Cancer Causes Control (2010) 21:1995–2004
DOI 10.1007/s10552-010-9655-x

ORIGINAL PAPER

Models for local implementation of comprehensive cancer control: meeting local cancer control needs through community collaboration

Bruce Behringer · Staci Lofton · Margaret L. Knight

Received: 11 June 2010 / Accepted: 23 September 2010 / Published online: 12 October 2010

Abstract The comprehensive cancer control approach is used by state, tribes, tribal organizations, territorial and Pacific Island Jurisdiction cancer coalitions to spur local implementation of cancer plans to reduce the burden of cancer in jurisdictions across the country. There is a rich diversity of models and approaches to the development of relationships and scope of planning for cancer control activities between coalitions and advocates in local communities. The national comprehensive cancer control philosophy provides an operational framework while support from the Centers for Disease Control and Prevention enables coalitions to act as catalysts to bring local partners together to combat cancer in communities. This manuscript describes multiple characteristics of cancer coalitions and how they are organized. Two models of how coalitions and local partners collaborate are described. A case study method was used to identify how five different state and tribal coalitions use the two models to organize their collaborations with local communities that result in local implementation of cancer plan priorities. Conclusions support the use of multiple organizing models to ensure involvement of diverse interests and sensitivity to local cancer issues that encourages implementation of cancer control activities.

Keywords Comprehensive cancer control · Local implementation of state health plans · Cancer coalitions

The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

B. Behringer (✉)
Division of Health Sciences, East Tennessee State University, Box 70712, Johnson City, TN 37614, USA
e-mail: behringe@etsu.edu

S. Lofton
Division of Cancer Control, Comprehensive Cancer Control Branch, Centers for Disease Control and Prevention, Atlanta, GA, USA

M. L. Knight
New Jersey Department of Health, Office of Cancer Control and Prevention, Trenton, NJ, USA

Introduction

Recently there have been noted reductions in national cancer incidence and mortality for both men and women [1]. Experts attribute these declines to many factors—reductions in new cases, advances in research resulting in improvements in prevention and treatment, greater use of screening, declining use of tobacco, and national dietary improvements. Many of these factors were fostered by national, state, and local health policy. For instance, in 1971, the national War on Cancer declared by President Nixon and the signing of the National Cancer Act of 1971 [2] was followed by a dramatic 136% growth of Federal cancer research spending, which was apparent under President Clinton. These efforts demonstrate a long-standing national commitment to address cancer control [3]. Despite many advances in cancer control, cancer continues to plague the nation as the overall second leading cause of death in the United States [4] and is now the leading cause of death among Asian or Pacific Islanders and among persons aged 45–54 and 55–64 [4]. Cancer surpassed heart disease to become the leading cause of death in Alaska, Colorado, Maine, Minnesota, Montana, New Hampshire, Oregon, and Washington [5]. Population and geographic–based cancer disparities persist [6] and low screening rates persist for some of the most preventable cancers [7].

In efforts to overcome some of the aforementioned challenges, cancer control leaders from across the nation collaborated to more comprehensively control cancer in the United States. The Centers for Disease Control and Prevention (CDC), the National Cancer Institute, the American Cancer Society, and other national organizations united in a collaborative effort to reduce cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation [8]. This approach, known as comprehensive cancer control (CCC), allows for a community and its partners to strategically improve cancer outcomes by coordinating efforts, pooling resources, and implementing evidence-based public health practices. As one of the national partners, CDC supports this national effort by funding the National Comprehensive Cancer Control Program (NCCCP) in 50 states, the District of Columbia, Puerto Rico, seven tribes and tribal organizations, and seven US-associated territories and Pacific Island Jurisdictions. CDC awards funding to states, tribes, territories, and Pacific Island Jurisdictions to enable public health agencies (or their designee) to act as conveners and sometimes facilitators of a CCC coalition, to organize the collaboration process among multiple cancer partners and communities. The example set forth by the nation's cancer control leaders set the stage for similar collaborative efforts at state and local levels to grow and flourish.

The CCC movement is mature enough for histories to be written [9, 10] but young enough for formative reflective summaries to begin. This article focuses on one critical aspect of the program—how the national partnering efforts of many have spawned a rich diversity of CCC programs and coalitions that have engaged and promoted cancer control in communities, through the local implementation of CCC plan priorities.

Encouraging local implementation of CCC plans

Comprehensive cancer control as an approach to addressing the cancer burden embodies several key elements that encourage local implementation. First, the approach adopts the cooperative effort of the CCC National Partnership (CCCNP) (see The CCC National Partnership—An example of organizations collaborating on comprehensive cancer control article in this Special Issue of Cancer Causes and Control for a listing of partners) to address cancer in a comprehensive manner by promoting a vision for the full spectrum of the continuum of cancer care for all cancer sites. Emulating this collaborative focus provides a framework for collaboration and resource sharing to comprehensively control cancer. Secondly, CDC funds NCCCP grantees to convene vested cancer control partners (a CCC coalition) to develop and implement CCC plans. CDC funding ensures participation of public health departments in comprehensive cancer control and enables local health agencies to organize or facilitate initiatives that prevent and control cancer. Third, the national sense of cooperation and goal setting is further emphasized and realized by CCC coalitions. These coalitions address cancer issues specific to their locale by collectively implementing relevant solutions to prevent and control cancer. Coalition membership, structures, processes, actions, and accomplishments vary, but participation of community representatives from throughout state, tribes, territories, and Pacific Island Jurisdictions is implicit in their success. Fourth, local participation is encouraged in CCC plan development to ensure inclusion of local communities when addressing the cancer burden. Community input helps to identify local cancer concerns, availability of cancer resources, understand local needs, and prioritize goals and strategies to encourage local action. All cancer plans introduce the use of important data sets (e.g., Behavioral Risk Factor Surveillance System, population, and cancer registry statistics) to improve local relevance and elicit support to implement local priorities for comprehensive cancer control.

Key elements for encouraging local implementation

1 A **comprehensive vision** to promote the full spectrum of the continuum of cancer care for all cancer sites.

2 A **comprehensive cancer control coalition** to convene vested cancer control partners and develop and implement CCC plans

3 A **national sense of cooperation** and goal setting to support cooperation and goal setting

4 **Local participation** in CCC plan development to ensure local communities are included in addressing the cancer burden.

With over 10 years of comprehensive cancer control planning and implementation through CCC collations, all partners have identified the need to increase the support for current and develop new local cancer control initiatives to better address the varied cancer control issues and needs that may occur across the United States. While CDC and other national partners have identified a national vision for comprehensive cancer control, the definition of local implementation is still evolving. Currently, CCC coalitions have the liberty to customize local implementation by using cancer burden data and by culturally adapting evidence-based strategies to meet communities' needs. Most notably, local implementation allows a community and its cancer control partners to experience a sense of ownership in the development of solutions to prevent and control cancer in their locality. This sense of local ownership promotes and sustains CCC coalitions' efforts to comprehensively control cancer as outlined in the CCC plan.

A study report prepared by CCCNP found state, tribal, and territorial support of local cancer control efforts used

a mix of two strategies (L. Given, unpublished observations). The first strategy engages local partners to implement CCC plan priorities at the local level. The second strategy engages and builds the capacity of local partners to develop and implement their own priorities that are linked to CCC coalitions and plans. These approaches follow different routes leading to collaboration, either by supporting existing community efforts or by participating in formation of new local partnerships and activities.

The coordination of CCC coalitions and communities spurs locally implemented cancer control activities that advance comprehensive cancer control initiatives across states, tribes, territories, and the Pacific Island Jurisdictions in several ways. Using either aforementioned strategy for local cancer control, the CCC approach does the following:

- Promotes a reciprocal relationship that supports identification of and connection to local resources, expertise, and local cancer activists that can coordinate with a CCC coalition's own resources.
- Leads to the introduction of relevant cancer statistics as well as evidence-based research and practices that may be unfamiliar to local advocates.
- Leads to greater appreciation of population-based approaches that link the health of the individual with the health of the community [11].
- Provides an opportunity to promote grass roots direction and support for local and state advocacy and policy initiatives promoted through CCC coalitions.

The potential of local cancer control implementation: challenges and dilemmas

Each CCC coalition is formed around a common understanding and recognition of the burden of cancer, the social environmental conditions, and the resource capacity of its government and partners. CCC coalitions have mixed memberships, often comprised of organizations (health and non-health oriented) committed to cancer control and individuals who volunteer because they have a personal interest in cancer. The coalitions also work to integrate and balance the interests of national, state/tribal/territorial/Pacific Island Jurisdictional, and local partners within its cancer plan and implementation activities. The organizational structures of CCC coalitions vary. Some CCC coalitions are structured as part of public health agencies, some as 501c3 corporations, and some as part of universities and major cancer centers. Each coalition recruits, involves, and channels volunteers into structures designed to engage partners and volunteers in activities that reflect CCC plan priorities. In addition to developing and implementing its consensus driven, evidence-based cancer plan, CCC coalitions often serve as a catalyst for policy change to better prevent and control cancer.

CCC coalitions can foster long-term relationships with a vastly diverse set of local projects and community groups through using the co-sponsorship approach. Over time, the use of current research and evidence-based interventions may encourage local groups to acknowledge the value of CCC expertise in helping them to make a difference in addressing the cancer burden. CCC coalitions can become important allies and partners in meeting local communities' immediate goals such as, providing cancer patients with the concrete information to make the informed decision along with their healthcare providers. Through this trust, the dedicated community effort and the CCC coalition may eventually team to provide recognition and empowerment to grassroots priorities.

Comprehensive cancer control planning and implementation is not, however, always found to be connected to local cancer control efforts. One continuing challenge requiring constant attention is reaching out and involving all points of geography, established cancer advocacy and service organizations, cancer survivors, and all underserved populations. For example, of the 578 participants who attended CCC-sponsored cancer forums and roundtables in the geographically distinct Appalachian regions of ten states in 2008–2009, only 22% were found to be members of state coalitions [Behringer (2009), unpublished observation]. Several reasons for this have been cited. Coalitions have capacity limitations, such as, lack of funding, resources, time, and training [8, 9], which limits their ability to effectively engage local partners in their efforts. It is often difficult for states to identify prospective local leaders and establish communication channels within communities from a centralized location. CCC coalitions' efforts to involve all coalition members are challenged by distance, geography, and diverse populations when trying to reach local cancer control champions among providers, survivors, and cancer-related organizations.

Cancer is a major concern for most communities. This local concern often leads to countless and widely diverse voluntary or funded efforts even in the poorest communities. The mix of those involved in local cancer control is vast. Frequent contributors are community clubs and organizations, health service providers, voluntary cancer advocacy organizations, schools, faith-based organizations, local businesses, and even local governments. Local communities support many types of voluntary efforts—fundraising to help family, friends, and neighbors; tobacco use prevention and physical activity educational programs; cancer screenings as part of local and regional health fair events; and adoption of locally relevant cancer issues by community organizations as their time-limited theme. Public health entities often provide leadership and linkages

to regional and state connections. Sometimes local actions are part of structured programs of national partners (e.g., ACS Relay for Life, Komen Race for the Cure). Local action is sometimes spurred simply by the cancer diagnosis or death of a community member. Frequently, community action is spontaneous and not associated with any specific cancer organization or coordinated with a state, tribal, or territorial plan. Activities are hoped to result in some community level improvement, to reduce a cancer or environmental threat in the community.

However, such activities are infrequently guided by sound data or evidence-based approaches. Measures of outcomes or thoughts of long-term impact are seldom considered and proactive strategic planning may be thought to quell interest and enthusiasm on the part of community advocates. The dilemma for CCC programs and coalitions is how to coordinate with local activities and volunteers without diminishing local knowledge, enthusiasm, and power as well as cultural identities. The goal is to encourage collaboration between CCC coalitions and local cancer control activities. Coalitions are often challenged in their efforts to find ways to synergize efforts and maximize resources, while maintaining local autonomy and demonstrating how cancer plans contribute to local initiatives. Building mutually beneficial and trusting relationships is a key to success. Accomplishing this can be achieved in several ways. Building on the findings of the CCCNP study, two models are proposed:

(1). *The Franchise Model* is characterized by a CCC coalition forming new or adopting existing community and regional groups within its structure. Essentially, each state, tribal, territorial, or Pacific Island jurisdiction has one central CCC "flagship" coalition. Local cancer committees or regional coalitions are organized or adopted to become sub-coalitions, committees, and task forces of the CCC coalition. Representatives from local communities are recruited or adopted and serve as members of the CCC coalition. Local groups are encouraged to adapt the CCC plan and implement evidence-based activities to meet the local needs and cultures. CCC expertise, connections, and resources are tapped to assist in planning, supporting, and strengthening local cancer control activities that become part of the cancer plan and its priorities. Local groups are encouraged to promote and participate in broader CCC coalition projects, an opportunity that is seen to empower local partners while providing broader reach and inclusiveness to coalition efforts.

(2). *The Co-sponsoring Model* is a less formalized approach. Local cancer control activities are generated by volunteers who may or may not become members of the CCC coalition or base their local efforts on the CCC plan or coalition priorities. Instead, the CCC coalition supports local activities, often co-sponsoring and co-branding events and publications. The emphasis on local initiative, ownership, and objectives are preserved. The CCC coalition gains a greater awareness of local cancer issues, resources, and champions while offering a broad range of assistance (e.g., speakers, clinical helpers, educational materials, etc.) to enhance local implementation.

Collaborative strategies to address relationships for local implementation

Himmelman's description of community betterment and community empowerment provides an excellent framework to understand the developmental process pursued through these models to promote long-term collaboration on cancer control efforts [10]. *Networking* must occur between the CCC coalition and community groups. Its purpose is to exchange information among parties about cancer control plans and activities. *Cooperating* occurs when existing activities are altered, for example, in modifying dates, times, locations, or target participants of cancer control or activities. *Coordinating* requires sharing resources. Finally, Himmelman defines *collaborating* as achieving the above three steps and engaging in activity that enhances each entity's capacity for a common purpose. Several state CCC coalitions and community representatives demonstrated how this contributions-benefits approach worked using a tool, the Give-Get Grid, as part of the Comprehensive Cancer Control in Appalachian Communities Program [Behringer (2010), in preparation]. Participants in a regional Appalachian cancer forum underscored the importance of shared identity and mutual benefits as the keys to true collaboration.

The results of the collaboration process clarify the intent and principles of comprehensive cancer control. Communities grow in an understanding of CCC plans, coalition goals, and common purposes of a diverse set of partners involved in shared effort to reduce the burden of cancer in their locale. By collaborating with local communities over time, CCC coalitions learn more about grass roots cancer beliefs and concerns, add to the pool of in-kind resources and volunteers, and build larger networks of partners for cancer control, policy, and advocacy activities.

Case studies demonstrating the model approaches

Each state, territorial, tribal, and Pacific Island Jurisdiction cancer coalition is different. The rich diversity of the national efforts can be described using multiple

characteristics. Table 1 summarizes five selected coalitions, highlighting one program from each coalition illustrative of the two models for local implementation. Each coalition is further described using five comparative characteristics: type of governance; coalition infrastructure; title of cancer plan; key community functions; and sample of targets for action including types of cancer and part of the continuum of cancer care. More details about each selected coalition program can be found below.

Local solutions to cancer control through franchising CCC initiatives in California

California's CCC efforts began through a joint initiative between the California Department of Public Health (CDPH) and the California Division of American Cancer Society (ACS) in 2001. From the start, California's CCC stakeholders recognized its diverse population and worked to ensure that its coalition, the California Dialogue on Cancer (CDOC), was representative of the state's population and localities. CDOC is comprised of three implementation teams including the Disparities/Access to Care/Early Detection (DAD Team), the Prevention Team, and the Treatment/Survivorship Team as well as an Executive Committee. The latter team includes two vice chair positions that are always held by the principal investigator of the Comprehensive Cancer Control Program (CCCP) at CDPH and an ACS representative.

CDOC convened a stakeholders meeting where 200 participants from the public and various sectors collaborated to draft the state's comprehensive cancer control plan. In preparing for the draft, a review of California's surveillance system's revealed an unequal burden of cancer among the poor, uninsured, and those who lacked access to quality cancer care. In nearly every type of cancer, members of underrepresented racial populations had a higher percentage of late-stage diagnoses. Access to quality care and reduction in risk factors (i.e. tobacco, poor nutrition, and physical inactivity) were two of many issues that cut across the state plan's colorectal, breast, prostate, and lung cancer strategies. To ensure a more direct impact on its heavily burdened communities, CDOC's disparities group the DAD Team, coordinated with key groups and leaders in the Oakland/Alameda County area in 2005 to tap existing and increase new community interest, education, and participation in access to care issues. The success of this pilot project served as a catalyst for DAD's expansion of such efforts in 2006–2007 into San Diego, Kern County, Ventura/Tri County area, and Sacramento. Again, grassroots interest in and commitment to addressing access to quality cancer care in underserved communities was undeniable. As a longtime partner and key collaborator, ACS provided $25,000 in grant funding to further expand the pilot project in 6 new regions: Los Angeles, Orange County, San Bernardino/Riverside Counties, Solano County, Santa Cruz County, and Fresno County.

In October 2007, DAD provided statewide training for the leaders of each region/county on forming a community coalition and developing a community profile, which was followed by informational "access to care" public forums in all 11 counties to further identify interest and participation among community representatives. ACS provided an additional $50,000 to help the communities develop, inform, and empower local community access to care coalitions that will advocate for policy change and programs to eliminate the prioritized barriers to cancer screening, detection, and treatment in their communities. After the training, each community coalition submitted a strategic plan outlining their local access to cancer care priorities and plans for implementation that directly relates to California's Comprehensive Cancer Control Plan.

The resources and capacity provided by CDOC and its ACS partner allowed communities to develop priority goals to address the varied access to care issues in each community. This effort contributed to reaching California's plan goal for all populations in California to have access to quality cancer care across the entire continuum of cancer with no disparity in outcomes. The coalition and its partners have adopted participatory evaluation approaches that will further empower and inform local efforts. The California experience exemplifies the key elements of the franchise model for local implementation.

One coalition, multiple locations: developing local implementation through the franchising model in New Jersey

The momentum for CCC in New Jersey was largely driven by state and local cancer control supporters who advocated with their political representatives to support the cancer control programs, policies, and practices across the state in an organized manner. The synergistic efforts at the federal, state, and local levels led to New Jersey's Executive Order 114 and now Public Law 2005, chapter 280, which mandated and accelerated the establishment of the Task Force on Cancer Prevention, Early Detection, and Treatment in New Jersey (Task Force—the coalition) and the Office of Cancer Control and Prevention (OCCP) within the state's Department of Health and Senior Services (NJDHSS). CDC's funding helped to further establish and support the state's CCC program; however, state appropriations significantly bolstered this effort by allowing New Jersey to expand its cancer control efforts to each of its 21 counties. New Jersey's financial commitment to the state's CCC efforts includes $1.5 M annually, of which $1.3 M is used to support personnel in each of its 21 counties.

Table 1 Characteristics of local implementation of comprehensive cancer control programs

Characteristics	California	New Jersey	South Puget Intertribal Planning Agency	Tennessee	Texas
Local implementation model type	Franchising model	Franchising model	Co-sponsoring model	Franchising model	Co-sponsoring model
Governance	CDC CCC funding to California Dialog on Cancer (coalition) formed by California Department of Health Services (CDHS) and the California Division of American Cancer Society (ACS)	State law created Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey supported by office in Health Department supplemented by CDC CCC funding	CDC CCC funding to Planning Agency works with tribes and coordinates with Washington State for cancer planning	CDC CCC funding to TN Department of Health which formed and supports statewide coalition	The Cancer Alliance of Texas (CAT)
Coalition infrastructure	4 statewide implementation teams (Disparities, Access to Care and Early Detection Team; Prevention Team; Research, Surveillance, and Evaluation Team; Treatment and Survivorship Team; guided by state collation Executive Committee	21 county coalitions with state funding for coordinator and projects	Advisory Committee with members from five tribes supported by Planning Agency	Executive Committee with statewide Standing and Resource Committees and 6 regional coalitions	Alliance and board plays statewide planning and coordinating roles with links to Texas Department of Public Health, state affiliates of national partners, American Cancer Society, and legislature. New Cancer Prevention and Research Institute formed with state funds.
Cancer plans	California's Comprehensive Cancer Control Plan Progress Report 2009	Comprehensive Cancer Control Plan, Report to the Governor, 2002	Plan developed by individual tribes with Planning Agency assistance	TN Comprehensive Cancer Control Plan 2009-2012	*Texas Cancer Plan, 2005 (4th edition)*
Key community functions	-Implementation of local activities based on state plan with Teams assistance	-County-based needs assessment -Coordinate local partnerships of one new cancer control activity yearly based on Plan data and statewide initiatives	Generated ideas for culturally appropriate projects and involved tribal members in development of support groups and materials	Generate local implementation activities based on regional networking and state plan priorities	-Use of Texas Cancer Control Toolkit for planning local activities - Local communities implement state cancer plan
Sample cancer targets (types) and parts of continuum of cancer care (e.g., primary prevention, screening, etc.)	Disparities Team sponsored regional Access to Cancer Care Community Forums Project and convened state training meeting for 6 coalitions to share success stories and provide technical assistance for local implementation	Statewide work group used incidence data to select Melanoma Awareness through statewide Choose Your Cover campaign	Formed first Cancer Survivor Support Groups engaged in local activities including development of a culturally acceptable survivors' handbook that about postdiagnosis issues including coping, support, and resources	Used annual summit to demonstrate process to engage statewide resource committees to identify community best practices and researchers through regional coalitions and review cancer registry data to promote cooperation and update state cancer plan	Cancer Prevention and Research Institute of Texas specifically included funding for community cancer prevention activities - Community Cancer Control Stakeholder Summit engaged Institute and 12 local community coalitions

The initial appropriation allowed the Task Force to conduct a first-time, statewide capacity, and needs assessment in each of New Jersey's 21 counties to obtain a baseline of the state's cancer burden in each county and inventory the numerous activities and resources in counties across the state. New Jersey utilized data, and these research results to determine its priorities for CCC activities. New Jersey's county data further confirmed the need for collaboration between state and local cancer control activities. Each of the 21 counties formed a coalition with a county cancer coalition coordinator that works to implement at least one new cancer-related activity per year that is driven by data findings.

One sample coalition activity illustrates the franchise model at work. Through its assessment, New Jersey found that with the exception of skin cancer, specifically melanoma, the incidence rates of most cancers have begun to decline. With 127 miles of coastline on the Atlantic Ocean, more than 9,800 farms covering 790,000 acres of farmland, and numerous other outdoor attractions, New Jersey's environmental context further underlined the need to promote melanoma/skin cancer risk education, early detection, and skin cancer screenings at outdoor venues.

The Task Force's Melanoma Work Group, which included members of the county coalitions, piloted a campaign called "Choose Your Cover" (CYC) to increase awareness about the need for protection from UV rays, the easiest way to reduce one's risk for melanoma. After piloting the program at three beach sites in New Jersey, free skin cancer screenings were expanded to eleven coastal beaches in 2009. This effort was strengthened by the collaborative efforts of volunteers from four county cancer coalitions who worked together to educate NJ beachgoers about prevention and early detection, and screen over 1,900 individuals for melanoma/skin cancer. As a result, 555 people were referred for follow-up, including 62 persons with suspected melanoma. This year the CYC campaign was further expanded statewide for a total of 42 outdoor recreational sites including beaches, lakes, pools, parks, ball stadiums, etc.

At the core of this project is New Jersey's evaluation of the CYC campaign to determine the effectiveness of its screening and education initiatives. A pilot program evaluation, which included a pre- and posttest, was administered to participants in one beach location to determine their knowledge in regard to sun safety behaviors. Results from these tests provided New Jersey's County Cancer Coalitions a rationale to celebrate their success, maintain their momentum, and sustain their efforts to continue this primary prevention model in their counties. New Jersey's coordination with county cancer coalitions furthered the state's reach to local communities where people live, work, and play. New Jersey's county cancer coalitions were able to address a real need in their communities, with access to resources from the State and Centers for Disease Prevention and Control [Marcia Sass, personal communication].

The South Puget intertribal planning agency's collaborative efforts to meet the needs of five tribal communities through tribal co-sponsorship

Tribal and community members of the Chehalis, Nisqually, Skokomish, Squaxin Island, and Shoalwater Bay Tribes in the state of Washington worked with the South Puget Intertribal Planning Agency (SPIPA) to address cancer, the second leading cause of death in Indian country. With funding from the CDC, SPIPA coordinated with representatives of the five tribal communities (the Advisory Committee) and partners from Washington State to plan and implement SPIPA's CCC plan. CCC efforts in SPIPA's tribal communities are driven by a future vision in which the tribal and community members of the Chehalis, Nisqually Shoalwater Bay, Skokomish, and Squaxin Island Tribes live a long, healthy, and cancer-free life. Prior to implementing the SPIPA cancer plan, the word "cancer" was largely unspoken by tribal community members. Many feared discussion of cancer would lead to a cancer diagnosis or other dreaded outcome. The experiences of cancer survivors were not shared or understood within this cultural context, and as a result the needs of cancer survivors were rarely met and families did not know how to comfort or deal with the loss of a loved one from cancer. Overcoming this cultural barrier was key in SPIPA's CCC plan goal to help survivors and their families' at all five tribes receive support.

SPIPA worked with its partners and tribal advisory board to implement cancer survivorship projects at each of the five tribal Cancer Survivor Support Groups. SPIPA's initiatives were developed in collaboration with tribal community members who well understood the unique needs of each tribe. Increasing awareness of cancer and issues of survivors were needed for each tribal community. SPIPA worked with its advisory committee to identify local survivors from the tribal communities. Tribal cancer survivors created a handbook of stages of what to expect after diagnosis including coping, support, resources, etc. for cancer survivors.

Led by local cancer survivors, the SPIPA CCC program developed cancer survivor support groups with each of the five tribes. SPIPA and its non-tribal unit partners provided resources for the implementation activities coordinated by the support groups. Service activities are numerous, from the basic provision of transportation/travel assistance, provision of errand/daily life support (e.g. shopping, yard work, etc.), education and grief counseling, and coordinating with Tribal clinics to increase tribal members' knowledge about their family history involving cancer diagnosis. The fearless actions of local cancer survivors

dispelled many myths about cancer and encouraged participation of other cancer survivors. The impact of cancer in tribal communities was realized due to the collaborative efforts of SPIPA's adoption of the co-sponsoring model with tribal cancer survivor partners.

Building the state coalition agenda through franchising WORKshops for the annual summit in Tennessee

In 2008, the Tennessee Comprehensive Cancer Control Coalition (TC2) completed the second edition and publication of the state's CCC cancer plan. The coalition membership topped 400 members. The coalition's infrastructure included numerous Resource Committees (cancer-specific issues, e.g., Colorectal Cancer, Women's Cancers, End of Life Care, Lifestyle/Environment.) and Standing Committees (Disparities, Advocacy, Surveillance, etc.). These committees authored state plan chapters, set workplan goals, and devised statewide strategies. Six sub-state regional coalitions were organized by TC2 to engage local cancer control organizations and advocates. This franchising approach assured local involvement across the state (550 miles east-to-west) and among its highly diverse racial populations, urban–rural communities, and cancer care organizations. Regional coalitions coordinated local implementation of community and state cancer control priorities and were assisted by the Tennessee Department of Health's Comprehensive Cancer Control Program staff supported through the CDC funded NCCCP grant.

Evaluation feedback from the 2009 annual summit evaluation suggested that TC2 change the summit format to allow more time at sessions for participants to hear, learn, discuss, and plan new ideas to address specific cancer topics important to address Tennessee's poor national cancer mortality ranking. Using the franchising strategy, TC2 resource committees were invited to submit proposals to conduct 3 h WORKshops at the 2010 summit. The title reflected the expectation that each session would WORK toward defined outputs (e.g., reports, new members, Resource Committee plans). Five submissions were accepted: Women's Cancers; Disparities; Clinical Trials; a combined workshop from the Colorectal and the Lifestyle and Environment committees; and a combined workshop from the Children's Cancers and the Survivors committees. The Coalition's Executive Committee leaders prescribed the workshop agendas. Each WORKshop was to include the following:

(1). Presentation of relevant risk, incidence and mortality data with contact with the Tennessee Cancer Registry.
(2). Panels of cancer researchers from Tennessee cancer centers and universities to provide updates on latest studies and findings.
(3). Panel of community best practices that used evidence-based strategies.
(4). Discussion and review-related sections of the state cancer plan and generation of new ideas for the coalition's workplan.

The workshops built upon TC2's key organizational strengths: local involvement through regional coalitions, statewide expertise offered through resource committees, data from the cancer registry, and a framework provided by the state cancer plan. Franchising WORKshops empowered resource committees to take charge of the summit while developing links to local communities and key state partners. The WORKshops provided a mechanism to engage both state partners (e.g., state health department, ACS, Komen Foundation) and actors in local implementation (cancer centers, community-based programs, etc.). WORKshops introduced new community programs and volunteers to the coalition. Several new programming ideas were introduced through the WORKshops, which created opportunities for collaborations between the coalition and local community partners.

Local cancer control in Texas: co-sponsoring to harness the power of state and local collaborations

As one of the first six states to be funded through the NCCCP by the CDC in 1998, the Texas Department of State Health Services Comprehensive Cancer Control Program (TCCCP) and its coalition The Cancer Alliance of Texas (CAT) realized the need for local implementation of the CCC approach early in its existence. CAT's mission is to actively engage critical statewide cancer stakeholders and to work collaboratively to reduce the impact of cancer on Texans. Using the *Texas Cancer Plan* as the statewide blueprint, CAT works to coordinate statewide cancer prevention efforts, with the vision of a cancer-free Texas. As one of the largest and more diverse states, a vision of a cancer-free Texas could be realized if partners from every part of the state collaborated toward implementing the *Texas Cancer Plan*. CAT began this initiative by assessing the cancer burden and cancer control activities across the state. CAT began state–local collaborative efforts through the development of key resources for state and local cancer control efforts. The Texas Cancer Control Toolkit became a cornerstone document for regional cancer control coalitions. The toolkit serves as a guide for developing local coalitions and implementing the *Texas Cancer Plan* at the regional level.

The creation of the Cancer Prevention and Research Institute of Texas (CPRIT) in 2007 as a result of a legislative mandate was another significant event in the Texas cancer control landscape. CPRIT's main charge is to

disseminate $300 million per year in grants that will expedite innovative research to find a cure for cancer and to fund prevention programs. Tireless efforts of CAT members enabled prevention to be added to CPRIT's charge and advocated for a percentage of its annual budget to be awarded to prevention grants.

In 2009, TCCCP seized the opportunity to connect in a more far-reaching way with local communities in Texas through convening a Community Cancer Control Stakeholder Summit. Twelve Texas communities engaged in state and local cancer control efforts attended the 1 1/2 day conference. The Summit provided a unique opportunity for participants to interact and forge linkages with the statewide cancer alliance whose membership is comprised of an extensive and diverse array of nationally renowned cancer control organizations and entities.

Partnerships with the Texas Department of State Health Services Comprehensive Cancer Control Program (TCCCP), and state Cancer Alliance have strengthened the community cancer coalition efforts. Local coalitions in Amarillo, Del Rio, Wichita Falls and Tyler continue to work on implementation of the *Texas Cancer Plan* in their respective communities. The Val Verde Cancer Task Force in Del Rio is addressing colorectal cancer in Val Verde and Kinney counties. Located on the US-Mexico border, these locales have high rates of uninsured residents and challenges to accessing cancer treatment services. The state-level partnership has supported the Val Verde Task Force in identifying colorectal cancer a priority, and implementing its first educational campaign, "Don't Turn Your Back on Colorectal Cancer!". The Task Force will continue further effective methods to educate the community on various cancer topics, using the "Don't Turn Your Back on [fill in cancer type most appropriate]!" campaign. The collaborative efforts of statewide and local partnerships and co-sponsoring local implementation have allowed Texas to make significant strides toward the vision of a cancer-free Texas.

Conclusions

The case studies and other similar examples of local implementation outline key attributes of a coalitions' work to implement CCC at a local level. The attributes of partnerships as listed below and exemplified in the case studies help improve the level of inclusion of and participation by local individuals, communities and organizations in CCC planning and implementation. Awareness of the strengths of each model and situations in which they can best be used can help coalitions to organize relationships that become mutually beneficial, and sustained.

The key elements of local implementation success for coalitions

- **A clear CCC vision**. To achieve success in local implementation, CCC coalitions need a clear vision that elicits a supportive spirit of cooperation that leads to collaboration to reduce the burden of cancer. Each coalition identified in the case studies uses a framework through which individual volunteers and local communities feel empowered to participate, contribute, and cooperate. Local contributions and interactions with the CCC coalition are seen as "value added" in efforts to plan and implement CCC plan goals as well as improving cancer issues at the local level.
- **Diverse coalitions**. The most successful coalitions are the most diverse coalitions, reflective of all individuals and geographic locations within a state, tribe, territory, or Pacific Island Jurisdiction. The dialog about cancer is enriched when many voices bring their first-person views to issues of cancer risk reduction, screening, diagnosis, treatment, and survivorship. Pooling of multiple partners' interests is essential and a key ingredient for success. Conversations and activities that involve health professionals and local cancer survivors, their caregivers, and their communities ensure that the direction of local implementation activities will be appropriate, identify gaps, address local needs and strengthen broader policy initiatives to directly impact local communities' cancer outcomes.
- **Skilled leadership**. Leadership is essential to convene multiple partners at various levels and from diverse backgrounds. Respecting, valuing, and balancing multiple interests require special leadership skills. Successful coalitions are often led by leaders who work to ensure that all coalition members, including local members, are actively involved and have a role in the effort to comprehensively control cancer. Commitment and support from higher-level representatives of national and CCC coalition organizations are necessary for community members to take on leadership roles in their respective communities as well the higher state and national levels.
- **Attainable priorities**. Coalitions should go for the attainable. Coalitions that try to do too much wear thin by trying to do everything. Although prioritizing can be difficult, it is essential to be realistic and choose winnable battles with the highest positive impact on the population. Achieving early success by going after "low hanging fruit" promotes visible action and impact, builds momentum, and evidences the effectiveness of collaboration.
- **Financial resources**. Financial resources are necessary to implement comprehensive cancer control locally.

While in-kind resources and volunteers significantly contribute to CCC efforts, funding is necessary to build capacity, momentum, and leadership at the local level. While large-scale local implementation requires significant funding, small amounts of assistance from CCC coalitions can prove pivotal in creating the foundation necessary to begin implementing local CCC initiatives.

- **Mutual benefits.** The collaboration between CCC coalitions sponsored through states, tribes, territories and Pacific Island Jurisdictions and community volunteers and organizations is built upon a developmental process that leads to building trust among parties. The process produces an increasing awareness of how coalition and community efforts can be mutually beneficial. This mutuality of interests and efforts, fed by use of multiple models of organizing over time, creates strong relationships that ensures a collective sense of ownership and involvement in cancer issues and outcomes.

In this article, we describe the various approaches to local implementation of comprehensive cancer control. These approaches exemplify the tremendous work that has been done by CCC coalitions to implement evidence-based cancer prevention and control strategies in heavily burdened communities.

As the case studies exemplify, the inputs, resources, objectives, and activities are as diverse as the populations targeted for local implementation. The case studies reinforce the primary finding that there are two models used in the growth and development of coalitions, franchising, and co-sponsoring. Coalitions evolve over time, formed by their context, issues, and relationships. Active participation and inclusion of local communities and organizations in CCC activities through franchising and co-sponsoring efforts will significantly advance initiatives to improve cancer outcomes for all individuals and their communities, thereby impacting cancer outcomes in every state, tribe, and territory and ultimately significantly decrease the cancer burden of the nation.

References

1. Edwards BK, Ward E, Kohler BA et al (2009) Annual report to the nation on the status of cancer, 1975–2006, featuring colorectal cancer trends and impact of interventions (risk factors, screening, and treatment) to reduce future rates. Cancer 116:544–573
2. National Cancer Institute (2010) Milestone 1971 The National Cancer Act. http://dtp.nci.nih.gov/timeline/noflash/milestones/M4_Nixon.htm. Access 21 May 2010
3. Brinkley WR, Wood J, Garrison HH (1988) Increased funding for NIH: a biomedical science perspective. FASEB J 12:1431–1435
4. Herin M (2010) Deaths: Leading causes for 2006. National vital statistics reports. http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_14.pdf. Accessed 21 May 2010
5. Deaths, percent of total deaths, and death rates for the 15 leading causes of death: United States and each state, 2005. Atlanta (GA): Centers for disease control and prevention; 2008. http://www.cdc.gov/nchs/data/ dvs/LCWK9_2005.pdf. Accessed 17 April 2010
6. Lisovicz N, Wynn T, Fouad M, Partride E (2008) Cancer health disparities: what we have done. Am J Med Sci 335(4):254–259
7. Frieden TR, Myers JE, Krauskopf MS, Farley TA (2008) A public health approach to winning the war on cancer. Oncologist 13:1306–1313
8. Given LS, Black B, Lowry G et al (2005) Collaborating to conquer cancer a comprehensive approach to cancer control. Cancer Causes Control 16(Suppl.1):3–14
9. Friedman C (2009) The promise of comprehensive cancer control. Preventing chronic disease 6 http://www.cdc.gov/pcd/issues/2009/oct/09_0085.htm. Accessed 24 May 2010
10. C-Change. Ten year history supported by the CCC national partnership. http://www.c-changetogether.org/pubs/pubs/Comp_Cancer_Ctrl_10Yrs.pdf
11. Koh HK, Walker DK (2003) The role of state health agencies in cancer prevention and control: lessons learned from Massachusetts. Cancer Epidemiol Biomarkers Prev 12(3):261s–268s
12. Georgeson M, Thorpe LE, Medino M et al (2005) Shortchanged? An assessment of chronic disease programming in major US city health departments. J Urban Health 82:183–190
13. Frieden TR (2004) Asleep at the switch: local public health and chronic disease. Am J Public Health 94:2059–2061
14. Himmelman AT (2001) On coalitions and the transformation of power relations: collaborative betterment and collaborative empowerment. Am J Community Psychol 29(1):277–284