

## Research and comprehensive cancer control coalitions

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**Abstract** The goal of cancer control research is “to generate basic knowledge about how to monitor and change individual and collective behavior and to ensure that knowledge is translated into practice and policy rapidly, effectively, and efficiently” (Division of Cancer Control and Population Sciences in Cancer control framework and synthese rationale, 2010). Research activities span the cancer control continuum from prevention to early detection and diagnosis through treatment and survivorship (Division of Cancer Control and Population Sciences in Cancer control framework and synthese rationale, 2010). While significant advancements have been made in understanding, preventing and treating cancer in the past few decades, these benefits have yielded disproportionate results in cancer morbidity and mortality across various socioeconomic and racial/ethnic subgroups (Ozols et al in *J Clin Oncol*, 25(1):146–1622, 2007). It has been a high

priority since the beginning of the Comprehensive Cancer Control (CCC) movement to utilize research in the development and implementation of cancer plans in the states, tribes and tribal organizations, territories and US Pacific Island Jurisdictions. Nevertheless, dissemination and implementation of research in coalition activities has been challenging for many programs. Lessons learned from programs and coalitions in the implementation and evaluation of CCC activities, as well as resources provided by national partners, can assist coalitions with the translation of research into practice.

**Keywords** Dissemination · Implementation · Research · Knowledge transfer · Comprehensive cancer control

### Introduction

One important outcome of cancer control research is the efficient and effective translation of cancer control research into clinical and public health practice and policy. In the past few decades, significant advancements have been made in understanding, preventing, diagnosing, and treating cancer. These advancements have generally resulted in reductions in cancer morbidity and mortality and improved quality of life for cancer survivors. Many of them can be attributed to the successful translation of cancer research into practice, which included the translation of basic cancer research into (evidence-based) interventions that were disseminated and implemented by clinical and public health practitioners [2]. While substantial reductions in cancer morbidity and mortality have been documented in the general population, disparities in cancer burden persist across socioeconomic and racial/ethnic subgroups [3]. With the translation of research into practice for these

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populations, the unequal burden of cancer will be addressed [4].

For years, it was widely assumed that implementing an evidence-based intervention into public health practice was not difficult [5]. Yet, the process of translating research into practice can be complex. While the body of scientific evidence on cancer prevention and control is growing, there is a gap between conducting research and translating the findings into practice [6–10]. Balas and Boren noted that it takes approximately 17 years for research evidence to reach clinical practice [11]. One factor contributing to the slow uptake of research by practitioners is the lack of clarity about who is responsible for moving research into practice. In 2002, the National Cancer Institute sponsored the “Designing for Dissemination” meeting that brought together cancer control intervention researchers, practitioners (clinicians and public health professionals), and funding agents to make recommendations on ways to improve the translation of cancer control research into practice [12]. One of the major findings of the meeting was that there was a lack of agreement regarding who was responsible for moving research into practice. While researchers saw their role as creating the evidence-based interventions (EBIs), they indicated that they lacked the funding and infrastructure for translating the research into practice. Practitioners saw their role as accessing and implementing EBIs but not disseminating them. The funding agencies felt they had a major role in assisting rather than taking the lead in the dissemination of EBIs but, to a varying degree, saw their role as assisting in the process and not taking the lead. While all of the stakeholders reported that the work of disseminating research into practice was important, they indicated that linkages between the groups needed to be developed.

The movement of research into practice, and the subsequent uptake of EBIs, is also impacted by the lack of consensus regarding the definition of the term “evidence-based” and the most valid sources of EBIs. Cancer control programs have often been expected to identify and implement these activities and interventions with little guidance from researchers or other stakeholders. Thus, policies and programs have frequently been implemented based on varying levels of evidence identified from a variety of sources (e.g., systematic reviews identified in the *Guide to Community Preventive Services (the Community Guide)*, other peer-reviewed research findings [i.e., randomized studies, case-control studies], evaluation reports, white papers, and personal/professional experience). Additionally, cancer control planners seeking to identify and implement EBIs at the local level often encounter many complex issues including conflicting screening recommendations from national organizations, challenging political environments, diverse cultural norms, organizational

differences in definitions of evidence, limited knowledge of the evidence base, and a lack of capacity (e.g., financial, expertise) for implementing scientific findings.

Systems-level challenges may also contribute to the slow implementation of EBIs and further translation of research into practice. For example, the Task Force for the *Community Guide* has found sufficient evidence to recommend implementation of client reminder systems such as post cards, letters or reminder telephone calls to increase screening rates for breast and cervical cancer and for colorectal cancer screening using fecal occult blood testing [13]. While this should be standard practice in primary care, systems barriers, time constraints, and workforce shortages often impede real-life implementation. Schmittiel et al. [14] reported in 2005 that only half of physician practices in the United States actually use these systems.

Disseminating EBIs to the public (as well as evidence-based cancer communications, policies or behavioral interventions to communities) requires active collaboration between researchers and practitioners. Through their efforts to bring together various members of communities to reduce the burden of cancer, comprehensive cancer control (CCC) coalitions are in a good position to promote partnerships between the scientific and clinical communities. Connecting researchers to practitioners, and building the capacity of communities to engage in evidence-based program planning and adaptation of interventions, is a critical first step to strengthening the link between CCC activities and the cancer research community. Several CCC programs have effectively engaged in these types of partnerships ([15], [16]). In this article, we will highlight two different examples of comprehensive cancer coalition activities involving the implementation of evidence-based interventions and discuss the activities of several of the Comprehensive Cancer Control National Partnership (CCCNP) organizations (i.e., the Centers for Disease Control and Prevention, National Cancer Institute, American Cancer Society and Commission on Cancer) in supporting these endeavors.

### CCC coalition experiences

CCC coalitions are uniquely positioned to address many of the aforementioned issues related to the implementation of EBIs and translation of cancer control research into practice as the composition of most coalitions is diverse and includes relevant stakeholders (e.g., researchers, clinicians, public health practitioners, and other stakeholders). While there are significant challenges to moving research into practice, impressive gains have been made by CCC coalitions. Some examples follow.

## Georgia Cancer Coalition (GCC)-measuring clinical outcomes

One of the great challenges for CCC planning is to establish clear metrics for outcomes. Reducing cancer incidence and mortality is the ultimate intended outcome for cancer control planners. However, the impact of activities (such as cancer screening) may be delayed, and associated improvements in incidence/mortality rate for states, tribes and tribal organizations, territories and US Pacific Island Jurisdictions based on evidence-based prevention and control activities (e.g. educational campaigns) may be difficult to measure.

In 2003, Georgia asked the Institute of Medicine (IOM) for assistance in bringing scientific evidence into the CCC program relative to clinical outcomes. Two years later, the IOM released a report on its assessment entitled *Improving the Quality of Cancer Care in Georgia: An Approach to Measurement* (<http://www.georgiacancer.org/res-iom.php>). The report recommended that Georgia expand its information systems to address disparities, and it reminded the coalition not only to evaluate progress but to motivate change by making the monitoring process transparent and public. The GCC used the findings to begin an extensive effort to collect data to populate the 52 quality measures and report findings. In a departure from traditional surveillance, the plan called for “extracting from electronic medical records rather than abstracting from paper charts.”

The next breakthrough occurred in 2006 when the GCC adopted the 52 metrics recommended by the IOM as the framework for updating the State Cancer Plan. The result was that every goal, objective, and strategy tied back to a specific dashboard metric describing the current status of the entire state and each American College of Surgeons (ACOS)-accredited hospital providing cancer care. Thus, the updated 5-year CCC plan for Georgia has a feedback loop to inform planners of progress made, successes achieved, and improvements needed on these medical care issues. The result is that the CCC plan is not a static document, but a dynamic tool used regularly to determine and evaluate performance.

An example of how data for the goals, objectives and strategies are being collected and will be rolled into the Georgia Cancer Quality Information Exchange can be seen in the implementation of a tobacco control program in Chattooga County (near Rome, GA). The Northwest Georgia Cancer Coalition identified a need for a tobacco control project. Data were collected on the metric related to tobacco use and showed tobacco use was significantly higher than state prevalence data, age of onset of tobacco use was lower than the state rate, and the total estimated annual cost for tobacco use per citizen was \$186,672. Based on these metrics, multiple interventions were introduced that included school-based interventions, physician

training, social worker training, and education with employers, and a *Community Guide* recommended multi-component intervention that incorporated quit line publicity with nicotine replacement therapy. As a result of these interventions, current tobacco use decreased from 31.49% in 2008 to 26.5% in 2010 and the quit rate increased from 20 to 24.3% for the same time period [17].

## Pacific Island Jurisdiction experience

To understand how research is moved into practice in the Pacific and the challenges faced by researchers and coalitions, it is necessary to understand the research context of the Pacific and its 10 cancer coalitions.

The United States Associated Pacific Island Jurisdictions (USAPIJ) is located to the west and south of Hawaii—covering a geographic area larger than twice the Continental United States. It is composed of two US Territories (Guam and American Samoa), a US Commonwealth (Commonwealth of the Northern Marianas), and countries that are “Freely Associated States (FAS)” with the US and tied to the US via a treaty called the COMPACT of Free Association (COFA). The COFA countries are the Republic of the Marshall Islands, the Republic of Palau, and the Federated States of Micronesia. Each USAPIJ has its unique Pacific Island language and culture.

Each of the USAPIJ has operational community cancer coalitions who are implementing their country-specific CCC plans. Additionally, there is an overarching Pacific Regional Cancer Coalition, composed of representative members from each of the USAPIJ, called the Cancer Council of the Pacific Islands (CCPI). The CCPI has developed and is currently implementing a Pacific Regional Cancer Control Plan ([http://cancercontrolplanet.cancer.gov/state\\_plans.jsp](http://cancercontrolplanet.cancer.gov/state_plans.jsp)) that addresses cancer control issues across the Jurisdictions that may be accomplished in a more efficient and cost-effective manner through regional coordination and utilizing economy of scale. Many cancer control research projects pass through both the country-specific coalitions and the CCPI.

All research within the USAPIJ must be operationalized within an international, multi-cultural context. The Territories, Commonwealth, and FAS each have specific politico-economic relationships with the United States that determine the extent, type, and duration of their respective grant and economic support. The disparity between health care financing between the USAPIJ and the United States is significant. The per capita health care expenditure of the United States was 10–54 times greater than any of the various USAPIJ in 2006 [18].

There are two major categorical challenges that must be overcome to develop meaningful research with the USAPIJ coalitions. The first is for the funding agencies, researchers,

and coalition members to understand that the politico-economic, research, and health care infrastructure of the USA-PIJ are very different from anywhere in the Continental United States. Therefore, meaningful cancer control measures and programs will likely look and operate differently in the USAPIJ compared to the United States. The nature and structure of meaningful research requires unique approaches and innovative methods. Sustainability and practicality are core issues for all USAPIJ research because of variations in political and economic support from the United States.

Secondly, the diverse sociocultural norms of the USAPIJ indicate that all research is undertaken in a cross-cultural setting with indigenous Pacific Islander communities. The coalitions and researchers must account for indigenous Pacific cultural/operational paradigms about science, acquisition of knowledge, processing knowledge, time, individual versus group priorities, and how the world works. The amount and intensity of cultural differences between those of the USAPIJ and the majority of continental US population cannot be discounted. Many of the indigenous Pacific peoples are not immersed in the day-to-day living of the dominant culture of the USA.

Culturally competent cross-cultural research with the indigenous peoples of the Pacific requires an understanding and application of indigenous peoples' paradigms of health, knowledge, science, and research. It is not sufficient to train more indigenous Pacific Islanders to do more Western-style research. Unraveling the complex health situation and determining the changes that need to be made are dependent on the dominant culture engaging the indigenous Pacific populations in a way that bridges cultural paradigms. Positively affecting the disparity of health in the indigenous populations of the Pacific is, in part, dependent on employing an indigenous-peoples-centered model of research.

Because of the CCPI, the organization and infrastructure now exist in the USAPIJ to carry out meaningful cancer control research. The community-based participatory research model can facilitate developing meaningful research; however, the participatory model is not enough or sufficient to improve cancer outcomes. A successful partnership between the coalition, researchers, community members, and funding agency means that the community, community needs, community control, and indigenous paradigms of science and research are core operational values.

### **National partner activities: enhancing the implementation of evidence-based interventions**

The Comprehensive Cancer Control National Partners (see the article “The CCC National Partnership-An example of organizations collaborating on comprehensive cancer

control” in this edition of the journal for more information about the CCC National Partnership) have worked individually and collaboratively to provide funding opportunities, scientific/technical, and administrative support and training for CCC coalitions and funded programs. They have launched and supported several initiatives specifically focused on enhancing activities that link cancer research to public health practice.

### **Funding opportunities**

Recently, federal agencies such as the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Prevention and Control (CDC), and the National Institutes of Health (NIH) have increased the number of funding opportunities that include dissemination and implementation activities. For example, CDC's National Comprehensive Cancer Control Program (NCCCP) funds states, tribes/tribal organizations, and selected US territories and associated Pacific Island jurisdictions to develop and implement state, tribal, and territorial CCC plans [7]. NCCCP funding is used primarily to support infrastructure in states, tribes and tribal organizations, territories, and Pacific Island Jurisdictions for various cancer control initiatives. Funding is also used to write cancer control plans, assure evidence-based implementation of each plan, and conduct CCC evaluation activities. Coalitions can vary widely in size and makeup, but often are comprised of professional associations, state and local health departments, cancer centers, advocacy groups, community practitioners, cancer survivors, and policy makers; all of these groups may play significant roles in the successful translation of research to practice. While CCC programs are public health practice-based, and not research-based, the programs and coalitions are linked to research opportunities through CDC and NCI as well as their own academic partners.

### **CDC's Cancer Prevention and Control Research Network**

The Cancer Prevention and Control Research Network (CPCRN), established in 2002, is funded by the Centers for Disease Control and Prevention and the National Cancer Institute ([www.cpcrn.org](http://www.cpcrn.org)). The focus of the CPCRN is to accelerate the adoption of evidence-based cancer prevention and control in communities. By drawing on the established Prevention Research Centers ([www.cdc.gov/pre](http://www.cdc.gov/pre)), evidence-based recommendations and strong community ties, the CPCRN conducts community-based, participatory cancer research across its ten network centers, regardless of academic affiliations and geographic boundaries. The CPCRN goes beyond advancing the science of cancer

prevention and control to also influence public health and primary care practice, enhancing large-scale efforts to reach underserved populations and reduce their burden of cancer.

Each of the Centers has collaborated with its state CCC coalition, participating in developing or updating state cancer plans, developing and conducting training on EBIs, and educating state legislatures, among many other activities. Two notable success stories are found in North Carolina in 2007 and more recently, in Texas. In conjunction with the North Carolina Comprehensive Cancer Control Coalition and others, the Comprehensive Cancer Control Collaborative of North Carolina (4CNC) (CPCRN Center at University of North Carolina [UNC] at Chapel Hill) assisted in garnering \$50 million a year for cancer research from the North Carolina legislature in 2007. A cornerstone of the initiative is applying dissemination approaches to extend the reach of UNC's cancer research and treatment services throughout the state. In 2008, the 4CNC work in North Carolina on using evidence-based interventions for reducing tobacco use was highlighted in a congressional briefing. In fact, the implementation of an evidence-based approach (an increase in excise taxes on cigars and smokeless tobacco products) was enacted and revenues from this tax will be used as one source of the \$50 M annual appropriation. (<http://ucrf.unc.edu/about/UCRF%20Key%20Facts%203-2010.pdf>).

In a second success story of working with coalition partners, the University of Texas at Houston and the United Way's 2–1–1 telephone information system received just under a million dollars in 2010 from the Cancer Prevention Research Institute of Texas (formerly the Texas Cancer Council) to expand the existing collaboration on a cancer prevention research project that will test the benefits of offering cancer prevention information to 2–1–1 callers, many of whom have limited resources. Through a pilot study conducted with the United Way Gulf Coast 2–1–1 service, Latinos in Network for Cancer Control (University of Texas CPCRN Center) researchers found that currently 2–1–1 callers rarely request information on cancer, although they are often in need of services for cancer screening, vaccination and smoking cessation. Through the newly funded prevention program, callers will be referred to dedicated 2–1–1 operators in Texas trained to identify callers in need of cancer prevention services including mammography, Pap tests, and colorectal cancer screening examinations, as well as human papillomavirus (HPV) vaccination against the most common types of cervical cancer. Researchers will examine the effect of their cancer control program compared to providing basic information on cancer prevention services without the additional support [19].

## NCI's Cancer Information Service

Over the course of almost two decades (1991–2010), as a nationwide network of regional offices, NCI's Cancer Information Service (CIS) Partnership Program helped bridge the gap between practitioners and researchers and create a substantive link between researchers and comprehensive cancer coalitions. Until the program's end due to fiscal constraints and a realignment of NCI's dissemination efforts, CIS Partnership Program staff served as chairpersons, task force leaders, and active participants of each of the CCC coalitions in the states, tribes and tribal organizations, territories, and US Pacific Island Jurisdictions, CIS vigorously forged connections between research and CCC by sharing staff with several CCC programs, purposefully integrating NCI and cancer control grantees with coalition initiatives, and by working with coalition partners to develop and implement evidence-based cancer plans. Working closely with the underserved communities, CIS facilitated incorporation of community values and cultural competence in cancer control efforts and provided ongoing technical assistance to build coalitions' capacity to engage in research. The integration of NCI grantees such as NCI's Centers for Excellence in Cancer Communication Research (CECCRS) and the Community Networks Program (CNP) resulted in projects that brought communication and disparities research to bear on CCC interventions. Two examples of successful relationships include the following:

- The Heartland Region CIS, as a member of the Missouri Cancer Consortium since its inception in 2000, collaborated on multiple projects related to implementing evidence-based cancer prevention: (1) testing of Cancer and Chronic Disease Messages, (2) training on *Using What Works: Adapting Evidence-Based Programs to Fit Your Needs Training* for the consortium and local cancer coalitions, and (3) a coalition needs assessment. Involvement of researchers at Washington University at the St. Louis Cancer Prevention and Control Research Network and the Program for the Elimination of Cancer Disparities was fostered by CIS. Both of these programs provide resources for cancer education, training, and evidence-based science, and researchers have consistently remained engaged in the process of the Consortium.
- CIS Mid-South, as members of the Kentucky Cancer Consortium, collaborated on the development of an evidence-based colorectal cancer toolkit for health care providers. CIS provided data, drafted the proposal, and served on the subcommittee which created and distributed 3,000 colorectal cancer screening guideline kits to Kentucky primary care physicians. Additionally, CIS

assisted the Kentucky Cancer Consortium's Colorectal Cancer mini-grant program by providing Cancer Control P.L.A.N.E.T. training to grant applicants and reviewing applications. Thirteen evidence-based projects received \$5,000 to \$10,000 for community educational interventions.

Numerous examples of how CIS helped move science into practice exist, and the influence that CIS had on CCC movement toward evidence-based practice is noteworthy. In January 2010, NCI launched an initiative called Research to Reality (R2R). The initiative includes a Cyber Seminars Series focused on connecting researchers and practitioners and creating a community dialogue. Seminars have been conducted on such topics as Making Data Talk: Communicating Public Health Data to the Public, Policy Makers, and the Press, Working with Partners to Implement Evidence-based Programs with Fit and Fidelity, Public Health Genomics, and a Dialogue on Dissemination. Augmenting the series is an emergent R2R Community of Practice web portal on Cancer Control P.L.A.N.E.T and an NCI mentorship program that matches experienced public health professionals with community practitioners with the purpose of building capacity to identify and implement evidence-based cancer control interventions in community and clinical settings. This and other NCI efforts provide researchers insights into community dynamics and expectations in order to facilitate appropriate research designs that include at-risk populations typically underrepresented in research.

#### Cancer control P.L.A.N.E.T

National partners have developed numerous resources to assist coalitions with linking research to practice. The Cancer Control P.L.A.N.E.T. (Plan, Link, Act, and Network with Evidence-based Tools) web portal (<http://cancercontrolplanet.cancer.gov>) assists coalitions and public health program planners in identifying and implementing evidence-based cancer control plans and programs. Launched in April 2003, P.L.A.N.E.T. outlines five steps for developing evidence-based plans and programs. The first step on the Cancer Control P.L.A.N.E.T. web portal links cancer control planners to the State Cancer Profiles (SCP) Web site ([www.statecancerprofiles.cancer.gov](http://www.statecancerprofiles.cancer.gov)) sponsored by the CDC and NCI. The objective of SCP is to provide a system to characterize the cancer burden in a standardized manner in order to motivate action, integrate surveillance into cancer control planning, characterize areas and demographic groups, and expose health disparities. SCP is geared toward a select group of users (health planners, policy makers, and cancer information providers) who need quick and easy access to descriptive cancer statistics in

order to prioritize investments in cancer control. The site allows users to access cancer-related public health surveillance data using interactive graphics and maps as well as data tables that can be queried.

The second step on the P.L.A.N.E.T. Web site was originally designed to provide linkages to state-specific program and research partners that would help connect individuals to state CCC activities and provide assistance with identifying and implementing evidence-based cancer control plans and programs. As described previously, P.L.A.N.E.T Step 2 has been redesigned as the R2R Community of Practice that hosts the R2R Cyber Seminar Series and the NCI Mentorship Program. R2R utilizes various social media that allow coalitions to share experiences focused on translating research into practice. Additionally, NCI's CD-ROM-based training tool, *Using What Works: Adapting Evidence-based Programs to Fit Your Needs* is being converted into an interactive online training tool to provide technical support in the adaptation of research-tested cancer control interventions. *Using What Works* will be located on the R2R portal. Step 3 on the P.L.A.N.E.T. portal links to systematic reviews of cancer control research. The two primary resources on this site are the *Community Guide* (sponsored by CDC) and the US Preventive Services Task Force guidelines (sponsored by AHRQ). The *Research-tested Interventions Programs (RTIPs)* Web site (sponsored by NCI and the Substance Abuse and Mental Health Services Administration) is the fourth step on Cancer Control P.L.A.N.E.T. and is a unique site that provides coalitions with access to programs that have been tested and have published positive behavioral and psycho-social outcomes in peer-reviewed journals. More than 100 programs are available, most of which provide access to materials free of charge.

#### National Comprehensive Cancer Control Program (NCCCP)

CDC promotes the use of evidence-based interventions through program management methods (e.g., performance measures and technical assistance). For example, CDC uses specific performance measures to monitor the extent to which interventions implemented by NCCCP-funded programs are evidence-based. Furthermore, these program management tools may be used to identify the sources of selected EBIs (e.g., RTIPs, Cochrane, and *Community Guide*) being used by these programs. Programs implementing previously untested or unevaluated interventions are also identified by these systems. For programs that are currently implementing interventions that have no "identifiable" evidence base, CDC encourages them to engage in rigorous evaluation and publication of these activities, thus contributing to development of an evidence base. By fall

2010, CDC will launch a new Management Information System (MIS) that will allow CDC to more closely monitor use of EBIs, their sources and issues with implementation.

### Stimulating and strengthening the link between research and CCC activities

Dissemination and implementation of evidence-based interventions (EBIs) is one of the critical strategies that CCC coalitions must incorporate in order to address the cancer health disparities and continue to make strides toward the reduction in the overall burden of cancer. There are numerous things that can be done to enhance the translation of research into practice in CCC. The activities need to occur in both the research and practice domains. Utilizing the resources and funding opportunities such as the Cancer Control P.L.A.N.E.T. or the CPRN provided by national partners can help bridge the two domains and support the NCCCP priorities for all CCC interventions to be evidence-based or in the absence of evidence to contribute to the evidence base.

In order to improve the capacity of coalitions to access and utilize research in the planning and implementation activities, existing training and technical support opportunities should be identified and new opportunities should be created. Coalition members should apply to participate in the pilot mentorship program sponsored by NCI, designed to enhance the ability of cancer control practitioners to identify, adapt, and implement evidence-based cancer control interventions. It will be launched on the Cancer Control P.L.A.N.E.T. Web site in early 2011. Coalitions are encouraged to access and implement evidence and utilize existing networks such as the CPRN (look for contract information at [www.cpcrm.org](http://www.cpcrm.org)) to explore mechanisms for training.

Another gap in the translation process that should be addressed is that researchers often end their work with a publication, which may or may not be read by practitioners. Additionally, the relevance of research findings in journals needs to be more clearly stated for practitioners. This needs to be addressed in editorials, in journals, and through funding opportunities that encourage the dissemination of research interventions that have proven to be effective and encourage research–practice collaborations for applied research with a focus on identifying and measuring dissemination and implementation processes and outcomes. (Funders need to pay for this activity and make it a requirement.) Researchers, practitioners, and funding agencies need to find ways to strengthen community-based participatory research efforts by encouraging evaluation of practices that are widely used but for which evidence is just emerging or not yet gathered.

Finally, responsibility for translation should be placed across many partners through establishing routine exchange among all who affect the movement of research into practice: researchers, state and local practitioners, policy makers, administrators, federal agencies, non-profits, and others depending on the specific content focus. By setting the expectation that all the partners are expected to play an active role in dissemination and implementation and will be contributing to the whole, the ownership of translation may no longer be seen as “someone else’s responsibility” and will become institutionalized.

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