CANCER SUMMIT
APRIL 26-28, 2016
TRaverse City, Michigan

One-Year Follow-Up Report

Looking Back and Looking Ahead:
Collaborating to Advance Cancer Control in American Indian/Alaska Native Communities
Introduction

The Centers for Disease Control and Prevention (CDC) 2016 Cancer Summit titled “Looking Back and Looking Ahead: The State of Cancer Control in American Indian and Alaska Native (AI/AN) Communities,” convened current and former Division of Cancer Prevention and Control (DCPC) tribal awardees from five CDC regions, CDC staff and Comprehensive Cancer Control National Partnership (CCCNP) members from April 26 to 28, 2016 at the Grand Traverse Resort in Traverse City, Michigan.

The George Washington University (GW) Cancer Center administered an online survey to tribal organizations and stakeholders who attended the summit in June and July 2017, over one year after the summit, to assess action plan progress, new partnerships and technical assistance needs. This report summarizes the findings.

For a description of summit proceedings, presentation highlights and key decisions made by attendees, as well as summit evaluation results, read the CDC 2016 Cancer Summit Report—Looking Back and Looking Ahead: Collaborating to Advance Cancer Control in AI/AN Communities, as well as the Six-Month Follow-Up Report.

Summit Objectives

1. Provide a forum for open dialogue about topics of interest to all CDC DCPC tribal awardees
2. Provide an opportunity for DCPC tribal awardees and DCPC staff to work together in teams to collaboratively identify priority areas and strategies to improve outcomes in cancer control for AI/AN communities over the next ten years, including data; policy, systems and environmental (PSE) changes; tobacco; human papillomavirus (HPV); and colorectal cancer
Methods

The GW Cancer Center emailed all summit attendees on June 22, 2017, a little over a year after the summit was held, with a link to an online survey that was accessible through July 7, 2017. The GW Cancer Center also sent reminders and targeted follow-up emails to ensure all CDC regions were represented.

The online survey asked basic demographic questions such as the organization respondents represented, current job role, length of time in that position and CDC region. The survey then asked respondents to review the action plans created during the workshop and assess and report related successes and challenges, as well as further technical assistance needs. For non-CDC awardees, the survey asked them to report activities related to AI/AN initiatives that are being planned, implemented or evaluated in their organization.

A limitation of collecting information by survey is that it does not allow for follow-up questions and responses are not always in-depth. Further, respondents from the one-year follow-up are not necessarily the same as those who responded to the six-month follow-up. Thus, respondents’ assessment of stages of change (not ready; getting ready; ready; currently implementing and evaluating activities; and currently maintaining and evaluating activities) pertaining to planned activities or perception of successes and challenges may differ. Further, lack of updates does not necessarily mean that there has been no progress, but merely reflect limited survey reach. This one-year follow-up report, therefore, should be considered a snapshot of current activities, rather than continuity from the six-month follow-up report.

Demographics

There were 15 survey respondents with at least one person from each CDC region represented (Table 1). There were also three respondents that may not directly be working on the action plans. The majority of respondents represented AI/AN programs, including the National Breast and Cervical Cancer Early Detection Programs and National Comprehensive Cancer Control Programs and AI/AN coalitions. One respondent represented a state National Comprehensive Cancer Control Program. Other respondents were Comprehensive Cancer Control National Partnership representatives, including one CDC staff, as well as National Native Network representatives. Further, 10 respondents were program coordinators, managers or directors, one was a data manager, one was a program consultant and two identified as AI/AN coalition members. Respondents were experienced, with 10 saying they have held their role for over two years and four between 12-24 months.

Follow-Up with Tribal Awardees and Stakeholders

The one-year follow-up updates are noted in bold in Tables 2-7.

Region E updates

The one respondent from Region E (Fond du Lac Band and Lake Superior Chippewa) did not give specific updates in addition to those provided for the six-month follow-up report; however, the survey respondent said they are “confident” that most of the planned activities will be achieved (Table 2).
### Table 1. Demographic data of survey respondents (N=15)

<table>
<thead>
<tr>
<th>Regional Representation</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region E: Fond du Lac Band of Lake Superior Chippewa</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Region F: Cherokee Nation and Kaw Nation</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Region H: Cheyenne River Sioux and Great Plains Tribal Chairmen’s Health Board</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Region I: Hopi Tribe, Navajo Nation and Tohono O’Odham Nation</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>Region J-2: Native American Rehabilitation Association, South Puget Intertribal Planning Agency, Northwest Portland Area Indian Health Board and California Rural Indian Health Board</td>
<td>4</td>
<td>28.6</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Native Network</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
<td>7.1</td>
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<table>
<thead>
<tr>
<th>Program/Organization Representation*</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI/AN National Breast and Cervical Cancer Early Detection Programs</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>AI/AN Comprehensive Cancer Control Programs</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>State Comprehensive Cancer Control Programs</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>AI/AN Colorectal Cancer Control Programs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>AI/AN Coalition Member</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>State National Breast and Cervical Cancer Early Detection Programs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CDC Staff</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>National Partnership representatives</td>
<td>3</td>
<td>23.1</td>
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<table>
<thead>
<tr>
<th>Job Role</th>
<th>n</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>AI/AN Coalition Member</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>Program Coordinator/Manager/Director</td>
<td>10</td>
<td>71.4</td>
</tr>
<tr>
<td>Data Manager</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Consultant</td>
<td>1</td>
<td>7.1</td>
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</tbody>
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<tr>
<th>Length in Role</th>
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<th>%</th>
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<tbody>
<tr>
<td>&lt; 12 Months</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12-24 Months</td>
<td>4</td>
<td>28.6</td>
</tr>
<tr>
<td>&gt; 2 Years</td>
<td>10</td>
<td>71.3</td>
</tr>
</tbody>
</table>

*totals may not add up to 100% because multiple responses were selected
Region F updates

One respondent from Region F (Cherokee Nation and Kaw Nation) provided updates building on progress reported for the six-month follow-up report (Table 3). The survey respondent said they are “confident” that most of the planned activities will be achieved.

Region H updates

One respondent from Region H (Cheyenne River Sioux and Great Plains Tribal Chairmen’s Health Board) provided updates building on progress reported for the six-month follow-up report (Table 4). The survey respondent said they are “confident” that most of the planned activities will be achieved.

Region I updates

Two respondents from Region I (Hopi Tribe, Navajo Nation and Tohono O’Odham Nation) provided updates building on progress reported for the six-month follow-up report (Table 5). Survey respondents said they are “very confident” that most of the planned activities will be achieved.

Region J-1 updates

Two respondents from Region J-1 (Southeast Alaska Regional Health Consortium, Alaska Native Tribal Health Consortium, Arctic Slope, Southcentral Foundation and Yukon-Kuskokwim Health Corporation) provided updates building on progress reported for the six-month follow-up report (Table 6). One survey respondent said they are “unconfident” that most of the planned activities will be achieved. The other respondent did not answer. One survey respondent added that they will “discuss and evaluate” the action plan with the Alaska Breast and Cervical Health Partnership during their next meeting.

Region J-2 updates

Four respondents from Region J-2 (Native American Rehabilitation Association, South Puget Intertribal Planning Agency, Northwest Portland Area Indian Health Board and California Rural Indian Health Board) provided updates building on progress reported for the six-month follow-up report (Table 7). Two survey respondents said they are “confident” and one said they are “unconfident” that most of the planned activities will be achieved. One survey respondent added that “chronic underfunding of the Urban/Tribal/Indian Health Service health programs leading to understaffing and lack of available personnel to implement best practices is the leading barrier to conducting these activities.”

Other partners and stakeholders updates

Three respondents identifying as other partners and stakeholders reported activities related to AI/AN initiatives. National Cancer Institute is partnering with National Native Network to cosponsor and promote webinars for cancer control, especially in the field of tobacco.
**Table 2:** Summary of overarching policy, systems and environmental priorities and planned action steps during the summit and reported stages of change, successes and challenges six months later by Region E

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>Planned Action Steps</th>
<th>Stages of Change and Successes</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| **Systems**   | • Improve data reporting systems and internal sharing of data between departments at Fond du Lac  
• Work with Fond du Lac administrative services and the medical clinic to make sure any referral forms sent to outside agencies have correct information regarding race. This leads to truer percentages regarding Native American information at the state level  
• Human Services Advisory board will bring forth a plan to the tribal council to direct Human Services Division administration and upper management to increase data sharing among Fond du Lac and also with outside agencies | Stage of change six months post-summit: Getting ready  
• Established baseline data and quality measures for AICAF’s “I Quits” program tailored to Fond du Lac, which will help demonstrate program effectiveness. One program activity is to increase referrals to smoking cessation counselors | • Uncertainty with and timing of funding with next CDC Funding Opportunity Announcement |
| **Collaboration** | • Have initial discussions with primary department leaders in medical, community health services and administrative services to develop a cancer leadership team  
• Develop a plan to present to upper level management such as the human services division associates and directors regarding the importance of forming a leadership team  
• Form a leadership team with staff from specific Fond du Lac Human Services Division departments to continue the successes with the cancer program | Stage of change six months post-summit: Not ready  
• Communicated with department leaders in medical, community health services and administrative services to develop a cancer leadership team | • Several advisory members retiring  
• Uncertainty with and timing of funding with next CDC FOA |
| **Policy** | • Hire a smoking cessation counselor  
• Support the Clearway program and the smoking cessation program by integrating it into MCH and Social Services programs such as moving forward with smoke free foster homes and increasing referrals to smoking cessation  
• Increase cooperation and partnerships between the clinic and the tobacco programs | Stage of change six months post-summit: Maintaining and evaluating activities  
• Hired one smoking cessation counselor, who is working closely on cancer program outreach and smoke-free and second-hand smoke initiatives with ClearWay  
• Passed tribal ordinance, which mandates that foster care homes and transportation vehicles for children must be smoke-free  
• Increased tobacco-free ordinances around tribal offices except for casinos. One casino has become 100% smoke-free  
• Organized a smoke-free community gathering sponsored by law enforcement | • Keeping up the momentum to promote smoke-free policies |
Table 3: Summary of overarching policy, systems and environmental priorities and planned action steps during the summit and reported stages of change, successes and challenges six months later by Region F

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>Planned Action Steps</th>
<th>Time Frame</th>
<th>Stage of Change and Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy and health system</td>
<td>• Review policies and procedures that are in place for patient care to increase screenings and decrease the no-show rates for colposcopies</td>
<td>Quarterly and annually</td>
<td>Stage of change six months post-summit: Maintaining activities • Implemented new patient care policies and procedures to increase screenings and decrease no-show rates for colposcopies • Currently maintaining activities</td>
<td>Provider and recall systems are not enabled in the Cherokee Nation Electronic Medical Records (EMR) at this time</td>
</tr>
<tr>
<td>Systems</td>
<td>• Pull reports of number of screened patients, education, diagnosis code, etc.</td>
<td>Quarterly and annually</td>
<td>Stage of change six months post-summit: Currently implementing activities • Implemented a new EMR software that provides more accurate reports on cancer screening data • Currently working to create a report that automatically generates and sends data to investigators</td>
<td>Took 11 months to transition to the new EMR system. The clinical environment has therefore been stressful • The EMR is primarily built for business purposes and not necessarily to improve screening and patient care</td>
</tr>
<tr>
<td>Environmental (Outreach, communication and messaging)</td>
<td>• Contact program managers developing a plan • Conduct trainings • Develop messages and use evidence-based interventions</td>
<td>Oct. 2017 Annually</td>
<td>Stage of change six months post-summit: Getting ready • Currently getting ready to implement planned activities</td>
<td>Cherokee Nation Health Services implemented a new EMR system and all needed data are not being captured, but staff is currently working on correcting these issues</td>
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<td>Stage of change one year post-summit: Maintaining and evaluating activities • Cherokee Nation Comprehensive Cancer Control Program has a media plan that has guided outreach and communication efforts. They developed small and large media encouraging screenings and raising awareness • Trained Public Health Educators and Oklahoma Strategic Tribal Alliance for Health members</td>
<td>The Comprehensive Cancer Control Program has a very small staff. The Comprehensive Cancer Control Program and Breast and Cervical Cancer Early Detection Program are using staff shared by the Public Health program</td>
</tr>
<tr>
<td>Area of Focus</td>
<td>Planned Action Steps</td>
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| Systems       | • Investigate various software systems  
• Customize and implement new software that helps with reminder and billing issues | 1-2 years | Stages of change six months post-summit: Getting ready / maintaining activities  
  • Cheyenne River initiated conversation with IT department and are getting ready to turn on the customized reminder system  
  • Great Plains Tribal Chairmen’s Health Board worked with IT systems and reminder systems at the colorectal cancer facility  
**Stages of change one year post-summit: Currently implementing and evaluating activities**  
  • Conducted an HPV Seminar in our area | • It can take time to transition to a new IT system and train staff. Scaling up is the next challenge  
• **Coordinating with other programs to provide a speaker system and being unable to purchase food with grant funding** |
| Policy: Tobacco | • Include e-cigarettes to tax compact with state  
• Update the policy to include e-cigarettes  
• Increase awareness of e-cigarettes  
• Communicate with CDC’s Office of Smoking and Health  
• Partner with Food and Drug Administration (FDA) representatives | 1-2 years | Stages of change six months post-summit: Not ready / currently implementing activities  
  • Cheyenne River worked with the Canli Coalition to introduce cigarette tax compacts and update policy and ordinance to include e-cigarettes  
  • Efforts to increase awareness e-cigarettes are underway  
  • Incorporated the 5 A’s of tobacco cessation in services  
  • Trained 300 people on state quitline and National Indian Network quitlines, which increased referrals from 19% to 49.5%  
  • Tobacco Health Educator is working on communication and education efforts under the CDC Good Health and Wellness program  
**Stages of change one year post-summit: Not ready (No other updates)** | • Policies restricting e-cigarettes may not happen in the 1-2 year timeframe. Waiting on the state to set the precedence of increasing age of sales of e-cigarettes to 21  
• Policy change is hard and takes time |
| Environment: Physical activity and nutrition | • Increase the number of walking paths  
• Build funding opportunities  
• Create awareness for a lifestyle of healthy exercise and nutrition in schools  
• Youth diabetes management  
• Special diabetes management  
• Walking class | 1-2 years | Stages of change six months post-summit: Currently implementing / maintaining and evaluating activities  
  • Youth Diabetes Program at Cheyenne River has been given an award  
  • Conducted health fairs and powwows with adults and children, where they measure blood pressure and glucose levels and pass out health information  
  • Adapted and implemented CDC’s PSE Change Tool and developed a community action plan to tackle tobacco, nutrition and physical activity  
  • Reached about 500 youths though community events, where they educated youths on the importance of physical activity (funded by Partnerships to Improve Community Health grant)  
  • Created media consent forms to promote physical activity using social media and newspapers  
  • Planned the creation of a video of students being physically active  
  • Working with Special Diabetes Program that organizes physical activity and healthy eating challenges  
  • Instituted physical activity-leave, a type of administrative leave at the Tribal Health Department  
**Stages of change one year post-summit: Getting ready (No other updates)** | • Funding is needed to organize a survivorship support group  
• Funding to create walking paths is limited  
• **Coordinating with high schools to organize physical activity events on their tracks**  
• Being unable to purchase food with grant funding to promote healthy eating |
<table>
<thead>
<tr>
<th>Area of Focus</th>
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<th>Stages of Change and Successes</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| Colorectal cancer screening | • Educate Chief Medical Officers, Chief Executive Officers (CEOs), clinics and lab directors  
• Educate providers on fecal immunochemical test  
• Educate IHS administration and clinic staff on colorectal cancer screening  
• Educate Tohono O’Odham Nation health department management on colorectal cancer screening | 1 week  
4 weeks  
8 weeks  
Ongoing | Stages of change six months post-summit: Getting ready / currently implementing activities  
• Identified ownership and provided tribal language for education materials and PSAs on local radio stations about colorectal exams  
• Worked with IHS to assist clients who may need colorectal cancer screening using patient navigation  
• Created sub-committee of Tohono O’Odham Cancer Partnership to educate the population on FIT tests | Stages of change six month post-summit: Not ready / currently implementing and evaluating activities  
• Tohono O’Odham Nation Health Care has adopted the FIT test | • Time constraints and limited staff capacity  
• Changes in health department structure at Tohono O’Odham  
• “The Nation went to 638”                                                                                                                                                                                                                                                                  |
| Breast cancer screening in Navajo Nation | • Meet with the Breast and Cervical Cancer Prevention Program acting Director and create a road map  
• Solicit approval from and educate CEO  
• Train medical providers on breast cancer screening  
• Follow-up service unit by service unit | 3-4 weeks  
8-12 weeks  
Sep. 2016  
6 months | Stage of change six months post-summit: Ready  
• Clarified MOU for breast cancer screening  
• Confirmed Government Performance and Results Act standards have been met | Stage of change one year post-summit: Currently maintaining and evaluating activities  
• The number of women enrolled in the program that received breast and cervical cancer screening [increased]  
• Tribal leadership and community at-large have been supportive of program activities | • The CEO of the medical facility is new, which can affect whether the MOU remains or amendments or revisions will be made |
| Breast cancer screening for the Hopi community | • Review the Memorandum of Understanding (MOU)  
• Educate on program and program requirements  
• Talk with the CEO and Medical Director  
• Include clinical breast examination trainings at the November Tribal Collaborative | 1 week  
4-6 weeks  
6 weeks  
Nov. 2016 | Stage of change six months post-summit: Ready  
• Ready to review MOU for breast cancer screening  
• Breast surgeon spoke at the November Tribal Collaborative conference | Stage of change one year post-summit: Currently maintaining and evaluating activities  
• The number of women enrolled in the program that received breast and cervical cancer screening [increased]  
• Tribal leadership and community at-large have been supportive of program activities | • Conflicting recommendations from various organizations regarding clinical breast examinations  
• Limitations with CDC funding being used to screen IHS employees  
• Educating the community and convincing them to support and enroll in the program |
Table 6: Summary of overarching policy, systems and environmental priorities and planned action steps during the summit and reported stages of change, successes and challenges six months later by Region J-1

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>Planned Action Steps</th>
<th>Time Frame</th>
<th>Stages of Change and Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to services</td>
<td>• Develop employee wellness opportunities&lt;br&gt;• Offer employee time off for screenings&lt;br&gt;• Develop a Wellness Committee recognized by management</td>
<td>Aug./Sep. 2016</td>
<td>Stage of change six months post-summit: Getting ready / currently implementing activities&lt;br&gt;• Working on developing a Wellness Committee recognized by management&lt;br&gt;• Approved Well-Integrated Screening and Evaluation for WOMen Across the Nation (WISEWOMAN) program that gives discounts to access the swimming pool to consortium members and women&lt;br&gt;• Presented recommendation for employee time off for colonoscopies to executive management committee</td>
<td>• Hard to get organizations to allocate funding towards employee wellness with limited budgets and high turnover&lt;br&gt;• There is red tape, as each WISEWOMAN program is managed differently</td>
</tr>
<tr>
<td>Recruitment and retention</td>
<td>• Partner with high schools, colleges and professional schools&lt;br&gt;• Offer focused trainings for providers&lt;br&gt;• Identify opportunities for cross-training</td>
<td>Aug./Sep. 2016</td>
<td>Stage of change six months post-summit: Getting ready / currently implementing activities&lt;br&gt;• Partnering with University of Alaska that has a program to provide in-home support and looking to create online courses on patient navigation as a framework for “peer navigators” or “home navigators”&lt;br&gt;• Working with medical, nurse practitioner and physician assistant students to do monthly rotations in Alaska&lt;br&gt;• Identified behavioral health as an opportunity for cross-training&lt;br&gt;• Working on educating local providers to leverage their screening services&lt;br&gt;• Looking to replicate the process of state-wise mapping of colorectal cancer resources, so Dr. Brooks, Managing Director, Cancer Control Intervention, American Cancer Society, visited to inform that effort</td>
<td>• High staff turnover in rural areas&lt;br&gt;• Unique service area and geography&lt;br&gt;• Takes time and effort</td>
</tr>
<tr>
<td>Continuity of services; linking prevention to care</td>
<td>• Utilize unique partners&lt;br&gt;• Use updated technologies (mapping)&lt;br&gt;• Strengthen comprehensive cancer control, breast and cervical cancer and colorectal cancer partnerships statewide</td>
<td>Aug./Sep. 2016</td>
<td>Stage of change six months post-summit: Currently implementing activities / maintaining or evaluating activities&lt;br&gt;• Identified and built relationships with unique partners&lt;br&gt;• Mapped breast and cervical cancer screening resources&lt;br&gt;• Built unique partnerships such as the Young Women’s Christian Association</td>
<td>• Partnership can be difficult to build because they don’t have the same focus&lt;br&gt;• Unique service area and geography&lt;br&gt;• Finding new partners</td>
</tr>
<tr>
<td>Area of Focus</td>
<td>Planned Action Steps</td>
<td>Time Frame</td>
<td>Stages of Change and Successes</td>
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</table>
| Tobacco cessation for survivors | • Improve community messages for survivors to quit smoking  
• Talk with clinic providers to gain support  
• Create a one-page cheat sheet regarding smoking cessation for survivors  
• Contact the American Society of Clinical Oncology about adapting provider and patient materials  
• Support cancer plans  
• Identify survivors and increase referrals to diabetes, MIC and other programs  
• Reach out to tribes about cancer survivors who smoke  
• Identify survivors who smoke | Not provided | Stage of change six month post-summit: Not ready  
• Worked on creating smoking cessation resources in general  
• Currently verifying that datasets such as Behavioral Risk Factor Surveillance System, National Health and Nutrition Examination Survey, National Health Interview Survey, National Program of Cancer Registries and Surveillance, Epidemiology and End Results Program do not report smoking prevalence for AI/AN cancer survivors  
• The tribal clinic is posting no smoking signs; the tribal casino made the non-smoking area bigger and banned smoking in restaurants | • High rates of tobacco  
• Focusing on smoking cessation specifically among survivors is not a priority, given the high prevalence and need among the general population  
• Cancer centers do not have surveillance systems on survivors and smoking  
• Cancer centers and clinics do not have community-based cessation resources  
• Staffing changes and a big learning curve for new staff  
• Lack of resources available for tribal cessation programs. Washington State Medicaid does not reimburse clinical tobacco cessation programs |
| Survivor groups | • Convene groups covering women’s issues  
• Cancer survivor group  
• Collaborate with local tribes | Not provided | Stage of change six month post-summit: Getting ready  
• Planned a big women’s health event and training for providers and community health representatives and nurses for spring 2017  
• Connected tribal programs to survivorship programs, cancer centers and resources  
Stage of change one year post-summit: Getting ready / currently implementing and evaluating activities  
• Working with the Salish Cancer Center to develop a survivorship program in their facility | • Staffing changes  
• Lack of staffing within tribal health programs to facilitate support groups and provide follow-up with cancer centers and request survivorship care plans |
| HPV vaccinations | • HPV vaccination of males  
• Develop HPV education with tribal input | Not provided | Stage of change six month post-summit: Getting ready  
• Funded to conduct focus groups with community members for HPV immunization interventions at pharmacies  
Stage of change one year post-summit: Getting ready / currently implementing and evaluating activities  
• Conducted key informant interviews to learn more from tribes successfully vaccinating for HPV  
• American Indian OB/GYN oncologist provided training for tribal and Urban Indian Health clinics | • Staffing changes with partner organizations such as pharmacies  
• Limited time  
• Staffing changes  
• Lack of resources for staff time at clinics to provide outreach and follow-up for HPV immunizations |
Technical assistance needs

Survey respondents mentioned wanting further technical assistance on:

- Communication initiatives to increase community awareness including radio advertisements
- Ensuring AI/AN individuals are represented in national health surveys so that reporting on smoking prevalence among AI/AN cancer survivors can be made possible
- Additional funding that would allow programs to purchase food, such as meals and snacks, as an incentive, meals and snacks

Other comments included:

- “I appreciate this reminder to keep the project on the top of the pile!”
- “[Other partners and stakeholders] would be interested in partnering [with AI/AN programs and coalitions] further”
- “[The summit] was an informative gathering, and [it] was [a] great way to connect such important programs from across Indian Country”
- “The programs do a good job with a limited amount of resources and plan very well to implement locally in their respective tribal communities”

Conclusion

Over a year after the 2016 CDC Cancer Summit, AI/AN grantees and stakeholders continue to move the needle towards better health outcomes in their respective AI/AN communities. Programs request more flexible funding mechanisms, as funding restrictions and changes in staff are barriers. Other opportunities for technical assistance include topics such as media and communication and data collection methods that represent AI/AN people. The summit was valuable to attendees, and reminders of the action plans via follow-up interviews and surveys are reported to have been beneficial.