

Determination of Need

This document contains the summary of needs assessment data and identified practice gaps (section D of the NPWH application); the document contains the following:

- A. Literature Review
- B. 2017 Dialogue for Action evaluation survey data
- C. 2017 Dialogue for Action outcomes survey data
- D. 2018 Dialogue for Action committee meeting minutes

A. Literature Review

Despite effective screening tools, cancer still impacts the lives of millions of people. In 2018, over 1.7 million people will be diagnosed with cancer of all types, including 268,670 with breast, 13,240 with cervical cancer and 140,250 with colorectal cancer¹. For many of these people, their prognosis was improved, or could have been improved, by early detection through effective screening programs. Early detection often results in less extensive treatment and better outcomes. Unfortunately, 15–40% of people eligible to be screened for breast, cervical, colorectal or lung cancer are not being screened according to the guidelines. Research suggests that up to 50 percent of cancer cases and about 50 percent of cancer deaths are preventable with the knowledge we have today.

A successful cancer-screening and prevention program involves a diverse collection of stakeholders: physicians, public health educators, survivors, researchers and more. These stakeholders need to be educated on their roles in improving cancer screening and prevention rates and updated on research, policy and programs in cancer prevention and early detection. However, based on a multisource analysis, gaps exist between current and best practices among stakeholders. Specifically, education is needed on current screening guidelines, client- and provider-oriented intervention strategies to improve screening efforts and the uncertainties regarding the continuation of the Patient Protection and Affordable Care Act (ACA) on current screening programs.

Health care reform and the Affordable Healthcare Act will impact cancer screening in both the public and private sectors. Those who perform as quality team members in insurance companies, hospitals and large group practices will need to know how uncertainty regarding the continuation of the Affordable Healthcare Act may impact cancer screening and prevention.

Breast Cancer

Current Practice: The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) was established in 1991 by the Centers for Disease Control and

Prevention (CDC) to increase breast and cervical cancer screening among low-income, uninsured, and under-insured women.⁹ Since its inception, NBCCEDP-funded programs have served more than 5.3 million women, provided more than 12.7 million breast and cervical cancer screening tests, and diagnosed more than 63,293 invasive breast cancers.⁹ Among 1.8 million women who were screened between 1991 and 2006, the NBCCEDP program saved 100,800 life-years compared with no program and 369,000 life-years compared with no screening.¹⁰ Even with adequate health insurance, many women will still face substantial barriers to obtaining breast cancer screening, such as geographic isolation, limited health literacy, lack of provider recommendation, inconvenient times to access services and language barriers. Further, only two-thirds of NBCCEDP recruitment activities were evidence-based.¹¹ While there is agreement on the role of mammography and magnetic resonance imaging in women aged ≥ 50 years by the American College of Obstetricians and Gynecologists (ACOG) and U.S. Preventive Services Task Force (USPSTF), there is a moderate degree of discord regarding mammographic screening of women aged 40-49.¹² Although mammography remains the gold standard of breast cancer screening, there are subpopulations of women for whom mammography has reduced sensitivity.¹³ Mammography also has a moderate rate of false positives, which result in excessive biopsies, radiation dose, cost and patient anxiety.

Best Practice: Health care providers should be aware of the benefits of breast cancer screening and differences in current guideline recommendations between, for example, the USPSTF Final Recommendation Statement: Breast Cancer Screening and the American Cancer Society's recommendations for the Early Detection of Breast Cancer.^{12, 14} For women with dense breast tissue, or for whom standard mammography may be less effective, new technologies for breast cancer screening have been developed, including low-dose mammography, contrast-enhanced mammography, tomosynthesis, automated whole breast ultrasound, molecular imaging, and magnetic resonance imaging.¹³ Health care providers should understand these new technologies and their application to specific patients. Health care providers should be able to implement evidence-based recruitment activities. Health care providers should be aware of both the impact of the ACA on breast cancer screening costs and availability and the effect of uncertainty of the future of the ACA on patients' decisions about preventive care.

Cervical Cancer

Current Practice: In addition to improving access to breast cancer screening, the NBCCEDP provides access to cervical cancer screening. Since its inception, NBCCEDP-funded programs have diagnosed more than 4,360 invasive cervical cancer cases and 199,599 premalignant cervical lesions, of which 39% were high-grade.⁹ The USPSTF guidelines¹⁵ are similar to American Cancer Society/American Society for Colposcopy and Cervical Pathology/American Society for Clinical Pathology (ACS/ASCCP/ASCP). Providers need to understand the primary role of HPV in the

development of most cervical cancers (and several other cancers, including oropharyngeal).

Best Practice: Health care providers should be aware of the benefits of cervical cancer screening and current guideline recommendations.^{15, 16} Although cytology and colposcopy remain the standard technologies, health care providers should be aware of potential improvements in screening techniques, such as new optical imaging technologies, which can offer see-to-treat workflows and earlier therapeutic interventions.¹⁷ Health care providers should be aware of the uncertainties of the continuation of the ACA on cervical cancer screening costs and availability.

Colorectal Cancer

Current Practice: Most colorectal cancers develop from precancerous adenomatous and hyperplastic polyps.¹⁸ Progression of adenomatous polyps to cancer takes over 10 years in most people. Regular screening for and removal of polyps reduces the risk of developing colorectal cancer by up to 90 percent. Early detection of cancers that are already present in the colon increases the chances of successful treatment and decreases the chance of dying as a result of the cancer. The CDC's Colorectal Cancer Control Program (CRCCP) was begun in 2009 with the goal of increasing colorectal cancer (CRC) screening rates among uninsured and underinsured men and women aged 50-75 years to 80% in the funded states by 2014, under the assumption that higher screening rates will reduce illness and deaths from colorectal cancer.¹⁹ Since the program's inception to 2014, the CRCCP provided screening to nearly 55,000 people, finding 8,441 cases of precancerous adenomatous polyps and diagnosed 165 colorectal cancers.¹⁹ Recent critical reviews of the program have led to the development of a larger population-based program.²⁰

Currently, the USPSTF²¹ and American Cancer Society/US Multisociety Task Force on Colorectal Cancer/American College of Radiology (ACS/USMSTF/ACR)²¹ are in general agreement about when to initiate screening, what tests are appropriate and the frequency of testing. Screening rates differ by population; current national screening rates fall far below what guidelines would indicate, and many underserved communities have very low screening rates. Reasons for low screening rates are many; in the case of endoscopic screening, cost and access are problems, and other reasons include psychological barriers due to the indignity of the procedure, fear of procedure related pain, bowel preparation discomfort and potential need for sedation.²² The current "80% by 2018" colorectal cancer national initiative appears to be encouraging increased screening according to guidelines.

Best Practice: Health care providers should be aware of the benefits of CRC screening and current guideline recommendations.^{21, 23} Health care providers should know how to apply the recommendations to their specific patients. Health care providers should be aware of advances and alternatives to standard endoscopy that

may improve rates of screening. Health care providers should be aware of the impact of the ACA on CRC screening costs and availability and the effect of uncertainty of the future of ACA on patients' decisions about preventive care.

Skin Cancer

Current Practice: Skin cancer is the most common cancer worldwide, with a rate in the U.S. of 99,550 new cases and 9,320 deaths from melanoma¹ and over 3 million cases of non-melanoma skin cancers (primarily basal and squamous cell carcinomas) (NMSCs).²⁴ The incidence of NMSCs is more than all other cancer types combined, and increasing rapidly. There is no government-sponsored skin cancer screening program. Guidelines currently do not recommend population-based screening programs, instead "advising clinicians to remain alert for skin lesions with malignant features (asymmetry, border irregularity, color variability, diameter greater than 6 mm, rapidly changing lesions) noted in the context of physical examinations performed for other purposes" (e.g., "opportunistic" screening).²⁵ Screening programs have not conclusively demonstrated a link between screening and improved outcomes.²⁶ However, it is clear that skin cancer leads to significant direct and indirect costs associated with premature morbidity and mortality (\$28.9-39.2 million and \$1.0-3.3 billion per year, respectively) and years of potential lost life.²⁷

Best Practice: Health care providers should be aware of the benefits of opportunistic skin cancer screening. Health care providers should examine each patient on a regular basis and educate patients on skin cancer prevention.

Prostate Cancer

Current Practice: Current USPSTF guidelines do not recommend population-based screening.²⁸ Two large trials were carried out examining prostate-specific antigen (PSA) testing. In the Prostate, Lung, Colorectal, and Ovarian (PLCO) trial, no effect of PSA screening on prostate cancer mortality was demonstrated, though the results may have been affected by a large amount of screening in the control group.²⁹ In a European multicenter trial, a 21% reduction in prostate cancer mortality was demonstrated.³⁰ However, in each trial, over diagnosis was a significant problem. More recent analysis of these data is, to some degree, reopening the screening discussion.

Best Practice: Health care providers should understand the benefits and costs of PSA screening and the risks of over diagnosis. Health care providers should be able to discuss with patients the risks and benefits of screening within the context of each patient's risk for prostate cancer and life expectancy and engage in informed decision-making.

Lung Cancer

Current Practice: Screening with low-dose computed tomography (LDCT) has been shown to substantially reduce the risk of dying from lung cancer.³¹ In the National Lung Screening Trial (NLST), LSCT had a sensitivity and specificity of 93.8% and 73.4% and a positive rate of 24.2% while for chest radiography, the results were 73.5%, 91.3% and 6.9%, respectively.³² As a result of these positive results, the trial was halted early in 2011.³³ Based on that research, current guidelines-issuing organizations are generally in agreement about defining the target population as smokers or former smokers who have 30 pack-year histories of smoking. More needs to be done to increase screening of appropriate patients.

Best Practice: Health care providers should be aware of the benefits and risks of LDCT, current guideline recommendations such as USPSTF³⁴ and the criteria for which patients should be screened. Health care providers who want to offer LDCT screening should know best practices for such screening programs. Under the ACA, both private and public health care insurers have expanded coverage to include the cost of annual LDCT screening for lung cancer in appropriate high-risk individuals; there is uncertainty over the future of ACA and the effects on patients' decision making about preventive care.

Ovarian Cancer

Current Practice: Current recommendations still do not support screening programs for women with a low-risk of ovarian cancer.³⁶ Recent trials have demonstrated inconsistent results with some, such as the UK Collaborative Trial of Ovarian Cancer Screening (UKCTOCS), indicating a benefit from screening³⁷ and others, such as the PLCO trial, failing to reduce mortality as a result of screening.³⁸ Women with known predisposing genetic mutations or a family history of ovarian cancer may benefit from ovarian cancer screening. Opportunistic screening – assessing patients for symptoms suggestive of ovarian cancer during visits for other concerns – may offer some benefit.³⁹ The OvaSure blood test uses six biomarkers, including leptin, prolactin, osteopontin, insulin-like growth factor II, macrophage inhibitory factor and CA-125.⁴⁰ However, the NCCN Panel Members believe that the OvaSure screening test should not be used to detect ovarian cancer since several of these biomarkers do not increase rapidly enough in early stage cancer.⁴¹ More recently, the search for appropriate biomarkers continues.

Best Practice: Health care providers should be aware of the potential benefits and risks from erroneous (both false-positive and -negative) screening results. Health care providers should educate each woman on her individual risk of ovarian cancer.

Oral and Oropharyngeal Cancer

Current Practice: New cases of oral and oropharyngeal cancer are found in approximately 51,540 people every year and approximately 10,030 people will die of the disease.¹ Oral cancer rates, related to heavy tobacco and alcohol use, have been decreasing, but the rate of oropharyngeal cancer due to human papillomavirus (HPV) has been increasing. However, draft recommendations by the USPSTF conclude that the current evidence is insufficient to assess the balance of benefits and harms of screening for oral cancer in asymptomatic adults.⁴²

Best Practice: Health care providers, especially dentists, should be aware of the benefits of opportunistic oral cancer screening during routine dental care and other dental procedures.

Footnotes

1. American Cancer Society. Cancer Facts & Figures 2018. Atlanta: American Cancer Society; 2018.
- 2, 3, 4, 5, 6, 7, 8. Footnotes deleted.
9. National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Centers for Disease Control and Prevention. 2017. Available at: www.cdc.gov/cancer/nbccedp. Accessed February 22, 2018.
10. Hoerger TJ, et al. Estimated effects of the National Breast and Cervical Cancer Early Detection Program on breast cancer mortality. *Am J Prev Med.* 2011;40:397-404.
11. Escoffery CT, et al. Recruitment for the National Breast and Cervical Cancer Early Detection Program. *Am J Prev Med.* 2012;42:235-41.
12. Guideline synthesis: Screening for breast cancer in women at average risk. National Guideline Clearinghouse (NGC). Agency for Healthcare Research and Quality (AHRQ); 1998 Dec (revised 2012 Dec). Available at: www.guideline.gov. Accessed February 22, 2018.
13. Drukteinis JS, et al. Beyond mammography: new frontiers in breast cancer screening. *Am J Med.* 2013;126:472-9.
14. For example, compare these two sets of guidelines:
Final Recommendation Statement: Breast Cancer Screening, U.S. Preventive Services Task Force. November 2016.

<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening>. Accessed February 22, 2018.

American Cancer Society Recommendations for the Early Detection of Breast Cancer, 2017. <https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection.html>. Accessed February 22, 2018.

15. Final Recommendation Statement: Cervical Cancer: Screening. U.S. Preventive Services Task Force. December 2016.

16. American Cancer Society Cervical Cancer Screening Guidelines, 2016. <https://www.cancer.org/cancer/cervical-cancer/prevention-and-early-detection/cervical-cancer-screening-guidelines.html>. Accessed February 22, 2018.

17. Orfanoudaki IM, et al. Recent advances in optical imaging for cervical cancer detection. *Arch Gynecol Obstet*. 2011;284:1197-208.

18. Vakiani E, Yantiss RK. Pathologic features and biologic importance of colorectal serrated polyps. *Adv Anat Pathol*. 2009; 16:79-91.

19. Colorectal Cancer Control Program. Centers for Disease Control and Prevention. 2013. Available at: <https://www.cdc.gov/cancer/crccp/>. Accessed February 22, 2018.

20. Seeff LC, et al. Moving forward: Using the experience of the CDCs' Colorectal Cancer Screening Demonstration Program to guide future colorectal cancer programming efforts. *Cancer*. 2013;119:2940-6.

21. For example, compare these two sets of guidelines:
Final Recommendation Statement: Colorectal Cancer Screening, U.S. Preventive Services Task Force. June 2017.
<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening>. Accessed February 22, 2018.
American Cancer Society Colorectal Cancer Screening Guidelines, 2008.
<https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/colorectal-cancer-screening-guidelines.html>. Accessed February 22, 2018.

22. Obstein KL, Valdastrì P. Advanced endoscopic technologies for colorectal cancer screening. *World J Gastroenterol*. 2013; 19:431-439.

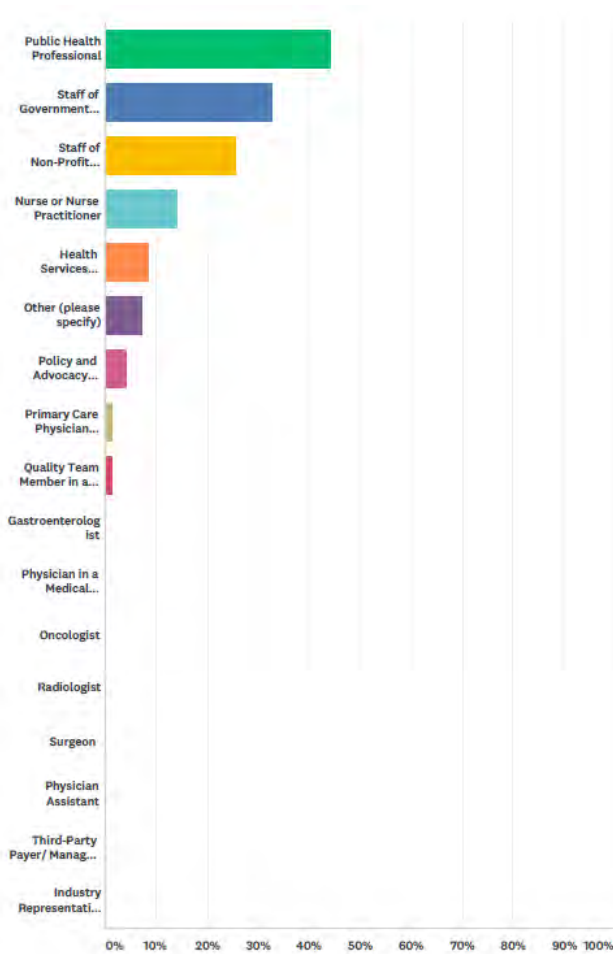
23. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) - Colon Cancer, Version 3.2013. http://www.nccn.org/professionals/physician_gls/pdf/colon.pdf. Accessed August 22, 2013.

- 24.** American Society of Clinical Oncology - Skin Cancer (Non-Melanoma) Guide, December 2016. Available at: <https://www.cancer.net/cancer-types/skin-cancer-non-melanoma>. Accessed February 22, 2018.
- 25.** Final Recommendation Statement: Skin Cancer: Screening. U.S. Preventive Services Task Force. December 2014.
<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/skin-cancer-screening2>. Accessed February 22, 2018.
- 26.** Wolff T, Tai E, Miller T. Screening for skin cancer: an update of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med.* 2009; 150:194-198.
- 27.** Guy GP, Ekwueme DU. Years of potential life lost and indirect costs of melanoma and non-melanoma skin cancer: a systematic review of the literature. *Pharmacoeconomics.* 2011; 29:863-874.
- 28.** U.S. Preventive Services Task Force. Final Recommendation Statement: Prostate Cancer Screening. May 2012.
<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening>. Accessed February 22, 2018.
- 29.** Andriole GL, Crawford ED, Grubb RL, 3rd, et al. Prostate cancer screening in the randomized Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial: mortality results after 13 years of follow-up. *J Natl Cancer Inst.* 2012; 104:125-132.
- 30.** Schroder FH, Hugosson J, Roobol MJ, et al. Prostate-cancer mortality at 11 years of follow-up. *N Engl J Med.* 2012; 366:981-990.
- 31.** Midthun DE, Jett JR. Screening for lung cancer: The US studies. *J Surg Oncol.* 2013;
- 32.** Church TR, Black WC, Aberle DR, et al. Results of initial low-dose computed tomographic screening for lung cancer. *N Engl J Med.* 2013; 368:1980-1991.
- 33.** Statement concerning the National Lung Screening Trial, October 28, 2010 *Data and Safety Monitoring Board, National Lung Screening Trial, National Cancer Institute.* Available at: www.cancer.gov/PublishedContent/Files/images/DSMB-NLST.pdf. Accessed August 22, 2013.
- 34.** U.S. Preventive Services Task Force. Final Recommendation Statement: Lung Cancer Screening. December 2016.
www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/lung-cancer-screening. Accessed February 22, 2018.

- 35.** Footnote deleted.
- 36.** U.S. Preventive Services Task Force. Final Recommendation Statement: Ovarian Cancer Screening. Available at: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/ovarian-cancer-screening>. Accessed February 22, 2018.
- 37.** Menon U, Gentry-Maharaj A, Hallett R, et al. Sensitivity and specificity of multimodal and ultrasound screening for ovarian cancer, and stage distribution of detected cancers: results of the prevalence screen of the UK Collaborative Trial of Ovarian Cancer Screening (UKCTOCS). *Lancet Oncol.* 2009; 10:327-340.
- 38.** Pinsky PF, Zhu C, Skates SJ, et al. Potential effect of the risk of ovarian cancer algorithm (ROCA) on the mortality outcome of the Prostate, Lung, Colorectal and Ovarian (PLCO) trial. *Int J Cancer.* 2013; 132:2127-2133.
- 39.** Committee Opinion No. 477: the role of the obstetrician-gynecologist in the early detection of epithelial ovarian cancer. *Obstet Gynecol.* 2011; 117:742-746.
- 40.** Visintin I, Feng Z, Longton G, et al. Diagnostic markers for early detection of ovarian cancer. *Clin Cancer Res.* 2008; 14:1065-1072.
- 41.** Buchen L. Cancer: Missing the mark. *Nature.* 2011; 471:428-432.
- 42.** Screening for Oral Cancer: Consumer Guide. *U.S. Preventive Services Task Force.* Available at: www.uspreventiveservicestaskforce.org/uspstf/uspsoral.htm. Accessed February 22, 2018.

B. 2017 Dialogue for Action evaluation survey data

Q1. 2017 Dialogue for Action attendee profession (check all that apply)



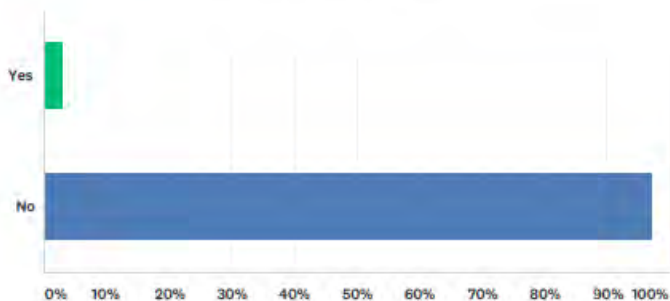
- Public Health Professional; 44.29%
- Staff of Government Health Agency (Federal, State, Local); 32.86%
- Staff of Non-Profit Health Organization; 25.71%
- Nurse or Nurse Practitioner; 14.29%
- Health Services Researcher
- Other (please specify); 7.14%
- Policy and Advocacy Professional, 4.29%
- Primary Care Physician (Internist, Family Physician, Osteopath); 1.43%
- Quality Team Member in a Hospital, Insurance Company, etc.; 1.43%

Q6 Overall assessment of conference. Rate the conference overall

	VERY SATISFIED	SATISFIED	NEUTRAL	UNSATISFIED	VERY UNSATISFIED	TOTAL	WEIGHTED AVERAGE
Rate the conference overall.	58.21% 39	38.81% 26	2.99% 2	0.00% 0	0.00% 0	67	1.45

Q7 Do you think any session or panelist was biased toward any specific commercial product?

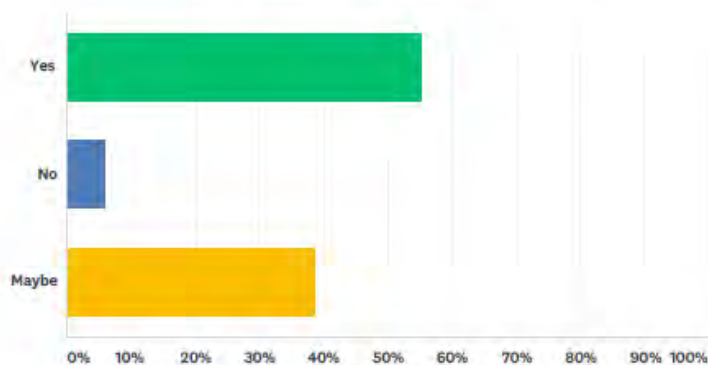
Answered: 67 Skipped: 3



ANSWER CHOICES	RESPONSES	
Yes	2.99%	2
No	97.01%	65
TOTAL		67

Q8 As a result of attending this conference, I intend to implement change in my workplace or community.

Answered: 67 Skipped: 3

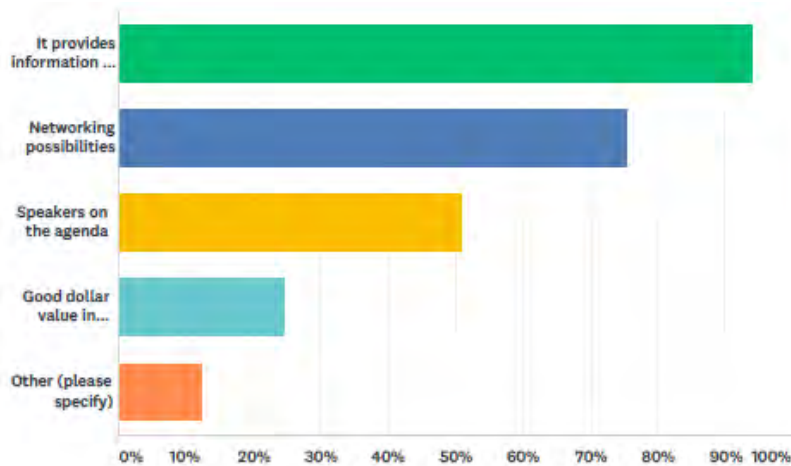


ANSWER CHOICES	RESPONSES	
Yes	55.22%	37
No	5.97%	4
Maybe	38.81%	26
TOTAL		67

Q10 After participating in the conference, I am better able to:

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
Briefly describe the current trends in research/development of screening methods for prostate and ovarian cancers.	33.33% 22	50.00% 33	15.15% 10	1.52% 1	0.00% 0	66	1.85
Describe how social determinants of health, such as where someone lives, affect the health of communities and how health care providers can use this information to improve the health of their patients.	51.52% 34	42.42% 28	3.03% 2	3.03% 2	0.00% 0	66	1.58
Identify one innovative way to provide cancer screening or prevention services in low-resource settings.	34.85% 23	56.06% 37	9.09% 6	0.00% 0	0.00% 0	66	1.74
Briefly describe the current national discussion on what (post-ACA) health care coverage will be like in the coming years.	27.69% 18	33.85% 22	33.85% 22	4.62% 3	0.00% 0	65	2.15
Give an example of how the use of big data can lead to improved health outcomes.	24.62% 16	56.92% 37	13.85% 9	4.62% 3	0.00% 0	65	1.98

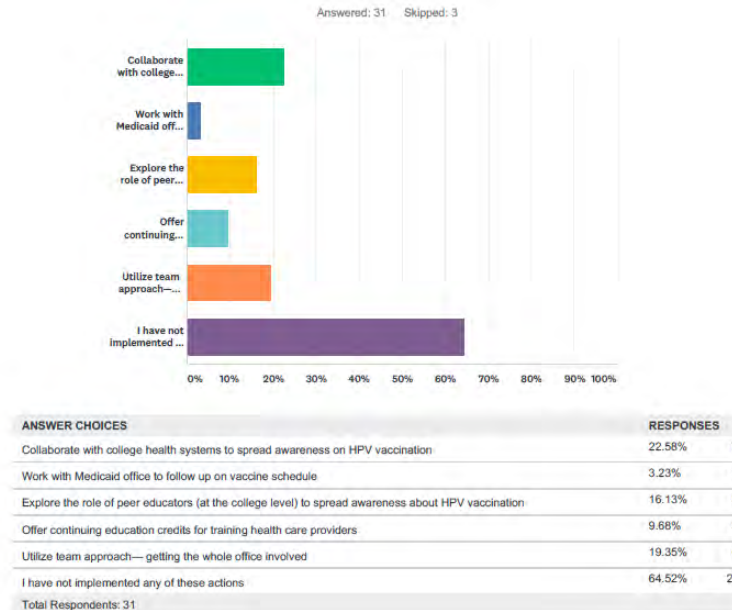
Q17 Check your top 3 reasons for attending this year's conference.



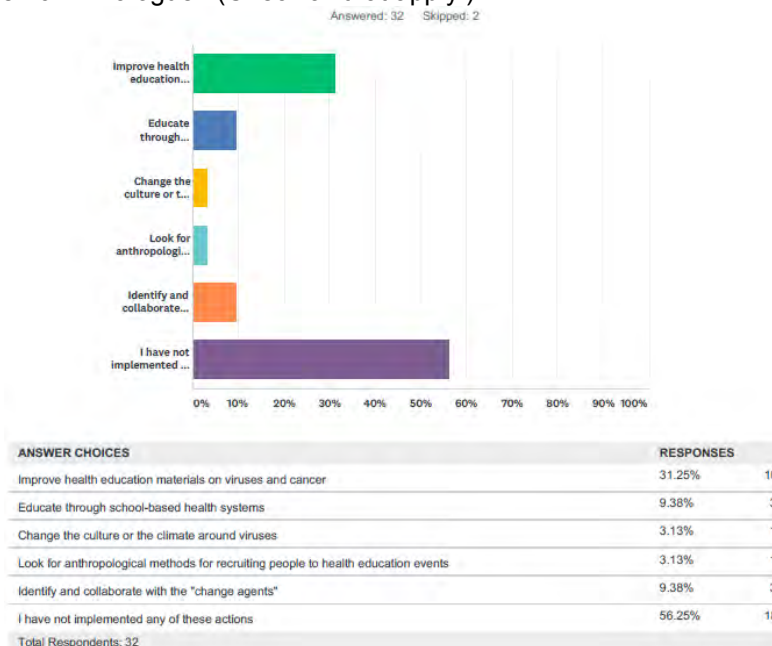
ANSWER CHOICES	RESPONSES
It provides information on current trends, innovations and updates on this subject	93.85% 61
Networking possibilities	75.38% 49
Speakers on the agenda	50.77% 33
Good dollar value in relation to the registration fee and content	24.62% 16
Other (please specify)	12.31% 8
Total Respondents: 65	

C. 2017 Dialogue for Action outcomes survey data

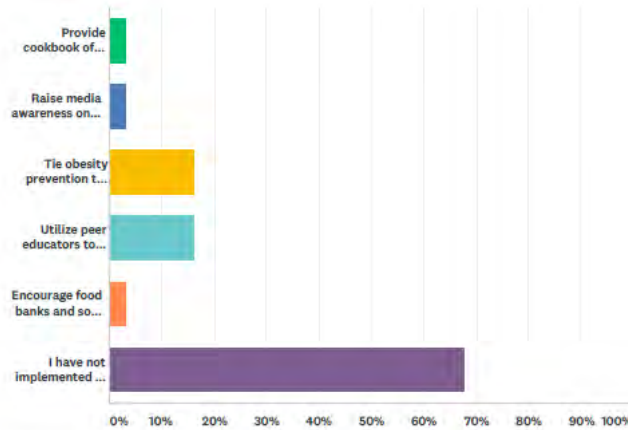
Q1 Conversation on “How to Improve HPV Vaccination Rates; Including Encouraging Primary-Care Clinicians” Which of these recommended practical actions have you implemented or do you plan to implement in your workplace or community since the 2017 Dialogue? (Check all that apply.)



Q2 Conversation on “Opportunities and Challenges for Community Programs on Viruses and Cancer (Hepatitis B or C and Liver Cancer, HPV and Cervical, Oropharyngeal, Other Cancers)” Which of these recommended practical actions have you implemented or do you plan to implement in your workplace or community since the 2017 Dialogue? (Check all that apply.)

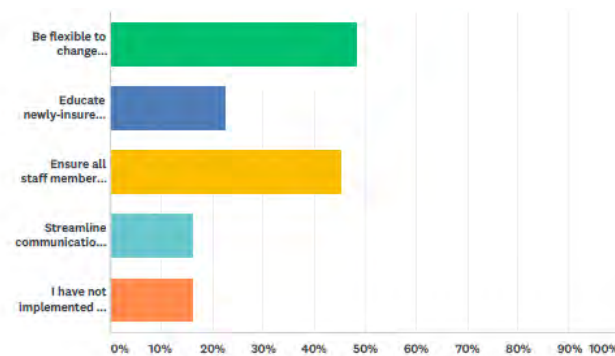


Q3 Conversation on “Strategies for Implementing Obesity Prevention Programs in Your Community”
Which of these recommended practical actions have you implemented or do you plan to implement in your workplace or community since the 2017 Dialogue? (Check all that apply.)



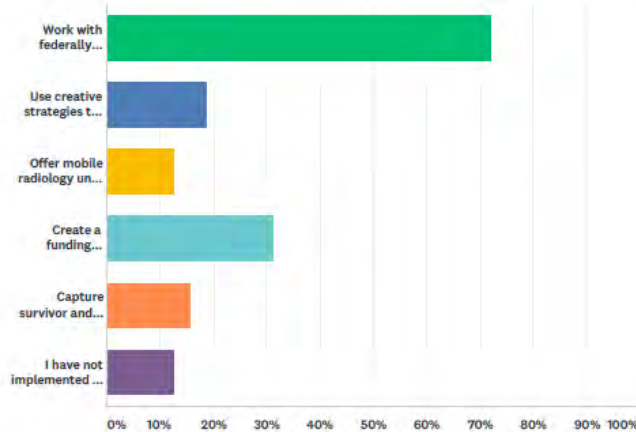
ANSWER CHOICES	RESPONSES
Provide cookbook of healthy, affordable recipes	3.23% 1
Raise media awareness on healthy and affordable food options	3.23% 1
Tie obesity prevention to what is important to the community	16.13% 5
Utilize peer educators to spread the message of eating healthy	16.13% 5
Encourage food banks and soup kitchens to provide healthy food options and resources	3.23% 1
I have not implemented any of these actions	67.74% 21
Total Respondents: 31	

Q4 Conversation on “Update on Reducing Cancer Screening Disparities: The Community-Level View From Across the Country” Which of these recommended practical actions have you implemented or do you plan to implement in your workplace or community since the 2017 Dialogue? (Check all that apply.)



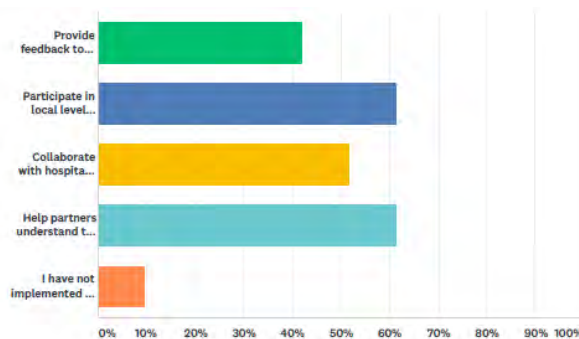
ANSWER CHOICES	RESPONSES
Be flexible to change directions and resources when challenges or populations change	48.39% 15
Educate newly-insured individuals	22.58% 7
Ensure all staff members have standard/ key messaging for patients	45.16% 14
Streamline communication across states—share what's working/ what is not working	16.13% 5
I have not implemented any of these actions	16.13% 5
Total Respondents: 31	

Q5 Conversation on “How Do We Move Forward with Cancer Prevention and Early Detection in the Changing World of Coverage for Health Care?” Which of these recommended practical actions have you implemented or do you plan to implement in your workplace or community since the 2017 Dialogue? (Check all that apply.)



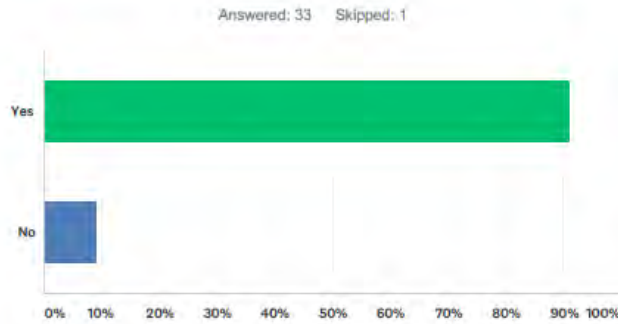
ANSWER CHOICES	PERCENTAGE	RESPONSES
Work with federally qualified health centers to increase cancer screenings	71.88%	23
Use creative strategies to raise funds for cancer prevention and early detection, e.g. tobacco taxes and license plate funding	18.75%	6
Offer mobile radiology units with low-cost screening in rural areas (using physician champions)	12.50%	4
Create a funding mechanism for providing patient navigation and education	31.25%	10
Capture survivor and early detection and prevention stories to share with patients	15.63%	5
I have not implemented any of these actions	12.50%	4
Total Respondents: 32		

Q6 Conversation on “How Can We Strengthen Public-Private Partnerships in Cancer Screening and Prevention?” Which of these recommended practical actions have you implemented or do you plan to implement in your workplace or community since the 2017 Dialogue?(Check all that apply.)

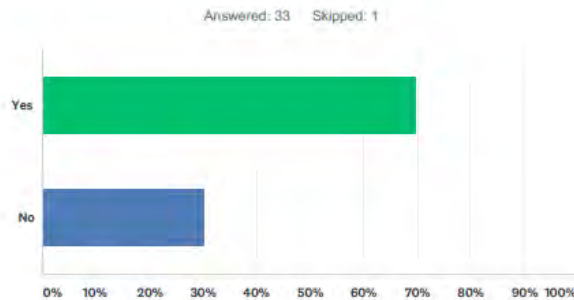


ANSWER CHOICES	PERCENTAGE	RESPONSES
Provide feedback to people who join/support your partnership	41.94%	13
Participate in local level cancer planning	61.29%	19
Collaborate with hospitals, physicians, and others to donate time and services	51.61%	16
Help partners understand the benefits of working together	61.29%	19
I have not implemented any of these actions	9.68%	3
Total Respondents: 31		

Q7 As a result of the 2017 Dialogue for Action: On Cancer Screening & Prevention, have you taken steps or do you plan to take steps to reduce disparities in cancer prevention and screening?

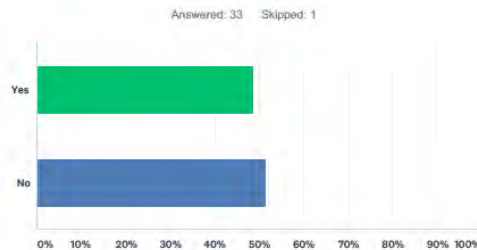


Q8 As a result of the 2017 Dialogue for Action: On Cancer Screening & Prevention, have you used or do you plan to use big data to improve health?



ANSWER CHOICES	RESPONSES	
Yes	69.70%	23
No	30.30%	10
TOTAL		33

Q15 Since the 2017 Dialogue, have you encountered barriers to implementing new prevention or screening strategies?



ANSWER CHOICES	RESPONSES	
Yes	48.48%	16
No	51.52%	17
TOTAL		33

D. 2018 Dialogue for Action Committee Meeting Minutes

Two samples of recent meeting minutes for 2018 Dialogue Committee Meeting on January 10, 2018 and meeting January 24, 2018. Meeting notes like these are taken at each 2018 Dialogue core team meeting. Nurse Practitioner representative, Claudia Christensen, NP, was added to the Dialogue Committee February 21, 2018.

Core Team Meeting NOTES

January 10, 2018, 11:30 am

Conference Call-In: 641-715-3580

Access Code: 837124#

Core Team:

Lisa Berry, Jan Bresch, Janet Hudson, Karen Peterson, Amy Sokal, Erica Childs Warner, Liz Hall, Lisa Han, Kim Jappell, Maggie Klee, Ann Mallari, Lorelei Mitrani, Taylor Patton

Key Dates:

January 12: Laurels Selection Committee decision deadline

January 19: Notify Laurels recipients

January 19: Poster abstracts deadline

February 28: Early Bird registration ends

March 16: Hotel Room Block closes

Agenda:

- Laurels
 - Liz announced that we have our MC, Marissa Jaret Winokur confirmed.
 - Lorelei reported on Laurels submissions (28 total)
 - Voting selections are due at the end of the week, so we will have our award winners soon!
 - Decision to remove Paul Engstrom from consideration for National Leadership Award and instead award him with a special Lifetime Achievement Award.
 - **ACTION ITEM:** Lorelei will send a draft award letter for Paul Engstrom to Bo. Draft based on the 2012 award letter to Sidney Winowaur.
 - Bo will give the award to Paul Engstrom at the Luncheon.
- Registration
 - Lorelei provided a registration update.
 - 11 total registrations (9 paid attendee registrations), which is very comparable to last year.
 - One registrant from Saipan.

- Communications
 - Maggie provided an update on the guest blog
 - Sanjeev Arora is confirmed, plan to have it go out towards the end of January.
 - **ACTION ITEM:** Maggie will draft questions for Sanjeev's blog and will send to Core Team for input.
 - Lisa Berry gave a List Pricing update
 - Nurse Practitioners and Physicians Assistants lists are each \$2500, so \$5000 total. Doing both would be over the budget.
 - Bo did not think the yield would be worth the list expense.
 - Bo suggested reaching out to Gay Johnson CEO for the National Association of Nurse Practitioners in Womens Health (NPWH) instead of lists.
 - **ACTION ITEM:** Karen will follow-up with Bo and Bo will help make the connection between Gay Johnson and Karen to help facilitate DFA cross promotion.
 - **ACTION ITEM:** Lisa Berry will check with the lists to see if the email can come from AAPA.
 - Lisa Berry reported on Google Adwords
 - Changes to google adwords policies, the click through rate now needs to hit 5% which is very high, this puts our group in danger of losing its grant from google.
 - **ACTION ITEM:** Lisa will do an audit of our Google Adwords past use and will choose highest performing key words.
 - **ACTION ITEM:** Keyword suggestions can be sent to Lisa Berry.
 - Discussion on 2018 professional Video Opportunities
 - We have not gotten good footage in the past. We may want to utilize professional video this year.

- Posters
 - Ann gave the poster update
 - 6 reviewers confirmed, 1 submission so far
 - Deadline is January 19th.
 - **ACTION ITEM:** Chris will need to embed the finished 2017 video on our poster site once it is ready.
 - **ACTION ITEM:** posters video should be shared on social media as well. (Maggie)

- Conference Agenda
 - Discussion on DFA promotion/outreach
 - **ACTION ITEM:** Have the DC coalition groups been reached out to?

- **ACTION ITEM:** Board members need to be give the Dialogue event information, and so do the SRP and MAB. Lisa will send SRP and MAB through convio (with address line from Bo)
- **ACTION ITEM:** Want to put out targeted emails to TATL stop groups (HPV and HEP are both well represented on the agenda this year). Should also send to the campaign advisory council.
- **ACTION ITEM:** Lorelei will send the info to the Hep health partner and other health partners from the 5k notifying them about DFA and asking for their help in promotion.
- Karen provided updates on the DFA agenda
 - Conversation with Richard Mousseau about ceremonial tobacco use movie
 - Idea of presenting that as part of the AIAN information-sharing meeting.
 - Would want someone connected to the film to present on it.
 - Discussion around Hepatitis C in Indian Country (liver cancer rate is 4x higher than national average)
 - Friday Keynote is in progress
 - **ACTION ITEM:** Really push Friday keynote panel in our communications
 - **ACTION ITEM:** In February and in March Lorelei will email registered attendees with info on the keynote panel and saying “before you book your planes... check out this Friday content...”
 - **ACTION ITEM:** Main DFA email blast will send out an email highlighting Friday content too.
 - 2 keynote panelists have been invited so far, Boris Lushniak and Luis Diaz
 - Bo is working the Luis Diaz connection
 - 8 spaces left to fill on the agenda right now.
 - **ACTION ITEM:** Will want to add info about check out time on Friday into Friday morning remarks.
- Lisa Berry brought up Gammapod as possible exhibitor
 - **ACTION ITEM:** Karen will be the one to lead the charge on the Gammapod reach out.

Next Core Team meeting is January 24th.

Core Team Meeting NOTES
January 24, 2018, 11:30 am
Conference Call-In: 641-715-3580
Access Code: 837124#

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Key Dates:

January 26: Extended Poster abstracts deadline
February 28: Early Bird registration ends
March 16: Hotel Room Block closes

Notes:

- Registration
 - Lorelei provided a registration update.
 - 22 total registrations (19 paid attendee registrations), which is slightly more paid attendees compared to this time last year.
 - **ACTION ITEM:** Lorelei will email all staff the registration info for DFA 2018 so they can start getting themselves registered.
- Laurels
 - Lorelei reported on current Laurels status: 2 winners finalized, 1 reviewer had not yet responded, need his vote to break a tie on Health Equity category.
- Fundraising
 - Less grant applications this year, more personal outreach and requests.
 - Lots of excitement currently, many potential sponsors in the works, including Hologic.
- Posters
 - 19 submissions so far and 15 reviewers, ahead of last year.
 - 10 submissions were colorectal
- Agenda
 - Karen provided agenda updates

- Content focus, highest is Cervical/HPV with 6, next is Lung with 5, third is colorectal with 3. Several presentations cover all types.
 - Bethany Kintigh + Melinda Wharton + Paul Carson = HPV Vax Panel
 - Jan asked Taylor about the HPV Report Card
 - ❖ Taylor needs to update this with recent Florida progress
 - ❖ **ACTION ITEM:** Taylor + EA will have this professionally printed, we can give this out at Dialogue during the HPV panel or smaller session.
 - ❖ **ACTION ITEM:** Report card should be added to Bos remarks
 - **ACTION ITEM:** Figure out having SuperColon at DFA
 - ❖ **ACTION ITEM:** Lisa Berry will print additional colorectal materials for this.
 - Movie Night
 - ❖ BHE at Movie night
 - ❖ **ACTION ITEM:** Lisa B and Erica will work together to figure out what videos are playing before morning welcome speeches.
 - Boris Luschniak said yes to visionary keynote
 - Luis Diaz said no to visionary keynote
 - Jan suggested Don Lisvin as a potential visionary keynote addition
 - Edith Mitchell as a potential visionary keynote addition
- Communications
 - Dr. Arora Blog - Goal of sending out mid-February
 - What should we send out content wise to the board?
 - ❖ General info, maybe include a quote from Marcia or Scott
 - ❖ 2 previous research grant recipients will be speaking
 - ❖ Wendy is a potential person for Medical Advisory Board
 - ❖ From line is coming from Bo
 - **ACTION ITEM:** Karen will send Jan and Lisa Berry the information about the progress in research on the front lines of cancer prevention panel.
 - TATL advisory committee emails
 - ❖ **ACTION ITEM:** Lisa/Erica will check with Gabbie on this piece.
 - Kim asked if there is an easy share option for emails through online express.
 - A number of core team members aren't getting PCF emails
 - ❖ **ACTION ITEM:** Lisa will talk to Henry about an online express audit.