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Lessons Learned from Revising the Cancer Plan for Michigan

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Lessons Learned from Revising the Cancer Plan for Michigan

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RESEARCH & PRACTICE

Lessons Learned from Revising the Cancer Plan for Michigan

OVERVIEW

The burden of cancer in Michigan is large and eliminating the burden requires a comprehensive approach. Cancer is the second leading cause of death in Michigan and is the leading cause of death for people under 80 years of age (Michigan Department of Health and Human Services, 2018). The American Cancer Society estimates there will be 56,590 new cases of cancer in Michigan and that 21,380 Michiganders will die from cancer during 2018 (Cancer Facts and Figures 2018, 2018). Michigan is the 10th most populous state in the country (U.S. Census Bureau, 2014) and has the 7th greatest number of cancer survivors, estimated at approximately 526,100 in 2016 (American Cancer Society, 2016).

Comprehensive cancer control (CCC) is a collaborative way to address cancer through partnerships and sharing resources. The Centers for Disease Control and Prevention (CDC) funds state, territories, and tribal CCC programs to develop, implement, and maintain cancer plans to guide CCC work (National Comprehensive Cancer Control Program (NCCCP), 2017). Cancer plans "identify how an organization addresses cancer burden as a significant public health challenge. They are data-driven, evidence-based blueprints for action" (Centers for Disease Control and Prevention, 2018). The Comprehensive Cancer Control Implementation Building Blocks suggest that when CCC priorities are implemented it will lead to both short and long-term outcomes, one of which is decreased morbidity and mortality (Rochester, Townsend, Given, Krebill, & Balderrama, 2010). CDC directs each CCC program to work with its partners to develop their plan (Cancer Plan Self-Assessment Tool, 2013).

The most recent version of the Cancer Plan for Michigan was in place from 2009-2015 and was updated periodically. But, given the rapidly advancing science of cancer care and population health interventions, by 2015 the plan no longer fully reflected state-of-the-art cancer research and innovations. In order for Michigan's Cancer Plan to direct CCC priorities and activities in the state, revisions were needed. To address this problem, Michigan developed and completed a process to update its Cancer Plan. The CCC program used its long-term experience, expertise, and network of partners to guide the necessary revision of the Cancer Plan (Hager, Given, Redmond, & Rogers, 2010) (Miller, Hager, Lopez, Salinas, & Shepherd, 2009). The objectives of this article are to describe the revision and implementation of the Cancer Plan for Michigan, to outline community engagement efforts and stakeholder involvement in the process, and to present outcomes of the cancer plan revision process.

DESCRIPTION

Michigan's CCC Program is coordinated and staffed by the Michigan Department of Health and Human Services (MDHHS), which also supports its partner, the Michigan Cancer Consortium (MCC). The MCC is a network of approximately 100 dedicated public, private, and voluntary organizations that implement cancer plan activities. The coalition includes members that represent the following organizational categories: health systems, insurance plans, local health departments, research institutions, universities, trade organizations and special population groups. While these organizations may have varied interests, working together through the MCC they

share resources and knowledge, reduce duplicative efforts, maximize resource use and develop strategic attacks against the cancer burden in Michigan.

With a diverse representation of member organizations, the MCC collectively serves a wide array of populations throughout the state of Michigan. In the 2017 MCC Annual Survey, 77% of member organizations (n = 86) reported serving people with lower socioeconomic status, 72% reported serving the black or African American population, 62% reported serving people of Hispanic/Latino ethnicity, 58% reported serving people with a disability, 57% reported serving an Asian and Arab/Middle Eastern population, and 55% reported serving the Native American population. MCC members also reported that they serve the lesbian, gay, bisexual, and transgender community and refugees. Michigan has a mix of urban, suburban, and rural communities. Approximately 74% of MCC members serve both rural and urban areas, 7% serve rural areas exclusively, and 11% serve urban communities exclusively.

The diversity of MCC organizations and the expertise of its members offers unique opportunities for Michigan's Cancer Plan implementation. Coalitions have an understanding and belief that the cancer burden will decline through successful coordinated action (Rochester, Townsend, Given, Krebill, & Balderrama, 2010). Michigan has made significant progress toward the achievement of many goals and objectives since beginning its CCC work with the CDC (True, Kean, Nolan, Haviland, & Hohman, 2005). Table 1 shows examples of the evolution of the Cancer Plan objectives over the lifetime of the MCC. The MCC member organizations engaged in and reported on multiple cancer control activities and these efforts were monitored and evaluated to determine progress and impact. Still, given advances in the field of cancer control a fully revised cancer plan was needed to direct the state's cancer control activities for the next five years.

Table 1. The evolution of objectives over the history of Michigan's Caner Plans.

	1998-2002	2009-2015	2016-2020
Colorectal Cancer Screening	By 2004, increase to 50 percent the proportion of average-risk people with a life expectancy of at least five years who have received appropriate colorectal cancer screening. (Baseline: 17.3 percent of people in 1992)	By 2015, increase to 75 percent the proportion of average-risk people in Michigan who report having received appropriate colorectal cancer screening and follow-up of abnormal screening results.	Increase the proportion of adults aged 50 to 75 years who are up-to date on appropriate colorectal cancer screening from 71% to 80%.19
End-of-life Care	By 2005, increase the timeliness of referrals to end-of-life services for breast, cervical, colorectal, lung, and prostate cancer patients.	By 2015, increase cancer patients' and caregivers' understanding of options for: 1) care up to, and during, the last phase of life, and 2) pain and symptom relief.	Decrease the number of Michigan adult cancer patients who are enrolled in hospice within 3 days of their death from 14.3% to 14%

Michigan's objective of revising the cancer plan was to create an updated blueprint to guide CCC work in the state. Building on the strong foundation in place for comprehensive cancer control in Michigan, two key outcomes of interest were identified for the strategy to revise the Cancer Plan for 2016-2020: 1) create a plan that meets criteria outlined by the MCC Evaluation Committee and 2) revise the plan using an efficient strategy that offers multiple venues for stakeholder participation.

In the fall of 2014, one year prior to when the 2009-2015 Cancer Plan came to a close, the MCC convened its Evaluation Committee, a group of stakeholders with expertise in evaluation, to guide and facilitate the revision process. The MCC Evaluation Committee, with support from expert consultants, developed the plan structure, revision process and timeline, and presented them to the MCC Board of Directors for approval. The evaluation committee represented the planning level of stakeholder input while the MCC Board of Directors represented the decision-making level of stakeholder input.

The first step to determine desirable parameters for the Michigan Plan was to look at cancer plans from other CCC programs, including Minnesota and New York. The Evaluation Committee recommended the following for Michigan's Cancer Plan content, layout, and features:

1. Reduce the overall length of the Cancer Plan to less than 50 pages.
2. Align the overarching goals with the continuum of cancer care.
3. Limit the number of objectives and strategies under each goal area.
4. Use common criteria to select the objectives and strategies while ensuring they are data driven and evidence based.

In January and February 2015, CCC staff reviewed the existing Cancer Plan to assess how it compared with recommendations set forth by the Evaluation Committee. The assessment revealed that the Cancer Plan was 100 pages above the recommended length, had 14 goals, none of which were aligned with the continuum of cancer care, and none of the objectives were specific, measurable, achievable, relevant, and timely (SMART).

During the same time period, the Evaluation Committee narrowed down the goals for the Cancer Plan to four modeled after the national CCC program priorities (Centers for Disease Control and Prevention, 2017):

1. Prevent cancer from occurring.
2. Promote early detection of cancer using tests that have been shown to reduce mortality.
3. Diagnose and treat all patients using the most effective and appropriate methods.
4. Optimize quality of life for every person affected by cancer.

The Evaluation Committee considered including health equity; policy, systems, and environmental changes; active partnerships; and continuous evaluation as goals. However, since these principles can be applied across the full continuum of cancer care, the Committee established them as "pillars"-- overarching concepts that should be incorporated into implementation of the Cancer Plan. Once the goals and pillars were defined, the Committee developed a systematic process that included ways to engage MCC members in the revision.

After the Board of Directors approved the process in March 2015, the MCC created four workgroups, one to address each goal for the revised Cancer Plan. Workgroups consisted of two co-chairpersons, one MDHHS staff person and one subject matter expert from the MCC. Individual MCC members volunteered to participate in the workgroups. The number of members in each workgroup ranged from 12 to 21. The co-chairs for each workgroup held a planning session by phone prior to the first meeting of their group.

In order to develop plan objectives, MDHHS staff compiled a list of topics each goal might include. For example, the goal related to prevention of cancer included topics such as healthy eating, physical activity, HPV vaccination, tobacco use, and alcohol use. MDHHS staff developed worksheets with a list of potential SMART objectives for each topic. Every objective was linked to a consistent data source and included baseline data, if available.

Workgroups were given instructions (Figure 1) which outlined the revision process. In April 2015 the workgroups met over teleconference and used a worksheet (Figure 2) to narrow down the list of objectives using common criteria and to determine a realistic target to achieve for each objective by 2020.

Figure 1. Guidance for updating the Michigan Cancer Plan. This figure illustrates the guidance document outlining the revision process of the Cancer Plan for Michigan.

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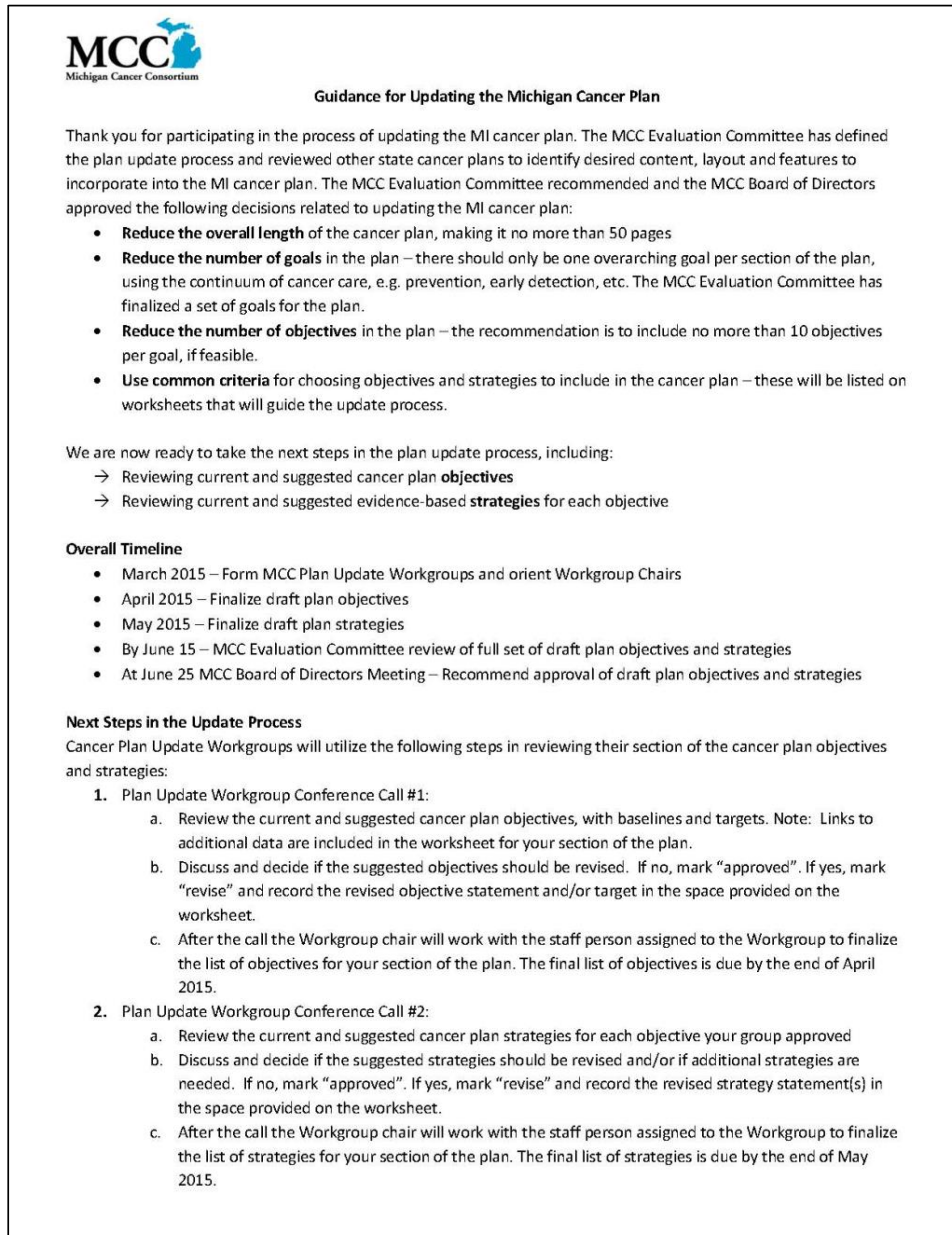


MCC
Michigan Cancer Consortium

Guidance for Updating the Michigan Cancer Plan

Thank you for participating in the process of updating the MI cancer plan. The MCC Evaluation Committee has defined the plan update process and reviewed other state cancer plans to identify desired content, layout and features to incorporate into the MI cancer plan. The MCC Evaluation Committee recommended and the MCC Board of Directors approved the following decisions related to updating the MI cancer plan:

- **Reduce the overall length** of the cancer plan, making it no more than 50 pages
- **Reduce the number of goals** in the plan – there should only be one overarching goal per section of the plan, using the continuum of cancer care, e.g. prevention, early detection, etc. The MCC Evaluation Committee has finalized a set of goals for the plan.
- **Reduce the number of objectives** in the plan – the recommendation is to include no more than 10 objectives per goal, if feasible.
- **Use common criteria** for choosing objectives and strategies to include in the cancer plan – these will be listed on worksheets that will guide the update process.

We are now ready to take the next steps in the plan update process, including:

→ Reviewing current and suggested cancer plan **objectives**
→ Reviewing current and suggested evidence-based **strategies** for each objective

Overall Timeline

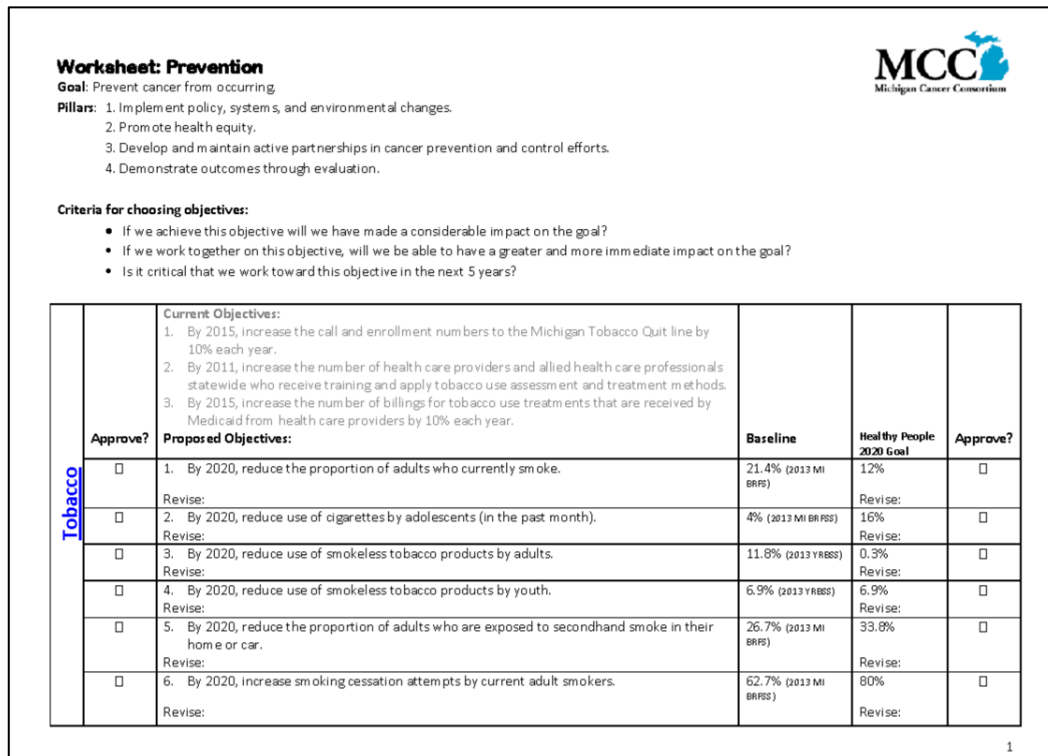
- March 2015 – Form MCC Plan Update Workgroups and orient Workgroup Chairs
- April 2015 – Finalize draft plan objectives
- May 2015 – Finalize draft plan strategies
- By June 15 – MCC Evaluation Committee review of full set of draft plan objectives and strategies
- At June 25 MCC Board of Directors Meeting – Recommend approval of draft plan objectives and strategies

Next Steps in the Update Process

Cancer Plan Update Workgroups will utilize the following steps in reviewing their section of the cancer plan objectives and strategies:

1. Plan Update Workgroup Conference Call #1:
   a. Review the current and suggested cancer plan objectives, with baselines and targets. Note: Links to additional data are included in the worksheet for your section of the plan.
   b. Discuss and decide if the suggested objectives should be revised. If no, mark "approved". If yes, mark "revise" and record the revised objective statement and/or target in the space provided on the worksheet.
   c. After the call the Workgroup chair will work with the staff person assigned to the Workgroup to finalize the list of objectives for your section of the plan. The final list of objectives is due by the end of April 2015.
2. Plan Update Workgroup Conference Call #2:
   a. Review the current and suggested cancer plan strategies for each objective your group approved
   b. Discuss and decide if the suggested strategies should be revised and/or if additional strategies are needed. If no, mark "approved". If yes, mark "revise" and record the revised strategy statement(s) in the space provided on the worksheet.
   c. After the call the Workgroup chair will work with the staff person assigned to the Workgroup to finalize the list of strategies for your section of the plan. The final list of strategies is due by the end of May 2015.

Figure 2. Worksheet for selecting objectives. This figure illustrates the worksheet used by Cancer Plan workgroups to select the objectives that would be included in the Cancer Plan for Michigan.



Worksheet: Prevention

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Goal: Prevent cancer from occurring.

Pillars:
1. Implement policy, systems, and environmental changes.
2. Promote health equity.
3. Develop and maintain active partnerships in cancer prevention and control efforts.
4. Demonstrate outcomes through evaluation.

Criteria for choosing objectives:

- If we achieve this objective will we have made a considerable impact on the goal?
- If we work together on this objective, will we be able to have a greater and more immediate impact on the goal?
- Is it critical that we work toward this objective in the next 5 years?

	Approve?	Current Objectives: 1. By 2015, increase the call and enrollment numbers to the Michigan Tobacco Quit line by 10% each year. 2. By 2011, increase the number of health care providers and allied health care professionals statewide who receive training and apply tobacco use assessment and treatment methods. 3. By 2015, increase the number of billings for tobacco use treatments that are received by Medicaid from health care providers by 10% each year. **Proposed Objectives:**	Baseline	Healthy People 2020 Goal	Approve?
Tobacco	☐	1. By 2020, reduce the proportion of adults who currently smoke. Revise:	21.4% (2013 MI BRFS)	12% Revise:	☐
	☐	2. By 2020, reduce use of cigarettes by adolescents (in the past month). Revise:	4% (2013 MI BRFSS)	16% Revise:	☐
	☐	3. By 2020, reduce use of smokeless tobacco products by adults. Revise:	11.8% (2013 YRBSS)	0.3% Revise:	☐
	☐	4. By 2020, reduce use of smokeless tobacco products by youth. Revise:	6.9% (2013 YRBSS)	6.9% Revise:	☐
	☐	5. By 2020, reduce the proportion of adults who are exposed to secondhand smoke in their home or car. Revise:	26.7% (2013 MI BRFS)	33.8% Revise:	☐
	☐	6. By 2020, increase smoking cessation attempts by current adult smokers. Revise:	62.7% (2013 MI BRFSS)	80% Revise:	☐

1

Once the workgroups had a final list of objectives, MDHHS staff researched evidence-based strategies for each objective. In May 2015, a second teleconference meeting was held with each workgroup to choose the final list of strategies for each objective. A worksheet with criteria for choosing strategies was used to narrow down the list. At the end of the revision process, there were 36 objectives and 111 strategies across the 4 goals. The final objectives and strategies were vetted by the Evaluation Committee and then approved by the Board of Directors in June 2015.

Although the plan covers the full cancer continuum, it was recognized that the MCC is not able to actively work on all 36 objectives. In order to be more strategic in implementing the plan, the MCC involved its partners in a process to select priorities. It was a deliberate decision to prioritize one objective in each goal area so the full cancer continuum is represented. Many stakeholders were involved in the prioritization process. Workgroup members completed an online survey to vote on the top two priority objectives within their goal. The objectives that received more than 50% of the votes were reviewed by the Evaluation Committee and presented to the Board of Directors in September 2015. The Board of Directors, the Evaluation Committee, and workgroup co-chairs discussed the feasibility and impact of achieving those objectives, and then the Board of Directors voted to determine the final four priority objectives. The MCC focused its efforts on the priority objectives during the first two years of the Cancer Plan, 2016 through 2017.

Discussion and Evaluation

The first goal of Michigan's cancer plan revision process was to create a plan that meets the criteria outlined by the MCC Evaluation Committee. This goal was achieved, as evidenced by the Cancer Plan available on the MCC's website, www.michigancancer.org (Michigan Cancer Consortium, 2017). Michigan's Cancer Plan for 2016-2020 is a 27-page document, well below the 50-page recommendation, that includes 36 SMART objectives across the four goal areas and each objective has a list of suggested evidence-based strategies. As previously described, the cancer plan goal areas are aligned with the cancer continuum. Worksheets and specific selection criteria were used to guide selection of objective and strategies. This planning and structure worked well to shape workgroup conversations and efficiently use workgroup members' time. The structure allowed workgroup members to suggest cancer plan topics not included in the prepared worksheets and the pre-established selection criteria kept those workgroup discussions focused.

However, this structure presented a few key challenges. The planning and worksheet preparation was time intensive for the MDHHS staff supporting the cancer plan revision process. Also, it was difficult to apply the same standards across the cancer continuum. Some areas had a wealth of established resources, such as The Guide to Community Preventive Services (The Community Guide) (Community Preventive Services Task Force, n.d.), while in other areas the science was just emerging so the level of evidence and ease of locating evidence was different. For example, there were extensive data and a large selection of Healthy People 2020 (U.S. Department of Health and Human Services, 2018) objectives and Community Guide strategies available for reference for most suggested topics in the prevention and early detection goal areas. The largest task for the prevention and early detection workgroups was to narrow the focus and select the most important objectives and strategies to improve the health of Michiganders. The diagnosis and treatment and quality of life workgroups had the opposite problem. Healthy People 2020 and the Community Guide offered minimal suggestions for objectives and strategies in these areas. In addition, there were limited statewide data in these areas, which restricted possibilities for SMART objectives.

Creating a cancer plan with SMART objectives highlighted that most public health data sources have limits in their ability to depict the needs of certain Michigan populations. Health equity was one of the pillars that all workgroups were asked to incorporate into the objectives. However, most statewide data was not consistently available for sub-populations, which limited the ability to demonstrate health disparities. In an effort to tackle this issue, after the completion of the Cancer Plan, Michigan began a process to identify additional data sources to better measure public health interventions across the cancer continuum for all Michigan populations.

The second goal was to use an efficient revision strategy that offered multiple venues for coalition stakeholder participation. The MCC requested volunteers to shape the Cancer Plan for Michigan around the four cancer continuum goal areas. This solicitation for volunteers differed from past processes because experts on a wide variety of topics were solicited at once. Still, a sufficient number of members were recruited for the workgroups. Some workgroup volunteers were active in the MCC and some had not been actively engaged prior to this cancer plan revision process. The revision process provided all MCC members an opportunity to offer their expertise along the full cancer continuum. Workgroup members were able to provide input on Cancer Plan objectives and strategies during multiple conference calls that were scheduled based on member availability. Workgroup members were also able to provide feedback by email throughout the process.

Thanks to a straightforward process and great stakeholder participation, Michigan now has a measurable cancer plan and a clear strategy for monitoring progress towards achieving the plan objectives (Michigan Cancer Consortium, 2017). Having such a structured, concise cancer plan and timing its release with the MCC Annual Meeting in November 2015 helped engage leaders, including national leaders, state government administration, and state health department leadership, in the release of the Cancer Plan while also bringing it to their attention. Moving forward, Michigan is adapting and applying the process used to revise the cancer plan, including the commitment to methodical preparation, to the MCC's Cancer Plan implementation activities.

The structured process that Michigan used to revise the state Cancer Plan resulted in a data driven plan created with involvement from a large number of stakeholders from across the state and across sectors. The process involved the development of guidance documents with criteria for the stakeholder workgroups to use when making decisions. It also involved worksheets to lay out potential cancer plan objectives and strategies and help workgroup members use the decision criteria to select objectives and strategies. This helped structure workgroup meetings and email communications and facilitated an efficient and transparent decision making process.

NEXT STEPS

There are a few things that will be done the next time the cancer plan is revised. First, provide clear written guidance on what it will mean to incorporate the cancer plan pillars of policy, systems, and environmental change, health equity, active partnerships, and evaluation, into the cancer plan objectives and strategies. While the pillars were stated and considered in the process of creating the 2016-2020 plan, there was no clear guidance on how to incorporate them into the plan.

Second, put in place a formal process to gather input from statewide chronic disease program partners. Given existing collaborative relationships, a few staff from other chronic disease programs in Michigan participated in the cancer plan workgroups but there is opportunity for more engagement in the future.

Third, have an evaluation plan to determine stakeholder satisfaction with the process. While MDHHS staff have received informal positive feedback, there was no official evaluation system in place.

The structured process and supporting guidance document and worksheets that Michigan used facilitated effective engagement of a broad base of stakeholders and resulted in a Cancer Plan that met the pre-established criteria. The staff anticipate that with some adaptations the process will continue to work well in the future. The authors encourage other CCC programs that use other stakeholder engagement and cancer plan revision processes to share their experiences.

KEY FINDINGS

- A structured process helped involve a wide array of public and private stakeholders and allowed participation at every step of the process.
- An emphasis on data and evidence-based strategies resulted in a measurable cancer plan and a clear strategy for monitoring progress towards achieving the plan objectives.
- Evaluating every step of the process is needed to determine its success and efficacy.

REFERENCES

1. American Cancer Society. (2016). *Cancer Treatment & Survivorship Facts & Figures 2016-2017*. Retrieved from https://www.cancer.org/research/cancer-facts-statistics/survivor-facts-figures.html
2. American Cancer Society. (2018). *Cancer Facts and Figures 2018*. Retrieved from Cancer Statistics Center: https://cancerstatisticscenter.cancer.org
3. Centers for Disease Control and Prevention. (2013, September 9). *Cancer Plan Self-Assessment Tool*. Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/cancer/ncccp/cancerselfassesstool.htm
4. Centers for Disease Control and Prevention. (2017, August 31). *About the National Comprehensive Cancer Control Program*. Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/cancer/ncccp/about.htm
5. Centers for Disease Control and Prevention. (2017, December 7). *National Comprehensive Cancer Control Program (NCCCP)*. Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/cancer/ncccp/index.htm
6. Centers for Disease Control and Prevention. (2018, April 19). *Comprehensive Cancer Control Plans*. Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/cancer/ncccp/ccc_plans.htm
7. Community Preventive Services Task Force. (n.d.). *The Community Guide*. Retrieved from The Guide to Community Preventive Services: www.thecommunityguide.org
8. Hager, P., Given, L., Redmond, J., & Rogers, K. (2010, December). Revision of comprehensive cancer control plans: experiences shared by three states. *Cancer Causes and Control, 21*(12), 2005-2013. doi:10.1007/s10552-010-9662-y
9. Michigan Cancer Consortium. (2017, November 1). *Cancer Plan Dashboard, 2016-2020*. Retrieved from http://www.michigancancer.org/CancerPlan/Dashboard.html
10. Michigan Cancer Consortium. (2017, August). *Comprehensive Cancer Control Plan for Michigan, 2016 – 2020*. Retrieved from http://www.michigancancer.org/CancerPlan/ComprehensiveCancerControlPlan-2016-2020.html
11. Michigan Department of Health and Human Services. (2018, March 18). *Vital Records & Health Statistics*. Retrieved from Number of Deaths and Age-adjusted Mortality Rates for the Ten Leading Causes of Death, 2018: https://www.mdch.state.mi.us/osr/deaths/causrankcnty.asp
12. Miller, S., Hager, P., Lopez, K., Salinas, J., & Shepherd, W. (2009, October). The Past, Present, and Future of Comprehensive Cancer Control From the State and Tribal Perspective. *Preventing Chronic Disease, 6*(4), A112. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2774626/
13. Rochester, P. W., Townsend, J. S., Given, L., Krebill, H., & Balderrama, S. (2010, December). Comprehensive cancer control: progress and accomplishments. *Cancer Causes Control, 21*(12), 1967-77. doi:10.1007/s10552-010-9657-8
14. True, S., Kean, T., Nolan, P. A., Haviland, E. S., & Hohman, K. (2005). In conclusion: the promise of comprehensive cancer control. *Cancer Causes and Control, Suppl 1*, 79-88.

15. U.S. Census Bureau. (2014). *Community Facts*. Retrieved from American Fact Finder: https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml
16. U.S. Department of Health and Human Services. (2018, April 27). Retrieved from Healthy People 2020: https://www.healthypeople.gov/