CONSORTIUM FOR CANCER IMPLEMENTATION SCIENCE

(CCIS) ANNUAL MEETING

October 4–5, 2023
National Cancer Institute, Shady Grove Campus and Virtual

NIH NATIONAL CANCER INSTITUTE

CCIS
Consortium for Cancer
Implementation Science

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This meeting was intended to feature a variety of presentations and discussion sessions focused on the future of implementation science in cancer.

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DAY 1

Overview of CCIS 2023

Graham Colditz, MD, DrPH
Associate Director for Prevention and Control, Alvin J. Siteman Cancer Center, Washington University in St. Louis

Dr. Graham Colditz welcomed attendees and thanked the CCIS Action Groups (AGs) and Steering Committee, whose members assisted in bringing the meeting to fruition. From the attendance statistics, he noted that the audience represented the following professional categories:

- Clinicians – 15%
- Community partners – 3%
- Practitioners – 9%
- Researchers – 67%
- Funding partners and others – 6%

Of those, 81% were online, while 16% joined in person, and another 3% solely attended the preceding AG meeting. In terms of educational background, 57% of the respondents identified as predoctoral or postdoctoral, and the remaining respondents chose "other."

Dr. Colditz reminded attendees that the goal was not to reinvent implementation science (IS) in cancer. A better approach, he said, was to look at events, such as COVID-19, as new opportunities (such as to drive equity) to augment what we have already accomplished. He thanked those who took the Cancer Moonshot^{SM} to the White House and noted the hard work that it took. He also relayed that implementation science in cancer prevention and control needs more community and survivor engagement, while thanking the grassroots partners at this CCIS in person.

Dr. Colditz looked back on the first Consortium meeting. Even in 2019 the meeting included online participants, growing to 400 online registrants this year. Interactivity is woven into the agenda, he said, particularly for early- and mid-stage investigators, who will have opportunities to network with professionals in areas of interest. Looking ahead to a robust exchange of ideas, he emphasized the driver of the meeting's agenda is how the field moves evidence into practice to change health outcomes. Dr. Colditz stated that the Consortium's intention is to bring population science and IS together, which is an intention that he shares. Regarding the recent Nobel awards, he lamented the large number of prizes going to men, which he said does not represent the sciences as a whole.

Cynthia Vinson, PhD, MPA, *Senior Advisor, Implementation Science, Division of Cancer Control and Population Sciences (DCCPS), National Cancer Institute (NCI)*

Seconding the sentiments of the participants, ***Dr. Cynthia Vinson*** shared her excitement to speak in person. She reiterated the Consortium's focus on developing cancer control priorities, building collaboration across centers and with grassroots partners, and creating innovative IS solutions. She introduced the Consortium's fifth annual gathering as a "working meeting," intended to move the field forward and make first-timers feel welcome through organized networking opportunities.

Dr. Vinson introduced the program's Steering Committee members so that they could be recognized for their efforts. She also lauded the efforts of the implementation science AGs, whose volunteer members develop and disseminate "public goods" as free resources to the field, such as podcasts, toolkits, and peer-reviewed papers.

See cancercontrol.cancer.gov/is/initiatives/ccis/public-goods.

Dr. Vinson itemized the AGs concentration areas: Community Participation, Context and Equity, Complex/Multilevel Intervention, Global Health, Learning Healthcare Systems as Natural Laboratories, Policy, Technology, and (new) Environmental Health. To keep the momentum going, she reminded participants to join a group and volunteer to chair. She noted a current call for proposals at cancercontrol.cancer.gov/is/initiatives/ccis/proposals:

> The deadline to apply for $20,000 grants to fund public goods projects is December 7, 2023. She recommended that new proposers engage mentors by means of the meeting's networking opportunities.

Katrina A.B. Goddard, PhD
Director, DCCPS, NCI

Dr. Katrina Goddard gave a warm welcome to the audience from NCI's Division of Cancer Control and Population Sciences. She emphasized that the Consortium welcomes everyone, while applauding the practitioners and policymakers who bring together diversity in thought. She added that "we" should spread this inclusivity as far as we can in the cancer community. Dr. Goddard noted her appreciation for the sharing of public goods and the new Environmental Health AG.

Welcome Remarks

David Chambers, DPhil
Deputy Director, Implementation Science, DCCPS, NCI

Dr. David Chambers recounted when CCIS was founded under a "big tent" to foster diversity of understanding, and the Consortium was an early adopter of the hybrid format for a meeting entitled "Setting the Context for NCI, CCIS & Next Steps in Implementation Science." He stated what we have learned over this journey is that context matters and your work matters. Dr. Chambers underscored the Institute's commitment to getting "what we know works out there" to all who will benefit, serving the public by reducing illness and fostering optimal care. He reminded the audience that the National Institutes of Health's (NIH) National Cancer Plan (NCP) and the Cancer Moonshot directly support IS and IS was included as an original working group. Because "everyone has a role," the NCP can be explored at nationalcancerplan.cancer.gov/.

The Cancer Moonshot is described at cancer.gov/research/key-initiatives/moonshot-cancer-initiative/blue-ribbon-panel.

Regardless of the cancer setting or the population of concern, Dr. Chambers underscored that members of the Consortium share a common vision, and NCI welcomes insight from practitioners and partners on the future direction of the shared mission focusing on the following priority areas:

- Inherited cancer syndromes
- Prevention and early detection of cancer
- Smoking cessation
- Colorectal cancer (CRC) screening
- CRC screening for American Indians
- Cervical cancer control
- Implementation of IS centers

We can also learn globally, Dr. Chambers said, adding that justice is achieved when benefits are supplied to all. Next, he outlined the 2022 DCCPS highlights in the following areas:

- **Health equity**–Make equity explicit in all we do by:
    - Asking the right questions and not assuming that equity is implicit in our work.
    - Considering the cultural, contextual, and historical impacts on those we serve.
    - Deliberately considering whether our practices will exacerbate or create inequities.
- **Data strategies**–Help researchers in their work and people in their lives, with strategies for:
    - Sharing and opening access to data.
    - Protecting the sensitivity and confidentiality of the data that we collect.
    - Capturing data in a systematic way, including obtaining the right sets for IS analysis.
- **Modifiable risk factors**–Consider multiple risk factors “in concert,” rather than alongside or in opposition to each other by:
    - Bundling the modifiable risk factors.
    - Blending interventions.
- **Climate change**–Address the impacts of climate change on health and populations by:
    - Applying research to mitigate climate change and publicizing what we know.
    - Advancing environmental health equity.
    - Understanding the health adaptations that are necessary due to climate change.
- **Evidence-based policy**–Integrate evidence-based interventions into practice by:
    - Influencing policy while objectively understanding those who are affected.
    - Creating implementation strategies to apply that policy for better health outcomes.
- **Digital health**–Understand and adapt to rapid technological changes in the ways that people interact, congregate, and obtain (health care) information.

More information about the divisional 2022 overview and highlights can be found at cancercontrol.cancer.gov/overview-highlights/2022/index.html.

Dr. Chambers asked attendees to see themselves in NCI’s priorities and apply their unique lenses to solving the problems that these priorities seek to address. He reminded today’s practitioners and partners that IS has a long history beginning in 1997. Against that backdrop, he invited attendees to actively scale up, sustain, and adapt IS projects or “deimplement” when something does not work.

Current and Future Directions for Implementation Science

This session featured an interactive discussion that identified strategies and best practices for enhancing the application of IS in real-world contexts that focus on the who, what, where, why, when, and how to align IS with practice and policy. This interactivity aimed to contribute to generating practical recommendations for bridging the gap between research and practice. The session was organized as case studies in five promising cancer-control contexts. Input from the live breakout discussions was captured on flip charts, and comments from the online contributors were recorded on a Mural board.

Moderated by:

Graham Colditz, MD, DrPH

Case Study: Colorectal Cancer

This group began by acknowledging that although the American Cancer Society goal of reaching 80% colorectal cancer screening in the at-risk population is worthwhile, this percentage does not reflect equity.

What success looks like:

- Defining success at the community level.
- Retaining prior patients because they are likely to help recruit others.
- Developing diverse metrics for different populations and communities because a single measure can hide or obscure inequity.
- Using resources more efficiently to disseminate the knowledge we already have (e.g., models):
  - Understanding and implementing how to translate information so that it makes sense to the different communities.

Recommended CCIS AGs:

In addition to creating a (new) Dissemination AG, the following AGs were deemed to have the best alignment with the issue at hand:

- Community Participation in Implementation Science
- Context and Equity in Implementation Science
- Implementation of Complex/Multilevel Interventions

The latter two AGs are equity focused.

New opportunities to advance the field:

- Look at general "well-being" and take a holistic perspective:
  - Learn from what works for other cancers—and beyond cancer—and use the lessons to address disparities in colorectal screening.
  - Make one screening intervention an opportunity to screen for another.
- Take "Science to the Streets" as an approach to apply across the next 2 days.

Case Study: Vaccinations for Preventable Cancers

This case study group concentrated on the uptake of the hepatitis B and human papillomavirus (HPV) vaccines in populations exhibiting disparities, including Asians/Pacific Islanders (particularly first generation) and rural and youth populations, respectively.

Success is defined as:

- Equitable uptake for the identified populations among the number of people vaccinated.
- Sustainable programs and outcomes.
- Improved clinical outcomes and reduced occurrence of disease.

The barriers to success are:

- Financing the cost in the United States
- Lack of access to health care around the globe
- Lack of better measures of the acceptability of vaccines
- Lack of resources, particularly in rural areas:
  - Mentorship capacity
  - Dissemination and implementation (D&I)

Recommended CCIS AGs:

Although most AGs have some synergy with the topic, this breakout group highlighted three AGs:

- Community Participation in Implementation Science
- Context and Equity in Implementation Science
- Learning Healthcare Systems as Natural Laboratories

New opportunities to advance the field:

- Improve research by learning from non-cancer vaccine programs.
- Model campaigns such as Community–Campus Partnerships for Health in the COVID-19 space.

Recommended projects:

- Estimate the effects of two evidence-based education strategies for HPV vaccine uptake at community health centers.

Dissemination and implementation:

- Leverage learning health systems (LHS) to engage patients, clinicians, and researchers.
- Embed best practices into care delivery.
- Generate data on the above.
- Improve practices based on the newly acquired knowledge.

Case Study: Obesity

This group was struck by the contrast between the large number of existing evidence-based programs and the limited number of grant-supported IS projects tackling obesity in relation to cancer. To address this dichotomy, the members recommended:

- Branding IS (i.e., labeling the field in a better way so that what we do is immediately recognized by diverse types of audiences).
- Giving patients a voice and ensuring that patients have formalized roles in the obesity domain.

Recommended CCIS AGs:

- Implementation of Complex/Multilevel Interventions
- Policy of Implementation Science

What a successful process looks like:

- Engage partners (e.g., policymakers).
  - Make sure we do it and do it well at all levels (e.g., community, state, national policy).
- Partner with content domain experts in obesity.
- Develop adaptations for regional and local differences (e.g., lifestyle, dietary issues).
- Create resources/interventions relevant to the particular group of interest or concern.
- Focus on the “D” of D&I—dissemination.

After discussing the concept of aligning incentives to existing interventions (e.g., the interplay between health care policy and a national policy), the group considered whether there was access to data for ascertaining if these interventions are effective. They contemplated the outcome and impact of these evidence-based programs, as well as the notion of shared decision-making based on patient values and preferences. They wanted to know whether uptake was informed or paternalistic.

Case Study: Tobacco Cessation

This case study group tackled the issue of tobacco cessation among cancer patients that aims to reduce both smoking and the use of other tobacco products.

What success looks like:

- Zero smoking.
- Gaining knowledge of the following:
  - The baseline
  - The evidence-based interventions to apply
  - The resources that are available

Barriers are found in the following areas:

- Lack of funding
- Many priorities, including those of patients, practitioners, policymakers/funders, and the community
- The need for simplification of interventions
  - Use of technology
  - Engaging communities

The African American Tobacco Control Leadership Council's "Anti-Tobacco Poetry" campaign is described at savingblacklives.org/poetry.

Case Study: Lung Cancer Screening

A breakout discussion examined lung cancer screening and follow-up as a complement to the need for tobacco cessation.

What success looks like:

- Inquire into what has been successful.
  - Can we adapt successful interventions to various populations?
- Define success:
  - Complete screening.
  - Complete follow-up testing.
- Make changes at the health-system level:
  - Prioritize lung cancer screening.
    - Refer in rather than refer out.
  - Bundle screenings.

New opportunities to advance the field:

- Heat map the areas with the highest rates of deaths from lung cancer.
- Concentrate diagnostic equipment and personnel strategically.
- Make sure that post-diagnostic care is covered for all.
- Partner with community groups and cultural artists to destigmatize screening and treatment.
- Use an emergent-type evaluation to encourage out-of-the-box thinking and innovation.

Barriers are found in the following areas:

- The need for granular data
- Knowing relevant partner organizations:
  - Academic
  - Medical (i.e., diagnostic equipment resources)
  - Community (to identify and scale up access to screening)
- Patient level:
  - Engaging patients in shared decision-making
  - Reimbursement
  - Rural
  - Stigma

Implementation Science in Action: Not Starting from Scratch

This panel session delved into how researchers and practitioners can gain valuable insights from experts in the field about adapting and transferring evidence-based policy and programs, and how we can draw on lessons learned from local, national, and global experiences.

Moderated by:

Jennifer Falbe, ScD, Associate Professor of Nutrition and Human Development, Department of Human Ecology, University of California, Davis

Ramzi Salloum, PhD, Associate Professor, Department of Health Outcomes and Biomedical Informatics, University of Florida College of Medicine

Adapting Evidence-Based Interventions to Increase Uptake of the Human Papillomavirus (HPV) Vaccine: The Role of Local Knowledge

Presented by:

Julie H.T. Dang, PhD, MPH, Assistant Professor, Department of Public Health Sciences, and Executive Director, Office of Community Outreach and Engagement, University of California, Davis, Comprehensive Cancer Center

Dr. Julie Dang described her project in a diverse catchment area of 5 million majority-minority residents that includes racial/ethnic enclaves and non-metropolitan areas, where "one size" does not fit all. Pre-implementation findings from an environmental scan, electronic medical records (EMRs), focus groups, and interviews informed her investigation of barriers to HPV vaccine uptake for older children:

- Barriers for parents:
    - Influenced by social/religious factors, lack of a doctor's recommendation, and schools not requiring the HPV vaccine.
    - Even if key informants supported vaccination, they delayed vaccination since the child had not engaged in sexual activity.
- Barriers for providers (mostly primary care):
    - Felt it was a challenge to discuss with intransigent parents.
        - One doctor mentioned that minds could be changed about 20% of the time.
    - Lacked or had outdated patient education materials.

The following groups were less likely to vaccinate:

- African American/Black and American Indian/Alaska Native (versus white)
- Boys (versus girls)
- Patients with a family doctor (versus a pediatrician)

Negative media coverage and "horror stories," Facebook posts, and oppositional religious affiliations signaled resistance in the community. Signs with anti-vaccine sentiments were even displayed along the roadside. A local health care provider expressed his opposition, and health care staff members made conflicting recommendations to parents. Because local vaccine registry data showed that the highest cancer rates corresponded to an area of low vaccine uptake (i.e., 42% first shot and 18% completed), Dr. Dang located a partner in Northern Valley Indian Health, a practice having about 270 adolescent patients.

From the Community Preventive Services Task Force's Community Guide, she explained, this client center chose six interventions that focused on clients, combined community-health system activities, and providers. The center also chose an external trainer from UC Davis. Four target areas for cultural adaptation guided the implementation approach:

1. **Primary care team**—Improve dynamics and confidence.
2. **Dissemination strategies**—Consider who delivers the message.
3. **Organizational structure**—Consider implications, such as supportive culture, updating procedures/standing orders, vaccine availability, and EMR for tracking.
4. **Community outreach**—Increase awareness and support.

Messaging included pre-appointment delivery of information to parents, patient posters, and computer pop-up alerts for health care personnel. These multilevel strategies increased both vaccination initiation and completion among rural adolescents by about 31%.

A limited program at the Health and Life Organization to train medical assistants and talk to physicians increased vaccine completion among Asian American and Pacific Islanders from 35% to 43%. Likewise, the Tahoe Forest Health System increased HPV vaccine initiation from 66% to 79%. Dr. Dang outlined the following considerations for implementing a successful intervention program:

- Identify a community's "uniqueness."
- Use culturally/locally appropriate scenarios in training.
- Apply appropriate interpersonal styles and create educational materials in multiple languages.
- Employ bilingual/bicultural staff.
- Embed values that reflect the audience and how they seek care and view the world.
- Understand the influence of environmental and historical factors on health-related behaviors.

Perfect Versus Good: Soda Taxes as Community-Centered Investments

Presented by:

Xavier Morales, PhD, MRP, Executive Director, The Praxis Project

Dr. Xavier Morales relayed how his team changed conventional wisdom on implementing tax- and revenue-based behavioral change programs. Offering a frontline perspective, he sees parallels between efforts to reduce the consumption of sugary drinks and the IS interest in applying evidence-based research to preventing cancer.

His Berkeley group, The Praxis Project, engages in policy advocacy to obtain health justice and racial equity. Dr. Morales identified three structures that are necessary to bring about change in root systems that negatively affect outcomes and create inequities:

1. **Base-building groups** – A network of community-led organizations drives solutions to address the negative effects of social determinants of health.
2. **Institutions** – Sometimes established entities can also inhibit systematic change.
3. **Philanthropy** – Funders determine what research and programs move forward.

Noting abundant economic modeling and behavioral/communications research, Dr. Morales highlighted the lessons learned from tobacco cessation initiatives. At first, he said, his group couldn't obtain funding for their soda-tax ideas, because the research status quo has been perpetuated by embedded pipelines; and many advocates seeking reduced consumption of sugary drinks didn't care where the revenue went.

Their community-centered story began when the local school system lost its grant for a cooking and gardening program. As a replacement source of funding was sought, his team wanted those suffering from the effects of sugary drinks to be at the table, and the roots of disease surrounding soda consumption to be addressed. To ensure a participatory process, an expert panel was assembled to determine how to invest the revenue.

Although the soda-tax initiative faced stiff resistance and a powerful communication blitz by the opposition, Dr. Morales reported that 74% of voters expressed their support. Referencing transferable health equity principles, he advised adopters of community-based programs to:

- Act with care, authenticity, and inclusivity in community collaborations.
- Have a commitment to transformation and develop sustainable solutions.

It is important to balance what is grounded in science, Dr. Morales explained, with what works on the ground. When we think outside the box—and beyond what is reimbursed by funders or what the research findings tell us, he said, we can find innovative solutions.

Transferring Evidence from a Primary Context to a Target Context in Lower and Middle Income Countries (LMICs)

Presented by:

Donna Shelley, MD, MPH, Professor and Co-Director, Global Center for Implementation Science, New York University School of Global Public Health

Dr. Donna Shelley described tools and frameworks for assessing transferability and guiding adaptation, with a focus on the Population-Intervention-Environment-Transfer Model of Transferability (PIET-T model) and a case example from Vietnam. Relying on the literature, she defined transferability as the determination of whether the primary evidence and guidelines are conveyable to the target context, based on the interaction of conditional criteria. The limitations of this analysis include:

- How do you know if the evidence is transferable?
- What local contextual evidence must be considered in making the decision?
  - Who makes the decision?
- What factors may influence the effectiveness of transferability?
  - For example, incompatibility, adaptation flaws, implementation failure, and evidence weaknesses.

Developing the answers, Dr. Shelley explained, requires engaging decision-makers in the target country, such as the Ministry of Health in Vietnam, where this “outer” setting is the primary influence on clinical operations. Continuing, she defined **adaptation** as an intentional modification to the intervention to create a better fit in the new environment. In addition to being dynamic (e.g., proactive, reactive), she explained, adaptation can occur without a transfer of evidence.

Dr. Shelley described the Consolidated Framework for Implementation Research (CFIR) model, which guides the implementation cycle for complex interventions. From theory and strategy to application and evaluation, the goal is to advance theory and improve processes. She also highlighted a myriad of transferability and adaptation planning tools:

- **Assessing the TRANSFER approach**—Supports review authors in collaborating with decision-makers on the transferability of primary findings to the review context (Munthe Kass et al.).
- **Reporting FRAME**—Framework for Reporting Adaptations and Modifications–Enhanced (Stirman et al.)
- **The ADAPT guidance**—Consensus-informed guidance for adapting and transferring interventions to new contexts (Moore et al.)
- **IDEA**—Iterative Decision-making for Evaluation of Adaptations (Miller et al.)
- **MADI**—Model for Adaptation Design and Impact (Kirk et al.)
- **PIET-T**—Population-Intervention-Environment-Transfer Model of Transferability (Schloemer and Schröder-Bäck)

For a compiled list of resources, attendees were directed to med.stanford.edu/content/dam/sm/fastlab/documents/Adaptation_annotated_reading_list.pdf.

Of these resources, Dr. Shelley focused on the **PIET-T model**, which aligns factors from the primary and target contexts, facilitating the consideration of each one:

- **Population/Person**—Characteristics and perceptions
- **Environment**—Health systems (including condition), policymakers and their perceptions
- **Primary Intervention to Adapted Intervention**—Evidence basis, content, and fidelity
- **Transfer/Evaluation**—Knowledge transfer; sustainability; evaluation at the organizational, local, and national levels; and modification as necessary
- **Outcome**—Intervention implemented as intended and the desired health outcome achieved

Dr. Shelley presented a case study on the rapid-cycle transfer of an evidence-based tobacco use intervention to (1) community health centers and (2) HIV clinics in Vietnam, whose patients exhibited high smoking rates. She asked attendees to contemplate the following in their policy-based projects:

- Review the context and the setting to ascertain strategies and agents at every level.
- Decision-makers want data before they spend money.
  - Although both fidelity to guidelines and clinical outcomes are important, sometimes the policymakers are persuaded by one justification over another.
  - Perhaps change the form, not the concept.
- Transformation comes down to the individual’s change in behavior.
- In many countries, the government decides.

Dr. Shelley advised that implementation scientists should defer to the partner’s expertise; prioritize the decision-maker’s goals; and balance rigor with pragmatism.

PIET-T Activity

Following the panel, an interactive roundtable activity took place utilizing the Population-Intervention-Environment-Transfer Model of Transferability (PIET-T model) to explore transferability. Participants engaged in a card-draw exercise, which prompted them to consider key factors when transferring interventions. This activity aimed to generate actionable strategies for successful policy implementation.

Three groups completed a hypothetical PIET-T activity to plan a smoking-cessation intervention. This activity involved transferring the US 2-1-1 community-request line to schools in another country. (The 211 service is provided by local organizations and is staffed by experts who help requestors deal with basic needs and crises through information and referrals.) Participants were asked to contemplate what strategies were effective, what could make the intervention sustainable, and what insight they gained from applying the model to the test scenario.

Group 1 focused on sustainability from the start, indicating that in a top-down environment governmental agencies and decision-makers are critical to maintaining an implementation. Considering an intervention in the family home, where smoking involves one or more members, the following ideas were proffered:

- In the traditional sense, everyone has a mailing address and can receive a smoking cessation kit.
- The family-based intervention should be decoupled from a political party or governmental agency, while not losing the initial momentum.
- Family dynamics must be understood, such as who makes or influences decisions in the home.

Additional insights for communication, adaptation/implementation, and evaluation included the following:

- Understanding privacy laws as they pertain to the school setting.
- Alongside person-to-person methods, understanding technology capabilities and deploying them (e.g., web, telephone).
- Identifying local coalitions.
- Understanding jurisdictional issues, including involved systems and communication channels.
- Determining the evaluative factors (e.g., people served, referrals, other).

Group 2 acknowledged their lack of experience with the PIET-T model, before choosing communication and sustainability domains as areas for strategizing. The plan to optimize communications included the following steps:

- Perform a needs assessment.
- Choose households with one or two smokers.
- Develop communication strategies to address the concerns of school administrators and parents.
  - Collect data on how they would like to learn about smoking cessation.
- Reach everyone possible through the 211 service.
- Make a sufficient number of coaches available to problem solve.

Group 3 acknowledged the activity's complexity but relied on the likelihood that people in the other country have email addresses and telephone numbers, and kids take items home from school. Relevant stakeholders were identified as school administrators, parents, and some children, based on age. In this context, there are groups of children, then schools, and then school districts. Some key questions for an implementation are to identify barriers and determine who the facilitators are, and if there is an expert panel or advisory board.

To further the adaptation, the following actions were planned:

- Obtain buy-in:
    - Include parent–teacher associations.
    - Identify a champion in every school to be the program specialist.
    - Develop a train-the-trainer model, which lends itself to sustainability.
- Assemble an expert panel or advisory board in the school system.
- Understand the capacity at each school.
- Adapt existing materials to the teen population.

Additional insight on communications planning included the following:

- Partner with the target community.
    - Include individuals with similar lived experiences to build trust.
    - Rely on stakeholders to identify needs and keep them informed.
- Discover who should be at the table and whose voices should be heard.
    - Ask "Who are we missing?" And develop strategies to include more voices.
    - Rely on focus groups to explain what is working and what is not.
- Tailor materials with culturally appropriate language.

Speed Networking (in-person only)

Moderated by:

Graham Colditz, MD, DrPH

This session provided attendees an opportunity to engage in quick but impactful conversations with a diverse range of individuals. Attendees moved from table to table or breakout room to breakout room, engaging in conversations with fellow attendees who shared a common interest or expertise in the specific topic assigned to each table. This format allowed for a diverse exchange of ideas, perspectives, and experiences, enabling participants to expand their professional networks and gain valuable insights.

DAY 2

Welcome Back

Cynthia Vinson, PhD, MPA
Graham Colditz, MD, DrPH

CCIS Awardee Presentations

This session featured presentations by the CCIS 2022 awardees on the development of their publicly available tools and resources to address key challenges and advance the IS agenda in cancer.

Moderated by:

Jennifer Damonte, MA, Program Analyst, Implementation Science, DCCPS, NCI

Informing Practice–Researcher Partnerships for Policy Implementation Science

Presented by:

Randy Schwartz, MSPH, President, Public Health Systems Consultants, Inc.

Matthew Hudson, PhD, MPH, Director of Cancer Care Delivery Research, Prisma Health

Randy Schwartz and ***Dr. Matthew Hudson*** joined forces in efforts to encourage the uptake of policy IS research by elevating advocacy practitioner and policy stakeholder perspectives for utility and application. With this goal in mind, the team has developed two resources for the benefit of the nascent policy IS field:

1. **Compendium of Resources** – Forthcoming
2. **Lessons Learned in Policy IS** for researcher–policy practitioner relationships – Submitted

The team conducted interviews with representatives of seven recognized national organizations to understand their experiences working with researchers. During the first two discussions, these advisors mostly spoke about evidence and research concerning the "why." Consequently, the pair honed their approach to get at the interviewees' "what" and the "how." Key themes emerged in the following areas:

- Public health 101: Community and partner engagement
- Incentives for researchers and policy advocacy partners
- Dissemination and communications to policymakers and legislators
- Opportunities, including ad hoc and formal convenings

The key takeaways in maximizing the policy practitioner–researcher relationship are to:

- Find mutuality and differences to understand one another (e.g., publish or perish versus immediate utility for a media campaign).
- Bring researchers together with community partners and build the policy advocacy agenda through policy practitioners and people with lived experiences.

Spotlight on Program Champions: A Series of 1-on-1 Interviews for Insight and Impact Stories

Presented by:

Eva May, MBA, Patient-Powered Research and Engagement Advocate

As a trained marketer, ***Eva May*** discussed her endeavor to document the progress made by program champions in implementing evidence-based practices. In conjunction with a Champions Working Group, she developed an interview guide for conducting semi-structured interviews with 15 effective champions. These program ambassadors work in geographic areas throughout the United States and across the cancer care continuum—from screening to survivorship. In settings such as academic centers, rural centers, and in the community, these champions include those who are engaged in patient navigation, outreach, and recruitment for screening. Also included is a fundraiser who sets up free medical clinics to create screening access within the community.

The results will be realized in a series of insight and impact stories (including images), which is expected to be completed by the end of the year. Dissemination planning is underway, and a link will be provided for researcher access.

Simplifying Implementation Science: An Interactive, Visual Web Tool to Assess and Align Content to Context Across a Program's Life Cycle

Presented by:

Katy Trinkley, PharmD, PhD, Associate Professor, University of Colorado

Dr. Katy Trinkley introduced the iterative Practical, Robust Implementation and Sustainability Model (iPRISM) Webtool intended to simplify an often complex IS analysis process and reinforce a systematic approach. She explained that professionals with or without IS expertise, those who speak English or Spanish, and diverse users can all employ iPRISM, a tool that also is flexible with regard to settings and programs.

By answering a series of questions within the tool, the researcher is guided to identify strategies that optimize the alignment of an implementation with its context. iPRISM provides a personalized report with an action plan designed to strengthen the planned program. iPRISM is designed to support the full implementation lifespan and help users consider equity in the representation of perspectives and representativeness of outcomes and develop feasible adaptations, particularly as the context changes. The application provides templates for concrete, time-dependent action plans, added Dr. Trinkley. She noted that iPRISM has been tested by a group of 20 users as the development team's work continues. The tool is available at www.prismtool.org.

Case Studies of Engaging Champions in Implementation Science for Cancer Prevention and Control

Presented by:

Ha Ngan (Milkie) Vu, PhD, Associate Professor, Northwestern University

Dr. Milkie Vu gave an update on her project to compile qualitative case studies on champions in community- and clinic-based settings as a public goods resource. By conducting 25 semi-structured interviews, her team explored the processes for identifying, engaging, and sustaining champions and their activities. Based on the literature, she defined a champion as an individual who is:

- Responsible for driving change, motivating others, and using position and knowledge to drive the adoption of an innovation within an organization.
- Dedicated to the marketing and support of an innovation, and overcoming any resistance to change.

Of the interviewees, 8 were principal investigators, 10 were champions, and 7 were affiliates. From them, her team gained insight regarding items of interest, anecdotes that contradicted the literature, and variance among the responses. Preliminary findings from the case studies include the following:

- Organizations tapped diverse strategies for selecting champions, such as nomination, self selection, and referrals from existing champions.
- A key reason for champion efforts was to give the community or health system partner a voice.
- Champions in community-based settings were involved throughout the life cycle in many activities, while those working within clinics had a more limited role.

Dr. Vu learned that champions have high levels of commitment, social capital, and knowledge of people and systems.
Her team also found that respondents placed value on building a relationship between the research team and the champion through open communications, defined expectations, and shared feedback. The project's abstract has been accepted at AcademyHealth's 16th Annual Conference on the Science of Dissemination and Implementation in Health. The manuscript will be published in late 2024.

Engaging Community Partners

This panel session featured a diverse range of partners who shared their experiences, insights, and success stories in developing and nurturing partnerships that promote health equity. Panelists discussed effective strategies for engaging community partners, building trust, and fostering meaningful collaborations that lead to the translation of research into impactful programs.

Moderated by:

Prajakta Adsul, MBBS, MPH, PhD, Assistant Professor, Department of Internal Medicine, University of New Mexico

Montserrat Soler, PhD, MPH, Project Scientist, Cleveland Clinic, and Research Consultant, Basic Health International

Cleveland African American Prostate Cancer Project: Implementation Science and Community Partnerships

Presented by:

Waverly Willis, Executive Director, The Urban Barber Association (TUBA)

Erika Trapl, PhD, Associate Professor of Population and Quantitative Health Sciences, Case Western Reserve University

Presented in a conversational form, barbershop owner ***Waverly Willis*** and ***Dr. Erika Trapl*** told the story of relationship-building as the foundation for implementing a barbershop outreach program intended to address the disproportionate risk to Black men of being diagnosed with and dying of prostate cancer. By disseminating information directly to the Cleveland community, this research concept is to elevate or even start the discussion among Black men about this cancer, using a nontraditional environment and learning what works and what does not work.

The owner of three barbershops and a barber instructor, Mr. Willis said that he noticed men dying unnecessarily. At the same time, he recognized that his community was not letting the medical and science folks in because of past harms from experiments and racism.

Mr. Willis relayed that he had heard about the Case Western Reserve University Comprehensive Cancer Center Community Advisory Board. By getting involved, his name was on the line, and a reputation for being a community activist and stakeholder grew. But without Dr. Trapl's efforts to build a relationship, Mr. Willis admitted that he would not have taken her call. When she informed Mr. Willis about the screening disparity, his response to Dr. Trapl was, "You need to be in the barbershop."

Yet he echoed the community's resistance, thinking that academic institutions just want the community for numbers and as "guinea pigs." He asked, "Are they doing this for a paycheck or out of passion?" He realized the research team was doing this work out of passion.

Dr. Trapl asked, "What is our shared goal?," and the answer is what kept the two talking. As the pair explained, in turn, Mr. Willis asked that Dr. Trapl and the Case Western Reserve group be "straight" with him to support his role as a messenger, Dr. Trapl understood trust is "gained in teardrops but lost in buckets."

Dr. Trapl indicated she used to be a tobacco control scientist but was drawn to IS for the opportunities to see bigger outcomes. For this outreach research project, she asked, "How do we build a partner relationship before we get to the transaction?" As workshops were held and the strategy tweaked, Mr. Willis explained, the research team was informative and transparent, supported by a consistent Board.

During a year of preparing her partner for research readiness, Dr. Trapl also brought in other perspectives and colleagues to address the complex perceptions about prostate cancer screening. She described doing "researchy" things, such as deciding whether half the barbershops should implement one intervention design, while the other half does something else.

While Dr. Trapl understood her role as a guest in the business owner's space, and her role is not to show up and disrupt the clients' experience, instead, she asked, "What is valuable to the barber? What is valuable to the client?"

Mr. Willis countered that he boosted screening numbers by avoiding the "jargony stuff." He simply relayed that 1 in 6 Black men are diagnosed with prostate cancer, 17 men die needlessly every day—and the mobile screening unit will be here at specified time. Dr. Trapl added that it is "our big idea," and she surely would not call it a research implementation project. And to that, Mr. Willis answered, the community would have said "Heck, no!"

The Family Listening Program, a Culturally Centered Dissemination and Implementation Research Study in Three Southwest Tribal Communities

Presented by:

Lorenda Belone, PhD, MPH, Professor, College of Population Health, University of New Mexico

David J. Tsosie, EdD, Consultant, Nahata Dziil Community

Dr. Lorenda Belone described a community-based participatory research (CBPR) collaboration among her University of New Mexico research team, tribal research partners (TRTs), and community advisory boards (CABs) to address negative coping behaviors among teens. She was joined by ***Dr. David Tsosie***, who offered additional historical and cultural context. The goals of this multiple-team project are to:

1. Explore and assess the implementation context of an evidence-based intervention, called the Family Listening Program (FLP).
2. Refine and implement the implementation strategy.
3. Evaluate and test the effectiveness of the program, with the goal of sustainment.

Dr. Belone described CBPR as an approach intended to involve the community, develop a research topic of interest to the people, and, ultimately, create the social change necessary to improve community health. Fostering a co-learning synergy, CBPR is concerned with building local capacity and systems. Some key CBPR principles are as follows:

- Respect and honor tribal systems.
- Obtain tribal government review and approval.
- Protect tribal data.
- Incorporate reciprocity.
- Balance research with action.

Comprised of four prongs, the CBPR process (1) guides investigators as they work with tribal communities and understand context, (2) partners with the community, (3) performs the intervention and research, and (4) assesses outcomes. Accompanying guidance for conducting research with members of Tribal Nations includes such values as dialogue, humility, respect for native timeframes, and accountability.

As a Navajo Diné scholar, Dr. Belone reinforced the value of traditional knowledge, including the concepts of time and space that foster harmony, peace, beauty, and balance. Outcomes are looked at first to think about how to return the community to this harmonizing state.

Dr. Tsosie recounted that the historical—and recent—trauma of forced relocation by the federal government has caused a loss of spiritual connection and communication between the Nahata Dziil tribe and the natural environment. Consequently, the trauma has trickled down to the young people. Dr. Tsosie explained that FLP was developed to reestablish communications among children within families and, therefore, deter drug and alcohol use by teenagers.

In partnership with community influencers, Dr. Tsosie developed a curriculum for 12 household-oriented sessions, covering topics from history and family to tribal vision and building positive relationships. Dr. Belone said they used an exercise called “River of Life” with tribal members, during which the group was asked to draw out their history along the river. This outline was then recreated as digital art by a high school student to map out and illustrate the extent of this unchosen trauma.

Dr. Belone explained that her team applied the Interactive System Framework model, combined with CBPR principles. The planned implementation is to hold the 12 FLP sessions in three southwestern tribal communities—Nahata Dziil, Torreon/Star Lake, and Santa Ana Pueblo.

Coaches from the partner TRTs helped community representatives understand what a family-based session would look like and how information would be shared with families. Dr. Belone emphasized that “It's not me and it's not the university telling communities what to do.” Their goal is to harness research to help their communities, Dr. Belone explained, so we explain and include them in every step along the way—from training in research ethics and developing the curriculum to recruiting families and collecting data. The team is currently in the process of certifying trainers, using Harvard's catalyst training, and expects to begin data collection in fall 2023.

Action Group-Identified Priorities

AG leaders shared ideas generated during their working meetings to expand existing or create new projects to address key challenges and advance the IS agenda in cancer.

Moderated by:

Cynthia Vinson, PhD, MPA

The **Community Participation AG** prioritized equity in funding distribution, engaging CABs, maintaining a capacity-building pipeline, and, ultimately, “keeping up” with the speed of practice.

The **Complex/Multilevel Intervention AG** emphasized identifying successful intervention examples, creating sustainment strategies, developing a toolkit for new investigators, building resources to measure interactions across multiple influence levels, classifying best practices for developing systems science, and creating cultural adaptation and implementation strategies.

Members of the **Context and Equity AG** highlighted their priority areas as the dissemination of training and other resources, equity measures and study design, translating narratives into research, and inclusive language and terminology.

The priorities for the **Global Health AG** are to foster partnerships with in-country, non-academic communities to decolonize the field and build capacity to support international cancer control.

To foster **Learning Healthcare Systems as Natural Laboratories**, this AG seeks to create a core function-and-form matrix, the High-Performing LHS Handbook, a public forum, case studies and a cross-sectional survey, and an LHS “comparative health systems 101” curriculum.

Members of the **Policy in Implementation Science AG** found areas of focus in networking, measurement models, and policy-as-strategy learning.

The **Technology AG** looks to advance equitable implementation of health information technologies (HITs) in cancer care, capacity-building to employ digital technologies for cancer control, and effective use of HITs for cancer prevention and control.

Town Hall and Next Steps

Participants had the culminating opportunity to set the direction for IS in cancer for the coming year.

Remarks by:

Graham Colditz, MD, DrPH

As the public health deputy editor for *Science Advances*, Dr. Colditz linked conference discussions on writing products—broad summaries, systematic reviews, and opinion pieces on the field—to the journal's publishing opportunity. Citing Dr. Karen Emmons' article on advancing gender equity in science, he encouraged attendees to send in their work, noting that assistance/waivers can be provided for fees.

Remarks by:

David Chambers, DPhil

Dr. Chambers expressed his gratitude for the contributions of CCIS attendees over the 2 days of the conference and over the preceding 5 years. He recognized the specific and deep contributions from the AGs in their specific areas of focus. We are evolving the public goods model, he explained, and seek feedback on this approach. He connected this work to five key questions affecting future plans:

1. Beyond the activities within the action groups, how can the Consortium add value to the field?
2. Are there AG topic areas that we should focus on in the future?
3. CCIS has used the Public Goods model of developing tools and resources that further support the adoption of IS in cancer. Provide feedback on how the model has been used in your experience.
4. Beyond supporting the development of individual public goods, what do you think CCIS can do to incentivize growth in the field of IS in cancer?
5. Are there any further ideas or suggestions you have for ways that CCIS can add value?

Although vital interactions are occurring under the tent, Dr. Chambers urged that there is more space to fill.

Town Hall Comments

The town hall format allowed attendees to raise their hands and contribute informed and passionate ideas about how to move the field forward.

To fully **realize the big tent**, attendees focused on modeling the NIH Community Partnerships to Advance Science for Society (ComPASS) initiative to engage community partners and developing synergy among AGs. This is a proposal to include health system leaders under the tent to help alleviate funding uncertainty. Commenters also believe that decentralization would encourage diversity of thought. Because the existing infrastructure offers space, people, and linkages, "chapters" could be created to align with catchment areas or other organizational structures.

Addressing how to **create the field's identity**, an IS professional proposed renaming "implementation science" to a name that draws people in, like "Moonshot" does for cancer. Another participant remarked that there is now a field called "Health Systems Science," when this "new science" appears to be IS. A third argued that efforts should be focused on partnering with others rather than identifying ourselves. And one attendee looked forward to transferring the strength of IS methods into the community.

Another area of comment was how to **"do" the dissemination** (and communications) in D&I. Input was provided that CCIS should provide more sessions on dissemination. Although controlled project designs are developed, communication plans and the need for dissemination partners are often overlooked. Another participant cited the opportunity for research into health communications, such as one idea that is being floated by not calling cancer "cancer" to address the stigma.

Regarding how to **build volunteer capacity**, a producer of public goods stated that her "goods" took longer to develop than expected. A suggestion was made to offer dedicated workshop time at CCIS for practical efforts, bringing in collaborative partners. Another idea was to pair up junior and senior researchers on projects. One commenter thought that more volunteers would commit if they knew such details as the task, the time expected, and the number of people needed. The conclusion was "It's about teamwork."

Final Thoughts

Brief remarks by:

David Chambers, DPhil

Dr. Chambers closed the meeting by acknowledging the opportunity cost of producing public goods or participating in CCIS. Therefore, we must think of ways that NCI can support "your" investments, he added. Every annual meeting is an experiment, he surmised, and we at NCI want to know how we are doing, whether terrible or good, and whether we need to do more or less of something in the future.

APPENDIX

Questions and Comments

Welcome Session

- An inquiry was raised about the future of the Cancer Moonshot: ***Dr. Chambers*** explained that the initiative was originally authorized as part of the 21st Century Cures Act, and the 7-year authorization period is nearing its end.
- Clarity on NCI's role in educating and motivating policymakers to adopt evidence-based interventions was sought: ***Dr. Chambers*** responded that we must not only better inform decision-makers during rulemaking, but we must also continue to engage them after a rule or legislation is enacted. ***Dr. Colditz*** noted that the Policy Action Group has developed an initiative to bring the lived-community perspective together with researchers and policymakers via two-on-one interviews. He proposed that all of these stakeholders should be brought together all at once for a dialogue on lessons learned.
- A fellow presenter was concerned about the lack of follow-up on policy roll-out, including learning about the intended audience and the impacts, policy enforcement, and equity in its delivery. Seeing that 9% of the current audience are practitioners, he believed the goal—and the need—is to increase the representation of practitioners for the next meeting.
- Another researcher mentioned an existing bootcamp that brings those working with Congress (e.g., mayors of medium-size cities and their chiefs of staff/policy teams) together to focus on equity. Although health is not a current part of this effort, this matter could be included there.
- The discussion continued with input from a community partner who asked how scientific information—the great work done in laboratories, offices, and meetings—can be expressed in a simpler manner so that people on the ground can understand and we can save lives. This question received much acknowledgment and appreciation from those posting in the online chat. ***Dr. Chambers*** expressed his hope that the answer to this question will fuel the meeting's conversations. Although we are aspirational in our communication efforts, he explained that it is our responsibility to make what and how we are saying it relevant to those with whom we seek to work. Because this is implementation science's promise, he added, we need to be held accountable. Not only must we ask the right questions and answer them properly, Dr. Chambers also noted that we must think about who asks the question and what the proper lens should be; we must get the information out there. We want to have a tangible impact, he implored, so that people are not being diagnosed late or dying needlessly.
- Because health literacy is a determinant of health, an attendee inquired why the IS community is not working hand-in-glove with artists as communicators, particularly in support of creating equity. ***Dr. Chambers*** answered that we must reach beyond those who are present today as soon as possible. He requested that anyone interested in engaging in this conversation should contact him. Noting the next session on the agenda, ***Dr. Colditz*** stressed the idea of moving beyond just making public goods for the academic world but also to affect populations. He introduced topics that would inspire participants to envision what successes—and opportunities—look like in reaching the NCP/Moonshot goals by better applying implementation science.

- Among online comments, interest was expressed in having more discussion about what an effective meeting for community partners would look like. A "big thank you" came in, along with a comment that emphasized the core IS value of having an effective and approachable means of communication to those most affected by the disparity. One attendee commented that this moment is such an important call to action. These themes were supported by another participant, who wrote that "community is everything."

Soda Taxes as Community Investments

In response to a question about whether there was observable change in product presentation, ***Dr. Morales*** cited another local annual study, which found a large drop in sugary drink consumption and an associated increase in water consumption.

Another listener exclaimed that "This is amazing!" and wanted to know what the next steps are for his team at the state level. Dr. Morales admitted that he did not want to tip off the huge beverage industry, but he pointed to cities that have instituted similar programs and others planning to come on board. As the result of a soda tax in another area, another commenter wrote that stores in that jurisdiction started stocking more unsweetened beverages.

Transferring Evidence to an LMIC

An online poster noted that mapping the target country's system sounds like a crucial part of the implementation process. Another poster stated that we all need to worry about state preemption of local public health laws.

Barbershop Prostate Cancer Screening Outreach

The first question from the audience was about the team's funding application and collaboration.

Dr. Trapl responded that initial 2020 talks led to a full proposal in January 2021. Because the project was funded in April 2021, the team had a lot of flexibility. Dr. Trapl stated that she worked hand in hand with Mr. Willis, who added that he or a TUBA representative was always at the table.

Another inquirer recognized the professional risk for Dr. Trapl and Mr. Willis if individuals were not receptive to the message. So both were asked about bearing these risks.

Mr. Willis said that the risk of losing "another brother" weighed more heavily than losing money. Staff and clients, he acknowledged, may be uncomfortable talking about prostate cancer screening; however, he had powerful bullet points to counter any resistance. Also concerned about the barbershop losing clientele, Dr. Trapl's team designed "value" phrases that could facilitate natural conversations.

"Paycheck or passion," wrote a chat participant, "this is a powerful way to describe how academic–community relationships are perceived." Another indicated that passion is mandatory for this work.

The Family Listening Program

An attendee asked whether the team had more ideas for and resources on working with community advisory boards to learn what is effective and what to avoid.

Dr. Tsosie recounted the past history of "outside" people coming onto the reservation and performing one-sided activities. In contrast, he said, CPBR exploration views the actual problems from the community's perspective and the people are part of the research.

Concurring with Dr. Trapl, ***Dr. Belone*** underscored that researchers are "guests" in the community. Regarding CABs, she stated a need for capacity-building that will facilitate more partner engagement. For example, relationships between tribal clans helped foster reciprocity between volunteer board members, bringing with it a responsibility of service to restore harmony, particularly in light of the elders' hopes for the children.

Online, many participants thought that these projects comprise spectacular and wonderful work. One poster contributed a link to another example of embedded community engagement: pubmed.ncbi.nlm.nih.gov/37125054/.

Partnerships for Policy Implementation Science

A request was submitted for lessons learned from early community engagement to be considered within the greater concept of "nothing about us without us."

Mr. Schwarz indicated that health equity—in policy and practice—came up early and often in team discussions and subject interviews, including the necessity of identifying and having people with lived experiences involved. So "pull people together early and often," he advised; "it is a three-legged stool, held up by the researcher, the policy practitioner, and the engaged community." ***Dr. Hudson*** described the desire to build a bridge to the space where academics, community organizers, and policy practitioners can work together. He commented that while researchers are invested in data and assessments, interviewees sought an exemplar IS case study that they could apply to policy advocacy.

Program Champion Interviews

A question was asked about how to define a program champion. In addition, the attendee was interested in what criteria was met for the chosen champions in comparison with Dr. Milkie Vu's study.

Ms. May defined a program champion as an individual who is recognized by others as a strong contributor to the success of an evidence-based implementation across the cancer care continuum. This definition helped her uncover those serving vulnerable populations, but it is not intended to limit the definition. ***Dr. Vu*** added that key contributors were asked during interviews to define or describe the key qualities of a champion.

iPRISM Implementation Tool

One interested member of the audience asked how iPRISM tailors an assessment based on the phases of planning, implementation, or sustainment.

As a standard feature, ***Dr. Trinkley*** explained, the tool accommodates pre-implementation, implementation, and evaluation/sustainment, and prompts are provided for users to understand the software's stage definitions. She added that the same 21 assessment questions are asked; however, the language is tailored to the particular stage.

A poster in the online chat found the translation of theories, models, and frameworks to be quite useful, while another expressed an interest in going to the tool's website. Other comments responded positively to both the tool and these remarks.

Additional Comments

A participant explained that the Context and Implementation of Complex Interventions framework is valuable in guiding context analysis, and this concept graphically links implementation and intervention.

In the online chat, an important request was made, asking the field to clearly define what a *policy practitioner* is and what one does.

"IS Demographics" Poll Results

- The largest group of attendees works in the academic/university setting (50%) and the smallest sector comprised representatives of nonprofit organizations (5%).
- When asked about their prior level of IS knowledge, 60% indicated an intermediate level of familiarity, while 10% rated themselves as expert.

- Sixty-five percent of respondents said that they had received formal IS training.
- Among the 73% who acknowledged having had an industry mentor, 26% said that they were still looking for more guidance and 26% answered that they were seeking to find their first mentors.
- Fifty-three percent of attendees answering the poll have received funding to support an IS project.
- The vast majority (93%) replied that it was difficult or very difficult to obtain funding.

Action Group Priorities Poll Results

CCIS participants were asked to complete a survey online, with real-time results. Fifty-two people responded with their feedback to (1) prioritize the future work of the Action Groups, (2) explore topics to build the field, and (3) collect representational data from the perspectives of the professionals and partners in attendance. Key findings with regard to public goods to be produced by the relevant AGs are as follows:

- Community Participation – **Capacity-building pipeline** (54%)
- Complex/Multilevel Intervention – **Successful examples of complex/multilevel interventions** (48%)
- Context and Equity – **Equity measures and study design** (70%)
- Global Health – **Partnerships with communities – decolonize the field** (79%)
- Learning Healthcare Systems – **High-performing Learning Healthcare Systems handbook** (50%)
- Policy – **Policy-as-strategy learning** (76%)
- Technology – **Building capacities to use emerging digital technologies for cancer control; effective use of HITs for cancer prevention and control** (tie, 63%)

Open Text Poll Responses

In this poll, respondents were given the opportunity to address identified topics and include additional comments as they wished.

Identifying major gaps in cancer IS to reduce health disparities in medically underserved communities

- Understand that the field will remain undersupported if we rely on biomedical funding models.
- Address the lack of knowledge of US history, particularly as it relates to underserved populations.
- Communicate effectively without resorting to jargon.
- “Evidence based” is not always representative.
- Address the reality that evidence-based interventions are not implemented in some cases.
- A broad range of stakeholders exist for academic research; however, there is not enough embeddedness.
  - Express humility in allowing community health workers to be the voice.
- Understand the value of engagement and the time it takes to build relationships.
  - Take the time to explain what IS does, meet people where they are, and tell community members how their experiences are essential to identifying approaches.
  - “Nothing about us without us” should be the guiding principle.
- There is a lack of cancer screening in rural areas.
- “Open the door” for vulnerable populations while being sensitive to the history of harm.

Developing strategies to enhance sustainability through collaboration with community partners

- Invest in sustainability by focusing on work that is important to the community and is feasible.
- Keep partners informed and involved in decision-making. Build it together.
    - Align what is introduced with what is already being done.

Integrating an asset-based approach in IS to foster resilience and resourcefulness as community traits

- Join in advocacy to address structural disadvantage and embrace the history of community trauma.
    - Allow space for members to guide the process.
- Embed research using an inductive, listening approach.
    - Use systems visualization to align mental models.
- Start with what exists rather than what does not exist.

Additional ideas and comments that have not been captured through answers to the preceding questions

- Facilitating AGs
    - Create a cross-AG workgroup on dissemination practices, collecting metrics on existing goods.
    - Have an AG focus on scale-up or the incorporation of sustainability across all AGs.
    - Staff the AGs with a paid facilitator.
    - Rethink the organization of AGs—combine, sunset, align, and make the scope narrower.
    - Pause the brainstorming of new ideas and provide more resources to work on existing ideas.
- Developing Public Goods
    - It is hard to contribute new ideas.
        - For early career investigators, public goods work will not advance one's career.
        - Consider how to pay the AG members.
    - Find ways of measuring the impact (e.g., which are beneficial, to whom, and why).
    - Can NCI collaborate with other funders to bring more resources to CCIS public goods?
- Focus on Sustainability and Scale-up
    - Look outside ourselves to find out how to make research last once the initial funding ends.
    - Foster the idea of a journey with IS that goes beyond implementation/adoption.
- Capacity-Building, Mentorship, Networking, and Training
    - Address the vacuum in senior field expertise attending CCIS by creating more mentorships.
    - Build more IS capacity by bringing in new researchers and training them.
    - Provide training for researchers in budgeting.
    - Introduce a network for IS studies across centers.
- Working with Underserved or Vulnerable Populations
    - Discuss how to balance tension settings (e.g., under-resourced communities).
- Bring IS to the Community

  - A rebranding suggestion is “Catalyst.”
  - Funding requirements should have the community partner co-lead the grant application.
  - Leverage community partnerships that already exist in CCIS.
  - Involve community members in planning so they can see the value.
  - Encourage greater involvement of academic centers within their community settings.
  - Bring in patient research advocates and advocacy organizations.
- Involve Community Partners in CCIS
  - Can we conduct more CCIS meetings for the communities using the town hall concept?
  - Provide an opportunity at this meeting to support a community organization activity.
  - Invite researchers to bring their community partners with them to this meeting.
  - Include community partners in meeting planning.
  - Cover the opportunity cost for community partners to attend CCIS.
- Community Partner Participation in Implementations
  - Community partners who provide input should gain revenue from it.
  - NCI should support IS training and capacity-building specifically for community partners.
- Support IS for Digital and Online Programs
  - We need models for building/scaling apps, dissemination systems, and funding prospects.
- Improving Funding Mechanisms
  - Build a new paradigm for funding. The traditional R01 funding is not enough.
  - Require IS as part of accreditation and funding.
- Cross-Cutting and Industry Collaboration
  - Leverage the NCI Cancer Center Networks, alongside the National Cancer Coalition.
  - Center of Excellence activities should incorporate IS principles.
  - Learn from, and collaborate with, successful IS in other disease areas.
  - Apply more systems approaches to bridge research and practice.
  - Foster the inclusion of other professionals doing implementation research/work.
  - Have NIH work with other federal programs (e.g., the Centers for Disease Control and Prevention) to build practice-based alliances.
- Miscellaneous Comment
  - What is our responsibility as members of the Consortium?

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