provide treatment for underserved as community benefit

Provide leadership in provider education/guidelines. Communicate with primary care networks about CRC screening

Educate. Conduct local media campaigns in the catchment area with a culturally-sensitive campaign and reading level, including by reaching their patients and families.

Provide centralized, systematized screening facility that is accessible and welcoming to the community. Be accessible and welcoming, especially in diverse communities; center of excellence.

Use stature to elevate the issue in the community. Collaborate to create a vision/plan for the community/Provide leadership in both the community and at that state level. Embrace role as flagship institution.

Advocate.

Lead by example. Assess own system and implement policy and systems changes/monitor physician performance, including follow up for a positive Fecal Immunochemical Test (FIT). Elevate issue internally.

Collaborate to support navigation/community health educators.

Collaborate on registries; share data with researchers

Conduct coordinated media campaigns. Collaborate with ACS, CDC, NCI, Fight CRC, other cancer centers to promote common messages to the broadest population.

Collaborate on quality initiatives. Link screening efforts with Commission on Cancer (CoC) standards.

## What are some of the biggest challenges that cancer centers face regarding these roles?

### Survey Responses

Competing priorities. Cancer centers do not always have dedicated resources for community outreach/cancer control. Incentive from funders is to focus on scientific/services provided

Funding. How best to cover costs for screening underserved populations), especially in non-Medicaid states. Long wait times. Lack of funding for staff or materials

New role. The traditional focus on treatment/research. Need to go beyond this to understanding the community and screening barriers (transportation, cultural barriers, etc.). Hard to get internal buy-in.

Readiness. Implementation, particularly among marginalized, will require intensive intervention; cancer centers may not be prepared to provide culturally competent outreach.

Developing new relationships. Need to develop new relationships and networks/learn to work collaboratively. Need to learn who has already been working in this space

Not knowing where to start. Less experience is going outside the cancer center "walls." How do they do it, what do they do first, who are potential partners? (Where is a navigator housed?)

Reputation. Some in the community may view the institution as elitist/mistrust. Reputation for disappearing from the community once funding is gone. Research fatigue.

Poor communication/coordination with primary care, even within the same system

Finding a model to adapt what works. Smaller practices may not have resources to adapt strategies cancer centers recommend. Other practices may not welcome CC as they are viewed as "competitors."

Ineffective use of FIT. View colonoscopy as the best test OR FIT interventions may be lacking (require a physical return to the lab, one-day focus on FIT testing, etc.).

Poor metrics. Some CoC metrics exist but are used on non-effective interventions such as health fairs.





### How do we overcome these challenges?

#### Survey Responses

Community presence. Consistent community outreach/presence to build trust, partnerships, and effectiveness. (ACS, CDC's Colorectal Cancer Control Program (CRCCP), CCC).

Make the case. Data showing that increased screening decreases late stage dx and the PN/CHW can reduce no-shows, equating to dollars for the system, etc.

Alignment of priorities. NCI should set specific standards for catchment population and set CRC screening targets for achieving/maintaining Cancer Center status.

Buy-in of leadership/Champions.

Funding. More funding mechanisms from NCI, including cancer center supplements, focused on CRC screening.

Data to show where to start/areas to target; demonstrate their capacity

Focus on reimbursement issues/collaboration with payers

Position cancer center as a leader in the community. Walk the line of being the go-to resource for gold standard info & treatment, and as a team player that will listen to community input.

Embrace screening options to address resource issues.

Encourage cancer centers to share models and methods to increase CRC screening.

*The full set of survey responses can be found in [Appendix B: Barriers, Needs, and Opportunities](#) on page 47.*

# EXCELLENCE IN ADVANCING CRC SCREENING - CANCER CENTER CASE STUDIES

## MD ANDERSON: CANCER PREVENTION AND CONTROL PLATFORM

**Ernest Hawk, MD, MPH**

MD Anderson, Vice President, Division Head Cancer Prevention and Population Sciences

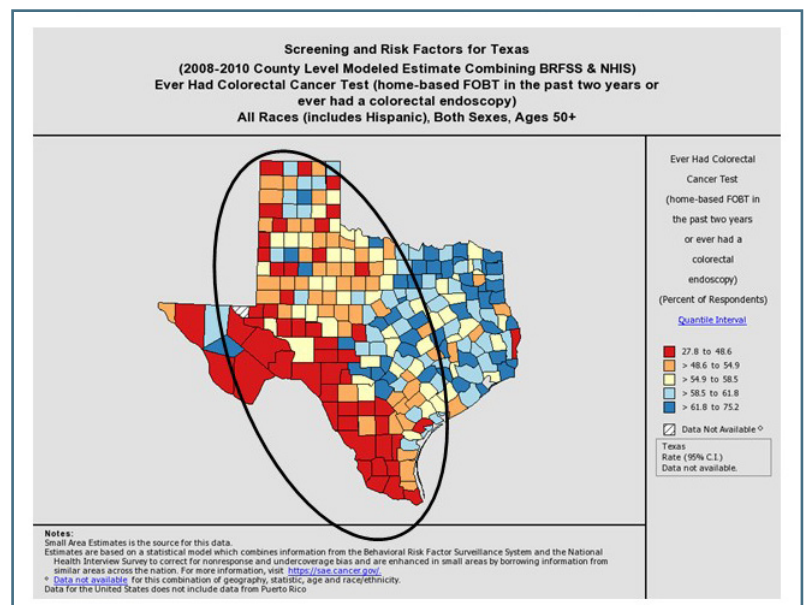
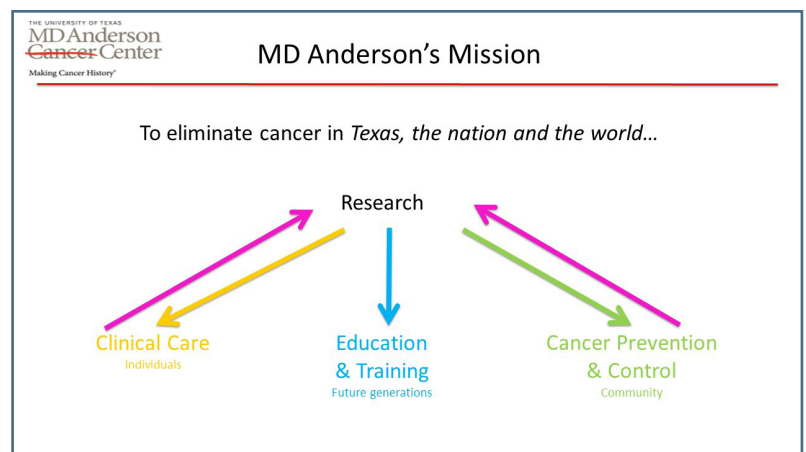
The goal of the MD Anderson Cancer Center is to eliminate cancer in Texas, the nation, and the world. In contrast to traditional academic medical center models that embrace three areas of service – research, clinical care, education, and training – MD Anderson has added a fourth domain of cancer prevention and control. That additional domain prioritizes implementation and dissemination of evidence-based cancer control actions, including colorectal cancer screening.

Texas has more than two million people who have not been screened. Significant portions of the state have high densities of people who have not been screened (red on the accompanying image indicates areas of 27% to 49% unscreened).

There are also large screening disparities across the state. High-need areas in the west of the state have few medical schools and cancer centers to serve residents.

Lack of support for CRC screening in uninsured populations is a major issue in Texas.

Maintaining communication and follow-up over time is a challenge because many undocumented immigrants return to their hometowns and families living elsewhere (e.g., Mexico) following a serious diagnosis, such as cancer.





## MD Anderson Program to Increase CRC Screening Services for Poor & Underserved Communities

### Program Components

- Partnerships: FQHCs & CHCs
- Patient education - culturally- & linguistically-tailored
- EHR reminder systems
- Clinician/staff education - to identify eligible pts. based on clinical & financial criteria
- Standing orders
- Take-home FIT test (results to clinic & MDACC)
- Patient navigation
- Referral to community endoscopists for diagnosis
- Funded thru Medicaid Waiver & CPRIT prev. grant
- Medicaid Health Plan (Community Health Choice – credentialing, claims) as Third Party Administrator

### Project Staff Navigation Responsibilities

- Partner with ACS team to deliver pt. education
- Track FITs distributed & returned
- Navigate pt referrals for evaluation of+ tests to community GIs for colonoscopy/polyp removal
- F/U pts diagnosed with polyps to arrange further assessment
- Navigate pts diagnosed with cancer to treatment
- Data analysis & reporting to funding agency
- Provide audit & feedback to clinics

Eliminates financial barriers by covering cost of endoscopy & polypectomy



CANCER PREVENTION & RESEARCH  
INSTITUTE OF TEXAS

Delivering screening services to underserved populations of Texas is a challenge because they are often under/uninsured, may be geographically isolated, and may be undocumented. Partnering with entities that already reach and serve such populations has been effective.

MD Anderson has been awarded three grants to fund its control efforts in colorectal cancer screening. Relationships have been established with clinics – largely navigational – that do the initial CRC screening with fecal immunochemical tests (FIT). Grants pay for subsequent diagnostic and therapeutic colonoscopies for patients who have abnormal FIT results.



## Colorectal Cancer Screening - Metrics to Date

Navigation & practice change expanded into 20 clinic systems with 68 sites

Project & Funding Source	FIT-FLU (CPRIT-funded Project)	1115 Waiver Project (43 sites)	ACT (CPRIT-funded Project – 25 sites)	Total
Reporting Dates	2011-2012	10/01/2013 – 9/20/2017	02/22/2016 – 09/20/2017	2011-2017
Total FITs Distributed	900	17,473	3,999	22,372
Total Returned	576 (64%)	11,996 (68.7%)	2562 (64%)	15,134 (67.6%)
Number Positive	22 (3.8%)	722 (6.0%)	194 (7.6%)	938 (6.2%)
Colonoscopies Completed	20	460	113	593
Pts with Polyps Removed	8	264	42	314
Cancers Diagnosed	1	35	7	43

## Project ECHO: Telementoring, not Telemedicine

(Leads - Ellen Baker, MD & Melissa Lopez, MSc)

Connects MD Anderson experts with community providers serving underserved populations to promote skill development & raise self-efficacy in novel areas of medical practice

- Weekly/monthly videoconferences (45 min cases, 15 min didactic)
- Community providers present cases (e.g., patient histories, lab results, treatment plans, challenges)
- Feedback and guidance provided by MD Anderson's (or partners') specialists
- Community providers & specialists forge stronger working relationships toward the shared goal of high-quality care delivery



The ECHO program is a telementoring program that connects cancer center experts with community providers via video conferencing on a recurring basis to build and enhance their knowledge and expertise in the delivery of cancer prevention, screening, and treatment services. The MD Anderson program does not currently provide CRC screening support.

## MD Anderson's Cancer Control Platform

Develop and deliver comprehensive evidence-based strategies (PES) in cancer prevention, screening, early detection and survivorship to achieve a measurable and lasting reduction in the cancer burden, especially among the underserved.

Actions	Expertise	Partners	Funding
<u>P</u> olicies	Gov'l Relations	UT Sister Institutions	Grants
	Health Policy	American Cancer Society	• CPRIT
<u>E</u> ducation – public & professional	Public Education	Harris Health & LBJ Hospital	Medicaid 1115 Waiver
	Professional Education	FQHCs & CHCs	Institutional
<u>S</u> ervices beyond MD Anderson's walls	D&I of Community-based Services	TX Dept State Health Svsc	Philanthropic
	• Tobacco cessation	Cancer Alliance of Texas	• ExxonMobil
	• Nutrition	Texas Medical Association	• Shell Oil
	• Physical activity		• Lyondell Basel
	• Cancer screening		• Jason's Deli
	• Vaccination	Local & nat'l health coalitions	

MD Anderson's Cancer Control Platform focuses on evidence-based actions involving public policies, public/professional education, and services (PES) delivered in the community outside of MD Anderson's walls.

Suggestions to promote CRC screening in NCI-designated cancer centers include:

- Promote, require, and reward broader consideration of disparities
- Define the difference between cancer-related dissemination and implementation research and community engagement in cancer control activities.
- Establish standards for evidence-based cancer control actions (e.g., policies, education, and services) across cancer risk factors, including tobacco cessation, diet and physical activity, cancer screening, risk assessment, alcohol prevention, and ultraviolet safety
- Strengthen the current community outreach and engagement section of the NCI Cancer Center Support Grant (CCSG) for NCI-designated cancer centers.
- Promote more funding for cancer control actions vs. "only" cancer research
- Promote the development and implementation of a national cancer control plan with national goals
- Support evidence-based cancer screening for everyone according to national guidelines, regardless of their individual ability to pay
- Advocate for patient and provider reminders built into electronic health records systems
- Disseminate screening decision support materials to all patients and providers



## THE OHIO STATE UNIVERSITY: COMMUNITY ENGAGEMENT

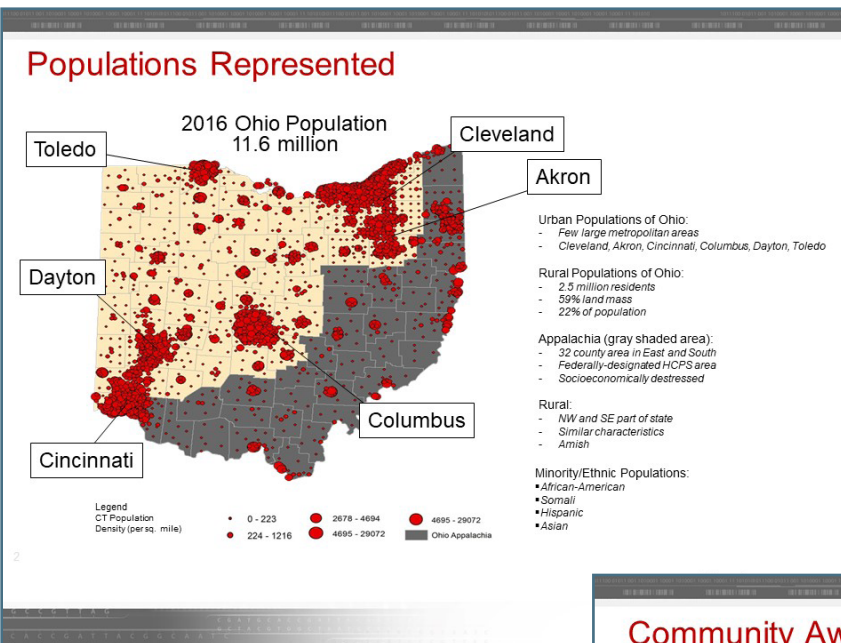
### Electra Paskett, PhD

The Ohio State University, Marion N. Rowley Professor of Cancer Research, Director of the Division of Cancer Prevention and Control

Most of the Ohio State catchment area is rural. Population groups are diverse and include African-American, Amish, Asian, Hispanic, Somali, and Hispanic/Latino.

Three topic areas and initiatives were described: in-house patient navigation practices, a CRC prevention initiative for the clinical community, and a community outreach initiative to promote screening.

The patient navigation program goal was to reduce no-show rates in a variety of participating clinics. For colonoscopy, no-shows were reduced by 80%, from 32% down to 6%. A second goal was to increase adherence to colorectal cancer screening for Medicaid patients upward from the baseline of 40% adherence. Adherence to screening was increased beyond the baseline by 35% and 29% respectively, at two family practice clinics within one year.



The statewide initiative for CRC screening is funded by philanthropy and supports three projects: universal screening for Lynch syndrome, adherence to CRC screening, and studies of the molecular epidemiology of CRC cancer.

Using a giant inflatable super-colon has been effective in outreach programs to increase community awareness of colorectal cancer and screening. Cancer center staff, volunteer physicians, and the students provide the guided tours through the super-colon and implement the events and screenings.

Many people in the catchment area do not get screened for Lynch syndrome (hereditary non-polyposis colorectal cancer) when indicated. They may not be aware of or understand their inherited risk, or may not be able to afford to get screened. Interventions are being tested to explore and address these issues.

### Community Awareness Activities (Center for Cancer Health Equity – CCHE)

- Super Colon (Columbus; Appalachia)
- Provider & Community Engagement Program (PACE)
  - March Colorectal Cancer Awareness Events – Wellness Wednesdays
  - Screening Saturdays (Free Colonoscopies & Patient Navigation)
  - Grocery Store Tours
  - Live Phone Bank and Webchat
  - Cancer Disparities Conference
- S2S – Screen to Save\*
- Men's Health Program\*



\*NCI-funded NON grant activities

Photos Courtesy of Darrell M. Gray, II, MD, MPH

The James

THE OHIO STATE UNIVERSITY  
COMPREHENSIVE CANCER CENTER

## How Do We Do This?

- **Funding:** \*NCI National Outreach Network grant (all populations); ACS Ohio Colorectal Cancer Innovation Grant; Departmental (James) and Philanthropic Funds; Pelotonia; Upper Payment Limit (Medicaid) Funds
- **Staffing:** CCHE Staff and volunteer physicians, staff and students provide guided tours for Super Colon, implement PACE events and screenings, provide outreach and educational sessions on colorectal cancer.
- **CCHE handles the coordination of outreach and Super Colon events and works in conjunction with the GI department for PACE program activities.**
  - **CCHE Staff include:**
    - Faculty Director and Deputy Director
    - Director
    - Program Director
    - Program Managers – Navigation; NON/Training; Immigrant/Refugee communities; Hispanic/Latino community
    - Program Coordinators
    - CHW's – Appalachia, Asian, Hispanic and Somali community
    - Patient Navigators

On Wellness Wednesdays, people can tour a grocery store in Columbus with a doctor. On Screening Saturdays, people who are underinsured or have no insurance from within the state can receive free colonoscopies at the clinic. Every single person, almost 60 people, screened in the first year had a polyp. Online web chats provide forums for discussing colon cancer.

Cancer disparities conferences are held each year at Ohio State University for community providers from throughout the state.

A health program for men that focuses on CRC screening is held as part of the NCI-funded National Outreach Network program.

Many challenges have been overcome to provide free colonoscopies. They include staffing, transportation, following up with no-shows, and arranging to fund bowel preparations.

In addition, the giant colon requires storage space, a large vehicle to transport it, and staff to operate it and clean it.

## Challenges Overcome

- **Free Colonoscopy:** F/up for (+); no-shows; staffing; funding for bowel prep; transportation
- **Community Events in PACE:** Participation
- **Super Colon:** purchase unit; space, staffing
- **S2S:** no additional funding; short time frame; staffing
- **Men's Health:** men to participate; worksites
- **WayFinder:** Integrating into clinic flow; buy-in from clinical staff; access to EHRs
- **Statewide Prevention Program:** slow uptake by clinics; funds for screening and f/up

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## Lesson Learned: Advice for Other Centers

- **Get buy-in from leadership – Center Director**
- **Have a budget, structure, dedicated staff**
- **Use a plan – short and long-term goals**
- **Community partnerships are key**
- **Have staff that represent the populations**
- **Apply for all types of grants to leverage your budget**
- **Take advantage of opportunities**
- **Network with researchers**
- **Evaluate and make course corrections, as needed**

Another challenge is encouraging public awareness and participation in cancer center outreach activities.

The most important lesson learned is that buy-in from the cancer center leadership is critical. Buy-in facilitates having a structure, a budget, and a dedicated staff.

Having a plan and community partnerships are very important. Minority/ethnic staff members who are part of the served populations are also helpful for assuring cultural competence.

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## UNIVERSITY OF CHICAGO: CDC COLORECTAL CANCER CONTROL PROGRAM

### Karen Kim, MD, MS

University of Chicago, Professor of Medicine, Dean for Faculty Affairs Division of the Biological Sciences, Director, Center for Asian Health Equity Director, UCCCC Office of Community Engagement and Cancer Disparities

The catchment area for the Comprehensive Cancer Center includes 9 million people who live in 10 counties that provide 81% of new cancer patients.

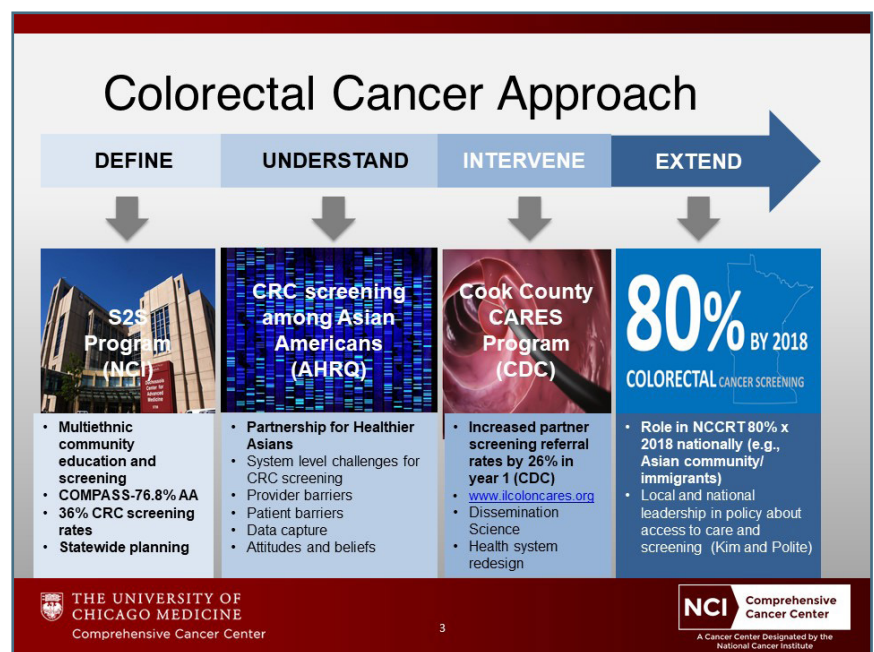
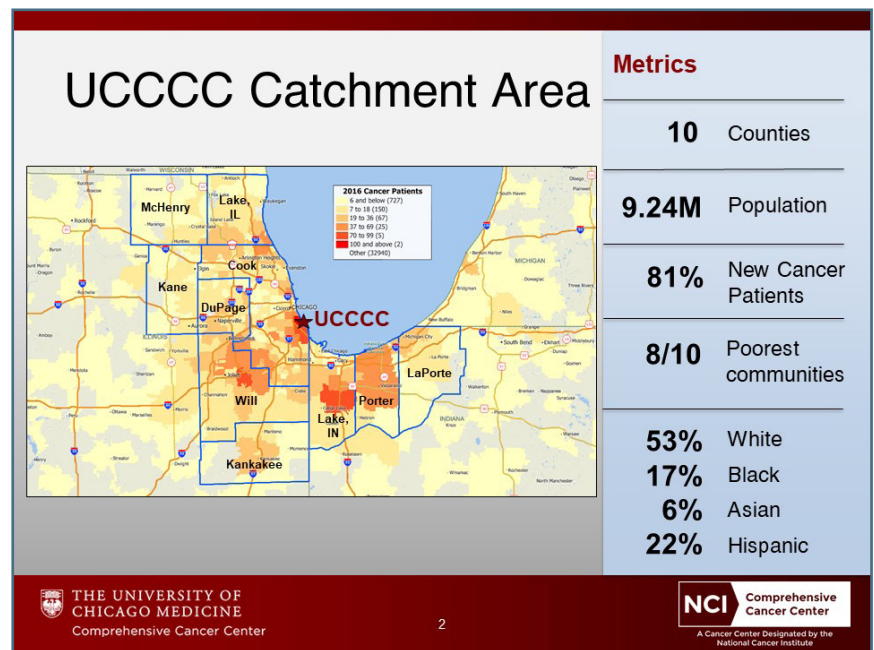
80% of the poorest communities in the state are located around the University.

About 47% of the population is nonwhite, including 22% who are Hispanic, 17% black, and 6% Asian.

The Cook County CARES program (Colorectal Cancer Alliance to Reinforce and Enhance Screening) is a CDC-funded program to implement evidence-based interventions across health systems. A broad partnership has been developed among the University of Chicago, FQHCs across the state, and the 80% by 2018 campaign.

Illinois will be launching a roundtable by December 2017. The goal is to address screening across 50,000 eligible individuals using an implementation-science approach for health system redesign.

Part of the approach includes understanding the implementation of evidence-based interventions, but an equal part is understanding, from the FQHC perspective, how to collect existing data that reflects true screening rates.



In one FQHC, screening rates increased 330% within one year, from 15% up to 50%. In a second FQHC, screening rates increased 43% within one year, from 28% up to 40%. The cancer center engages in several partnerships for its CRCCP program (Colorectal Cancer Control Program).

One key partner is the Illinois Primary Health Care Association, which represents all FQHCs across the state. The shared goal is to implement the state cancer plan for colorectal cancer.

Another key partner is the Blue Cross Blue Shield program, which represents 75% of individuals in the state. The shared goal is to understand how to implement evidence-based interventions among their stakeholders and how to capture data and look at progress.

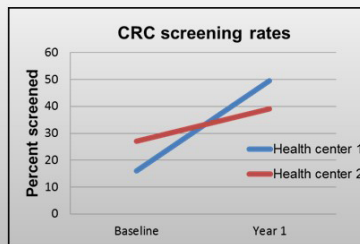
The BRFSS (Behavioral Risk Factor Surveillance System) data for Metropolitan Chicago shows areas of low screening rates in lighter colors (yellow, orange) and higher screening rate areas in dark red. This is surprising given the high number of health systems within a few of the lightly shaded areas.

Follow-up remains a major challenge. Studies show that only 47% of abnormal FIT results are followed up with diagnostic colonoscopy, even in areas with concentrated GI practices.

## Understanding Cancer Problems and Disparities

### Cook County CARES

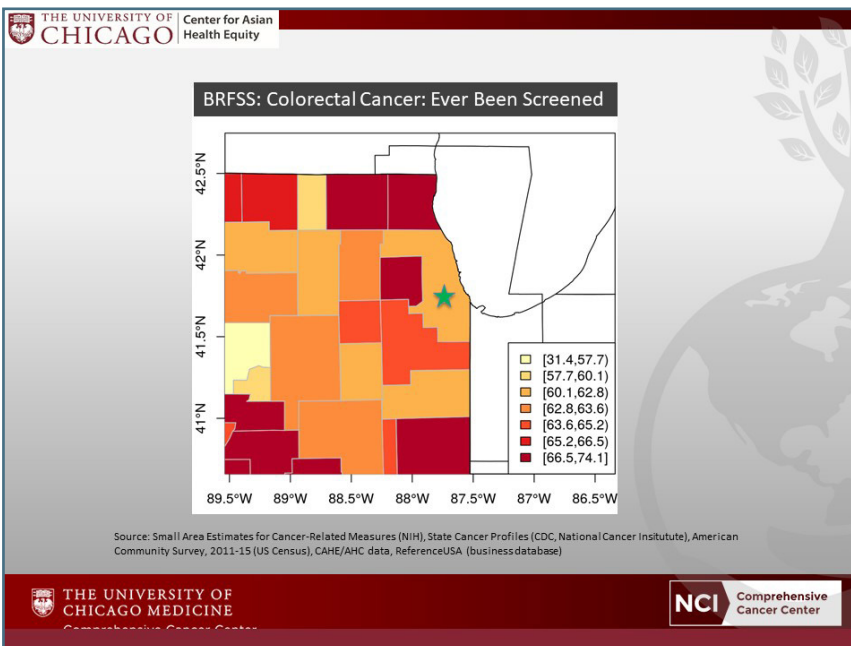
- Funded through grant from the CDC
- Addressing colorectal cancer screening across 50,000 eligible individuals
- Implementation science addressing
  - Health system redesign
  - Provider behavior



THE UNIVERSITY OF  
CHICAGO MEDICINE  
Comprehensive Cancer Center

4

NCI Comprehensive  
Cancer Center  
A Cancer Center Designated by the  
National Cancer Institute



The University of Chicago and hospitals in the community provide free colonoscopies as part of their community benefit and social missions. About 12-24% of all colonoscopy slots are not utilized, suggesting a potential need for more outreach and navigation activities.

The Illinois Colon CARES program uses a web-based portal to provide linkages for patients who need colonoscopies, clinics that need linkage programs, and hospitals that have many unfilled colonoscopy slots.

FQHCs can use the portal to get access to care without having a connection across health systems. This model can be easily replicated.

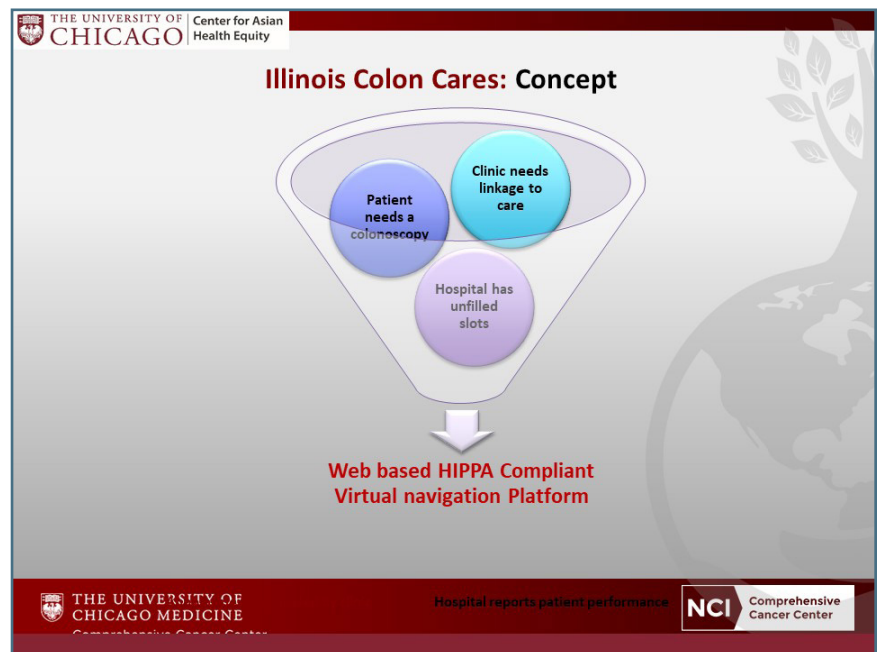
One challenge is being aligned with institutional priorities. Being very data-driven helps in this regard.

Another challenge is finding resources; a diversified portfolio of philanthropic foundations and granting organizations is desirable.

Broad partnerships within the healthcare system help to organize healthcare resources.

Having the personnel and staff to implement common goals is critical.

The linkage to care model is very important. Measuring FIT alone is not enough, and thinking about developing models that are sustainable without CDC funding is necessary for sustainable long-term care.



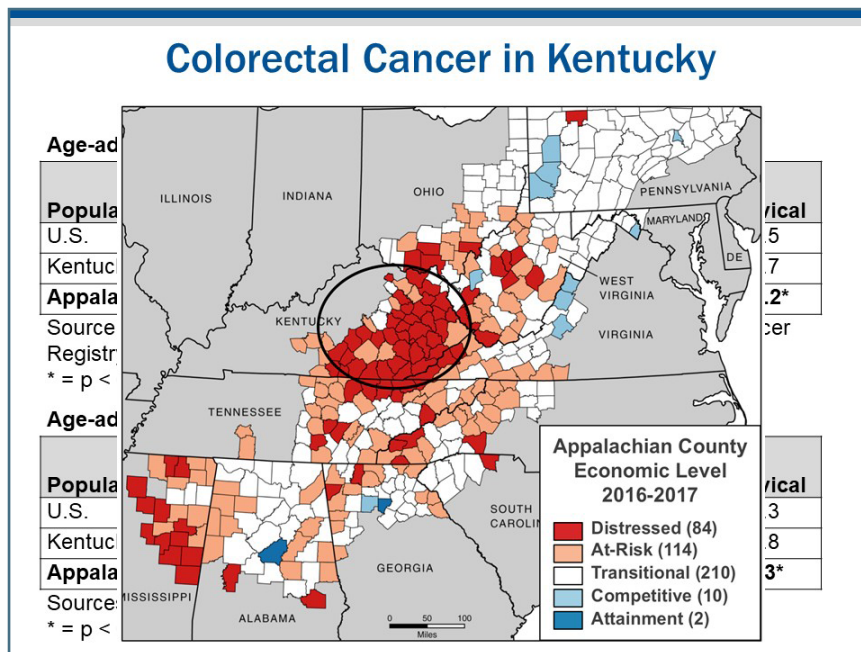
## Challenges → Solutions

1. Alignment with institutional priorities → data driven, broad buy-in
2. Need for Resources → diversified portfolio
  - Philanthropy, Foundations, NCI, CDC, ACS, IPHCA, Innovation Fund, CTSA, Community Benefit
3. Broad Partnerships → Public health, CBOs, Managed Care, Pharma
4. Need for Personnel/Staff → Collaborations to met common goals
  - Community Health Educator
  - Breast and Cervical Cancer Screening
  - CRCCP-Program Director/Manager, Data analyst, Evaluator, IT Specialist, Policy Specialist, FQHC teams

## UNIVERSITY OF KENTUCKY: DATA- AND CONTEXT-DRIVEN APPROACHES TO OUTREACH FOR CRC SCREENING

Robin Vanderpool, DrPH, CHES

University of Kentucky, Markey Cancer Center, Associate Professor



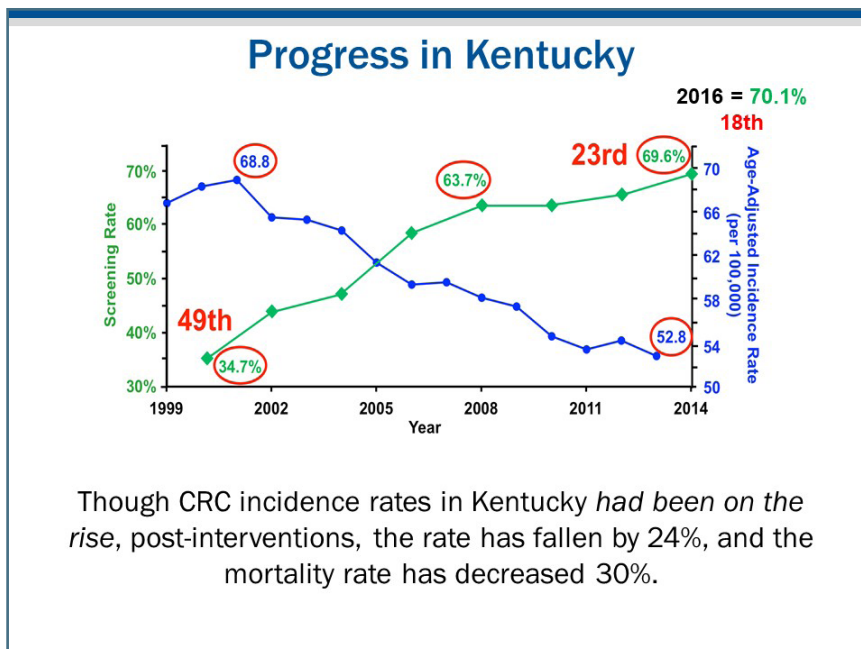
Kentucky is number one in colorectal cancer incidence and number five in mortality, driven mostly by the cancer burden in the Appalachian communities in eastern Kentucky (red counties circled in the image).

The catchment area for University of Kentucky Markey Cancer Center is the entire state, with special emphasis on the 54 Appalachian-designated counties. Most of the counties are socioeconomically distressed (shown in red) and are among the poorest counties in the nation.

The cancer center has both research and clinical care partnerships with 26 community hospitals. Health departments, federally qualified health centers, and faith-based organizations are also priority partners because 70% of Kentucky is rural.

The state funds a regional cancer program called the Kentucky Cancer Program. Data is collected and presented to district cancer councils each year to help them prioritize their local cancer control efforts.

Tremendous progress has been made over the past 15 years by reducing cancer incidence and mortality by 29% (69 down to 53 per 100,000) and increasing screening rates by 100% (35% up to 70%).



Several projects have contributed to the improved colorectal cancer results. One project focuses on provider education in primary care practices, in partnership with Area Health Education Centers, to increase screening in Appalachian counties. The program educates providers about baseline screening rates, CRC screening tools, and follow-up testing.


A second project partners with 70 faith-based organizations to disseminate wellness and cancer prevention information, including smoking cessation, energy balance, and CRC screening. Lay health advisors provide screening education to promote screening. This is a replicable model for communities.

A third project uses rural emergency departments to promote CRC screening to patients who may not have a primary care provider. Lay health advisors use motivational interviewing methods to promote screening.

A fourth project is a short video called “I Did FIT,” produced by the University of Kentucky Prevention Research Center (PRC). The video stars local residents and healthcare providers and promotes community outreach and screening. The PRC distributes and processes the FIT kits (3,000+ delivered) and has a goal of promoting annual adherence to FIT testing.



Three legislative successes have been achieved: insurance coverage of CRC screening; a free, state-funded screening program for qualifying individuals in select Kentucky counties; and full coverage with no copay for diagnostic colonoscopies.

Sustainability is a challenge because many programs are funded over five years and must be restarted with each new funding cycle. More rural-focused dissemination and implementation science would be helpful. Local cancer coalitions are critical to the overall effort.



- **MCC Community Outreach Office staff have provided almost 3,000 FIT kits to community partners across central and eastern Kentucky, including *MCC Network sites and a patient navigation organization.***
- **Over 1,700 kits have been distributed to patients, of which 1,000 have been returned**
  - 18% testing positive (180)
  - Over 100 individuals have received colonoscopies, and
  - One individual was diagnosed with CRC

- **NCI-supported National Outreach Network (NON) Community Health Educator (CHE)**
  - 100+ individuals in Appalachian KY reached with CRC education
  - *Coupled with pop health assessment data collection*

Vanderpool: 3P30CA177558-03S2

## State Policy Changes

KCC and KCP were also instrumental in *legislative successes*, including passage of:

- **KRS 304.17A-257**, which mandated coverage of CRC screening as a health insurance benefit;
- **KRS 214.540-544**, which helped establish the Kentucky Colorectal Cancer Screening Project to provide free CRC screening tests to qualifying individuals via 14 health departments across the state; and
- **KRS 304.17A-257**, which ensured coverage of "complete colon cancer screening" based on ACS guidelines without a co-pay or deductible [*also closed coding loophole: screening/diagnostic*]

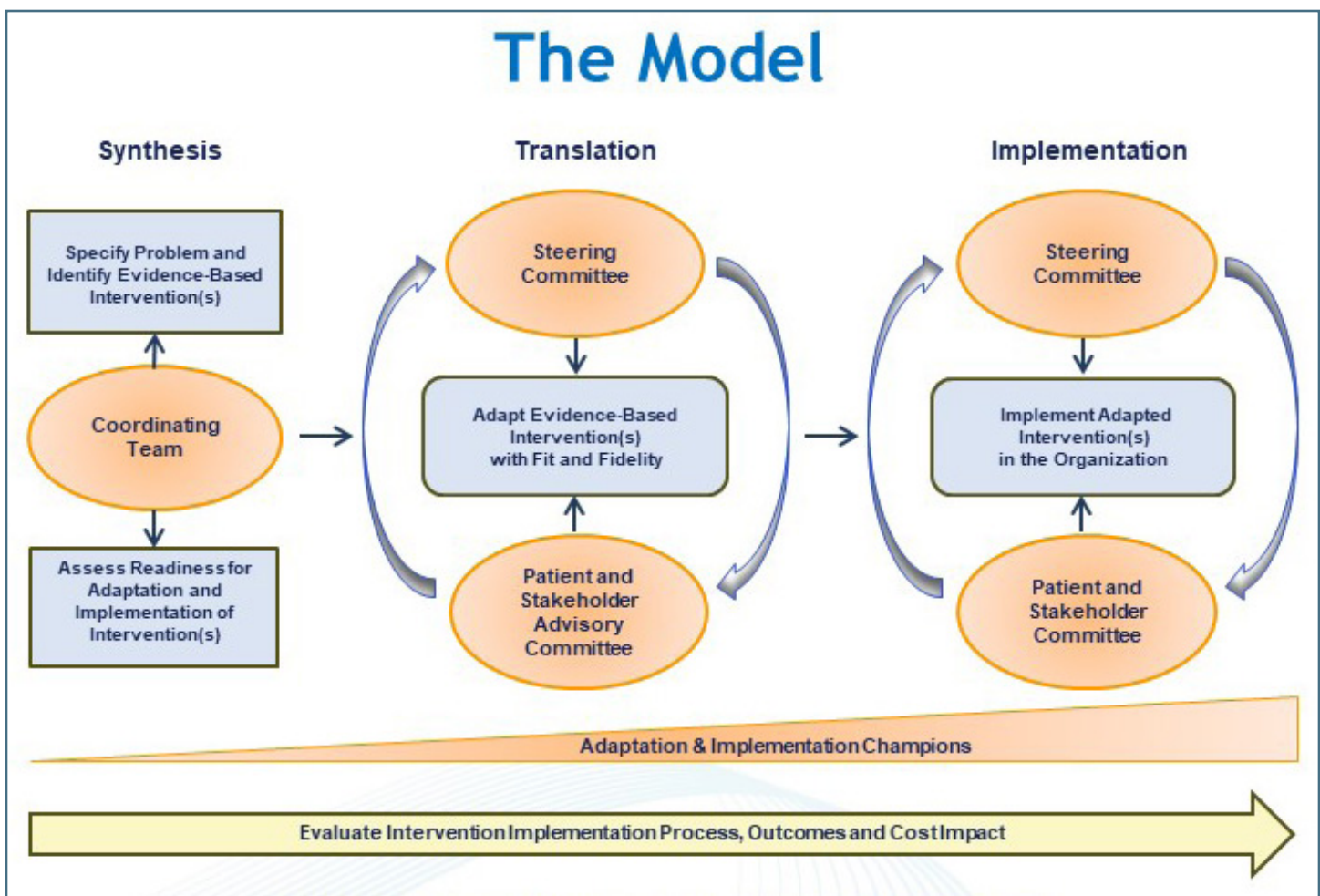


## THOMAS JEFFERSON UNIVERSITY: REDUCING CANCER DISPARITIES BY ENGAGING STAKEHOLDERS (RCADES) INITIATIVE

**Ronald Myers, DSW, PhD**

Thomas Jefferson University, Kimmel Cancer Center, Director, Cancer Prevention and Control, Director, Department of Medical Oncology, Division of Population Science, Professor, Department of Psychiatry and Human Behavior

Colorectal cancer screening rates in health systems are below 80%, so focusing on the implementation of interventions that work in health systems is important. A key goal of the RCaDES Initiative is to develop a scalable model to facilitate the adaptation of evidence-based interventions that raise cancer screening for implementation in health systems. Funding was provided by the Patient-Centered Outcome Research Institute and Thomas Jefferson University.



The model uses a learning community approach (a patient and stakeholder committee and champions inside of a health system) to guide intervention adaptation and implementation.

This strategy involves identifying evidence-based interventions, adapting the interventions to fit population and health system needs, and implementing the adapted interventions.

A central aspect of the model is to build a learning community that coordinates people across health systems who know how things work to deliver the necessary care. Patient/stakeholder engagement has been high, and feedback has been positive.

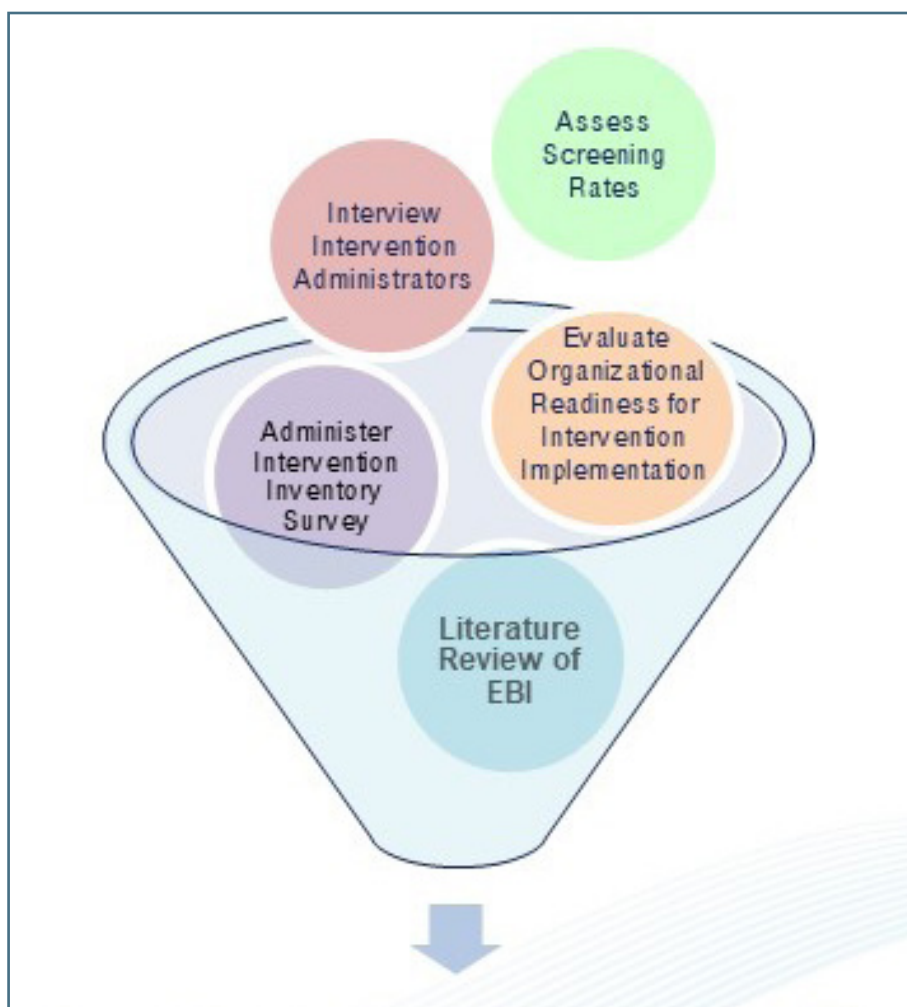
Interventions that work in health systems include patient education; patient decision support and navigation; patient reminders; and provider engagement.

The goal is to increase CRC screening rates to at least 80% by 1) identifying screening adherers and non-adherers in primary care, and by 2) delivering an adapted intervention to achieve a high screening rate among non-adherers.

For example: If a health system (or a given primary care practice) has a 60% screening rate, encouraging at least half of the non-adherers (50% of the 40% non-adherers) to screen can achieve the goal.

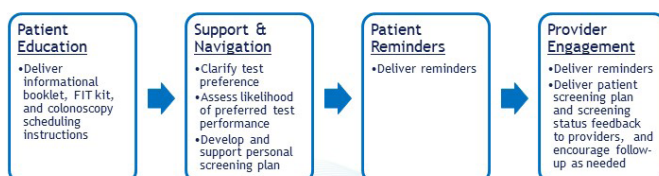
National Cancer Institute (NCI)-designated cancer centers could lead the way to achieve 80% by 2018 goals by applying a learning community active intervention implementation model to catalyze intervention adaptation and implementation with health systems and payers that serve individuals who reside in their catchment areas.

NCI-designated cancer centers can play a central role in determining how to develop and evaluate learning communities that are engines of intervention implementation in health systems, and they can develop sustainable strategies for improving cancer prevention and control and population health outcomes.



## Interventions that Work in Health Systems

### Combined Interventions: Patient Education, Decision Support and Navigation



**Goal: 60% adherers + 50% of non-adherers = 80%**



The RCaDES Initiative  
Center for Health Decisions  
at Jefferson

**Sidney Kimmel  
Cancer Center**  
at Thomas Jefferson University  
NCI-designated



## DARTMOUTH HITCHCOCK MEDICAL CENTER: THE POWER OF PATIENT NAVIGATION

### Lynn Butterly, MD

PI and Medical Director, New Hampshire Colorectal Cancer Screening Program, Director, Colorectal Cancer Screening, Dartmouth – Hitchcock Medical Center, Associate Professor of Medicine, Geisel School of Medicine at Dartmouth, Member, NCCRT Steering Committee

The New Hampshire CRC Screening Program (NHCRCSP) is one of the CDC funded Colorectal Cancer Control Programs (CRCCPs) working to increase CRC screening. Collaboration with our Norris Cotton Cancer Center over many years has successfully addressed mutual community goals.

Examples include the creation and ongoing work of the Comprehensive Cancer Coalition (CCC) in NH, American Cancer Society projects, a program providing statewide Expos (fairs) to bring CRC screening information to underserved communities, multiple community education programs, and the CDC CRCCP program (NHCRCSP) that provided free colonoscopies to uninsured low-income individuals.

### Cancer Center Collaborations

- Comprehensive Cancer Coalition (CCC)
- American Cancer Society Projects
- Statewide Expos (CRC screening “fairs”)
- Community Education (NCI Screen to Save)
- Support and disseminate screening guidelines and **patient navigation**
  - NHCRCSP Medical Advisory Board (MAB): CC members provide diversity of expertise

Patient Navigation has shown tremendous promise for increasing screening rates, and the NHCRCSP program developed and implemented a patient navigation model to support all patients receiving colonoscopies through the free program.

An essential Cancer Center contribution to this program was the wide-ranging expertise provided to the NHCRCSP Medical Advisory Board by Cancer Center members.

The statewide screening fair program offered free food, videos, and sometimes an inflatable colon to provide education from doctors, nurses, and volunteers.

Screening rates measurably increased after the fairs, with many people signing up for testing.

Cancer Center collaboration was also instrumental to the success of the NHCRCSP, in support of the goal to increase CRC screening in NH to 80% and for the free colonoscopy part of the program with Patient Navigation to ensure receipt of high-quality screening.

There is compelling rationale to increase CRC screening. CRC is the second most common cause of death from cancer, despite being a preventable disease.

### Initial Goals of the NHCRCSP

- Increase CRC screening for all NH individuals over age 50 to **80%** (80% by 2018 Initiative)
- Address Disparities: Offer *high quality free colonoscopies* to low income, uninsured or underinsured individuals
- NHCRCSP works with NH health centers (**FQHCs, CHCs, health systems**) to reach the 80% goal

Prevention and early detection are provided through high-quality CRC screening. Despite strong evidence on the effectiveness of CRC screening tests, screening rates remain low, especially for low-income individuals and racial and ethnic minorities, who face many barriers.

Navigation is a highly effective intervention that has been shown to increase screening in underserved groups.

The heart of patient navigation is identifying and resolving individual barriers. Therefore, the NHCRCSP navigation program was designed to address specific barriers and support patients in completing colonoscopy.

The NHCRCSP program provided over 2,000 free colonoscopies for uninsured, low-income NH residents and navigated them through the process. Specific outcomes were evaluated.

The NHCRCSP program achieved a colonoscopy completion rate above 96% and a no-show rate of 0.1% (1 per 1000), compared with 20-40% no-show rates reported. Less than 1% of patients were inadequately prepared for the test. 100% of patients and their primary care providers received a report with follow-up recommendations. Patients reported high satisfaction with the program.

Because of the positive program outcomes, the CDC and NHCRCSP did a comparison study at one of the 12 sites that were part of the statewide program. Comparison of navigated to non-navigated patients showed that navigated patients were 40 times less likely to be no-shows, 11 times more likely to complete colonoscopy, and six times more likely to have an adequate bowel preparation. A replication manual was created for dissemination and is available online.

The results of the statewide program and of the comparison study showed that patient navigation is extremely effective for increasing screening rates and reducing disparities. Cancer centers can support these statewide efforts, and through increased CRC screening can improve public health.


### NHCRCSP Patient Navigation


- NHCRCSP provided over 2000 colonoscopies for uninsured NH residents at or below 250% of the federal poverty level.
- Patients were navigated throughout screening process:
  - Medically appropriate
  - Had understanding of test and prep
  - Received results and recommended follow-up
  - *Barriers* identified and addressed throughout the process (NHCRCSP navigation protocol designed to address common barriers)

### Evidence For NHCRCSP PN Model

#### Outcomes of the Comparison Study

 **11 times**  
more likely  
to complete  
colonoscopy than  
non-navigated patients.

 **40 times**  
less likely  
to miss the  
colonoscopy  
appointment.

 **6 times**  
more likely  
to have adequate  
bowel prep than  
non-navigated patients.

# LESSONS FROM CASE STUDIES

## COMMON THEMES OF EXEMPLARY CENTERS AROUND CRC SCREENING PRACTICES

The following themes were common among cancer centers conducting exemplary work advancing CRC screening in their surrounding communities. **Exemplary centers:**

- **Are present in the community to advance CRC screening.** Community presence may include conducting community education, collaborating with local clinics and health systems; partnering with payers; delivering clinical care (including for uninsured/underinsured individuals), participating in state cancer control coalitions, and even launching learning collaboratives to coordinate people across health systems. Importantly, this goes beyond collaborating on research.
- **Promote and implement diverse evidence-based interventions in the community.** These interventions include provider education, public education, addressing access issues, policy, and navigation. Further, these centers are data-driven in their approaches.
- **Integrate population health work into cancer center operations.** Exemplary cancer centers have a defined structure, staff, and budget to support work on colorectal cancer screening. Many noted that leadership buy-in was crucial to this alignment.
- **Adapt their interventions to fit the population and health system needs.** Often, this means having a clear understanding of what local barriers and needs are, as well as understanding where those barriers and needs are strongest. Many cited the importance of taking a data-driven approach but coupled this data-driven approach with including staff from the communities they serve to help ensure cultural competence in delivery.
- **Have diverse funding mechanisms.** Diverse funding mechanisms allow for greater program stability and flexibility. Funding and resources come from federal grants, non-federal grants, philanthropy, institutional endowments, other health system partners, and payers, including Medicaid.
- **Focus on addressing the needs of underinsured and uninsured people.** All were keenly aware of the importance of providing CRC screening to the underserved if CRC screening goals were to be met and had come up with innovative solutions to address this challenging issue.



## KEY DISCUSSION TOPICS

This meeting session contained an open discussion and Q&A with the Centers of Excellence presenters.

## ALLOCATION OF DOLLARS BETWEEN RESEARCH AND COMMUNITY-BASED CLINICAL SERVICE

Most of the NCI-designated cancer centers are affiliated with university medical centers, although several are freestanding centers that engage only in cancer research. The 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. Basic Laboratory Cancer Centers conduct only laboratory research and do not provide patient treatment. There are 13 Cancer Centers, 49 Comprehensive Cancer Centers, and 7 Basic Laboratory Cancer Centers. NCI funds are used for research, not service delivery. So NCI funds are limited to cancer control research, not funding of services unless the services are related to research.

## SCREENING AND CLINICAL CARE

Most cancer center directors focus on their research mission, typically with a primary emphasis on supporting and sustaining basic science research. Cancer centers nonetheless are also required to have community-based outreach activities, and community engagement is an increasingly important component of translational research. However, cancer centers currently have few external incentives to invest substantial resources in community-based CRC screening activities.

The NCI Office of Cancer Centers and other NCI programs could consider providing incentives and funding for cancer centers to engage with local stakeholders in their catchment areas, either with funding included in CCSGs or through translational research funding opportunities targeting cancer centers. NCI could also facilitate sharing of best practices across cancer centers.





NCI's most recent Cancer Center Support Grant Funding Opportunity Announcement (FOA) specifically requires community outreach and engagement for all clinical and comprehensive cancer centers. The FOA specifically states that cancer centers are “expected to perform research relevant to their catchment area and engage the populations within their catchment area in the research they conduct and other Center activities.

To decrease cancer incidence and mortality among populations within its catchment area, including minority and underserved populations, Centers also establish partnerships with other healthcare delivery systems and state and community agencies for dissemination of evidence-based findings.”

While Comprehensive Cancer Centers have always had a focus on cancer control, the depth of cancer control research and clinical care varies by cancer center. Perhaps this is because funding for cancer control action is not as widely available. The latest NCI CCSG is a step forward but has created some confusion because the definitions are not clear to stakeholders.

Coupling the community outreach and engagement concept with funding support for cancer center actions to advance CRC screening in their catchment areas is critical to engaging cancer centers that would otherwise focus primarily on research.

The NCI core grant does not fund or support the delivery of care because clinical services are available elsewhere within the cancer center network or through collaborations organized around the research. Institutions are expected to provide the clinical context for the high-priority research being conducted by cancer centers.

One possible approach for funding is to emphasize the need to establish clinical care systems around which a center of excellence could be established. Only a few cancer centers enjoy extensive philanthropic funding support; others have more restricted funding. On-again-off-again funding is a reason that cancer centers become engaged for a brief time and then back away when their funding resources expire. There is a need for continuous funding to support infrastructure that enables community engagement

## ALIGNMENT AMONG STAKEHOLDERS

Coordinated alignment with stakeholders such as the NCI, CDC, local health plans, local healthcare providers, and state and county health departments would be very helpful.

**Health systems and universities like having the triple-C Comprehensive Cancer Center designation, as it helps the health system to compete for patients in their communities.**

Achieving Comprehensive Cancer Center designation requires centers demonstrate reasonable depth and breadth of cancer research activities in each of three major areas: basic laboratory; clinical; and prevention, control and population-based science. Therefore, it's important to engage the university level in these decisions and program

One attendee suggested that the logical funder from the cancer center perspective is the larger health system that works in the areas where the cancer are located. It is also the health system that will have the greatest capacity to engage the payers since most of the health systems that work with comprehensive cancer centers are large, dominant care providers in those regions.

## COMMUNITY-ENGAGED PREVENTION AND SCREENING OF OTHER TYPES OF CANCERS

While this summit is focused on cancer center support for community-based CRC screening, it is important to place these efforts in the context of support for prevention and screening of other cancers, as well. Consideration of other cancers is important to achieve broader engagement from the cancer research community and from community stakeholders.

CRC-focused screening programs are often felt to be complex, due to multiple steps in the screening process and multiple recommended screening options. However, other types of community-based screening activities may have their own unique challenges. To the extent possible, cancer researchers and stakeholders for all forms of evidence-based cancer prevention and screening (e.g. breast, cervix, lung) should work together across to identify shared strategies and opportunities to work together and maximize limited resources. Cancer center funders and leaders are positioned to incentivize and facilitate this type of collaboration, perhaps with multi-year funding opportunities and plans.



### DEDICATED OR COORDINATING CANCER CENTER UNITS FOCUSED ON CRC SCREENING

It is difficult to create a coordinated priority for CRC screening when researchers, state programs, and health networks are each focused on creating and implementing their respective goals independently. For example, the Texas and Ohio presentations showed that their successful cancer centers had dedicated units for colorectal cancer that function independently of their cancer prevention and control program. This enabled them to convene stakeholders outside the cancer center and develop focused interventions that quickly advanced their goals.

**Having a dedicated unit within a cancer center focused on CRC screening and stakeholder engagement would help to create more coordinated efforts.**

One comprehensive cancer center started an office to reduce cancer disparities in 2010. A grant to support the new office was critical because it provided funds for personnel to supplement the outreach and engagement part. The grant program paid for the personnel and then asked the cancer center to buy-in and support those individuals.

### ENGAGING MORE CANCER CENTERS IN COMMUNITY-BASED PREVENTION AND SCREENING ACTIVITIES

NCI has created funding supplements which incentivize community engagement, but cancer centers currently compete for them. Perhaps the supplements could be structured to be a tool to help engage and encourage cancer centers to coordinate their overall efforts rather than competing for individual supplement grant dollars. For example, if NCI were to decide to fund only 5 or 10 cancer centers to engage in these activities, there would be competition among cancer centers, but only a few that would actually have the opportunity gain this needed support. An alternative approach could be for NCI to invest such funds in incentives that would be accessible to any cancer center that actively engaged in such activities.

### LEVERAGING NEW CANCER CENTER SUPPORT GRANTS (CCSG)

One attendee was under the impression that the Cancer Center Support Grants now allow requests for support for associate directors, for community outreach and engagement, and for staff.

**In the community outreach and engagement section, it is very important that applicants have a hub or central place to coordinate all their efforts.**

One model used for the community outreach and engagement section in the guidelines is the University of California San Francisco model. A paper has been written about how to define a catchment area and how to apply research findings to the defined population. (Caroline G. Tai, Robert A. Hiatt; The Population Burden of Cancer: Research Driven by the Catchment Area of a Cancer Center, *Epidemiologic Reviews*, Volume 39, Issue 1, 1 January 2017, Pages 108–122, <https://doi.org/10.1093/epirev/mxx001>)



## CURRENT PROGRAM REACH

The NCI Screen to Save program is a special initiative underneath the overall national outreach program. It is not intended to be a comprehensive, all-encompassing effort. Instead, it is meant to augment existing cancer center resources and to be a catalyst for increased community engagement, outreach, and education.

Even under the best of circumstances, cancer centers can only do so much on their own. There are 2 million people in Texas who need screening. The MD Anderson program has reached 20,000 of them over 10 years. The most successful Southwestern program has reached 50,000.

These programs, even though they are successful, are not close to meeting the total need, and the problem is often funding, especially when it comes to programs designed to reach uninsured populations.

Having said that, participants commented that many people who are not being screened are insured, so the problem is not limited to underserved and uninsured populations. Payers should have an incentive to collaborate with cancer centers that bring expertise to help them achieve their goals.

Delaware is an example in which they were able to largely eliminate disparities in CRC incidence, mortality, and screening. They had state funding and buy-in from the governor, the legislator, and achieved both outreach and in-reach with navigation. They paid for those who could not pay for a colonoscopy, treatment, and follow-up. Cancer centers can play an important role in supporting the development of similar initiatives in other states.

### SUSTAINABILITY

The NCI has begun to emphasize and provide opportunities for implementation-science research in CRC screening, using mechanisms such as the Cancer Moonshot program to fund them. But sustaining the development and use of the approaches developed and tested through these initiatives may remain a challenge without additional investments.

Payers are supporting the Comprehensive Primary Care Plus (CPC+) program by paying for cancer screening services and navigation through the program. Payers negotiate with health systems to support this kind of effort. It may be more effective for sustainability to expand existing mechanisms such as the CPC+ program, rather than creating totally new mechanisms.

Infrastructure to support community partnerships is often limited. A diverse portfolio of funding sources is often required for sustainability. The American Cancer Society and other organizations have begun to recognize these barriers and have reorganized their activities to support a greater number of long term partnerships. Cancer centers could become more engaged with these efforts.



#### CPC+ PROGRAM

The Comprehensive Primary Care Plus (CPC+) program is a Centers for Medicare and Medicaid Services (CMS) national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reforms and care delivery transformations.

There are 2,850 primary care practices participating in Round 1, which began on January 1, 2017.

Round 2 will begin in January of 2018.

# PERSPECTIVES FROM COMMUNITY PARTNERS

In this session, several community leaders who work with CRC issues were asked about the ideal role that cancer centers could play in supporting CRC screening. Speakers included a cancer coalition, a state health department, an FQHC, a non-profit organization active in the community and a representative from a program supporting community health workers.

## STATE CANCER COALITION

**Katie Bathje, MA, LPCC**

Program Director, Kentucky Cancer Consortium

The Kentucky Cancer Consortium (KCC) is the comprehensive cancer control coalition for the state of Kentucky, with over KCC is the only cancer coalition in the United States which is located within a state university and NCI designated cancer center as well as designated as a bona fide agent by their state health department to receive the National Comprehensive Cancer Control Program grant from the Centers for Disease Control and Prevention. The coalition's placement within the cancer control program of the Markey Cancer Center lends it a great deal of regional credibility, as NCI designated centers are considered the "gold standard" for cancer research and information.

Yet, despite this advantageous placement, it remains a challenge to sustain consistent coalition representation and engagement from high-level cancer center staff due to their multiple clinical and research commitments and responsibilities. One suggestion is to identify a respected person within the cancer center—not necessarily the cancer center director—who obtains the Director's support and encouragement to actively participate in the state's cancer coalition and represent the cancer center on the Director's behalf.

Because NCI-designated cancer centers are often default leaders in regional cancer control efforts, it may be unfamiliar territory for centers to participate in an organizational coalition as a partner. Many coalition efforts require a team-oriented view that respects the unique contributions of individual organizations. Therefore, it is critical that the identified representative of the cancer center has extensive experience in community outreach and engagement, and recognizes the give and take necessary in building trusted community partnerships.

A third suggestion is for cancer centers to coordinate and help lead best practice interventions for cancer screening with those of their affiliated healthcare institution. Coordinated provider education between the oncology system and the wider primary care provider health care system could result in wider dissemination of evidenced-based screening practices and more efficient referrals.

## LAND GRANT INSTITUTIONS

A land-grant institution is an institution of higher education in the United States that is designated by a state to receive the benefits of the Morrill Acts of 1862 and 1890. Ultimately, most land-grant colleges became large public universities that today offer a full spectrum of educational opportunities.

The last suggestion is to more fully staff the community outreach and engagement cores at NCI-designated cancer centers. By enlisting a team that would include experienced dissemination and implementation cancer control researchers, as well health educators and community health workers -- a robust staff in outreach and engagement would go far to engender trust with the community.



**Community health workers represent an important and often underutilized nexus between cancer centers and the catchment area populations they seek to serve.**

**Community health workers can act as trusted cultural brokers, playing a key role in building bridges between the community and healthcare providers.**

## STATE HEALTH DEPARTMENT

**Ken Lin Tai, MD, MPH**

Director, Center for Cancer Prevention and Control, Maryland Department of Health

In Maryland, our two NCI-designated comprehensive cancer centers have been great partners and have worked with us to develop and implement our state-level cancer control plans. The State of Maryland, through the Cigarette Restitution Fund Program administered by the Department of Health, allocates funding towards cancer research at these two cancer centers, and because of that existing relationship, it has been much easier to invite them to the table for potential collaborations on other cancer-related issues, compared to other states.

From our perspective, it would be helpful to know what cancer centers are doing in the community so that duplication of outreach and prevention efforts could be avoided, and it would also allow us to identify any gaps in coverage. One way of doing that is to have cancer centers share with us what they are currently doing in their communities and where there might be opportunities for collaboration.

A second suggestion is to leverage the reputation of the cancer centers to build bridges with local resources such as FQHCs and community providers to promote cancer screening efforts in those practices. The cancer centers can also easily reach out to health system networks that are affiliated with them. For instance, the cancer centers could provide educational opportunities for community providers, with a focus on cancer prevention. Engaging providers in the community is often challenging because they are busy individuals with competing priorities, so it helps to have a respected institution reach out to these providers.

Another suggestion is for cancer centers to work with their state health departments to evaluate ways in which their incidence and mortality data and research findings can be used to inform the state's cancer programming decisions. The data could be used to focus more effort on the areas that need it.

Lastly, cancer centers can leverage the reputation and influence that they have with state policymakers to shape policies that can positively impact cancer prevention efforts in the state.

## COMMUNITY HEALTH CENTER

### Suzanne Lagarde MD, MBA, FACP

Chief Executive Officer, Fair Haven Community Health Center

For the past three years, Fair Haven Community Health Center (FHCHC) has had a dedicated navigator who is funded by ACS and the Links of Care program. During that time, by reaching out to the GI faculty at the cancer center of Yale New Haven Hospital, an average of 250 colonoscopies are performed annually on uninsured and under-insured patients of FHCHC. Twenty-five percent of FHCHC patients are uninsured because they are uninsurable due to their immigration status. All services provided through the hospital and medical school are free to patients who are below 250% of the federal poverty level.

Community health centers (CHCs) can be a bridge to the cancer centers and can help cancer centers with community outreach because it is an area of CHC expertise. About 1400 CHCs served over 27 million people in 2016. Community health centers can be excellent partners for cancer centers.

There are opportunities for cancer centers to partner with community health centers, because CHCs screen for multiple cancers (colorectal, breast, HPV, and cervical). CHCs would be valuable partners because they have the existing outreach programs, the connections, and the trust of the community.

With effort, it is possible for private providers to form partnerships that can deliver free colonoscopies. One group of 13 GI providers partnered with a group of anesthesiologists to deliver one free colonoscopy per month per provider. Over 2.5 years, 232 free colonoscopies were performed.

Proper navigation is critical for such efforts because navigation can keep no-shows to a minimum and ensure high-quality bowel preps. No-shows and bad preps discourage GI providers from participating.

One challenge that has emerged over the past two years is that the number of independent specialty groups within the healthcare system has grown. As a result, organizational champions are experiencing increasing difficulty in making connections and bridges even within their own organizations. This has further caused difficulty in rallying support within the system for the Link of Care program.

## NON-PROFIT PARTNER

### Holly Guerrero

Health Systems Manager, Hospitals, North Region, American Cancer Society, Inc.

The American Cancer Society works with health systems to reduce the incidence, burden, and mortality of cancer. In Minnesota, ACS has formed partnerships with Allina Health over the past 15 years, working on projects that involve patient programs and services; Allina's Commission on Cancer accreditation, and prevention and detection efforts for many cancers.

Many prevention and detection efforts have involved education and information, such as using an inflatable giant colon for community outreach and provider education. One ACS goal of the partnership with Allina was to present the opportunity for the health system to participate in the Links of Care program and provide free screening for patients. ACS has formed relationships with primary care providers and has convened healthcare system champions to identify ways to offer screening to patients and communities within their systems.

The Minnesota Commission on Cancer Network has partnered with ACS to reach out to key physician champions to come together as a medical neighborhood two reach out to the community for education and screening. A December meeting among the Twin Cities hospitals is planned to identify ways to help both insured and uninsured patients to obtain screening and follow-up.

## COMMUNITY HEALTH EDUCATOR

**LeeAnn Bailey, MD, PhD**

Chief, Integrated Networks Branch, Center to Reduce Cancer Health Disparities (CRCHD), National Cancer Institute

NCI works with the research enterprise of the cancer center to build bridges to communities. The CRCHD focuses specifically on racial and ethnic populations, and rural communities. There are community health educators that assess needs, facilitate resources and capacity for community outreach, and perform health promotion and message integration through the National Outreach Network program. The CHCs are located at 38 NCI-designated comprehensive cancer centers and are reflective of the communities in which they serve.



Many underserved communities have significant medical mistrust, so some community health centers have engaged providers from the cancer centers to go out into the community.

An ideal cancer center might be viewed as a culturally-competent source for information and services throughout the entire care continuum.

CRCHD is currently supporting the Screen to Save program, which was designed to be facilitated in three phases.

- The first phase was for community engagement involving outreach, education, and mobilization. Community cancer centers, advocacy groups, faith-based organizations, and legislative stakeholders should be at the table for these conversations.
- The second phase envisioned challenges with linkages to care for the patient populations. It promoted discussions to identify partnerships and different models that might be efficacious in such situations.
- The third phase was to migrate to a comprehensive care coordination model.

Cancer centers can support this model in several ways.

- The first way is to use available resources to help with the continuum of care for the uninsured. This is because cancer centers offer colonoscopies, processing the FIT tests, and have a system in place to annually track the population and ensure that appropriate referrals are made.
- The second way is that cancer centers have extensive partnerships with both local state and national partners and could possibly articulate the voice of the community to those stakeholders. That would give a face to patients, patient advocates, and to the things that are most important to the community.
- The third way is that cancer centers might help to develop culturally-competent training for physicians and providers at all stages of the care continuum. It would be helpful to bring together people who are trying to navigate the nebulous community outreach and engagement efforts. There might be an opportunity for a collaborative initiative among cancer centers to implement a CRC screening initiative.

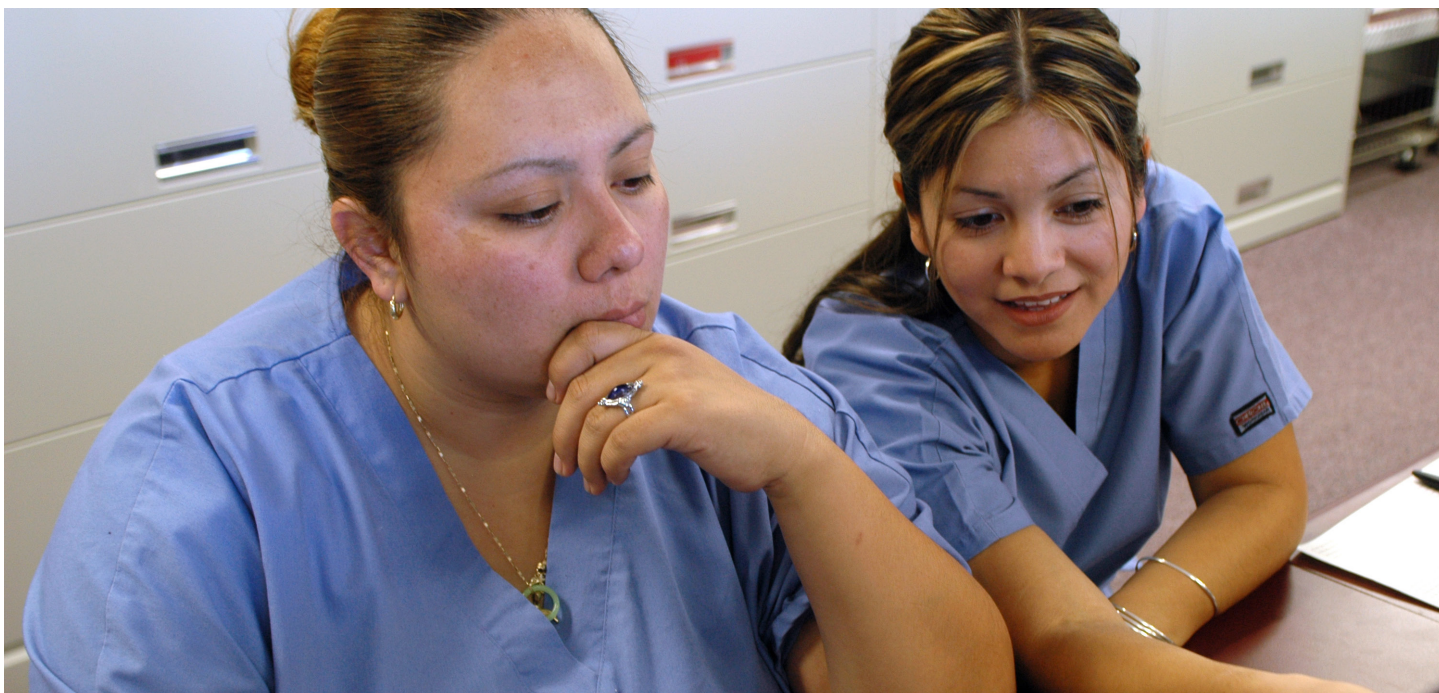
## NEEDS FROM COMMUNITY PARTNER PERSPECTIVE

### Common Themes

The following themes were common in the community partner discussion of what the ideal role of a cancer center could be in advancing CRC screening in the surrounding community:

- **Promote best practices with affiliated health institutions and providers in the community.** Cancer centers have researchers and faculty with cutting-edge knowledge about prevention, early detection, and treatment, as well as experts in dissemination and practice. The expertise and prestige put cancer centers in a strong position to promote wider dissemination of evidence-based interventions.
- **Be active in the state's cancer coalition.** Steady participating in a coalition as a partner may be unfamiliar territory for cancer centers, but steady, long-term involvement would be of high value in building a trusted partnership.
- **Fully staff a cancer center community outreach and engagement unit.** The cancer center unit staff should include not only cancer control researchers, but also community health workers, who can serve as a bridge between the community and healthcare providers.
- **Share both data, research findings and cancer center activity that is underway in the community.** Cancer centers often have access to data that can help communities see how they are doing in terms of cancer incidence and mortality. This data – along with research findings – can help inform state's cancer programming efforts. Additionally, sharing current cancer control activity can help avoid duplication of effort and identify gaps.
- **Work with community health centers.** CHCs have the expertise needed to work with the community and can be a bridge to the cancer center.
- **Use available resources to help with the continuum of care.** Cancer centers can identify partnerships and leverage resources to help the uninsured and others receive the full continuum of care. Cancer centers can leverage their screening systems to conduct navigation, track FIT processing, referrals, and perhaps provide a finite amount of free screening.
- **Develop culturally competent training for cancer center physicians and providers.** This can further help build trust between the cancer center and the community.
- **Leverage reputation with policymakers.** Take a role in shaping policies that can impact cancer prevention efforts and be willing to serve as a voice of the community.
- **Consider a collaborative model among cancer centers to implement a CRC screening initiative.**





## Q&A/DISCUSSION SESSION

### Community Training

The National Partners—ACS, CDC, NCI, and the NCCRT—have trained 33 six-person state teams during intensive 1.5-day trainings around colorectal cancer. The charge for the state teams is to create an action plan for each state to address CRC screening. State teams were comprised of a CCC Program Director, an ACS Health Systems Manager, the state primary care association representative (PCA), an FQHC representative, and two wild-card positions that could be a state CRCCP program representative or a physician champion.

### HRSA Grant Opportunities

The Health Resources and Services Administration (HRSA) has issued large supplemental grants over the past few years, including one on substance abuse expansion and one on oral health integration. Usually, the competition ratio for funding is 1:4 or 1:2, and if goals are met funding continues (unlike one-year grants).

The group discussed if there is an opportunity to meet with HRSA about cancer prevention or CRC as a funding opportunity for FQHCs. If the FQHCs received more funding, it would make relationships between cancer centers and FQHCs more robust. It could have a strong impact if this request is made by the participants of this meeting.

### Existing Resources

The need to “connect the dots” with other payers, organizations, and health systems can benefit from the use of technological communication mechanisms such as Google Health. Two participants were from organizations that had developed online programs that were available to facilitate navigation.

The discussion of partnerships continued into the next section of the meeting.

## The Business Case

Business cases must communicate the benefits of participation to cancer centers, such as:

- Cancer centers can benefit from being recognized as a leadership catalyst for efforts.
- Cancer centers might benefit financially from reductions in the costs of care resulting from earlier detections and corresponding improvements in population health.

Currently, the business case for cancer centers to be involved in screening is weak because of the costs of putting together a large screening program and screening people who need free screening. It would be better if screening was part of the mission of the cancer center.

Implementation science and implementation are different things. Evaluation of an action is always important, and to that extent, it is science. For implementation science, it is easier to get a grant to answer a question than it is to put the responsibility on cancer centers to implement evidence-based strategies that are later published in respected journals.

**Cancer centers have a responsibility for taking actions that build research knowledge, but funding is usually not available for actions that are not related to research needs.**



## Catchment Area

The definition of a catchment area should be considered by our community because there are different definitions. Some centers define it as the patients that make their way to the institution, whereas others define the catchment area in geographic terms of where the patients come from.

Many cancer centers are matrix organizations that do not have mandates to provide services. This point should be kept in mind when constructing business cases.

# NEXT STEPS

## Implementation: Turning the Vision into Reality

***How do we turn this vision into reality? What will be the responsibility and role of national organizations? Individual partners? What should key next steps be? Long term goals?***

An open discussion was held to discuss the questions above with emphasis on specific actions that might be implemented. Participants were asked to fill out a form that listed the next steps organizations could take to advance the vision for leveraging the role of NCI-designated cancer centers to advance CRC screenings within communities.

Participants were each asked to focus on one realistic commitment and one action that they would like to own or lead on behalf of their organizations. Leaders from NCI and ACS opened the discussion with their own thoughts about next steps.



### National Cancer Institute

Robert Croyle, PhD, Meeting Co-Chair, Director Division of Cancer Control and Population Sciences, NCI

#### ***Target help towards a full range of cancer centers, including smaller cancer centers***

Some cancer centers are matrix centers that are a suite of offices in the medical school, with a cancer director, deputy director, administrator, and three or four other people. Their job is to work with people in cancer areas within their school of medicine. This model is at one end of the cancer center spectrum. At the other end are large centers with extensive philanthropic and other resources.

We need to identify ways to help the smaller cancer centers that have smaller budgets, and fewer resources is a challenge.

#### ***Consider NCI funding supplements to support public health and cancer center collaboration***

We could consider funding supplements to support cancer center collaboration with state cancer coalitions and cancer planning.

NCI added several requirements to the core grant to get more of a population health mindset within cancer centers. Supplements, which are for one or two years and a small amount of money, do not create any kind of sustainable infrastructure. They are more about brokering and trying to get people to collaborate within their communities.

#### ***Consider funding national implementation science network on cancer control***

Identify larger and more ambitious funding initiatives, and ways to fund them would be helpful. Should there be a national implementation science network on cancer control that funds larger-scale projects that are more sustainable?

## American Cancer Society/National Colorectal Cancer Roundtable

Richard Wender, MD, Meeting Co-Chair, Chair NCCRT,  
Chief Cancer Control Officer, American Cancer Society

### ***Produce a Toolkit for Cancer Centers***

The NCCRT identified opportunities for toolkits for cancer centers, including helping to organize a white paper around best practices.

### ***Bring in other Leading Organizations, such as HRSA***

Another competency of the NCCRT is connections to local communities. It also has strong relationships with HRSA, which is a major funder of FQHCs through various grant models. The NCCRT could bring in senior leaders to meet with other high-level leaders if the opportunity is right.

### ***Leverage ACS Health Systems Staff Structure***

A shared grant between ACS and a designated cancer center might be possible. There are examples where the grant used ACS as a delivery device or used a national cancer center as a delivery device.

### ***Recognize the Importance of Cancer Center Staff Dedicated to Community Cancer Screening***

The cancer centers that are doing well had a defined central unit that was committed to screening and disparities; that seems to be a predictor.

### ***Organize Cancer Center Consensus Statement on CRC Screening***

ACS has an organizational competency and reputation as a trusted convener and connector. ACS could help catalyze the commitment/consensus statement including the signing of the 80% by 2018 pledge.

### ***Evaluate***

Progress requires evaluations to determine what is working and what is not.



### **Dorothy Lane, MD, MPH**

Co-Chair, NCCRT Professional Education & Practice Implementation Task Group, American College of Preventive Medicine

Review the meeting report and provide feedback; suggested having a speaker or panel focused on cancer centers roles and CRC screening at the national meeting. Cancer Center directors attend this meeting, so it is the right audience.

### **Nikki Hayes, MPH**

Branch Chief, Comprehensive Cancer Control Branch, CDC

Help coalitions to reach the 80% by 2018 goal by delivering successful technical assistance forums and training and working to fold cancer centers into that work.

### **Paul Doria-Rose, DVM, PhD**

Acting Chief, Healthcare Assessment Research Branch, NCI

Collaborate to bring together teams and new partners involving cancer centers to look at issues and create an action plan for working towards shared goals.

### **Antoinette Percy-Laurry, DrPH, MSPH**

Health Scientist, Implementation Science Team, Division of Cancer Control and Population Sciences, NCI

Help to provide or facilitate the training required around evidence-based resources or around the implementation strategies required to move the evidence into practice.

### **Nina Miller, MSSW, OSW-C**

Manager Cancer Liaison Initiatives, American College of Surgeons Commission on Cancer

Work to improve the language to strengthen the screening initiative standard; start to work on finding out what partners are going to give and get if they participate in the mission to increase CRC screenings.

### **LeeAnn Bailey, MD, PhD**

Chief, Integrated Networks Branch, NCI

Help to build connections among cancer centers, community cancer centers, and communities and provide help in the areas of provider education and cultural competence; help to leverage navigators in the most efficacious manner.

### **Paul Limburg, MD**

Professor of Medicine, Mayo Clinic

Provide population-health expertise on CRC screening and other preventive services such as HPV vaccination; help to develop a vision for success for cancer centers that involves broader screening for CRC in the community and incentivizing them to move in that direction; helping to create new partnerships.

### **Ken Lin Tai, MD, MPH**

Director, Center for Cancer Prevention and Control, Maryland Dept of Health

Provide a platform as a state health department for discussions where all stakeholders in cancer centers and potential partners can meet to talk about issues.

### **Robin Vanderpool, DrPH, CHES**

Associate Professor, University of Kentucky

Collaborate with cancer center colleagues who have dedicated units to either community outreach, engagement, or disparities; share knowledge from Kentucky projects, such as the emergency room method of reaching out to people, or the model of using local surveillance cancer data, behavioral health data, and socio-economic data to form presentations for local cancer coalitions; help to develop the consensus statement.

### **Ronald Myers, DSW, PhD**

Director, Kimmel Cancer Center, Cancer Prevention and Control, Director, Dept of Medical Oncology, Division of Population Science, Professor, Dept of Psychiatry and Human Behavior, Thomas Jefferson University

Invite everyone to the second annual RCaDES initiative conference in Philadelphia on December first at Thomas Jefferson University; offer the white paper that describes the RCaDES initiative, and the companion guides that describe how to bring people together to address the CRC and lung cancers covered by the project; collaborate to create a more specific description of how the CPC+ program could be used as a strategy that could support sustainability for implementing approaches and increasing cancer screenings.

**Katie Bathje, MA, LPCC**

Program Director, Kentucky Cancer Consortium

Review and edit documents; help to create a technical assistance workshop for national partners to learn how to engage cancer centers, rural populations, and rural hospitals.

**Todd Lucas, PhD**

Associate Professor, Population Health Sciences, Wayne State, Karmanos Cancer Institute

Help cancer centers to work more closely with FQHCs.

**Karen Kim, MD, MS**

Professor of Medicine, Dean for Faculty Affairs, University of Chicago, Director, Center for Asian Health Equity

Engage the 22 state teams that attended CRC forums this summer to understand which teams are working with cancer centers as part of their action plans; document their experiences; work to support their engagement with cancer centers; collaborate to define the give-get model as it applies to interactions between cancer centers and coalitions; collaborate to review documents.

**Holly Guerrero**

Health Systems Manager, Hospitals, North Region, ACS

Continue to move forward in a convener role as an ACS staff person to help fulfill expectations that ACS should be a key facilitator of bringing people together.

**Electra Paskett, PhD**

Marion N. Rowley Professor of Cancer Research, Director, Division of Cancer Prevention and Control, Ohio State University

Share methods for funding a free colonoscopy program and mobilizing volunteers to operate it; share information about the inflatable super-colon initiative; help cancer centers with defining their catchment area and assessing it, and help with community outreach and engagement office staffing and plan development.

**Chyke Doubeni, MD, FRCS, MPH**

Presidential Professor, Family Medicine and Community Health, University of Pennsylvania

Share experiences working on a multi-year process to have GI colleagues support FIT screening as an option and acquiring an auto-analyzer; and from running experiments on screening incentives and choice architecture; continue to work to create a center of excellence to bring all the community health centers together.

**Kristina Thomson, LCSW**

Senior Director, Hospital Systems, North East Region, ACS

Collaborate with partners at the meeting table; work with ACS health systems staff to explore and identify how relationships can be leveraged; help to identify best practices and share them with 11 other colleagues across the country; work with the NYC C5 coalition and the NCI-designated cancer centers there to move the numbers toward the mark.

**Letitia Thompson, MPPA**

Vice President, Regional Cancer Control, South Region, ACS

Share experiences about navigation; work more closely with NCI-designated cancer centers to make them aware of helpful ACS health systems staff that have daily contact with FQHCs, hospitals, payers, health plans, Medicare, Medicaid, etc.

**Lynn Butterly, MD**

NCCRT Steering Committee, Director, Colorectal Cancer Screening, Dartmouth-Hitchcock Medical Center

Continue to work with local FQHCs because CRCCP programs are ideal connectors; continue to work with the local CCC coalition; continue to work with the local cancer center; continue to build the relationships from the CRCCP to FQHCs and communities and to bring the cancer center into the mix; share experiences with navigation and populations in a rural state; collaborate on a consensus statement.

**Cynthia Vinson, PhD, MPA**

Senior Advisor for Implementation Science, Implementation Science Team, Division of Cancer Control and Population Sciences, NCI

Support efforts to move toward a national implementation strategy; find ways to engage the cancer centers that are not yet participating in the different CRC activities; share experiences about successful HPV consortia and cancer center supplements; partner with the NCCRT to help bring the cancer centers together as a consortium by acting as a convener.

### Michael Potter, MD

Co-Chair, NCCRT Professional Education & Practice Implementation Task Group, University of California, San Francisco

Seek to understand the gap between the large number of counties (48) in the northern California UCSF catchment area and the relatively low interactions with communities outside of the immediate bay area; share lessons learned from the perspective of the co-chair of CRC initiatives; share a white paper that was published last year; help to build a toolkit for cancer centers; bring more cancer center representatives into the professional education and state practice implementation activities; continue to bring more people into the 80% by 2018 pledge

### Mary Doroshenk, MA

Strategic Director, Colorectal Cancer Intervention, Director, NCCRT, ACS

Continue to make excellent work available on the NCCRT website for use by others; help with the CRC workgroup of the national partners organization; possibly organize a workshop at the annual NCCRT December meeting featuring people from this meeting, as an example of what a good relationship with a cancer center might look like; pursue getting this topic on the agenda for the upcoming AACI meeting.

### (Unknown)

Share expertise around the idea of prevention in practice as an institution; learn from other cancer centers



## SUMMARY NEXT STEPS

### Roles for National Organizations

NCI, CDC and ACS leaders committed to reconvening to discuss immediate and long-term next steps, which could include:

- **Setting goals and expectations** around cancer center engagement in CRC screening and accountability, including for special populations.
- **Exploring how to align priorities** through funding supplements and long-term investment in national implementation science network on cancer control.
- **Incentivizing cancer centers to become more engaged in advancing CRC screening in their catchment areas.** Ideally, these incentives span across cancer centers, rather than concentrating some resources in select areas.
- **Incentivizing cancer centers to become more actively engaged in the development and execution of state cancer plans.** Cancer centers should be encouraged to engage with the community through their community advisory boards and through health systems within their catchment areas to decide on optimal strategies within their catchment areas to increase colorectal cancer screening rates. Cancer centers should engage with state and local health departments and offices of organizations such as the American Cancer Society on these activities, as well.
- **Defining cancer center catchment** areas and how they can play a more constructive role in cancer screening.



- **Developing a cancer center learning collaborative or workgroup**, in which cancer centers can learn from each other about adapting and implementing colorectal cancer screening interventions with health systems and payers that serve individuals who reside in their catchment areas. Additionally, leaders could create opportunities for cancer centers to collaborate and address issues, including bringing in cancer centers who have not yet invested in this cancer screening outreach activities.
- **Facilitating the training required** to move developed evidence-based interventions into practice or to create a technical assistance workshop for national partners to learn how to engage cancer centers, priority populations, and health systems.



## Roles for Cancer Centers

Cancer Centers could create a workgroup with staff support from the NCCRT, NCI or CDC, to conduct the following:

- **Support a vision in which cancer centers serve as “change agents” in their communities.** By bringing their expertise, experience, reputations, resources, and relationships, cancer centers can lead the way in promoting evidence-based CRC screening and other actions in cancer prevention and control. For example, an editorial promoting CRC screening signed by a cancer center director who cares for and daily witnesses the human tragedy of cancer diagnoses and treatments typically carries much more weight than a similar encouragement from an average citizen. Cancer centers can become more proactive in advocating, crafting data-driven arguments, and providing opportunities to interact with cancer survivors to help the public realize the tremendous promise of prevention and screening.
- **Develop and circulate a cancer center consensus statement** committing to activities that support the goal of achieving an 80% CRC screening rate nationally and within their catchment areas.
- **Make a case for involvement**, by creating a document enumerating potential incentives or alignments for cancer centers to collaborate with community stakeholders to increase colorectal cancer screening rates in their catchment areas. This could become a useful tool for cancer centers seeking to assess opportunities for new programs and partnerships.
- **Engage cancer center directors** by sharing findings from this summit at a meeting of American Association of Cancer Institutes (AACI) meetings to help increase awareness and forge broader consensus among cancer center directors who are just beginning or who have not yet considered engaging in these activities.
- **Share existing resources**, such as the Give/Get model, RCaDES, Project ECHO, etc.

## Role for the National Colorectal Cancer Roundtable

- **Convene a committee** of key stakeholders to review findings from this document to draft a set of strategic priorities.
- **Regularly invite cancer center leaders to engage** in its activities and initiatives and help bring cancer center leaders into more frequent and productive contact with each other and with community providers and payers across the country working on these issues. Encourage NCI designated cancer centers to apply for NCCRT membership.
- **Bring other important leaders to the table.** One competency of the NCCRT is its ability to bring other needed partners to the table, such as NACHC and HRSA. With help from NCI, we should also bring AACI to the table to help support a widespread effort that motivates widespread activities.
- **Leverage training with 33 state teams** to ensure cancer centers are a part of their teams and action plans (in partnership with the CCCNP).
- **Strategize about how to connect FQHCs with Cancer Centers.**
- **Develop a Toolkit for Cancer Centers on Community Engagement** that includes examples of steps they can take toward the goal of 80% screening within their catchment areas should be developed. This toolkit could:
  - Include a statement of the rationale for cancer centers to engage in this work as well as assessment tools to understand the current landscape within their catchment areas.
  - Include examples of best practices that have been put into place in leading centers such as those instituted by cancer centers participating in this summit.
  - Include guidance on how to support community-led initiatives through letters of support, small grants, co-branding, or assistance with program evaluation could also be useful.
  - Outline possibilities for diversified funding support, including fundraising, a partnership to increase available resources, identifying existing resources within the community, and identifying incentive.
  - Include examples of successful partnerships with federally qualified health centers that serve underinsured or uninsured populations, such as technical assistance with patient navigation and/or arranging discounted screening and treatment when necessary.
  - Help cancer centers consider opportunities to work together and engage with and support communities outside their catchment areas that are not currently served by any other cancer center.

## Roles for Meeting Attendees

- **Volunteer to serve on a committee to review findings** from this summit and draft a set of strategic priorities, an action/implementation plan, and metrics.
- **Look for opportunities to present the findings at upcoming meetings** to promote awareness, discussion, interest, and refinement of strategies.
- **Encourage cancer centers to sign 80% pledge and/or cancer center consensus statement** around common goals.

# APPENDIX A: OPENING COMMENTS

## Richard C. Wender, MD

Chair, NCCRT, Chief Cancer Control Officer,  
American Cancer Society, Inc.

The NCCRT is an organization of organizations supported by the *American Cancer Society (ACS)* and the *Centers for Disease Control and Prevention (CDC)*. The NCCRT, which has been in existence for 20 years, focuses with a laser-like intensity on increasing colorectal cancer (CRC) screening rates.

NCCRT efforts have been unified around the **80% by 2018** initiative, a shared goal to try to achieve 80% colon cancer screening rate by the end of 2018. There has been tremendous state-level coalition work focused on CRC screening. Pledges have been received from every state in the country. Over 1600 organizations have signed the pledge, and 80% screening rates have even been achieved by quite a few systems, including FQHCs, which serve the hardest to reach. Most importantly, all the major national measures of CRC screening rates are trending upward.

As a part of this effort, numerous partners proposed a meeting to explore the strategic role cancer centers can play in the effort to increase CRC screening rates. The Comprehensive Cancer Control National Partners, the NCCRT Professional Education and Practice Implementation task group and leaders of the National Cancer Institute (NCI) Cancer Moonshot initiative all proposed the same idea.

There is a strong interest in leveraging the expertise and talent from cancer centers to benefit the health of the surrounding communities by increasing CRC screening rates. Many cancer centers are doing just that.

## Robert T. Croyle, Ph.D.

Director, Division of Cancer Control and Population Sciences,  
National Cancer Institute

The NCCRT is coordinating CRC-related activities across many organizations nationally, as well as within other local and state roundtables that have been recently formed. Discussions have been held at a strategic level for ACS, NCI, and the CDC to help NCCRT to align its efforts for maximum program results while eliminating duplication of efforts across these and other organizations, where possible.

Goals of NCI-funded activities include trying to better understand population health management, the integration between population health and cancer center operations, and the connection between public health, community health engagement, and clinical care.

Diverse perspectives from the meeting participants today are important for identifying gaps, duplications, best practices, and opportunities for improvement. The meeting participants today are national exemplars; the intention is that the meeting will be followed with a broader effort to help advance community engagement in colorectal cancer screening among all cancer centers.

Three important topics on the agenda are to 1) explore the role of cancer centers with respect to enhancing CRC screening; 2) identify the actions required to fulfill that role; and 3) determine how they can be supported by others.



## THE NATIONAL CANCER INSTITUTE

The NCI is part of the National Institutes of Health and coordinates the U.S. National Cancer Program. The NCI conducts and supports research and other activities related to the causes, prevention, diagnosis, and treatment of cancer.

The NCI supports a nationwide network of 69 NCI-designated cancer centers that are focused on cancer research and treatment.

# APPENDIX B: BARRIERS, NEEDS AND OPPORTUNITIES

## PRE-MEETING SURVEY RESULTS

Prior to the summit, participants took part in a 12-question survey about the role of cancer centers in promoting CRC screening. Responses were received from 24 participants representing 17 groups. Question types were check-all-that-apply or were open-ended.

### What are the roles cancer centers can play in supporting CRC screening in communities?

#### Survey Responses

Promote their knowledge of evidence-based interventions to increase CRC screening and reduce disparities. Share best practices with both healthcare organizations and provider groups.

Collaborate with local health systems and community stakeholders (ACS, GIs, FQHCs, comp cancer, primary care), including those who serve the underserved. Be at the table and ENGAGED. Be present in the community.

Serve as a safety net. Provide accessible facilities for screening, including for underserved. Provide treatment for underserved as community benefit

Provide leadership in provider education/guidelines. Communicate with primary care networks about CRC screening

Educate. Conduct local media campaigns in the catchment area with a culturally-sensitive campaign and reading level, including by reaching their patients and families.

Provide centralized, systematized screening facility that is accessible and welcoming to the community. Be accessible and welcoming, especially in diverse communities; center of excellence.

Use stature to elevate the issue in the community. Collaborate to create a vision/plan for the community/Provide leadership in both the community and at that state level. Embrace role as flagship institution.

Advocate.

Lead by example. Assess own system and implement policy and systems changes/monitor physician performance, including follow up for a positive FIT. Elevate issue internally.

Collaborate to support navigation/community health educators.

Collaborate on registries; share data with researchers

Conduct coordinated media campaigns. Collaborate with ACS, CDC, NCI, Fight CRC, other cancer centers to promote common messages to the broadest population.

Collaborate on quality initiatives. Link screening efforts with CoC standards.



Cancer centers can play a strong role in supporting CRC screening in communities by collaborating with local health systems and community stakeholders such as ACS, GIs, FQHCs, comprehensive cancer, primary care, and those who serve the underserved.

Be at the table and be **ENGAGED**. Be present in the community.

### What are some of the biggest challenges that cancer centers face regarding these roles?

#### Survey Responses

Competing priorities. Cancer centers do not always have dedicated resources for community outreach/cancer control. Incentive from funders is to focus on scientific/services provided

Funding. How best to cover costs for screening underserved populations), especially in non-Medicaid states. Long wait times. Lack of funding for staff or materials

New role. The traditional focus on treatment/research. Need to go beyond this to understanding the community and screening barriers (transportation, cultural barriers, etc.). Hard to get internal buy-in.

Readiness. Implementation, particularly among marginalized, will require intensive intervention; cancer centers may not be prepared to provide culturally competent outreach.

Developing new relationships. Need to develop new relationships and networks/learn to work collaboratively. Need to learn who has already been working in this space

Not knowing where to start. Less experience is going outside the cancer center "walls." How do they do it, what do they do first, who are potential partners? (Where is a navigator housed?)

Reputation. Some in the community may view the institution as elitist/mistrust. Reputation for disappearing from the community once funding is gone. Research fatigue.

Poor communication/coordination with primary care, even within the same system

Finding a model to adapt what works. Smaller practices may not have resources to adapt strategies cancer centers recommend. Other practices may not welcome CC as they are viewed as "competitors."

Ineffective use of FIT. View colonoscopy as the best test OR FIT interventions may be lacking (require a physical return to the lab, one-day focus on FIT testing, etc.).

Poor metrics. Some CoC metrics exist but are used on non-effective interventions such as health fairs.

## How do we overcome these challenges?

### Survey Responses

Community presence. Consistent community outreach/presence to build trust, partnerships, and effectiveness. (ACS, CRCCP, CCC).

Make the case. Data showing that increased screening decreases late stage dx and the PN/CHW can reduce no-shows, equating to dollars for the system, etc.

Alignment of priorities. NCI should set specific standards for catchment population and set CRC screening targets for achieving/maintaining Cancer Center status.

Buy-in of leadership/Champions.

Funding. More funding mechanisms from NCI, including cancer center supplements, focused on CRC screening.

Data to show where to start/areas to target; demonstrate their capacity

Focus on reimbursement issues/collaboration with payers

Position cancer center as a leader in the community. Walk the line of being the go-to resource for gold standard info & treatment, and as a team player that will listen to community input.

Embrace screening options to address resource issues.

Encourage cancer centers to share models and methods to increase CRC screening.



### What challenges do cancer centers face on this issue that are unique to rural and underserved communities?

#### Survey Responses

Transportation issues, distance for rural poor/taking public transportation for colonoscopy in urban settings

Lack of meaningful communications and connections to primary care/ FQHCs serving those communities; care plans do not exist

Limited access to gastroenterology practitioners for follow up services; no medical neighborhood

Cultural issues (i.e., genetic testing can be a taboo topic for some racial/ethnic minorities, language issues; no word for cancer among AI/AN, etc.).

### What do you recommend for helping overcome challenges specific to rural and underserved communities?

#### Survey Responses

Address transportation issues. Extend hours, use new technology, start direct referral programs, use gas vouchers, use vans (include follow-up)

Collaborate. Collaborate with rural health clinics, FQHCs, state PCA, roundtables/coalitions, ACS, etc.

Use navigators.

Engage for the long term. A history of engagement will build trust among underserved. Establish a dedicated team. Engage gatekeepers. Go to the community.

Provide options such as FIT. Distribute FIT in community with appropriate follow up

Find alternative ways to communicate. Place CC staff in the community. Use Project ECHO. Use accessible technology such as Facebook AFTER trust has been established.

Develop plan. Develop plan/collaborative models with the community to ensure benefit.

Conduct culturally competent education campaigns. Provide providers with tailored education materials.

Mandates from funders

Provided low-cost services. Provide finite services and/or identify resources in concert with community

## What do you recommend for securing leadership buy-in for work on these efforts?

### Survey Responses

Demonstrate value and benefit. Showcase elimination of waste/increased revenue or other value – such as improved trust increases clinical trial participation

Requirements/incentives/funding from funders. Use NCI's strategic plan as a vehicle.

Develop collaborative funding strategy. Involve health systems and payers. Strengthen payment models that reward population management

Involve leaders in establishing medial neighborhood. Get leader out into community/meet with FQHC

Evidence. Share evidence that education, choice, and follow-up can move the needle CRC screening. Identify exemplars

Demonstrate alignment with CC priorities. (Community benefit/Link screening initiative to research).

Share cancer survivor testimonials with leadership. Share stories that emerge from a cancer center CRC screening project

Influence of state and congressional legislative members. State funding can help with sustainability

## What do you recommend for addressing financial/sustainability issues that are needed to advance cancer center work in this area?

### Survey Responses

Make the case that screening is financially rewarding for a cancer center.

Engage payers early in the process.

Diverse and/or collaborative funding. Grant funding for EBIs; utilize strategic partnerships across disease areas; local philanthropy.

Increase cancer center outreach staff. Think navigators and community liaisons.

Support for navigation programs. Federal/state funding; Community Benefit grants; other supporting grants; expand research cost/benefit of navigation.

Advocacy and Policy Change. Particularly at the state level.

Reframe the message. Make a case for screening underserved populations to health systems; demonstrate working models (ACS Links of Care)

Strategic Partnerships.

Help to engage other stakeholders. Pool resources and collaborate on grants.

However, little response from agencies on this question. Potential area of conversation for today.

### Which essential partners should cancer centers work with at the local level?

#### Survey Responses

General agreement on a wide range of community partners from all sectors of society – public, private, and nonprofit/voluntary.

Clinical/health (e.g., Federally Qualified Health Centers and other community health centers, Prevention Research Centers, health departments, other hospitals, nutrition centers, Red Cross chapters, pharmacies)

Planning/regulatory agencies (e.g., Area Health Education Centers)

Community (e.g., faith communities/organizations, multicultural community centers, shelters/soup kitchens, migrant worker groups, civic groups, minority and LGBTQ organizations))

Business (e.g., private businesses – barber/beauty shops, restaurants serving traditional cultural foods, etc.; Chamber of Commerce; rural economic development centers)

Academic (e.g., institutions serving underserved health disparity populations and underrepresented students; other colleges and universities)

Communication (e.g., health advocacy newsletters, media, state/local websites)

Government (e.g., city council members and other elected officials, Mayor's/County Executive's office, military installations)

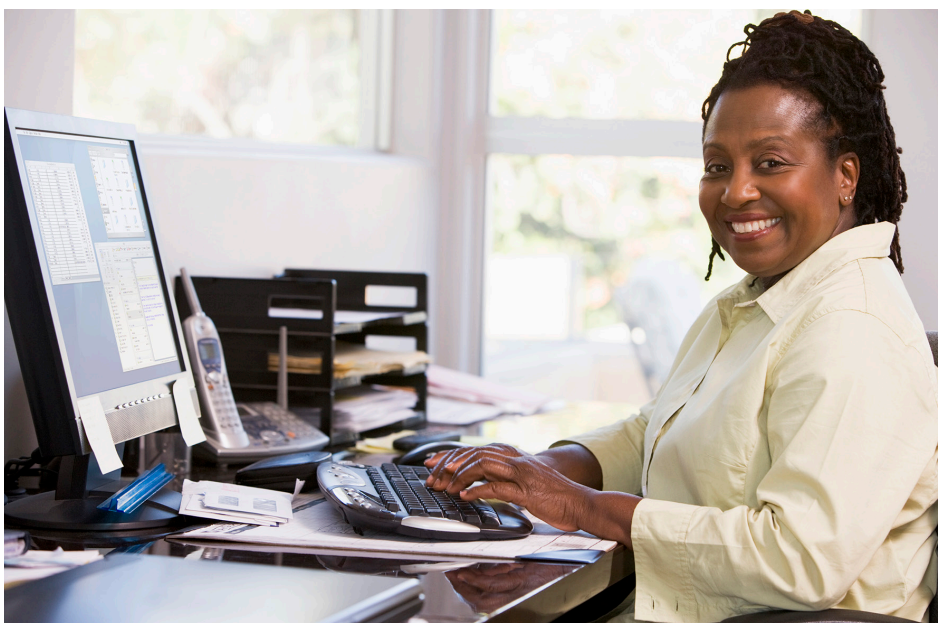
Funding resources (e.g., philanthropic institutions, foundations)

National Agencies (NCI, CDC, ACS)

Professional associations (Primary care, surgical, etc.)

Voluntary collaboratives (State cancer coalitions and cancer plans)

However, who are the ESSENTIAL partners?



Most survey respondents focused on three areas at the state level: funding, research and practice, and making sure that the national agencies were providing content, defining roles, and encouraging the responsibilities that cancer centers have in the CRC screening area.

## What should national leaders be doing to support cancer centers in this role?

### Survey Responses

Develop strong case studies; provide funding; connect; provide resources (funding, educational, TA)

Funding (particularly that encourages collaboration; also for demonstrated, successful EBIs)

Central, neutral hub for unified messaging. (Joint cancer center consensus statements, coordinated awareness campaigns)

Connector (cancer centers to cancer center; or to local stakeholders)

Guidance and Leadership (Setting expectations, benchmarks, and guidelines specifically for collaborations; recognition/distinctions)

Resources (toolkits, guides, case studies, technical assistance, workshops, etc.)

Aligned Actions. (Broader than messaging. Cooperation, communication, Sharing)

Also, federal advocacy in health care and ACA expansion/improvement

## What issues could benefit by being addressed from a policy or legislative perspective? Please explain how.

### Survey Responses

Advocate for federal and state CRC screening programs

Screening Copays – Positive FIT and Follow up Screening

Reimbursement / funding for Patient Navigation

Reimbursement for other screening modalities

Access to care (continued coverage of CRC screening, Medicaid expansion)

CPC+ Program Funding.

Critical to also focus on state legislative opportunities.

## What other advice do you have for us on accelerating cancer center support for CRC screening, not captured above?

### Survey Responses

Funding. Utilize Cancer Center Support Grants. Provide funding supplements to develop and promote implementation interventions for rural or underserved communities.

Research and Practice. Continue to invest in understanding consumer and patient perspectives (refine messaging for targeted populations). Convene national forums on barriers to CRC adherence and involve cancer centers in the conversations.

Provide content, define roles, and prove the responsibility. Checklist of actions. Identify appropriate actors within cancer centers. Articulate how cancer centers benefit from this focus, why it's important for catchment area, and demonstrate other successes.

# APPENDIX C: VISION AND BLUEPRINT REPORTS



Meeting participants were organized into three groups to consider questions in the topic areas shown below. Participants were randomly shuffled among topic areas every 15 minutes so that everyone could comment on each topic area. Each topic area discussion was guided by six questions. Group leaders reported back after the discussions. Please keep in mind these discussions do not reflect final meeting recommendations, but rather collectively helped inform the next steps found in the section [Summary Next Steps](#) on page 43.

## TOPIC 1: ROLES OF NCI CANCER CENTERS

**What are the critical roles that NCI-designated cancer centers should play in advancing CRC screening?**

**Break out led by Lisa Richardson; ACS Staff Support Caleb Levell**

**Q1**

Where cancer centers have emerged as leaders advancing CRC screening in their communities, what common roles have they played?

- The common roles included providing data for evaluation and need assessments, and serving as experts and leadership champions from the cancer centers.
- Cancer centers provide the comprehensive cancer center research role versus the delivery of healthcare and advocacy.
- Cancer centers can also provide staff and knowledge for how to get funding for resources that can benefit the community.

**Q2**

What are the common features of cancer centers that have emerged as leaders advancing colorectal cancer screening in their surrounding communities?

- Many of the leading cancer centers have centralized units to focus on disparities, screening, outreach, education, policy, and navigation.
- Alignment of goals and missions among stakeholders is critical (among cancer centers, the healthcare systems, the public health systems, ACS, etc.) Speaking with one voice is useful.

Q3

How can other cancer centers identify ways they can contribute to CRC screening in the surrounding community?

- The two main ways are to ask and listen. Talk back and forth with stakeholders and make a business case for desired actions and outcomes to the people in charge.

Q4

What is the role of cancer centers in advancing not only the implementation science around CRC screening but also the implementation of screening?

- It may not be possible to do one without doing the other, but there was some disagreement among participants. While cancer centers primarily do research, most of the centers also deliver health care services and in fact, depend on the clinical revenue from that delivery of healthcare services. The point was made that the evaluation of delivering interventions is also a form of research. Interventions may be efficacious in a study but not be effective on the ground.

Q5

What barriers are getting in the way of cancer centers fulfilling these roles?

- Faculty members at universities can experience competition between the time required to write grant papers and time required to go out and do work in the community. Some community locations can be 3-4 hours away from the universities, which results in additional driving time. Peer pressure in the form of positive support for community work might help to reduce the conflict between time priorities.
- Competition for grants and business can make it difficult for stakeholders and organizations to work together. One participant mentioned the territorial culture within universities. Speaking with one voice would help, especially if it was developed at a national forum

Q6

How can we overcome those barriers?

- Making a good business case for CRC screening would be helpful, by articulating a business case from the perspective of a comprehensive cancer center and its parent institution.
- Focusing on chronic disease to achieve more collaboration across cancers would be helpful, but doing that is a challenge because funding is usually allocated for specific areas of work.



## TOPIC 2: ROLES OF NATIONAL ORGANIZATIONS

**What are the roles of national organizations, such as NCI, CDC, ACS and the NCCRT, in stimulating NCI-designated cancer center work around CRC screening in their surrounding communities?**

**Break out led by Michael Potter; ACS Staff Support Kerstin Ohlander**

**Q1**

**What unique challenges around CRC screening are cancer centers collectively positioned to address?**

- Cancer centers are well-positioned to address the issues of patient education and clinical best practices. Cancer centers can help to increase awareness and education among patients and clinical providers through media campaigns and educational programs.
- Cancer centers are responsible for large geographical catchment areas that contain diverse communities and clinical stakeholders with which they have ongoing relationships. Because of their name recognition and reputations for excellence, cancer centers are often positioned to convene these groups and mobilize them toward shared goals.

**Q2**

**What strengths can cancer centers bring to CRC screening in their areas?**

- Cancer centers have researchers and clinical faculty with cutting-edge knowledge about prevention, early detection, and treatment, as well as experts in the theory and practice of dissemination and implementation.
- Cancer centers often have access to data that can help communities see how they are doing in terms of cancer incidence and mortality.
- Cancer centers can lend their reputation, prestige, and marketing skills to create co-branding opportunities with community-based organizations, healthcare providers, and corporate entities to promote cancer screening in their catchment areas.

**Q3**

**How can cancer centers collectively come together to identify a common contribution to CRC screening and monitor that contribution over time?**

- While organizations like NCCRT can help to convene cancer centers around the topic of CRC screening, it is probably too much to think that this alone can provide sufficient incentives for a robust effort that reaches and motivates widespread initiatives. Champions for this cause within AACI can help.



## Q4

#### How can the NCI, CDC, ACS and the NCCRT stimulate the work cancer centers do around CRC screening?

- NCI and CDC can provide incentives through funding opportunities and/or funded mandates. CDC, through its programs, may be able to incentivize cancer centers to become more engaged. To the extent possible, these funding opportunities should be widely available with incentives for meaningful community engagement and for collaboration across cancer centers rather than “winner-take-all” approaches that end up leaving resources unduly concentrated in centers of excellence across the nation.
- ACS may also be able to provide resources and in-kind support to incentivize community engagement by cancer center clinicians and researchers.
- NCCRT could more regularly invite cancer center leaders to engage in its activities and initiatives and help bring cancer center leaders into more frequent and productive contact with each other, and with community providers and payers across the country that are working on these issues.
- The NCI and CDC can work together to create incentives for cancer centers to become more actively engaged in the development and execution of state cancer plans.
- The NCI, CDC, ACS, and the NCCRT could play a role in building a consensus around the issue of defining cancer center catchment areas and how they can play a more constructive role in cancer screening. For example, these groups could map out geographical areas of cancer centers in the United States to determine if there are regions that are currently not being served by any cancer center. They could develop collaborative programs with cancer centers to address these deficits regarding cancer screening outreach programs.

### Q5 What should our short- and long-term goals be to advance this vision?

Short Term:

- Increase the number of cancer centers signing on to the 80 by 18 pledge
- Create opportunities for cancer centers to convene and share best practices and opportunities to collaborate. There should be a workgroup for cancer centers to address these issues collaboratively. There should be efforts to bring cancer centers that have not yet committed resources to cancer screening outreach activities.

Long Term:

- Develop funded mandates and/or other types of funding opportunities to incentivize more robust engagement of cancer centers with their catchment areas, using models that incentivize collaboration and provide opportunities for all cancer centers to participate.

### Q6 What must happen next?

- Create a committee of key stakeholders to review findings from the Cancer Center Summit and draft a set of strategic priorities. Present the findings at an upcoming meeting of the Association of American Cancer Institutes to promote awareness, discussion, and refinement of strategic priorities. Goals might be to encourage cancer centers to sign onto the 80% by 2018 pledge and/or a cancer center consensus statement around common goals and aspirations relating to colorectal cancer screening which might guide decisions by federal funders around these issues.
- Start to build a toolkit for cancer centers and write a companion white paper for it.



## TOPIC 3: NEEDS OF CANCER CENTERS

What do individual NCI designated cancer centers most need if they are to play a more robust role in advancing CRC screening?

Break out led by Cindy Vinson; ACS staff support Sarah Shafir

**Q1**

What barriers are getting in the way of cancer centers playing an active role in supporting CRC screening in their surrounding communities?

- One barrier was the need for more support for community outreach and engagement.
- Another was the lack of relationships between the cancer centers and the community.
- Another is competition in the community among the hospitals and the cancer centers.
- Another is competing priorities within the cancer centers for different subjects and areas.
- Another is possible misalignments between the resources of the cancer centers (for research) and the health systems (for healthcare delivery).

**Q2**

How can these challenges be overcome?

- By diversifying funding sources. For example, MD Anderson in Texas partnered with Jason's Deli to develop a salad offering that would contribute one dollar per sale into a pool for supporting care delivery.
- By having a policy agenda that promotes paying for care that's tied to health outcomes.
- By partnering with other community organizations to increase the available resources.
- By identifying existing resources in the community and leveraging those resources.
- By identifying incentives for implementing evidence-based interventions.

**Q3**

Which key local partnerships are important?

- Key local partnerships for cancer centers include FQHCs, community health centers, county and local providers, state and local health departments, private primary care providers, gastroenterologists, and the local ACS organization.
- Cancer centers should partner with patients to assess the patient perspectives.
- Partnerships with local media outlets, payers, medical societies, primary care associations, retailers, and local Chambers of Commerce.
- Partnerships with employers, state and local cancer coalitions, electronic medical records vendors, faith-based organizations, and community advisory boards.

**Q4**

### How should cancer centers work with local coalitions focused on CRC screening or their Comprehensive Cancer Control Plans?

- If there isn't a local coalition, cancer centers should help to create one. Identifying clear roles and goals for cancer centers for this work might help to incentivize their participation.
- Cancer centers can bring data and subject matter expertise to the coalition table.
- Cancer centers can serve as champions for policy changes, including advocating for local and state legislation.
- Cancer centers could help coalitions to identify navigation resources.
- Cancer centers and coalitions can work together to address cultural competency issues.
- Coalitions should be able to articulate the give-get model to cancer centers to show how the centers can benefit from working with the coalitions.

**Q5**

### What can the NCCRT, NCI, CDC or ACS be doing to support this work?

- Work to create one voice and set goals and expectations around engagement in CRC screening and accountability.
- Help to develop clear quality metrics that go beyond self-reporting so that more reliable sources of data can be developed and collected.
- Metrics should cover the continuum from screening to follow-up. That approach would help to create a more comprehensive understanding of the entire screening process.
- Ensure that collected metrics include metrics for special populations.
- Fund community collaborations.
- Work to disseminate best practices.
- Help to develop some national models for Links of Care, an ACS/NCCRT pilot project to build specialty care linkages for FQHC patients. The pilots sought to accelerate development of clinical care linkages between FQHCs, gastroenterologists and local health care systems in the delivery of colorectal cancer screening, based on a “fair share” model.

## APPENDIX D: ATTENDEE COMMITMENTS

**There was a specific barrier mentioned at the meeting that I believe my organization can help overcome. Please contact me for details.**

Mike Potter	UCSF	Yes.
Nikki Hayes	CDC	Connecting CC and CCC coalitions, state-local level players – can help plan/deliver TA training – to convene[??] + action plan for collaboration. Priorities. Katie interested in being engaged-planning committee. [??]-...to the help
Paul Doria-Rose	NCI	Yes. [see next]
Paul Limburg	Mayo Clinic	Aligning cancer center priorities in catchment area with practice priorities more broadly.
Ronald E. Meyers	Thomas Jefferson University	CPC+ program as a vehicle for supporting cancer prevention and central sustainability
Electra Paskett	OSUCCC	Free colonoscopies
Holly Guerrero	ACS	Yes
Letitia Thompson	ACS	Convener[??] navigation. AUBS.
Cynthia Vinson	NCI	Keep Cancer Center Engagement at the forefront of CCCNP discussion. Think about NCI funding for this.

**There is analysis or research that my organization has conducted or might be able to conduct to help inform the work of other cancer centers in this area.**

Lisa Richardson	CDC	BRFSS (may have these statistics)
Paul Doria-Rose	NCI	I would be interested in helping with research that examines the CRC screening process in underserved communities/settings, perhaps with linkage to PROSPR
Robin Vanderpool	U of Kentucky / CPCRNI	Ex. Mary's[??] interested in the rural ED data presentations/project to our local ca. coalitions, Churches
Todd Lucas	Wayne State University Karmanos	Yes.

## APPENDIX D: ATTENDEE COMMITMENTS

### I would like someone to present about one of the projects described at today's meeting to my organization to discuss possible expansion.

Dorry Lane	The American College of Preventive Medicine	Will consider having a ...@...ACPM national meeting focusing on CC role in... community...[illegible]
Antoinette Percy-Laurry	NCI	Present project on the Research to Reality Platform
Robin Vanderpool	U of Kentucky / CPRN	Ex. MD Anderson/Ohio State, etc., specific units, centers, etc., dedicated to COE prev. and screening, health disparities, Give + Get model; pt. navigation
Katie Bathje	Kentucky Cancer Consortium	Hopefully Robin does too. COE high achievers (Ohio, IL, TX)
Sarah Shafir	ACS	We might like to call on Kentucky to share work with 22 state CRC teams.

### Our organization has created tools or materials related to CRC screening that may be of interest to other cancer centers.

Lisa Richardson	CDC	CHC tool to set clinic level screening rates. Navigation model from NH – manual online
Mike Potter	UCSF	(Manuscript just submitted to Health Affairs on SFCAN)
Nikki Hayes	CDC	Yes
Paul Doria-Rose	NCI	PDQ Summaries
Leeanne Bailey	NCI	Translations of CRC education and outreach material (cultural competence), social media toolkits
Antoinette Percy-Laurry	NCI	Yes
Ernie Hawk	UT MD Anderson	Cancer control platform; educational materials; project ECHO
Ronald E. Meyers	Thomas Jefferson University	RCaDES initiative guide/conference...for NCI cancer centers Designated cancer centers[??]
Electra Paskett	OSUCCC	Super Colon initiative; Give-Get model
Holly Guerrero	ACS	Yes
Nina Miller	ACS-COC	Yes

**I am with a community partner who would be interested in exploring a stronger relationship with our local NCI designated cancer center.**

Ken Lin Tai	Maryland Dept of Health	Yes
Holly Guerrero	ACS	Yes
Letitia Thompson	ACS	Yes
Kristina Thomson	ACS	Yes

**I am willing to review the meeting and provide feedback.**

Lisa Richardson	CDC	Yes
Mike Potter	UCSF	Yes
Dorry Lane	The American College of Preventive Medicine	Yes
Nikki Hayes	CDC	Yes
Paul Doria-Rose	NCI	Yes
Paul Limburg	Mayo Clinic	Yes
Ernie Hawk	UT MD Anderson	Yes
Robin Vanderpool	U of Kentucky / CPCRN	Yes
Katie Bathje	Kentucky Cancer Consortium	Yes
Ronald E. Meyers	Thomas Jefferson University	Yes
Cynthia Vinson	NCI	Yes

## APPENDIX D: ATTENDEE COMMITMENTS

### My organization would be willing to contribute to this effort in the following capacity, not described above.

Ernie Hawk	UT MD Anderson	Participate in better defining[??] and promoting cancer control among centers, including CRC screening.
Robin Vanderpool	U of Kentucky / CPCRn	Consensus statement review/feedback and toolkit.
Katie Bathje	Kentucky Cancer Consortium	Participate in planning a TA workshop by national partners. Targeting CC re: collaborating on CRC screening.

### Comments:

Dorry Lane	The American College of Preventive Medicine	More ACPM members are employed in...health departments, federal agencies, primary care, etc.
Ken Lin Tai	Maryland Dept of Health	Very insightful comments and discussion. Fantastic meeting – some very practical next steps that I can bring back with me.
Katie Bathje	Kentucky Cancer Consortium	Kentucky partners are willing to be a sounding board as this moves forward; and even plot projects re: how we can better connect with our rural communities with CC
Electra Paskett	OSUCCC	I can also help Cancer Centers with: Catchment area definition and assessment; Community outreach office, ... and plan.
Todd Lucas	Wayne State University Karmanos	Interested in any initiatives towards collaborations with FQHCs
Sarah Shafir	ACS	22 funded state teams help define “Give/Get” between cancer centers and local coalitions. Influence engagement of cancer centers in this work.

### Other necessary steps will be:

Mike Potter	UCSF	I am here to help...
Paul Limburg	Mayo Clinic	Happy to participate in further discussion re: any of the topics below: Cancer Center toolkit for community engagement “Cancer Center Consortia” model New standards + metrics for Cancer Centers, related to community screening rates and/or outcomes
Ernie Hawk	UT MD Anderson	1. Enlisting the support of leaders inside and outside the CC community 2. Forging stronger partnerships with front-line screening[??] communities
Electra Paskett	OSUCCC	To have a program like BCCEDP for CRC in all states. Reimbursement from payers for patient navigation.
Letitia Thompson	ACS	Better education for ACS staff on NCI centers and COEs. Project ECHO.
Kristina Thomson	ACS	What Mary and Rich ask me to do that’s within reason. Work with Nina Miller/COC re: ACS/State Chairs/CLP Leverage info shared to review on the ground...CC/ACS staff from ME-DC NE corridor[??] Work with Letitia/Sarah/Holly – Apply it to ACS line staff Figure out how to leverage C5 Coalition/NCI in NYC

# APPENDIX E: AGENDA

## CANCER CENTER SUMMIT: A STRATEGIC LOOK AT CANCER CENTERS AND COLORECTAL CANCER SCREENING

Monday, October 2nd – Washington, DC

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**Objective:** Convene representatives from key national and local organizations to explore how to leverage the expertise and community presence of cancer centers in the effort to increase CRC screening rates.

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- Goals:**
1. Document centers of screening excellence that have leveraged their position as community leaders to increase CRC screening rates for the surrounding community;
  2. Explore how these cancer centers became leaders in the effort to increase CRC screening and identify best practices;
  3. Understand cancer center barriers to focusing on CRC screening as a priority issue;
  4. Identify strategies to overcome barriers so that cancer centers can leverage their role in the community to achieve higher CRC screening rates; and
  5. Begin the process of developing a strategic plan to spur cancer center action in this area.
- 

**8:30 am**      **Continental Breakfast**

**9:00 am**      **Summit Opening**

Welcome & Opportunity

- Richard C. Wender, MD, Chair, NCCRT, Chief Cancer Control Officer, American Cancer Society, Inc.
- Robert T. Croyle, Ph.D., Director, Division of Cancer Control and Population Sciences, National Cancer Institute
- Nikki Hayes, MPH, Branch Chief, Comprehensive Cancer Control Branch, Division of Cancer Prevention and Control, National Center of Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Introductions

**9:40 am**      **Barriers, Needs, and Opportunities**

Pre-Meeting Survey Results

- Mary Doroshenk, MA, Director, National Colorectal Cancer Roundtable, Strategic Director, Colorectal Cancer Intervention, American Cancer Society
- Caleb Levell, Program Manager, National Colorectal Cancer Roundtable, American Cancer Society, Inc.

**10:00 am**      **BREAK**

**10:15 am Excellence in Advancing CRC Screening: Case Studies**

8-minute Presentations

- Cancer Prevention and Control Platform  
Ernest Hawk, MD, MPH, MD Anderson, Vice President, Division Head Cancer Prevention and Population Sciences
- Community Engagement  
Electra Paskett, PhD, The Ohio State University, Marion N. Rowley Professor of Cancer Research, Director of the Division of Cancer Prevention and Control
- Colorectal Cancer Control Program Grantee  
Karen Kim, MD, MS, University of Chicago, Professor of Medicine, Dean for Faculty Affairs Division of the Biological Sciences, Director, Center for Asian Health Equity Director, UCCCC Office of Community Engagement and Cancer Disparities
- Data- and Context-Driven Approaches to Community Outreach for Colorectal Cancer Screening  
Robin Vanderpool, DrPH, CHES, University of Kentucky, Markey Cancer Center, Associate Professor
- Reducing Cancer Disparities by Engaging Stakeholders (RCaDES)  
Ronald Myers, DSW, PhD, Thomas Jefferson University, Kimmel Cancer Center, Director, Cancer Prevention and Control, Director, Department of Medical Oncology, Division of Population Science, Professor, Department of Psychiatry and Human Behavior
- The Power of Patient Navigation  
Lynn Butterly, MD, Director, New Hampshire Colorectal Cancer Screening Program, Dartmouth – Hitchcock Medical Center, Member, NCCRT Steering Committee

**11:20 am BREAK**

**11:35 am What can we learn from these high performers?**

Q&A and open discussion with presenters

- What are the common themes with respect to each of these roles?
- What has been crucial at each location?
- What challenges elude them?
- What advice do they have for us on:
  - Getting buy-in (leadership and community)
  - Logistics/coordination (community presence, navigation, transportation, partnership, state cancer plan, etc.)
  - Resources (staff, budget, philanthropy)
  - Financial (costs, funding, sustainability, role of payers, etc.)
  - Policy issues
  - Replication

**12:35 pm LUNCH**

**1:35 pm The Partner Perspective -- Reflections from Key Community Partners**

- Katie Bathje, MA, LPCC, Program Director, Kentucky Cancer Consortium
- Ken Lin Tai, MD, MPH, Director, Center for Cancer Prevention and Control, Maryland Department of Health
- Suzanne Lagarde MD, MBA, FACP, Chief Executive Officer, Fair Haven Community Health Center
- Holly Guerrero, Health Systems Manager, Hospitals, North Region, American Cancer Society, Inc.
- LeeAnn Bailey, MD, PhD, Chief, Integrated Networks Branch, Center to Reduce Cancer Health Disparities (CRCHD), National Cancer Institute

**2:15 pm Vision and Blueprint: Key Questions**

Small Group Discussion

(All groups discuss all topics for 15 minutes each, rotating through each topic; leaders stay where they are for all three sessions)

### **Topic Area #1: What are the critical roles that NCI designated cancer centers should play in advancing CRC screening?**

Break out led by Lisa Richardson; ACS Staff Support Caleb Levell

1. Where cancer centers have emerged as leaders advancing CRC screening in their communities, what common roles have they played?
2. What are the common features of cancer centers that have emerged as leaders advancing colorectal cancer screening in their surrounding communities?
3. How can other cancer centers identify ways they can contribute to CRC screening in the surrounding community?
4. What is the role of the cancer center in advancing not only implementation science around CRC screening but also implementation?
5. What barriers are getting in the way of cancer centers fulfilling these roles?
6. How can we overcome those barriers?

### **Topic Area #2: What is the role of national organizations, such as NCI, CDC, ACS and the NCCRT, in stimulating NCI-designated cancer center work around CRC screening in their surrounding communities?**

Break out led by Michael Potter; ACS Staff Support Kerstin Ohlander

1. What unique challenges around CRC screening are cancer centers collectively positioned to address?
2. What strengths can cancer centers bring to CRC screening in their area?
3. How can cancer centers collectively come together to identify a common contribution to CRC screening and monitor that contribution over time?
4. How can the NCI, CDC, ACS and the NCCRT stimulate the work cancer centers around CRC screening?
5. What should our short-term and long-term goals be to advance this vision?
6. What must happen next?

### **Topic Area #3: What do individual NCI designated cancer centers most need if they are to play a more robust role in advancing CRC screening?**

Break out led by Cindy Vinson; ACS staff support Sarah Shafir

1. What barriers are getting in the way of cancer centers playing an active role in supporting CRC screening in their surrounding communities?
2. How can these challenges be overcome?
3. Which key local partnerships are important?
4. How should cancer centers work with local coalitions focused on CRC screening or their Comprehensive Cancer Control Plans?
5. What can NCCRT, NCI, CDC or ACS be doing to support this work?

**3:10 pm Vision and Blueprint Reports (5-minute reports, followed by 10-minute open discussion)**

**3:35 pm Taking Action:** How do we turn this vision into reality? What will be the responsibility and role of national organizations? Individual partners? What should key next steps be? Long term goals?

Open Discussion

**4:20 pm Next Steps**

**4:30 pm ADJOURN**

# APPENDIX F: ROSTER

## ADVISORY COMMITTEE

### David Chambers, DPhil

Deputy Director for Implementation Science  
National Cancer Institute

### Robert Croyle, PhD

Meeting Co-Chair  
Director,  
Division of Cancer Control and Population Sciences  
National Cancer Institute

### Nikki Hayes, MPH

Speaker  
Branch Chief  
Comprehensive Cancer Control Branch  
Centers for Disease Control and Prevention

### Dorothy Lane, MD, MPH

Co-Chair  
NCCRT Professional Education & Practice Implementation Task Group  
American College of Preventive Medicine

### Michael Potter, MD

Co-Chair  
NCCRT Professional Education & Practice Implementation Task Group  
University of California, San Francisco

### Lisa Richardson, MD, MPH

NCCRT Steering Committee  
Director,  
Division of Cancer Prevention & Control  
Centers for Disease Control and Prevention

### Robert A. Smith, PhD (Not Present)

National Colorectal Cancer Roundtable  
Co-Chair  
Vice President, Cancer Screening  
American Cancer Society

### Cynthia A. Vinson, PhD, MPA

Senior Advisor for Implementation Science  
Implementation Science Team  
Division of Cancer Control and Population Sciences  
National Cancer Institute

## ATTENDEES

### LeeAnn Bailey, MD, PhD

Speaker  
Chief  
Integrated Networks Branch  
National Cancer Institute

### Katie Bathje, MA, LPCC

Speaker  
Kentucky Cancer Consortium  
Program Director

### Lynn Butterly, MD (By Phone)

Speaker  
NCCRT Steering Committee  
Dartmouth – Hitchcock Medical Center  
Director, Colorectal Cancer Screening

### Paul Doria-Rose, DVM, PhD

Acting Chief  
Healthcare Assessment Research Branch  
National Cancer Institute

### Chyke Doubeni, MD, FRCS, MPH (By Phone)

Presidential Professor  
Family Medicine and Community Health  
University of Pennsylvania

### Holly Guerrero

Speaker  
Health Systems Manager,  
Hospitals, North Region  
American Cancer Society

### Ernest Hawk, MD, MPH

Speaker  
Vice President  
Division Head  
Cancer Prevention and Population Sciences  
The University of Texas  
MD Anderson Cancer Center

### Djenaba Joseph, MD (By Phone)

Medical Director  
Colorectal Cancer Control Program  
Centers for Disease Control and Prevention

### Karen Kim, MD, MS

Speaker  
University of Chicago  
Division of the Biological Sciences  
Professor of Medicine, Dean for Faculty Affairs  
Director, Center for Asian Health Equity,  
UCCCC Office of Community Engagement and Cancer Disparities

### Suzanne Lagarde, MD

Speaker  
Chief Executive Officer  
Fair Haven Community Health Center

## ATTENDEES (CONT'D)

### Paul Limburg, MD

Professor of Medicine  
Mayo Clinic

### Ken Lin Tai, MD, MPH

Speaker  
Director  
Center for Cancer Prevention and Control  
Maryland Department of Health

### Todd Lucas, PhD

Associate Professor  
Population Health Sciences  
Wayne State, Karmanos Cancer Institute

### Nina Miller, MSSW, OSW-C

Manager Cancer Liaison Initiatives  
American College of Surgeons  
Commission on Cancer

### Ronald Myers, DSW, PhD

Speaker  
Director, Kimmel Cancer Center  
Cancer Prevention and Control,  
Director, Department of Medical  
Oncology,  
Division of Population Science  
Professor  
Department of Psychiatry and Human  
Behavior  
Thomas Jefferson University

### Electra Paskett, PhD

Speaker  
Marion N. Rowley Professor of Cancer  
Research  
Director  
Division of Cancer Prevention and Control  
The Ohio State University

### Sarah Shafir, MPH

Strategic Director  
State and National Systems  
American Cancer Society

### Letitia Thompson, MPPA

Vice President  
Regional Cancer Control  
South Region  
American Cancer Society

### Kristina Thomson, LCSW

Senior Director  
Hospital Systems, North East Region  
American Cancer Society

### Robin Vanderpool, DrPH, CHES

Speaker  
Associate Professor  
University of Kentucky

### Louis Weiner, MD

Director  
Georgetown Lombardi Comprehensive  
Cancer Center

### Richard Wender, MD

Meeting Co-Chair  
Chair  
National Colorectal Cancer Roundtable  
Chief Cancer Control Officer  
American Cancer Society

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### Caleb Levell

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## NOTES

This image shows a full page of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page, typical of notebook paper. There are no margins, text, or other markings on the page.

