

# NATIONAL COMPREHENSIVE CANCER CONTROL PROGRAM PY 02 EVALUATION REPORT



Best Practice



Centers for Disease Control and Prevention  
National Center for Chronic Disease Prevention and Health Promotion

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## INTRODUCTION

Since 1998, the National Comprehensive Cancer Control Program (NCCCP) has recognized the benefits of a collaborative approach to cancer control and has supported the establishment and coordination of on-the-ground efforts. NCCCP funds all 50 states, the District of Columbia, Puerto Rico, eight tribes or tribal organizations, and six U.S.-associated Pacific Island jurisdictions to design coordinated approaches to cancer control and prevention that cumulates into the implementation of cancer control plans.

This report summarizes partnerships and evidence-based practices (EBPs) implemented during Program Year 2 (2018–2019 NCCCP). Data submitted by NCCCP awardees representing Program Years 1 and 2 were extracted from CDC's Chronic Disease Management Information System (CDMIS), cleaned, and analyzed using descriptive statistics in Microsoft® Excel. For this study, we define EBPs as public health practices (interventions, programs, strategies, policies, procedures, processes, and/or activities that have been tested or evaluated and shown to be effective.<sup>1</sup>

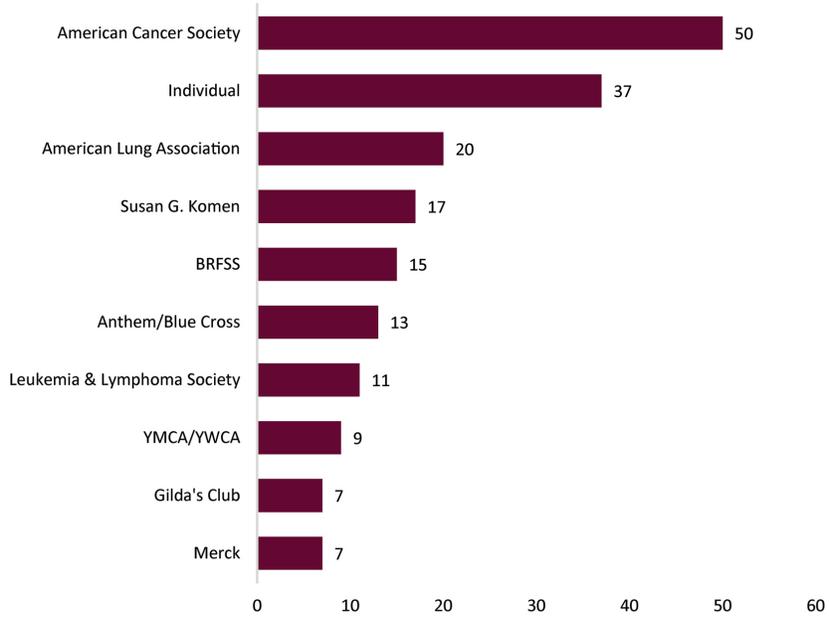
## **NCCCP'S FOUNDATION IN PARTNERSHIPS**

Coalitions are the backbone of NCCCP. In each state or jurisdiction, groups of stakeholders are critical to creating strategic plans and implementing interventions to reduce the number of people affected by cancer.

These coalitions bring together state, tribal, territorial, and local health departments, community organizations, health care providers, decision makers, cancer survivors, researchers, and others. Thus, effective partnerships are critical to efforts to expand and sustain the work of coalitions, and coalition membership evolves according to implementation needs.<sup>2</sup>

# MOST COMMON PARTNERS OF NCCCP AWARDEES

*Many of the most common partners of NCCCP awardees were national organizations, or local chapters of national organizations.\**



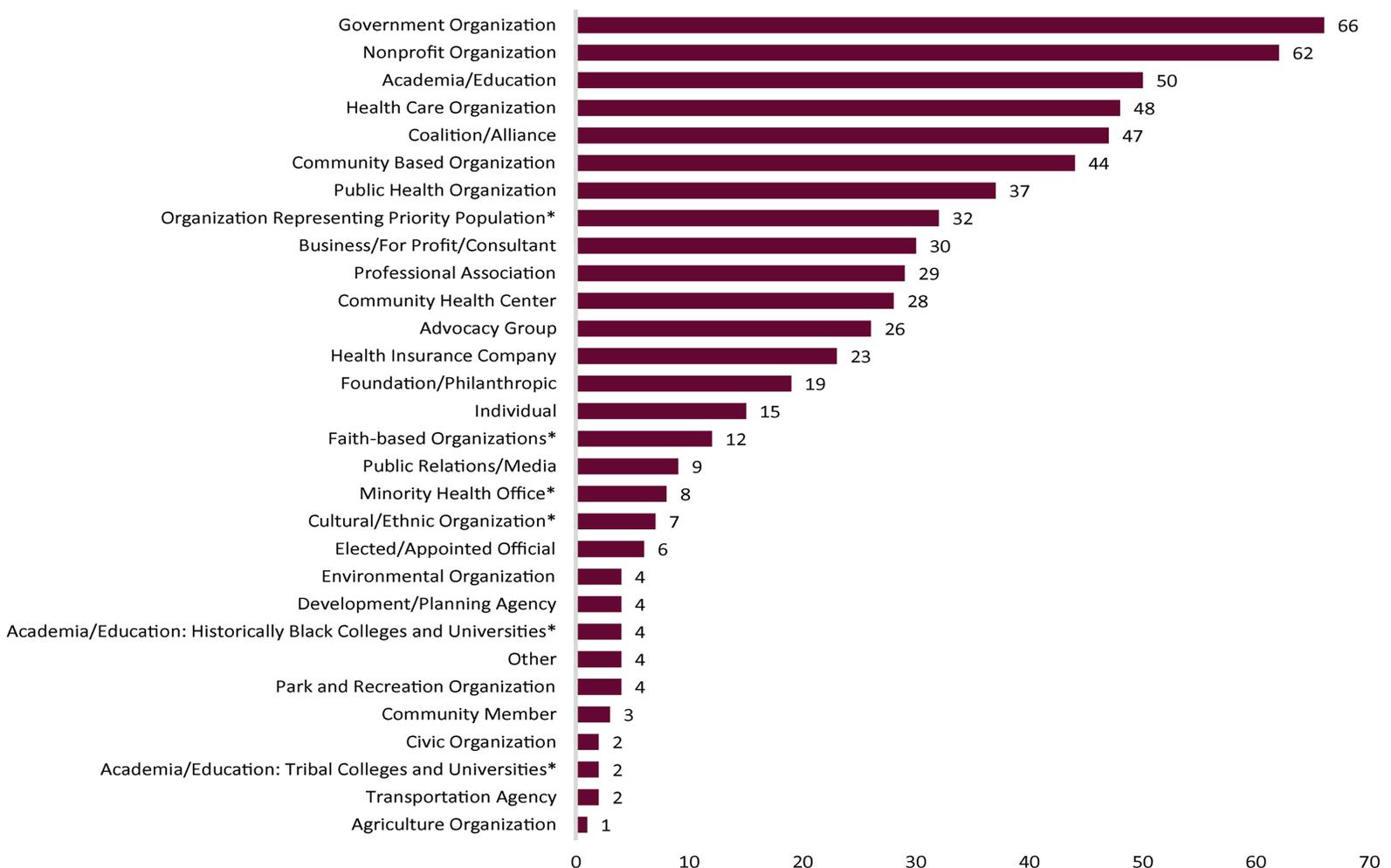
\*Awardees also commonly reported individuals as partners, without specific organization affiliations; some of these partners are independent (such as consultants), while others are affiliated with an organization that has not been specified.

Abbreviations: YMCA: Young Men's Christian Association; YWCA: Young Women's Christian Association; BRFSS: Behavioral Risk Factor Surveillance System

## PARTNER TYPES

Awardees reported working with a broad range of partner types, especially government, nonprofits, academic, health care, and community-based partners. Almost all awardees (n=66) reported partnering with government organizations.

The range of partners in the charts reflects the breadth of expertise and varieties of capacity needed to implement interventions across the cancer continuum and using environmental, health systems, and community-clinical linkage strategies. Some partner types, noted with an asterisk (\*), also reflect efforts related to health equity.



## **PARTNERS BY THE NUMBERS**

**2,335:** the number of **different partners** awardees reported.

**25:** the **median number of partners per awardee** (compared to a median of 21 in year 1).

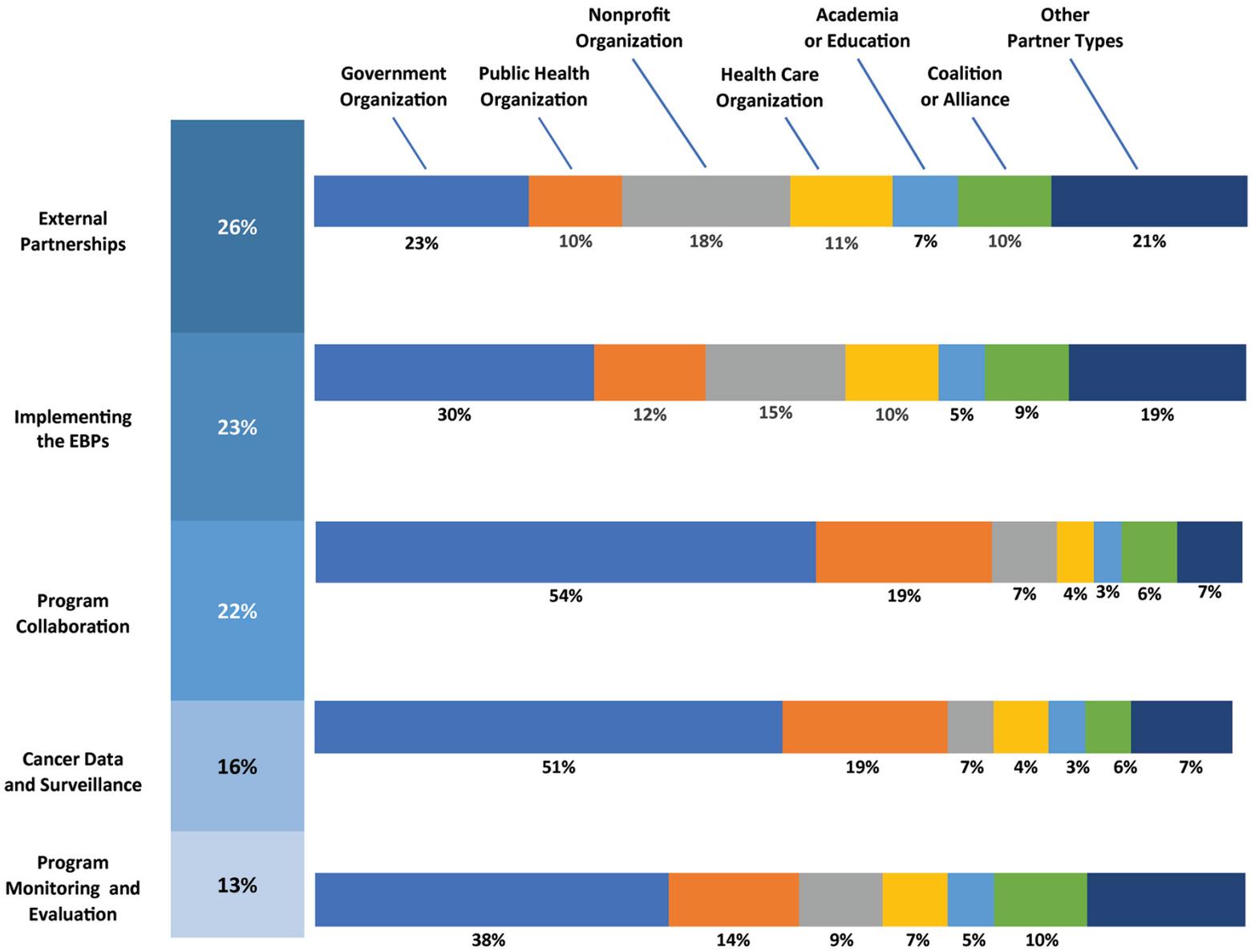
**1–157:** The **range in number of partners across awardees.**

## **PARTNER SUPPORT FOR IMPLEMENTATION ACTIVITIES**

**Most partner support was described as part of program strategies: external partnerships, implementing EBPs, and program collaboration (22%–26% for each activity). A smaller proportion of partner support was in the area of: (1) cancer data and surveillance and (2) program monitoring and evaluation (16% and 13%, respectively). For 27% of reported active partnerships, specific partner support for implementation activities was not reported.**

**For all implementation activities, government organizations were the most commonly reported partner type.** However, the proportion of government partners varied considerably by activity, from 23% for external partnerships to 54% for program collaboration. The most commonly reported partner types were the same across implementation activities, with one exception. For implementing the EBPs, community health centers made up 6% of reported partners (data not shown). **These findings suggest that awardee work with similar partner types regardless of activity.**

# Distribution of implementation activities with the most common partner types for each implementation activity



## IMPLEMENTATION ACTIVITIES

1. Program collaboration – supportive activities implemented with CDC-funded programs.
2. External partnerships – collaborative activities implemented with coalitions or external stakeholders.
3. Cancer data and surveillance – activities that facilitate the use of data for program planning, implementation, and evaluation.
4. Implementing the EBPs – supportive activities necessary to implement EBPs for cancer prevention and control.
5. Program monitoring and evaluation – activities devoted to facilitating quality improvement and communication of outcomes through assessment and evaluation.

## PARTNERSHIP SPOTLIGHT

### **Leveraging partnerships to impact cervical cancer: Puerto Rico Comprehensive Cancer Control Program Cervical Cancer and HPV video *The Wise Girl***

The Puerto Rico Comprehensive Cancer Control Program worked with partners in the community to create an evidence-based and culturally-appropriate small media production called *The Wise Girl*. The three-minute video showcases dialogue from four women in three generations of the same family who discuss the importance of cervical cancer screening, the human papillomavirus (HPV) infection as a risk factor for cervical cancer, and decisions around getting the HPV vaccine.

The program collaborated with Molina Healthcare to host six focus groups to inform the creation of the video. Molina Healthcare provided invaluable access to the community that allowed for important recommendations and considerations to drive the development of the messages and representation in the video. To ensure relevance and sensitivity toward the communication needs of the population, the video used real members of the community, trusted leaders, subtitles, and sign language. The program also worked with the Puerto Rico Public Housing Department to recruit underserved women as actresses.

In Year 3, the program plans to leverage partnerships with the Puerto Rico Primary Care Association, the Public Housing Department, and the Breast and Cervical Cancer Early Detection Program to develop a shared dissemination plan to increase the reach of the video.

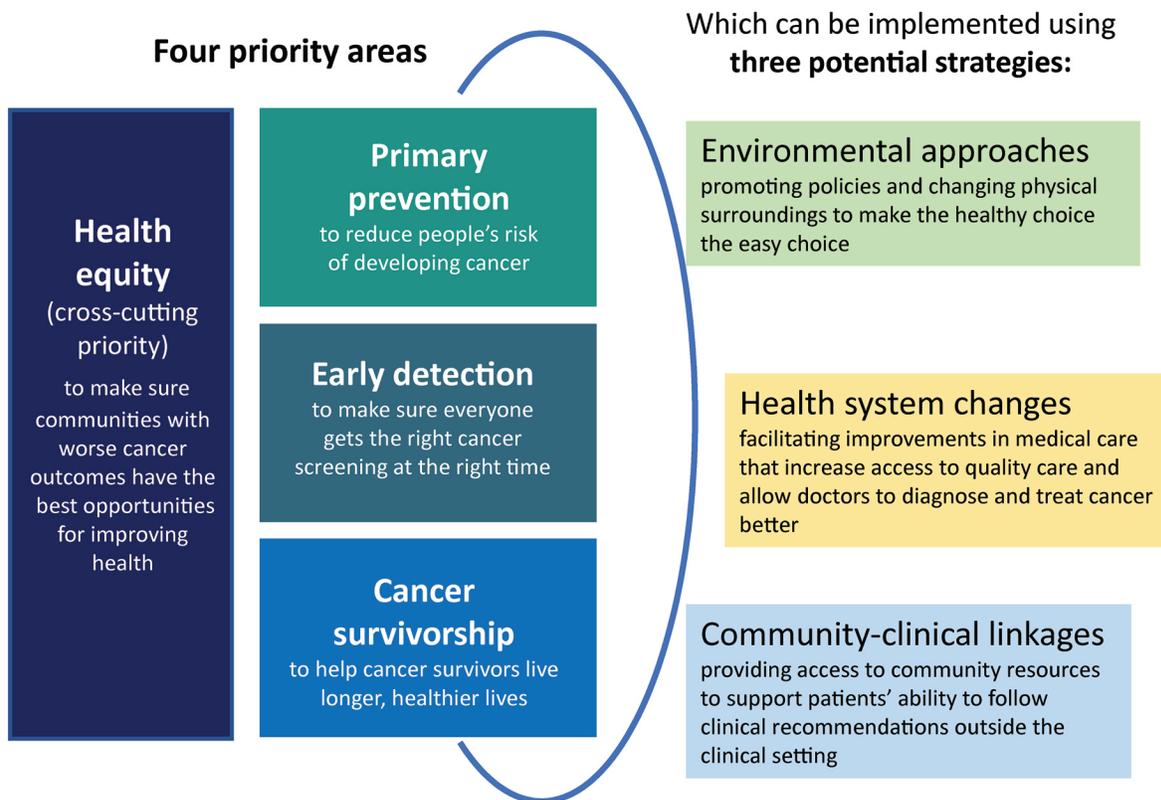
## AWARDEE IMPLEMENTATION ACTIVITIES

Awardees are expected to implement EBPs in **four priority areas** (primary prevention, early detection, cancer survivorship, and health equity) along the cancer continuum.

Health equity is considered a cross-cutting priority because population groups with limited or no access to quality health care are less likely to receive recommended cancer screenings and are more likely to be diagnosed with late-stage cancer.<sup>3</sup> Cancer disparities are observed for a broad range of additional measures, including morbidity, mortality, survivorship, and burden of cancer. Disparities in behavioral and environmental risk factors for cancer are observed. Minority racial and ethnic groups experience cancer and risk factor disparities, but groups defined by disability, gender or sexual identity, geographic location, income, and education experience cancer disparities.<sup>4</sup>

To address these four priority areas, awardees can use **three broad strategy types** (environmental approaches, health system changes, and community-clinical linkages).

# Four NCCCP Priority Areas: Primary Prevention, Early Detection, Cancer Survivorship, and the Cross-Cutting Area Health Equity



## IMPLEMENTATION BY THE NUMBERS

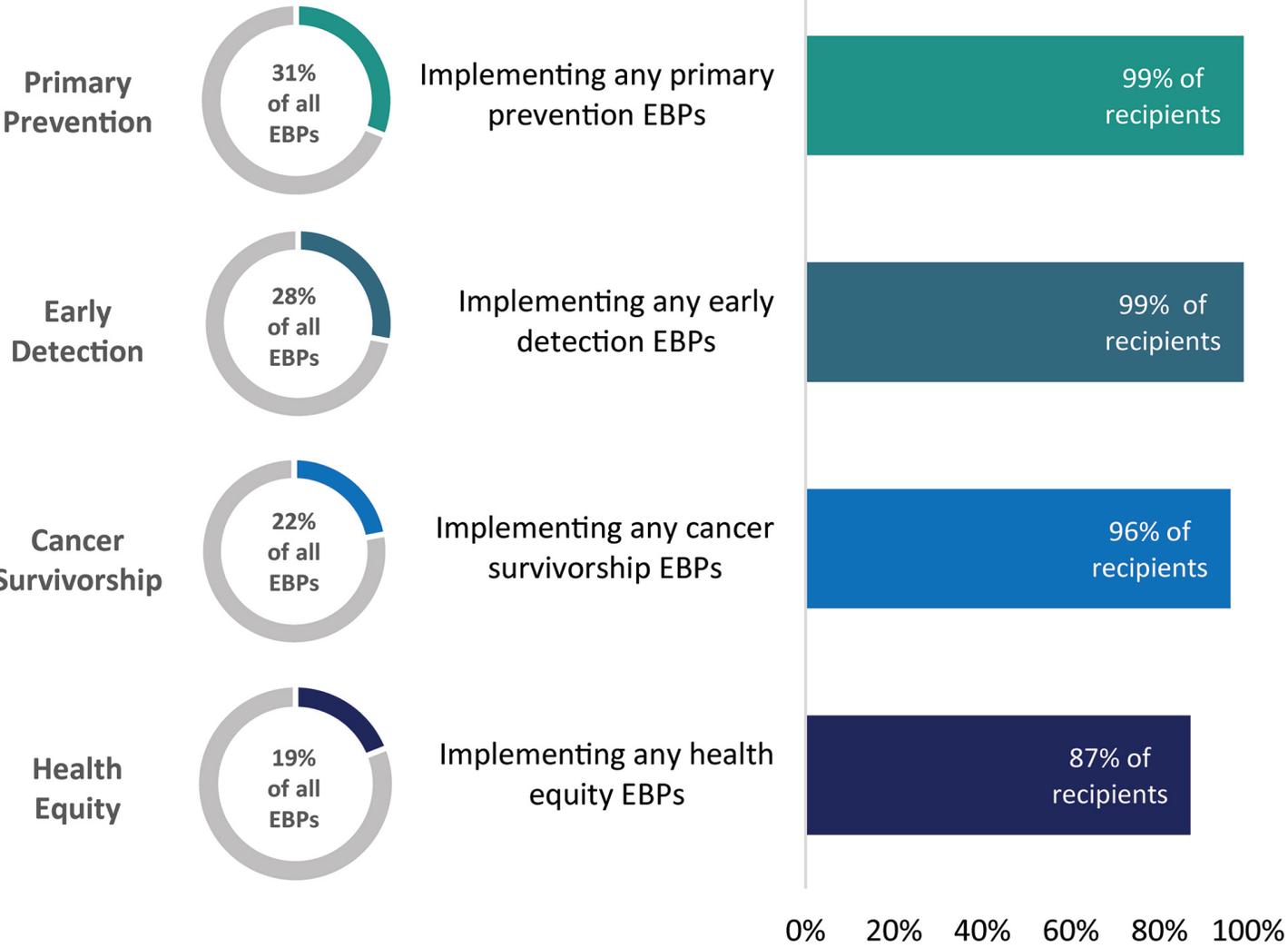
NCCCP awardees reported implementing **1,174 EBPs in program year 2**, with an **average of 17 EBPs** per awardee (median of 15, range of 4–47 EBPs).

## **EBPs BY PRIORITY AREA**

Primary prevention and early detection EBPs make up more than half (59%) of all EBPs that awardees reported implementing. Cancer survivorship and health equity make up a smaller proportion (41%) of the EBPs.

Almost all awardees are implementing EBPs in all four priority areas, which will help ensure achievement of short- and long-term outcomes across the cancer continuum and for health equity.

**Percentage of EBPs in Four NCCCP Priority Areas:  
Primary Prevention, Early Detection, Cancer Survivorship,  
and Health Equity**



## HEALTH EQUITY SPOTLIGHT

### **Promoting Health Equity in Local Shops**

The Connecticut Department of Public Health Comprehensive Cancer Control Program (CCCP) implemented evidence-based strategies focused on improving prostate cancer outcomes among African-American and Latino men. The program addresses health disparities by adapting materials for survivors in order to improve outcomes for survivors and provide community education to increase awareness to prostate health.

The Connecticut CCCP collaborated with community partners to disseminate culturally relevant small media to local shops. During Year 2, Hartford Healthcare in Hartford County provided approximately 250–300 prostate health and cancer brochures adapted for survivors at various events in places such as barbershops and local stores. The program was able to provide educational materials to prostate cancer survivors, as well as the public about cancer survivors and their needs.

The program is planning to continue partnering with Hartford Healthcare and will work to increase prostate screening among African-American and Latino men as well.

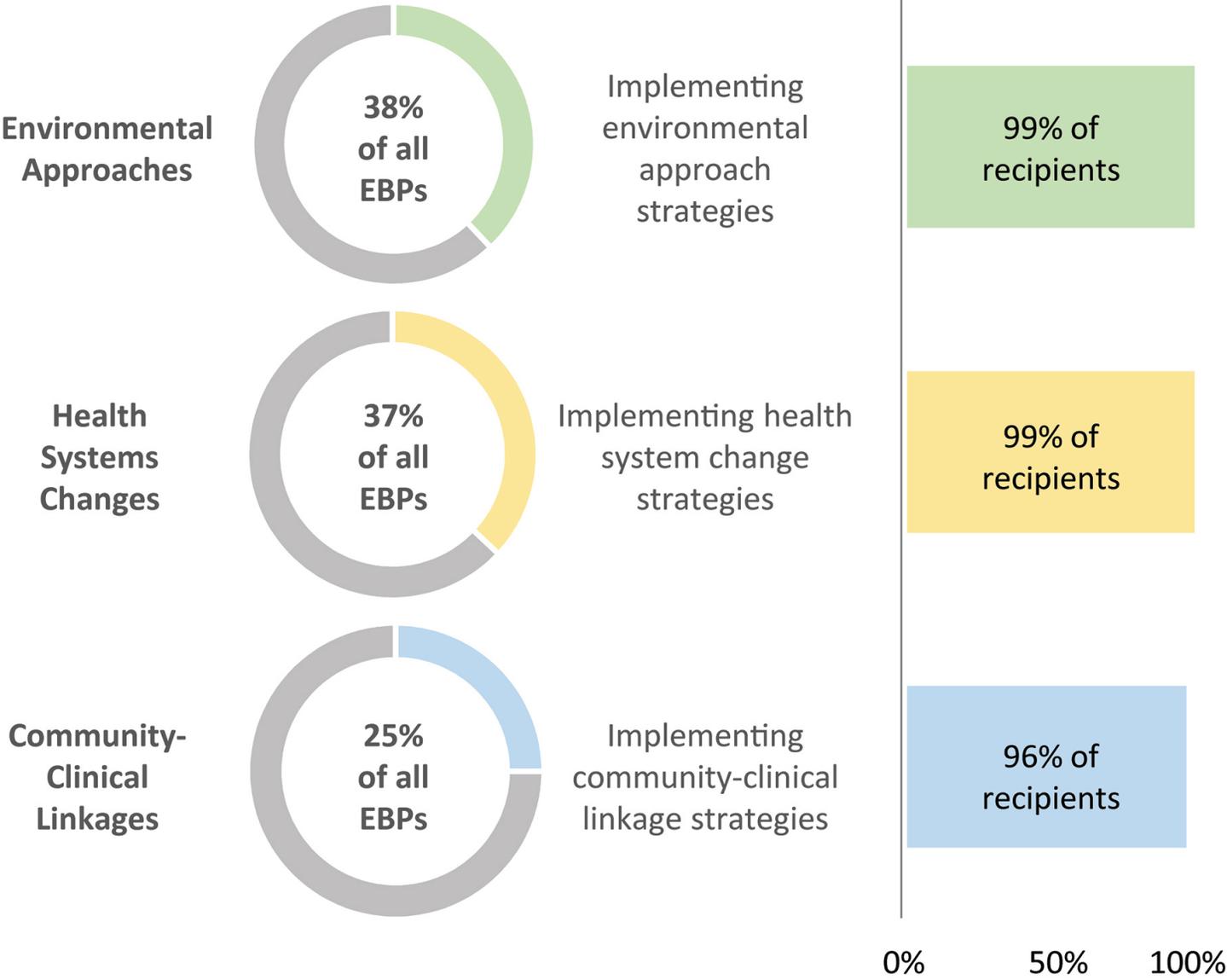
## EBPs BY STRATEGY

Awardees implemented environmental approaches and health systems changes EBPs more often than community-clinical linkages EBPs.

In the context of EBPs from which awardees can choose, the variation in percentage of EBPs implemented by strategy is relatively small. Environmental approach EBPs make up the largest proportion (62%) of EBPs from which awardees can choose. Health systems changes make up about 25% of the EBPs from which awardees can choose, and community-clinical linkages just 13% of the EBPs from which awardees can choose.

The observed distribution represents the comprehensive approaches awardees are taking to improve cancer-related outcomes.

**Percentage of EBPs of Each Strategy Type: Environmental Approaches, Health Systems Changes, and Community-Clinical Linkages**



## ENVIRONMENTAL APPROACHES SPOTLIGHT

### **Removing Barriers to Colorectal Cancer Screening**

After the Hawaii Legislature adopted a resolution requesting the Department of Health to convene a working group to develop recommendations to increase colorectal cancer screening prevalence, the Hawaii Comprehensive Cancer Control program collaborated with the American Cancer Society Cancer Action Network to convene a broad range of stakeholders from across the public health community. The mission of the working group was to develop a set of actionable recommendations before the next scheduled legislative session.

The resolution cited seven strategies from the 2016–2020 Hawaii State Cancer Plan. With time limitations, the working group decided to focus on two strategies: small media campaigns and provider-client reminder systems.

The final report recommended the following strategies as a road map for action on increasing colorectal screening prevalence in Hawaii:

#### Small Media Campaign

- Review current colorectal cancer screening data and determine which populations to target for a small media campaign.
- Reach out to key stakeholders representing the target populations to engage in creating campaign messaging and testing target messages.

#### Provider-Client Reminder Systems

- Examine clinical quality measures and provider practices related to colorectal cancer screening. Assess successful clinical practices among providers achieving higher screening prevalence.
- Examine whether provider-client reminder tools are effective, and if so, in which populations.
- Assess ways to partner with health systems to implement effective electronic and non-electronic strategies to improve screening rates.

### Other Identified EBPs: Reducing Structural Barriers

- For colorectal cancer screening, strong evidence supports the benefits by removing other barriers to screening in ways such as flexible clinic hours, working in non-clinical settings, and offering on-site translation, transportation, and patient navigators.

Although the final report did not result in recommendations for the legislature and working group members to pursue immediately, the resolution allowed the formation of the working group to focus on colorectal cancer screening prevalence as a community issue.

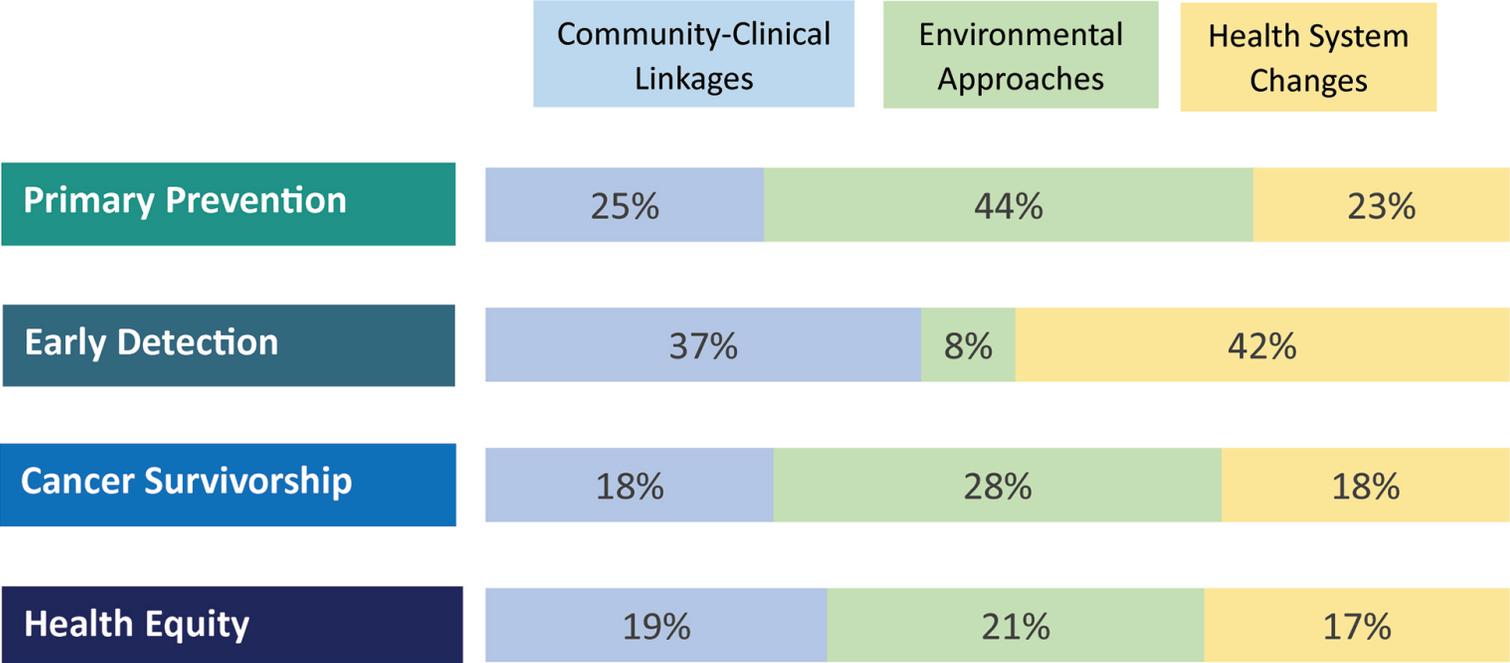
## EBPs BY PRIORITY AREA AND STRATEGY

The distribution of strategies across the four priority areas varied. Most priority areas included substantial representation from all three strategies.

**Primary prevention included the largest proportion of environmental approach EBPs.** This reflects the fact that many primary prevention interventions take place in a range of settings to improve access to healthy choices and environments.

**Early detection included a relatively small number of environmental approach EBPs,** with a greater focus on community-clinical linkages and health system change EBPs. This reflects the fact that early detection often takes place in a clinical setting.

*Distribution of strategies by priority area.*



## **EBPs BY CANCER OR RISK FACTOR FOCUS AND PRIORITY AREA**

**Many awardees EBPs (85%) included a focus on all cancers.** The prevalence of these types of EBPs suggests broad reach of awardee EBPs, changing environments, systems, and relationships to improve cancer prevention, screening, and survivorship, and to reduce health disparities.

**The most common specific cancers addressed by EBPs included cervical, colorectal, and breast cancer.**

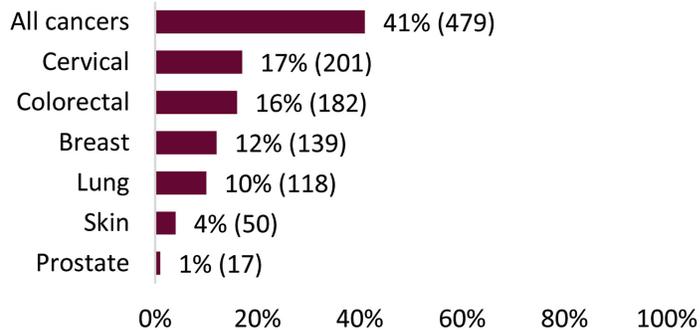
This may reflect the fact that many awardees have or recently had separate funding support to focus on these specific cancers (through the Colorectal Cancer Control Program and the National Breast and Cervical Cancer Early Detection Program<sup>3</sup>). Thus, awardees may have engaged in collaborations with these programs and leveraged resources to ensure continuation and expansion of efforts focused on those cancers.

Less than a quarter (22%) of awardee EBPs included a focus on cancer risk factors. This may be because only one of the four priority areas, primary prevention, is focused on cancer risk factors.

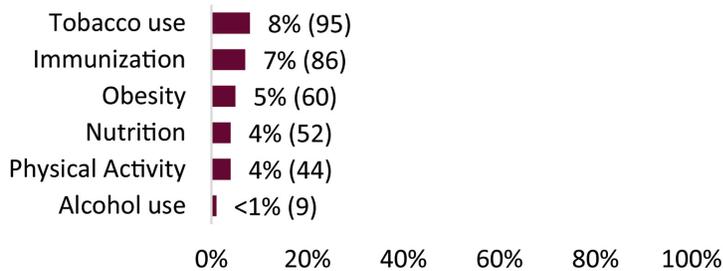
The awardee focuses on these screenable cancers aligned with CDC's Division of Cancer Prevention and Control and contributes to the division's aspiration of assuring that the "all people get the right screening, at the right time." This work will contribute to the body of knowledge regarding early detection and screening, thus facilitating the scalability of best screening practices required to impact disease burden.

## Charts of all evidence-based practices

85% (999) of all EBPs included a focus on at least one specific cancer and/or on all cancers\*



22% (263) of all EBPs included a focus on at least one cancer risk factor



\*Awardees could identify one or multiple cancer types or cancer risk factors. Thus, in some cases, recipients did not identify any cancer types (only risk factors) for a given EBP.

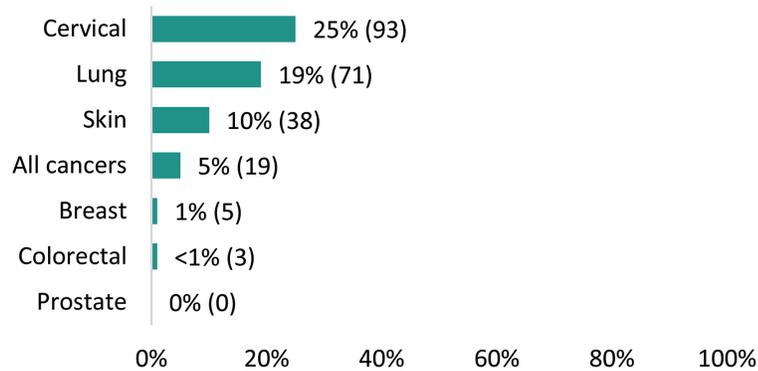
## PRIMARY PREVENTION EBPs

**Most awardee primary prevention EBPs focused on specific cancers, specific risk factors, or both. The most-targeted specific cancers included cervical, lung, and skin cancer.** These are all cancers with known approaches to primary prevention (HPV immunization, tobacco use cessation, UV-protective behaviors).

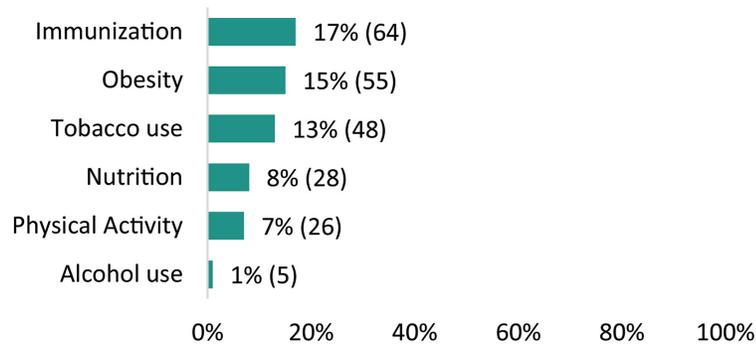
The most-targeted risk factors included immunization, obesity, and tobacco use—risk factors with clear links to cancer.<sup>[5.6](#)</sup>

## Charts for Primary Prevention EBPs

59% (216) of primary prevention EBPs focused on at least one specific cancer and/or on all cancers



52% (193) of primary prevention EBPs focused on at least one cancer risk factor



\*Awardees could identify one or multiple cancer types or cancer risk factors. Thus, in some cases, recipients did not identify any cancer types (only risk factors) for a given EBP.

## WORKING TO IMPROVE HUMAN PAPILLOMAVIRUS VACCINATION UPTAKE IN MICHIGAN

In Michigan, HPV vaccine initiation and completion rates among adolescents aged 13–17 years old is less than 50% (MCIR, 2018). According to researchers, identified barriers associated with low HPV vaccine uptake include provider hesitancy, vaccine stigma, and low uptake among the male population (Southall, 2016). In the statewide Cancer Plan for Michigan 2016–2020, the goal to reduce cervical cancer through the increase in HPV vaccination by 2020 is to:

- Increase the proportion of females and males ages 13–17 years who have received at least three doses of HPV vaccine from 24.2% (females) and 7.4% (males) to 80% (females and males).

The Michigan Cancer Consortium (MCC) Board of Directors selected this primary prevention objective as one of four priorities for 2016–2017 and convened the MCC HPV Vaccine Priority Workgroup.

Upon examining the data, the priority workgroup members decided to focus the work plan on increasing HPV vaccinations in the Hispanic population in Michigan. The workplan included conducting focus groups with the Hispanic population to gauge knowledge about HPV and cervical cancer and observe reactions to three advertisements about the HPV vaccine. Focus group findings revealed women were the primary health care decision makers of the family and reported more sources of health information than men. The male focus group reported being unaware of the HPV and its effects on men. Both focus groups identified a need for Spanish-language materials about HPV. Important aspects of communicating about HPV vaccination included addressing the parents, having a direct message, and making the information relatable to the Latino community.

The focus group outcomes resulted in translation of HPV public service announcements and an educational brochure into Spanish.

The media campaign included radio ads on Spanish stations in Grand Rapids, Kalamazoo, and Big Rapids, as well as print ads in the Spanish language newspaper, *Lazo Cultural*.

With the media campaign completed, the MCC website includes the Spanish-language resources developed during this project. The HPV Vaccine Workgroup is using CDC's AFIX (Assessment, Feedback, Incentives, and eXchange) model to evaluate provider performance in offering and administering the HPV vaccine to clients 9–26 years old according to the current recommended vaccine schedule in five regions of the state.

Cole Courtney and McFall, Angela (2018) "Working to Improve Human Papilloma Virus Vaccination Uptake in Michigan" *Michigan Journal of Public Health*: Vol. 9: Iss.1, Article 6.

Available at: <https://scholarworks.gvsu.edu/mjph/vol9/iss1/6>

## SCREENING EBPs

**Awardee EBPs focused primarily on cancers with effective screening tests: colorectal cancer, breast cancer, and cervical cancer.<sup>7</sup>**

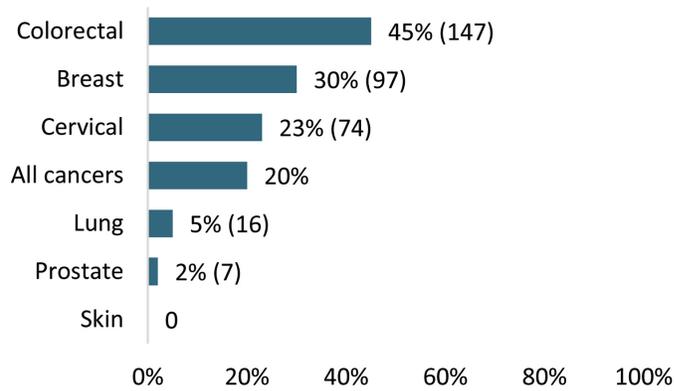
In addition to EBPs that focus on increasing cervical, breast, and colorectal cancer screening, a few awardees also implemented EBPs to increase lung cancer screening.

Awardee EBPs also included a focus on all cancers in about one in five cases. This may reflect the fact that some EBPs apply broadly to improving early detection and screening (provider assessment and feedback, client reminders for screening services, patient navigation to facilitate access, reducing structural barriers to increase community access to screening services).

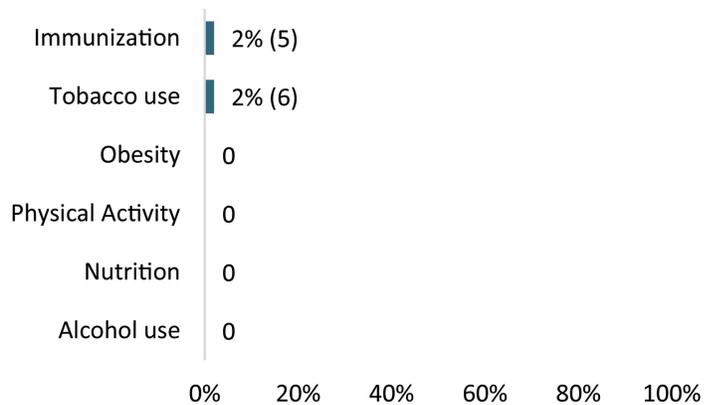
CDC advises implementing strategies that facilitate early detection and screening to assess cancer earlier and impact outcomes. Collaborating with partners to identify underserved or high-risk populations can generate faster linkages to treatment and possibly improve the chances of long-term survival. During Year 2, National Comprehensive Cancer Control Program awardees continued to optimize resources to address high-burden cancers in their regions.

## Charts of Early Detection EBPs

100% of early detection EBPs focused on at least one specific cancer and/or on all cancers



Very few early detection EBPs included a focus on cancer risk factors\*



\*Awardees could identify one or multiple cancer types or cancer risk factors. For early detection EBPs, most awardees did not select any cancer risk factors. However, early detection EBPs might still have considered cancer risk factors in identifying candidates for cancer screening.

## SCREENING SPOTLIGHT

### **Paid Time Off for Cancer Screening**

The New York State Comprehensive Cancer Control Program worked with the Cancer Prevention in Action (CPiA) initiative to promote cancer screenings by employers. Through the CPiA, contractors recruited businesses to adopt paid leave policies to help facilitate cancer screenings. The initiative was implemented in various regions throughout the state and focused on educating and engaging key stakeholders such as community members and policy makers on building support for paid time off for cancer screening policies.

The contractors were able to reach more than 850 individuals, including 40 governmental and organizational officials. Furthermore, during Year 2, the program recruited five worksites and provided technical assistance to four of the five sites on strategies for adopting paid time off policies. The program plans to provide additional data on worksite policies adopted after the project has been implemented for an entire year.

## **SURVIVORSHIP EBPs**

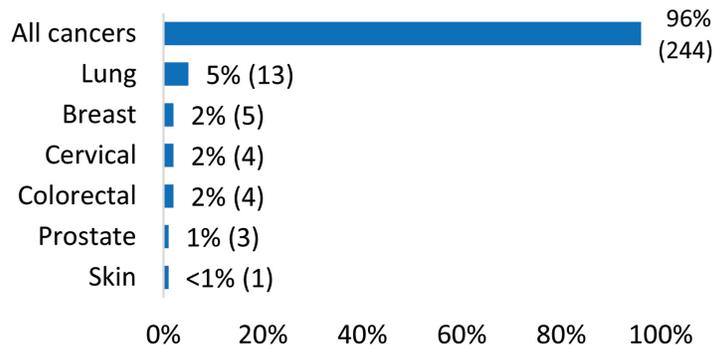
**Almost all awardee cancer survivorship EBPs included a focus on all cancers.** This reflects the nature of survivorship EBPs, which address issues faced by survivors of all cancers, rather than being specific to any individual cancer.

Examples of EBPs addressing broad survivor needs include educating health care providers about survivorship issues, creating public education programs to empower survivors, promoting patient navigation systems for better survivorship care, and establishing guidelines for quality service provision to survivors.

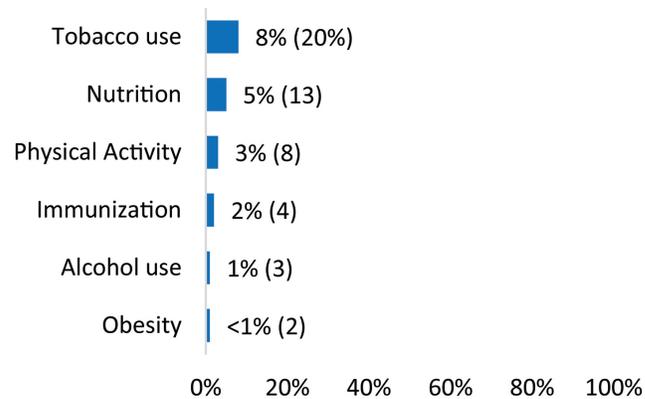
Addressing the needs of cancer survivors has been a priority for the National Comprehensive Cancer Control Program since 2010. CDC continues to support surveillance, communication and education activities, programs through the NCCCP, supplemental programs, and dissemination and implementation science projects. Given the growing population of cancer survivors, it is essential to support the widespread adoption and sustainability of these efforts.

## Charts of Cancer Survivorship EBPs

99% (252) of cancer survivorship EBPs focused on at least one specific cancer and/or on all cancers



10% (26) of cancer survivorship EBPs included a focus on at least one cancer risk factor



## **SURVIVORSHIP SPOTLIGHT**

### **Expansion of Patient Navigation**

The state of Louisiana had a pre-existing patient navigation program that offered diagnostic and treatment navigation services to breast and cervical cancer patients. Upon receiving funding from CDC through the NCCCP Survivorship Demonstration Project, the Comprehensive Cancer Control Program further enhanced their patient navigation efforts to offer services to breast cancer survivors. The enhanced program identified low-income and African-American communities as priority populations. The program collaborated with a local community college to offer patient navigation courses to their workforce, and partnered with the Cancer Association of Greater New Orleans to provide survivors with resources.

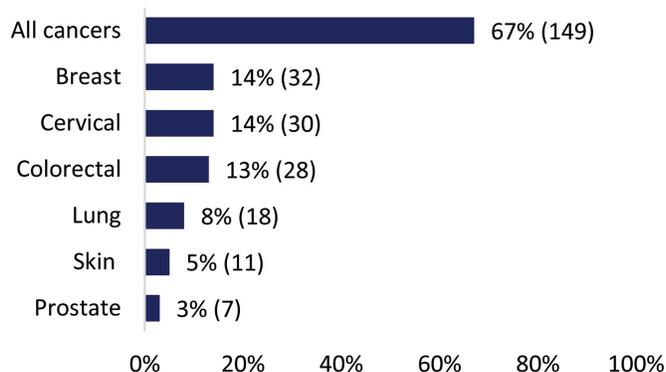
## HEALTH EQUITY EBPs

Health equity EBPs covered all individual cancers and risk factors, reflecting the broad range of cancer disparities that have been documented.

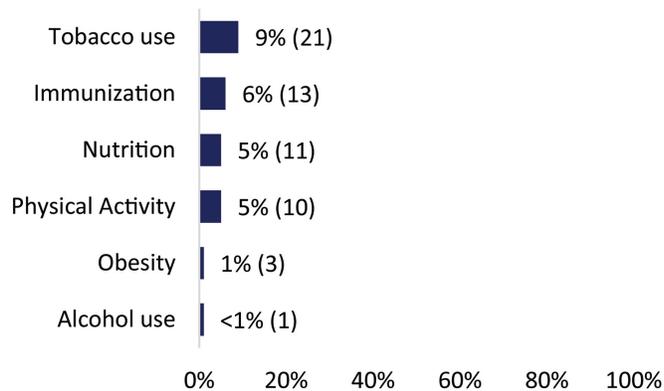
CDC prioritizes EBPs that advance health equity through activities that educate providers and practitioners on the importance of adopting interventions that meet the needs of underrepresented groups, link high-need communities to equitable resources, and use data to identify underserved populations and guide community efforts. NCCCP awardees continue to focus their work on using surveillance data to reach underserved populations in addition to efforts that tailor small media to promote screening among vulnerable populations.

## Charts of Health Equity EBPs

91% (203) of health equity EBPs focused on at least one specific cancer and/or on all cancers



16% (36) of health equity EBPs included a focus on at least one cancer risk factor



## HEALTH EQUITY SPOTLIGHT

### **Screening Incarcerated Adults for Cancer**

*By the Rhode Island Comprehensive Cancer Control Program*

The Rhode Island Department of Health's (RIDOH) Comprehensive Cancer Control Program (CCCP) and its Cancer Screening Programs (NBCCEDP and Colorectal Cancer Screening Program) have established a partnership with the Rhode Island Department of Corrections (RIDOC) to increase cancer screening for incarcerated adults. This partnership, focused on breast and colorectal cancer screening, has developed a model program to improve wellness among incarcerated adults that could help to reduce cancer disparities in incarcerated populations.

Through this collaboration, after eligibility screening, incarcerated adults are offered opportunities to be screened for colorectal cancer via fecal immunochemical testing (FIT), followed by diagnostic colonoscopy for those with positive results. The RIDOC Medical Director and her staff facilitate system-wide same-day FIT kit distribution and have established partnerships with off-site laboratories for rapid processing, gastroenterologists for follow-up colonoscopy procedures, and, where necessary, with oncologists for treatment.

Similarly, through collaboration with the RIDOH Women's Cancer Screening Program (NBCCEDP), eligible incarcerated women are also offered free mammograms. RIDOC does not own the equipment necessary to conduct these screenings, but a partnership with a mobile mammography provider brings screening to the women's correctional facility. While the incarcerated female population is small, this important service provides an opportunity for early detection and early access to treatment for those diagnosed. Both screening programs also allow adults to leave the corrections system with up-to-date medical records.

## **MOST COMMON EBPs OVERALL**

Several of the most common EBPs focused on access to and demand for cancer screening services. Other common EBPs focused on service delivery, cancer survivorship, and vaccines.

**55** EBPs: **Patient navigation** to facilitate **timely access to screening**.

**37** EBPs: Community-based interventions implemented in combination to **increase community demand for vaccines**.

**41** EBPs: Educate health care providers about **cancer survivorship issues** from diagnosis through long-term treatment effects and end-of-life care.

**42** EBPs: **Client reminders** to increase **community demand for cancer screening services**.

**43** EBPs: Provider assessment and feedback to **increase service delivery by health care providers**.

**50** EBPs: Reducing **structural barriers** to increase **community access to cancer screening services**.

**53** EBPs: **Small media** to increase **community demand for cancer screening**.

## **MOST COMMON EBPS FOR TRIBES, TRIBAL ORGANIZATIONS, AND TERRITORIES**

The list of top EBPs was the same for state awardees as shown on page 21. **For tribes, tribal organizations, and territory awardees, the list of top EBPs differed some after the top three EBPs (marked with an \* below). However, the most common EBPs for these awardees also focused on cancer screening, service delivery, cancer survivorship, and vaccines.**

**19** EBPs: **Small media** to increase **community demand for cancer screening services.**

**15** EBPs: **Patient navigation** to facilitate **timely access to screening.**

**11** EBPs: Reducing **structural barriers** to increase **community access to cancer screening services.**

**9\*** EBPs: **Vaccination requirements** for child care, school, and college attendance **to increase community demand for vaccines.**

**8\*** EBPs: **Group education** to increase **community demand for cancer screening services.**

**8** EBPs: **Provider assessment and feedback** to increase **service delivery by health care providers.**

**8\*** EBPs: **Educate** the public that **cancer is a chronic disease that people can and do survive.**

# COMMON EBPs IMPLEMENTED BY AWARDEES, BY PRIORITY AREA AND STRATEGY

## *Most Common Primary Prevention EBPs*

The most common primary prevention EBPs (shown in bold below) focused on community- and health system-based interventions to increase HPV vaccinations.

### **Environmental Approaches:**

- Multicomponent interventions to increase tobacco use cessation (14; 14%)
- Smoking bans and restrictions to reduce secondhand smoke exposure (11; 11%)
- Increase healthy food and drink availability to improve healthy behavior (11; 11%)
- Vaccination requirements for child care, school and college attendance to increase community demand for vaccines (11; 11%)

### **Clinical-Community Linkages:**

- **Community-based interventions implemented in combination to increase community demand for vaccines (37; 50%)**
- Immunization information systems to increase appropriate vaccination (9; 12%)

### **Health System Changes:**

- **Health care system-based interventions implemented in combination to increase appropriate vaccination (26; 30%)**
- Provider education to increase tobacco use cessation (14; 16%)
- Client reminder and recall systems to increase community demand for vaccines (11; 13%)
- Reducing client out-of-pocket costs to increase tobacco use cessation (11; 15%)

## ***Most Common Early Detection EBPs***

The most common early detection EBPs (shown in bold below) focused on community- and health system-based interventions to increase demand for and access to screening.

### **Environmental Approaches:**

- Group education to increase community demand for cancer screening services (19; 56%)
- One-on-one education to increase community demand for cancer screening services (15; 44%)

### **Clinical-Community Linkages:**

- **Patient navigation to facilitate timely access to screening (55; 50%)**
- **Reducing structural barriers to increase community access to cancer screening services (50; 46%)**

### **Health System Changes:**

- **Small media to increase community demand for cancer screening services (53; 29%)**
- Provider assessment and feedback to increase service delivery by health care providers (43; 23%)
- Client reminders to increase community demand for cancer screening services (42; 23%)
- Reducing client out-of-pocket costs to increase community access to cancer screening services (4; 4%)

## ***Most Common Survivorship EBPs***

The most common survivorship EBPs (shown in bold below) focused on education of providers and the public about survivorship with the aim of better care and empowerment of survivors.

### **Environmental Approaches:**

- **Educate health care providers about cancer survivorship issues from diagnosis through long-term treatment effects and end-of-life care (41; 34%)**
- **Develop and disseminate public education programs that empower survivors to make informed decisions (26; 21%)**
- Educate the public that cancer is a chronic disease that people can and do survive (21; 17%)

### **Clinical-Community Linkages:**

- Teach survivors how to access and evaluate available information (22; 42%)
- Develop, test, maintain, and promote patient navigation or case management programs that facilitate optimum care (20; 38%)
- Develop, test, maintain, and promote patient navigation systems for people living with cancer (11; 21%)

### **Health System Changes:**

- Provide information to cancer survivors, health care providers, and the public about cancer survivorship and meeting their needs (25; 32%)
- Establish and/or disseminate guidelines that support quality and timely service provision to cancer survivors (23; 29%)
- Assess and enhance provision of palliative services to cancer survivors (17; 22%)

## ***Most Common Health Equity EBPs***

The most common health equity EBPs (shown in bold below) focused on identifying and describing health disparities and using linguistically and culturally appropriate health education materials to promote health equity.

### **Environmental Approaches:**

- **Enhancing methods to identify and describe health disparities (32; 40%)**
- Education-related recommendation from *The Community Guide* to promote health equity (16; 20%)
- Educate the public that cancer is a chronic disease that people can and do survive (5; 6%)

### **Clinical-Community Linkages:**

- **Use of linguistically and culturally appropriate health education materials to promote health equity (27; 49%)**
- Reducing structural barriers to increase community access to cancer screening services (8; 15%)
- Use of interpreter services or bilingual providers to promote health equity (5; 9%)

### **Health System Changes:**

- Cultural competency training for health care providers to promote health equity (14; 21%)
- Access to quality care and services (10; 15%)
- Provider assessment and feedback to increase service delivery by health care providers (8; 12%)

## NCCCCP PROGRAM YEAR 1 AND YEAR 2 COMPARISONS

Overall, there were **minimal differences in partnerships and the distribution of EBPs across priority areas, strategies, cancer types, and risk factors**. This suggests that awardees are largely continuing the work they initially planned in year one, rather than changing focus in their efforts. This may also indicate priority and goal setting activities determined a plan of action for programs that can be observed in later years of the cooperative agreement.

These improvements suggest that more awardees may be able to meet NCCCCP goals, ultimately contributing to longer-term health outcomes.

- Overall, between years 1 and 2, **numbers of partners, common partners, and types of partners were quite similar**. Awardees are expected to foster relationships with other chronic disease programs and internal partners, as well as organizations that serve the same population or have priorities that mirror NCCCCP priorities. In addition, the awardees are strongly encouraged to conduct annual partner assessments to recruit the diversity of partnerships that support implementation of the program and jurisdiction cancer plan. The maintenance of partner types from year 1 to 2 may suggest that awardees have sufficient partners to support implementation of the respective EBPs; however, as programs continue implementing their plans, membership is expected to evolve and expand to ensure that a coordinated, collaborative approach is taken to achieve implementation goals.

- Across awardees, the **total number of EBPs was higher in year 2 (1,174) than in year 1 (1,140)**. The **distribution of these EBPs among the four priority areas and three strategies changed very little** (no more than 2 percentage points for any given priority area or strategy). Whereas an increase in EBP numbers cannot be used to articulate breadth, depth, and overall reach, it may be possible that after the start-up phase in year 1, awardees saw opportunities to implement additional EBPs that use different approaches (policy, community-clinical linkages, and health system changes) to achieve program outcomes. Focusing on each priority with a “three-prong” approach ensures awardees are better positioned to impact the priority and achieve outcomes. It is hoped that awardees will assess, select, and implement EBPs that are cost-effective and have optimum impact.
- **Enhancing methods to identify and describe health disparities was among the seven most common EBPs in year 2**. The most common EBPs reported by awardees remained mostly unchanged; however, in year 2, a health equity EBP to monitor cancer disparities was also reported. Strategic use of disparities data allows for targeting interventions to populations experiencing the highest cancer-related health disparities and ensuring greater return on investment. This is aligned with DCPC’s priority of supporting data-driven decisions and the aspiration that “people have the best possible cancer care and outcomes.”

## SUMMARY AND RECOMMENDATIONS

- Partnerships are the cornerstone of the National Comprehensive Cancer Control Program. Awardees are sustaining relationships with a diverse group of partners from multiple sectors, including traditional public health partners in other government agencies, academic institutions, and health care organizations and less traditional partners such as business owners, insurance companies, and faith-based organizations. These organizations are also contributing directly to comprehensive cancer control activities as documented in awardee work plans for implementation activities (program collaborations, external partnerships, cancer data and surveillance, implementing the EBPs, and program monitoring and evaluation).
- The program is experiencing implementation successes in the areas of primary prevention and early detection. Through commonly reported strategies that promote tobacco use cessation, increase community demand for vaccines, or involve health care systems in our efforts to increase vaccination, awardees are positioning the NCCCP to impact tobacco-related and HPV-associated cancers. Commonly reported strategies in the areas of early detection move the mark on cancers for which a viable screening test is available. According to our report, awardees have reported efforts to provide group education to increase community demand for cancer screening services, patient navigation to facilitate timely access to screening, and small media to increase community demand for cancer screening services.

- Although each awardee adopts and implements EBPs based on data to address their specific jurisdiction's cancer burden, awardees are working in all priorities, which will facilitate achievement of short- and long-term outcomes across the cancer continuum and for health equity.
- NCCCP awardees can strengthen their efforts to implement interventions that address all priorities by ensuring their constituents have the capacity to select, adapt, allocate resources to, and implement evidence-based strategies. The provision of technical assistance and training in these areas have the potential to accelerate program efforts. CDC has invested in cooperative agreements for technical assistance providers to tailor their educational opportunities to NCCCP and stakeholders. The Comprehensive Cancer Control National Partnership, National Networks, George Washington Cancer Center, and the American Cancer Society are uniquely positioned for this effort.

- Although awardees are leveraging resources to implement strategies that ensure health equity and improve quality of life among cancer survivors, there is much more work to be done. Cancer survivorship and health equity EBPs represent a smaller proportion of overall EBPs implemented in year 2. Lessons learned from supplemental demonstration projects and cooperative agreements such as Supplemental Funding Guidance NOFO DP 17-1701 Component – Program 2 – National Comprehensive Cancer Control Program, Improving the Health and Wellness of Cancer Survivors in Rural Communities, Demonstration Project to Increase Gynecologic Oncologist Treatment for Ovarian Cancer, Liver Cancer Prevention: Putting Strategies into Action, and Preventing Liver Cancer by Promoting Vaccination and Screening among Opioid Users provide NCCCP awardees a blueprint for action. Health equity interventions can also be accelerated if awardees engage and foster relationships with national networks that are committed to reducing tobacco- and cancer-related disparities across the nation.
- There are additional opportunities to accelerate EBPs in health equity and survivorship, such as the recently formed CDC Technical Workgroup with subject matter expertise in health equity and evaluation. With the program lead serving as the front line between CDC and awardees, this workgroup can help bridge the gaps and accelerate the efforts discussed above. Review of reports indicated CCC programs are implementing Leadership Team Plans (LTP) to coordinate and leverage efforts with NBCCEDP, central cancer registries (funded by CDC and/or NCI), and Colorectal Cancer Control Program. Thus, the LTP provides a road map for action and to monitor these collaborative activities among these programs over time.

## HOW 1701 CONTRIBUTES TO DCPC'S STRATEGIC PRIORITIES

### 1. DCPC Strategic Priority 1: Prevention

NCCCP programs directly implement evidence-based primary prevention activities in their jurisdictions to prevent cancer. These efforts are centered around reducing modifiable risk factors and promoting healthy behaviors that reduce the incidence of cancer. Examples of this include HPV vaccination and tobacco prevention and cessation efforts in many NCCCP programs. Implementation of evidence-based strategies such as culturally-appropriate education materials, media campaigns, and CDC's AFX (Assessment, Feedback, incentives, and eXchange) evaluation model have been used to increase vaccination uptake among the Hispanic population in Michigan and are a direct result of NCCCP's emphasis on using evidence-based strategies to increase the elimination of preventable cancers.

### 2. DCPC Strategic Priority 2: Screening

Early detection is also a priority of NCCCP. Efforts to promote screening include group education, patient navigation, and small media to address the screenable cancers. NCCCP supports opportunities to work in these areas. New York Comprehensive Cancer Control Program facilitated paid time off for cancer screening and is a direct result of NCCCP's effort to increase early detection and align with DCPC's aspiration of ensuring all people get the right screening at the right time.

### 3. DCPC Strategic Priority 3: Survivorship

Cancer survivorship is also a priority of NCCCP. Technical assistance providers and strategic partners facilitate NCCCP awardees' use of optimal EBPs to maximize survivorship impact. For example, Louisiana expanded its patient navigation program to assist breast cancer survivors to reach to low-income and African-American communities. This is a direct result of NCCCP's emphasis on addressing the needs of cancer survivors and improving health outcomes for cancer survivors to ensure survivors live longer, healthier lives.

NCCCP encourages use of data including the Behavioral Risk Factor Surveillance System, central cancer registries, and health disparities data to support data-driven decisions to target the right populations with cost-effective interventions. For example, Connecticut's Comprehensive Cancer Control Program used state registry data to assess burdens, and program reports to identify African-American and Latino communities for prostate cancer education. This program is a direct result of NCCCP's emphasis on using data sources to identify populations experiencing health disparities, ensuring that the right people are reached, and that they will have the best possible cancer care outcomes.

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