Celebrating 20 Years of Strong Connections in Cancer Prevention and Control
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Dear Cancer Control Partner:

On behalf of the Michigan Cancer Consortium, we are pleased to present the *Journal of Proceedings of the 2018 Michigan Cancer Consortium Annual Meeting*.

The theme of the Nov. 7 meeting was “Celebrating 20 Years of Strong Connections in Cancer Prevention and Control.” Cancer control stakeholders from across Michigan came together in East Lansing to learn, network and celebrate 20 years of cancer prevention and control work and accomplishments.

This journal highlights the content shared during the meeting’s keynote address and concurrent sessions, the peer-reviewed and approved poster abstracts exhibition, and the 2018 MCC award presentations.

It is our hope that the information in these pages will help inspire those who could not attend the meeting and will encourage further action toward achieving the Consortium’s goals. We urge you to read and enjoy this edition and then *share it widely with your colleagues and other stakeholders in cancer control*.

Visit [www.michigancancer.org](http://www.michigancancer.org) to learn more about what we do and how your organization can get involved.

We look forward to seeing you at the 2019 Michigan Cancer Consortium Annual Meeting on Thursday, Oct. 24 at The Kellogg Hotel & Conference Center in East Lansing!

Sincerely,

*Dana Zakalik, MD*

Co-Chair, MCC Board of Directors
Director, Beaumont Cancer Genetics Program
Beaumont Health System

*Tom Rich, MPH*

Co-Chair, MCC Board of Directors
Health Systems Manager, State & Primary Care Systems
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Journal of Proceedings of the Michigan Cancer Consortium Annual Meeting is a free access journal that is published once a year by the Michigan Cancer Consortium to summarize the content of the Consortium’s annual meeting and to promote the comprehensive cancer control work being done throughout the state by MCC member organizations and their collaborative partners. All current and past issues of the journal are available online at www.michigancancer.org.

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The Michigan Cancer Consortium unifies public and private organizations to reduce the burden of cancer for all people by addressing health disparities through a commitment to collaboration, evidence-based practices, and improved quality of care. For more information, visit www.michigancancer.org.
Peer-Reviewed Poster Abstracts
Implementing a Clinical Decision Aid Tool, Personal Patient Profile-Prostate (P3P), for Localized Prostate Cancer Patients across the State of Michigan

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MCC Cancer Plan component(s) addressed
Diagnosis and Treatment: Diagnose and treat all patients using the most effective and appropriate methods. (MCC Goal)

Purpose
To implement a clinical decision aid tool, P3P, for newly diagnosed prostate cancer patients in urology practices across the state of Michigan that will better inform and prepare patients for conversations about their treatment options with their physician.

Background/Significance
Decision aid tools are intended to increase patients’ knowledge about their disease and educate them on available treatment options so that they can be better informed when meeting with their physician. Recognizing the value of patient-centered care, the Michigan Urological Surgery Improvement Collaborative (MUSIC) began implementing a decision aid tool, Personal Patient Profile-Prostate (P3P), statewide in Michigan.

Methods
MUSIC, a physician-led quality improvement consortium comprised of 44 diverse urology practices and more than 250 urologists, focuses on improving the quality and cost efficiency of care provided to urologic patients in Michigan. MUSIC aims to improve treatment appropriateness for newly diagnosed prostate cancer (PCa) patients by optimizing the use of active surveillance and ultimately decreasing the burden of unnecessary overtreatment. To support this aim, MUSIC has partnered with Movember, a global nonprofit organization focused on improving men’s health, on a TrueNTH project to bring P3P
to Michigan patients. P3P helps prepare PCa patients for a conversation with their physician regarding treatment options that best align with their health preferences, values, and goals. To better understand the patient experience and satisfaction with P3P, patients are asked to complete a brief survey after meeting with their physician. The MUSIC Coordinating Center is integrating P3P into MUSIC practices in a phased approach with a vision to have it ultimately adopted statewide. MUSIC practices obtain local institutional review board (IRB) approval and undergo comprehensive in-person training prior to integrating P3P into their local processes.

**Results**
P3P was launched in MUSIC in May 2018. Five practices are actively enrolling patients into P3P, and more than 100 patients have been enrolled to date. Patients spend approximately 13.5 minutes completing the questionnaire, and 78 percent of patients complete the questionnaire before their treatment discussion appointment with their doctor. Other practices are actively working to obtain IRB approval, and MUSIC anticipates implementing P3P into one to two additional practices per month. While data is still preliminary, 100 percent of patients say they are satisfied with the amount and quality of information presented to them, and 94 percent of patients feel their treatment decision is consistent with their personal health preferences, values, and goals. Overall, 88 percent of patients said they believe P3P helped them to consider specific questions and/or concerns to discuss with their doctor, and 82 percent say they felt more informed about the risks, benefits and limitations of the different treatment options available to them. P3P implementation is an ongoing quality improvement project, but the initial results from the implementation of the shared-decision making tool are positive and indicate the potential for its success at other urology practices.

**Conclusions**
Through the integration of P3P statewide in Michigan, PCa patients receive education to enhance shared decision making so that they can make an informed treatment decision that considers their disease severity along with their health preferences, values, and goals. Shared decision making is a process for the patient and physician to embark on together, but the implementation of these types of programs depends on the practices to operationalize the use of the tool in the clinic.

**References**

Treatment of Prostate Cancer Using Cesium-131 Seed Implant: Dosimetric Comparison with Iodine-125

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MCC Cancer Plan component(s) addressed
Diagnosis and Treatment: Diagnose and treat all patients using the most effective and appropriate methods. (MCC Goal)

Purpose
To compare radiation dose distributions for prostate cancer treatments using implanted seeds containing Iodine-125 or the novel radioactive isotope Cesium-131.

Background/Significance
Radioactive Cesium-131 (Cs-131) has been introduced as an alternative isotope to Iodine-125 (I-125) and Palladium-103 (Pd-103) for prostate seed implant. Cs-131 has relatively short half-life (9.7 days) and moderate energy (29 keV) with high initial dose rate so that a radiobiologic advantage for treating high-grade tumors has been suggested. Only a few large series have examined dosimetric aspects of Cs-131 seed implants.

Methods
Post-implant dosimetric information was collected for 247 prostate cancer patients treated with radioactive Cs-131 or I-125 seed implant with or without external radiation at Ascension Macomb Hospital or Crittenton Hospital between the years 2007 and 2015. Of these implants, Cesium-131 was employed for 65 cases and Iodine-125 was used in 182 cases. The isotope selection was at the discretion of the treating physician at the two different institutions. Parameters reviewed included the percent dose received by 90 percent of the prostate (D90) and the percent volume of the prostate receiving 100 percent, 150 percent, and 200 percent of the prescribed dose (V100, V150, and V200). Prostate volume, number of seeds,
delivered activity, and total activity were also studied. A number of clinical and patient factors were not examined in this study. Statistical analysis was performed using SAS for Windows 9.4. Categorical variables were examined with Chi-square test where appropriate, otherwise Fisher’s exact tests were used. Continuous variables were examined with Wilcoxon rank sum tests.

**Results**
Using Cs-131, the delivered activity per seed and the number of seeds employed were greater compared to I-125. The D90 for Cs-131 and I-125 was 92 percent and 98 percent, respectively. Although these values were statistically different (p<0.0001), this shows a consistently high-quality implant dose coverage using either isotope. As expected, the total source strength was related to prostate volume for both isotopes. Corrected total source strength (normalized to the sample mean values) showed similar distribution for Cs-131 compared to I-125, suggesting that treatment planning was similar throughout the study. The percent V150 was 36 percent for I-125 versus 27 percent for Cs-131 (p<0.0001), consistent with superior homogeneity using Cs-131. The percent V200 was 13 percent versus 12 percent (p=0.012) for I-125 versus Cs-131.

**Conclusions**
Cs-131 dosimetry was qualitatively similar to I-125 in this review. This is evidenced by the finding that for essentially the same dose coverage of the prostate (D90), statistically greater V150 and V200 was observed using I-125 than Cs-131. Because of high initial dose rate, careful attention to patient selection and treatment planning is important in the clinical use of Cs-131. In the future, we will report comparison of clinical outcomes including PSA failure rates, survival, and acute and chronic morbidity for this cohort.

**References**

Note: Urethral and rectal doses were not carried for all cases presented here. Tumor and patient characteristics will be described in future report.
Engaging in Physical Activity after a Cancer Diagnosis: A Detroit ROCS Study

Authors
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MCC Cancer Plan component(s) addressed
Quality of Life: Optimize the quality of life for every person affected by cancer. (MCC Goal)

Purpose
The goal is this research is to examine patterns of physical activity (PA) and its association with health-related quality of life (HRQOL) in a cohort of African American cancer survivors.

Background/Significance
The benefit of regular exercise in improving cancer outcomes is well established. In 2012, the American Cancer Society (ACS) released a recommendation statement that cancer survivors should engage in regular PA as soon as possible after a cancer diagnosis with the goal of engaging in at least 150 minutes per week of moderate to vigorous PA.¹ However, few cancer survivors report meeting this recommendation.² Using data from the Detroit Research on Cancer Survivors (ROCS) study, we examined the patterns of PA and HRQOL in a cohort of African American cancer survivors, both at baseline enrollment and at the first year follow-up.

Methods
Detroit ROCS participants complete baseline and yearly follow-up surveys to update their health and provide information on health behaviors, including PA, using the International Physical Activity Questionnaire short form. We assessed the number of survivors who reported participating in regular PA and those who reported ≥150 minutes of moderate to vigorous PA per week by select characteristics and reported HRQOL measured using the Functional Assessment in Cancer Therapy (FACT)
and Patient-Reported Outcomes Measurement Information System (PROMIS) instruments.

Results
Among the first 1,000 ROCS participants, 58 percent reported participating in regular PA, with just 22 percent reporting engaging in ≥150 minutes of PA per week. While there were no differences by gender, prostate cancer survivors were the most likely to report participating in regular PA, while lung cancer survivors were the least likely (p=0.009). There was a positive relationship between self-reported education and area-level affluence based on U.S. census data with PA (p<0.001 and p=0.019, respectively). Survivors who reported participating in regular PA also reported higher HRQOL (p<0.001) and lower depression (p=0.036). The same patterns were observed among those reporting ≥ 150 minutes of PA per week. Additionally, we found lower reported anxiety among survivors who reported meeting ACS guidelines (PROMIS-Cancer anxiety score, p<0.001). Among survivors who had completed their first follow-up survey (N=389), a higher proportion of survivors reported participating in regular PA (71 percent, p<0.001) and getting ≥ 150 minutes of PA per week (32 percent, p<0.001).

Conclusions
Fewer than 25 percent of African American cancer survivors reported meeting the ACS guidelines for PA at baseline recruitment; however, it was encouraging to see significant increases in PA engagement over time. Given the established benefits associated with regular exercise and cancer outcomes, and the positive correlation on HRQOL and the inverse relationship with depression observed in this study, identifying, understanding and eliminating barriers to regular moderate to vigorous PA among African American cancer survivors is critical. Future study of ROCS subjects will attempt to establish the temporality of these relationships.

References
Health-Related Quality of Life among Detroit Lung Cancer Survivors: Findings from the Detroit ROCS Studies

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MCC Cancer Plan component(s) addressed
Quality of Life: Optimize the quality of life for every person affected by cancer. (MCC Goal)

Purpose
The Detroit Research on Cancer Survivors (ROCS) studies follow the experience of cancer survivors, including lung cancer survivors, in Detroit, MI. The Detroit ROCS studies include a pilot study of whites and African Americans in which baseline interviews were conducted 2015-2017,¹ and an ongoing study of African Americans started in 2017. Participants in both studies were diagnosed 2013 or later and are surveyed annually after enrollment for up to five years. Racial differences in self-reported well-being at baseline were assessed among lung cancer survivors who have participated in these studies.

Background/Significance
Patients diagnosed with lung cancer may face unique challenges due to a high mortality rate and a smaller likelihood of early stage diagnosis. These analyses explore factors that may influence differential quality-of-life (QOL) outcomes following a lung cancer diagnosis.

Methods
Participants in the Detroit ROCS studies complete the Functional Assessment in Cancer Therapy (FACT) instrument to evaluate their QOL during their baseline interview and during each subsequent annual follow-up. FACT scores are derived from subscales evaluating physical, emotional, social, and functional well-being. The FACT-G score is equal to the sum of the four subscales after adjusting for negatively worded questions by reverse-scoring these. Thus, higher scores indicate better QOL. In addition, participants are asked to provide basic demographic information, health history, family history of cancer, and history of lifestyle exposures, such as tobacco and alcohol use. Data related to their cancer diagnosis and census tract are gathered via the Metropolitan Detroit...
Cancer Surveillance System. Preliminary data were collected from 227 (131 African American and 96 white) lung cancer survivors who have completed the Detroit ROCS or Detroit ROCS pilot surveys to date. Racial differences in self-reported aspects of well-being were assessed. Descriptive characteristics were compared using Pearson’s Chi-square and Wilcoxon rank sum tests. Adjusted mean well-being subscores were modeled using general linear models.

Results
The mean age of African American participants was 61.9 years (SD=7.6) and the mean age of whites was 62.9 years (SD=8.9). Among African American participants, 40.5 percent were male; of white participants, 45.8 percent were male. The distributions of age and gender did not differ significantly between groups. African American participants were less likely to have any college education (p=0.0480), and more likely to live in a census tract with at least 20 percent poverty (p<0.0001). In a general linear model adjusted for age, gender, cancer stage, and time from diagnosis to interview, race did not predict differences in mean physical and functional well-being subscores. Race significantly predicted differences in adjusted mean emotional and social well-being scores (p=0.0379 and p=0.0466, respectively). The estimated adjusted mean emotional well-being subscore was higher among African Americans than among whites, while the estimated adjusted mean social well-being score was higher among whites.

Conclusions
While functional and physical well-being outcomes are similar for African American and white lung cancer survivors, emotional and social well-being outcomes diverge by race. These measures reflect disparities in QOL among lung cancer survivors. Future analyses will identify factors influencing this disparity in emotional and social well-being, and describe additional determinants contributing to the QOL of lung cancer survivors.

References
DISCO App: Acceptability Testing of an Intervention to Reduce Financial Toxicity

Authors
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MCC Cancer Plan component(s) addressed
Health Equity: Health equity is the achievement of the highest level of health for all people. This can only be achieved by eliminating health disparities, which are inequalities in health that exist among socially, economically, and/or environmentally disadvantaged populations. The Michigan Cancer Consortium is working to decrease cancer health disparities and promote health equity. This is done by addressing social issues affecting health and promoting access to high-quality services for cancer. (MCC Pillar)

Purpose
To test the acceptability of an individually tailorable, patient-focused question prompt list application (“app”) focused on patient-oncologist discussions of cancer treatment cost.

Background/Significance
Financial toxicity, or severe economic burden due to cancer treatment cost, affects 30 percent to 50 percent of patients. Patient-oncologist treatment cost discussions could help reduce financial toxicity, but they occur infrequently. Question prompt lists (QPLs) may increase cost discussions, but existing QPLs do not focus on cost, nor are they tailorable to an individual’s economic situation. To address this, the study team built an individually tailorable QPL application (app) focused on discussions of cost (DISCO) and tested its acceptability.

Methods
An expert panel of cancer survivors, oncologists, social workers, and a financial navigator (eight women, four men; five White, four Black, two Arab/Middle Eastern, one Asian/Pacific Islander) was
recruited to review the DISCO App. Using semi-structured interviews, participants were asked to review and provide feedback on the DISCO App’s design, the tailoring demographic questions, prompted cost questions, usefulness for patients, and suggestions for improvement. Each interview was audio recorded, transcribed, and thematically analyzed.

Results
Six participants reported liking the DISCO App’s design and found it easy to navigate. Eleven participants had suggestions for improvements to the demographic questions, such as rewording and reordering questions. Ten participants reported liking many or all of the prompted cost questions. Seven participants expressed concern that the physician may not be able to answer the questions. One oncologist suggested including a cost discussion tip sheet for physicians that would help them prepare for cost discussions. Two oncologists expressed concern that it would be difficult to respond to so many questions in a busy clinic setting and suggested reducing the number of cost questions. Ten participants reported that the DISCO App will likely be useful for patients.

Conclusions
The expert panel found the DISCO App acceptable, but offered several suggestions to improve it. A revised version of the DISCO App, and accompanying cost discussion tip sheet for oncologists, will be tested in a randomized controlled trial to determine the influence on the frequency and quality of patient-oncologist treatment cost discussions, patients’ efficacy with managing treatment cost, and financial toxicity.
Achieving Equity in Cancer Prevention and Control: Tools for Naming and Addressing the Impacts of Racism on Health

Presenter: Camara Phyllis Jones, MD, MPH, PhD, Past President, American Public Health Association (email: cpjones@msm.edu)

About the presenter: Camara Phyllis Jones, MD, MPH, PhD, is past president of the American Public Health Association and senior fellow at the Satcher Health Leadership Institute and the Cardiovascular Research Institute at the Morehouse School of Medicine in Atlanta, GA. She also serves as an adjunct associate professor in the School’s Department of Community Health and Preventive Medicine.

Dr. Jones is a family physician and epidemiologist whose work focuses on the impacts of racism on the health and well-being of the nation. She seeks to broaden the national health debate to include not only universal access to high-quality health care, but also attention to the social determinants of health (including poverty) and the social determinants of equity (including racism).

As a methodologist, Dr. Jones has developed new methods for comparing full distributions of data, rather than simply comparing means or proportions, in order to investigate population-level risk factors and propose population-level interventions. As a social epidemiologist, her work on “race”-associated differences in health outcomes goes beyond documenting those differences to vigorously investigating the structural causes of the differences.

Summary

In order to address the “racial” and ethnic health disparities that exist in our programs, we must first understand and address their underlying causes. Disparities in health care services can be attributed to differences in the quality of care received within the health system; differences in access to health care, including preventive and curative services; and differences in life opportunities, exposures, and stresses that result in differences in underlying health status.

The “cliff analogy” is used to illustrate the three elements of health intervention that can help keep individuals from falling off what Dr. Jones refers to as the “cliff of good health:” 1) providing universal access to high-quality health care; 2) addressing poverty and other social determinants of health; and 3) addressing racism and other social determinants of equity. Likewise, the analogy of “Life on a Conveyor Belt” demonstrates that although racism
is most often passive, showing up as inaction in the face of need, we can make the conscious effort to go against the flow and recognize racism and name it. After we accept the fact that racism is operating within our systems, we can seek it out and join with others to strategize and then employ actions that will dismantle racist systems and replace them with equitable ones that can help people develop to their full potential.

References cited in this presentation:
Levels of Racism: A Theoretic Framework and a Gardener’s Tale

Camara Phyllis Jones, MD, MPH, PhD

Race-associated differences in health outcomes are routinely documented in this country, yet for the most part they remain poorly explained. Indeed, rather than vigorously exploring the basis of the differences, many scientists either adjust for race or restrict their studies to one racial group. Ignoring the etiologic clues embedded in group differences impedes the advance of scientific knowledge, limits efforts at primary prevention, and perpetuates ideas of biologically determined differences between the races.

The variable race is only a rough proxy for socioeconomic status, culture, and genes, but it precisely captures the social classification of people in a race-conscious society such as the United States. The race noted on a health form is the same race noted by a sales clerk, a police officer, or a judge, and this racial classification has a profound impact on daily life experience in this country. That is, the variable “race” is not a biological construct that reflects innate differences, but a social construct that precisely captures the impacts of racism.

For this reason, some investigators now hypothesize that race-associated differences in health outcomes are in fact due to the effects of racism. In light of the Department of Health and Human Services’ Initiative to Eliminate Racial and Ethnic Disparities in Health by the Year 2010, it is important to be able to examine the potential effects of racism in causing race-associated differences in health outcomes.

Levels of Racism

I have developed a framework for understanding racism on 3 levels: institutionalized, personally mediated, and internalized. This framework is useful for raising new hypotheses about the basis of race-associated differences in health outcomes, as well as for designing effective interventions to eliminate those differences. In this framework, institutionalized racism is defined as differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legal, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed, institutionalized racism is often evident as inaction in the face of need.

Institutionalized racism manifests itself both in material conditions and in access to power. With regard to material conditions, examples include differential access to quality education, sound housing, gainful employment, appropriate medical facilities, and a clean environment. With regard to access to power, examples include differential access to information (including one’s own history), resources (including wealth and organizational infrastructure), and voice (including voting rights, representation in government, and control of the media). It is important to note that the association between socioeconomic status and race in the United States has its origins in discrete historical events but persists because of contemporary structural factors that perpetuate those historical injustices. In other words, it is because of institutionalized racism that there is an association between socioeconomic status and race in this country.

Personally mediated racism is defined as prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others accord-

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This article was accepted April 12, 2000.

August 2000, Vol. 90, No. 8
Institutionalized racism

- Initial historical insult
- Structural barriers
- Inaction in face of need
- Societal norms
- Biological determinism
- Unearned privilege

Levels of Racism: A Gardener’s Tale

When my husband and I bought a house in Baltimore, there were 2 large flower boxes on the front porch. When spring came we decided to grow flowers in them. One of the boxes was empty, so we bought potting soil to fill it. We did nothing to the soil in the other box, assuming that it was fine. Then we planted seeds from a single seed packet in the 2 boxes. The seeds that were sown in the new potting soil quickly sprouted and flourished. All of the seeds that were sown in the new potting soil quickly sprang up and flourished. A ll of the seeds sprouted, the most vital towering strong and tall, and even the weak seeds made it to a middling height. However, the seeds planted in the old soil did not fare so well. Far fewer seeds sprouted, dropping their progeny into the same soil in which they were growing. The next year the same thing happens, with the red flowers in the rich soil growing full and vigorous and the pink flowers in the poor soil struggle to survive. And these flowers go to make it, and the strongest among them died. It turns out that the old soil was poor and rocky, in contrast to the new potting soil, which was rich and fertile. The difference in yield and appearance in the 2 flower boxes was a vivid, real-life illustration of the importance of environment. Those readers who are gardeners will probably have witnessed this phenomenon with their own eyes.

Now I will use this image of the 2 flower boxes to illustrate the 3 levels of racism. Let’s imagine a gardener who has 2 flower boxes, one that she knows to be filled with rich, fertile soil and another that she knows to be filled with poor, rocky soil. This gardener has 2 packets of seeds for the same type of flower. However, the plants grown from one packet of seeds will bear pink blossoms, while the plants grown from the other packet of seeds will bear red blossoms. The gardener prefers red over pink, so she plants the red seed in the rich fertile soil and the pink seed in the poor rocky soil. And sure enough, what I witnessed in my own garden comes to pass in this garden too. All of the red flowers grow up and flourish, with the fittest growing tall and strong and even the weakest making it to a middling height. But in the box with the poor rocky soil, things look different. The weak among the pink seeds don’t even make it, and the strongest among them grow only to a middling height.

In time the flowers in these 2 boxes go to seed, dropping their progeny into the same soil in which they were growing. The next year the same thing happens, with the red flowers in the rich soil growing full and vigorous and strong, while the pink flowers in the poor soil struggle to survive. And these flowers go to seed. Year after year, the same thing happens. Ten years later the gardener comes to survey her garden. Gazing at the 2 boxes, she says, “I was right to prefer red over pink! Look how vibrant and beautiful the red flowers look, and see how pitiful and scrawny the pink ones are.”

Personally mediated racism

- Intentional
- Unintentional
- Acts of commission
- Acts of omission
- Maintains structural barriers
- Condoned by societal norms
This part of the story illustrates some important aspects of institutionalized racism. There is the initial historical insult of separating the seed into the 2 different types of soil; the contemporary structural factors of the flower boxes, which keep the soils separate; and the acts of omission in not addressing the differences between the soils over the years. The normative aspects of institutionalized racism are illustrated by the initial preference of the gardener for red over pink. Indeed, her assumption that red is intrinsically better than pink may contribute to a blindness about the difference between the soils.

Where is personally mediated racism in this gardener’s tale? That occurs when the gardener, disdaining the pink flowers because they look so poor and scraggly, plucks the pink blossoms off before they can even go to seed. Or when a seed from a pink flower has been blown into the rich soil, and she plucks it out before it can establish itself.

And where is the internalized racism in this tale? That occurs when a bee comes along to pollinate the pink flowers and the pink flowers say, “Stop! Don’t bring me any of that pink pollen—I prefer the red!” The pink flowers have internalized the belief that red is better than pink, because they look across at the other flower box and see the red flowers strong and flourishing.

What are we to do if we want to put things right in this garden? Well, we could start by addressing the internalized racism and telling the pink flowers, “Pink is beautiful!” That might make them feel a bit better, but it will do little to change the conditions in which they live. Or we could address the personally mediated racism by conducting workshops with the gardener to convince her to stop plucking the pink flowers before they have had a chance to go to seed. Maybe she’ll stop, or maybe she won’t. Yet, even if she is convinced to stop plucking the pink flowers, we have still done nothing to address the poor, rocky condition of the soil in which they live.

What we really have to do to set things right in this garden is address the institutionalized racism. We have to break down the boxes and mix up the soil, or we can leave the 2 boxes separate but fertilize the poor soil until it is as rich as the fertile soil. When we do that, the pink flowers will grow at least as strong and vibrant as the red (and perhaps stronger, for they have been selected for survival). And when they do, the pink flowers will no longer think that red pollen is better than pink, because they will look over at the red flowers and see that they are equally strong and beautiful. And although the original gardener may have to go to her grave preferring red over pink, the gardener’s children who grow up seeing that pink and red are equally beautiful will be unlikely to develop the same preferences.

This story illustrates the relationship between the 3 levels of racism. It also highlights the fact that institutionalized racism is the most fundamental of the 3 levels and must be addressed for important change to occur. Finally, it provides the insight that once institutionalized racism is addressed, the other levels of racism may cure themselves over time. Perhaps the most important question raised by this story is: Who is the gardener? After all, the gardener is the one with the power to decide, the power to act, and the control over the resources.

In the United States, the gardener is our government. As the story illustrates, there is particular danger when this gardener is not concerned with equity. The current Initiative to Eliminate Racial and Ethnic Disparities in Health by the Year 2010 is to be lauded as the first explicit commitment by the government to achieve equity in health outcomes.

Many other questions arise from this simple story. What is the role of public health researchers in vigorously exploring the basis of pink-red disparities, including the differences in the soil and the structural factors and acts of omission that maintain those differences? How can we get the gardener to own the whole garden and not be satisfied when only the red flowers thrive? If the gardener will not invest in the whole garden, how can the pink flowers recruit or grow their own gardener?

The reader is invited to share this story with family members, neighbors, colleagues, and communities. The questions we raise and the discussions we generate may be the start of a much-needed national conversation on racism.

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Concurrent Session A

Cancer Pain: A Deeper Look into the Experience across the Continuum of Care

Moderator: Deb Doherty, PT, PhD, CEAS
Michigan Physical Therapy Association

Pain from cancer treatment can affect survivors throughout the treatment continuum. This session considered cancer pain during treatment by exploring the concept of earlier palliative care referrals, and chronic pain in survivorship by looking at the role of cancer rehabilitation in addressing pain and the importance of pain management in end-of-life care.
Acute Pain in the Midst of Cancer Therapy

Presenter: Sandy Van Brouwer, MSN, ACNP, PNP, Nurse Practitioner Specialist, Pediatric Pain and Palliative Medicine, Helen DeVos Children’s Hospital, Grand Rapids, MI (email: sandra.vanbrouwer@helendevoschildrens.org)

About the presenter: Sandra Van Brouwer is a nurse practitioner specialist with Helen DeVos Children’s Hospital in Grand Rapids, MI. Her specialty is childhood palliative care medicine. She has more than eight years of diverse experiences, especially as a nurse practitioner, and graduated from the University of Illinois at Chicago with honors in 2010.

References cited in this presentation:
• Friedrichsdorf S. 8th Annual Pediatric Pain Master Class. Minneapolis, MN: Children’s Institute for Pain and Palliative Care, Department of Pain Medicine, Palliative Care and Integrative Medicine; June 20-26, 2015.

View this presentation
(Clicking this link will open an Adobe Acrobat PDF copy of the slides from this session.)
Treating Chronic Pain in Cancer Survivors: Diagnose and Rehabilitate

Presenter: Sean Smith, MD, Director, Cancer Rehabilitation Program, Department of Physical Medicine and Rehabilitation, University of Michigan, Ann Arbor, MI (email: srsz@med.umich.edu)

About the presenter: Dr. Smith is the director of the Cancer Rehabilitation Program in the University of Michigan Department of Physical Medicine and Rehabilitation. He has an outpatient practice comprised entirely of seeing oncology patients and also manages oncology and other medically complex patients admitted to the hospital.

He has served on multiple national committees focusing on cancer rehabilitation, including at the National Institutes of Health, and is involved with leadership activities within groups associated with the American Congress of Rehabilitation Medicine and American Academy of Physical Medicine and Rehabilitation.

Dr. Smith evaluates the quality of residency and fellowship programs on the Special Review Committee at the University of Michigan, and helped design a Global Health and Disparities Education Certificate Program for residents hospital-wide. He is a recipient of the Golden Crutch award, given to the educator-of-the-year as voted by the Physical Medicine and Rehabilitation residents, and has mentored several residents at the University of Michigan and elsewhere on research projects and career development. He was recently accepted to the Association of Academic Physiatrist’s Program for Academic Leadership (PAL) Program.

Among his current projects is the development of a multi-center academic consortium for cancer rehabilitation.

References cited in this presentation:


Treating Chronic Pain in Cancer Survivors: Diagnose and Rehabilitate

Sean Smith MD
Assistant Professor, Michigan Medicine
Medical Director, Cancer Rehabilitation

View this presentation
(Clicking this link will open an Adobe Acrobat PDF copy of the slides from this session.)
Pain Management as End of Life Nears

Presenter: Angela M. Chmielewski, MD, HMDC, Hospice and Palliative Care, Beaumont Hospital-Royal Oak, Royal Oak, MI (email: angela.chmielewski@beaumont.edu)

About the presenter: Dr. Angela (Angie) M. Chmielewski is a palliative care specialist at Beaumont Hospital-Royal Oak, where she leads an interdisciplinary Palliative Care team that has earned Advanced Certification for Palliative Care through The Joint Commission since 2014.

Dr. Chmielewski graduated from Wayne State University School of Medicine in 2006 and completed fellowship training in hospice and palliative medicine at Rush University in Chicago, IL. She has been recognized by her peers as a Top Doc in Hospice and Palliative Care in Hour Detroit magazine for four consecutive years (2015-2018).

References cited in this presentation:


- Essential Practices in Hospice and Palliative Medicine, Unit 3: Pain Assessment and Management. Glenview, IL: American Academy of Hospice and Palliative Medicine; 2017


Pain Management-As End of Life
Nears
Michigan Cancer Consortium-
Annual Meeting

November 7th, 2018

Angela Chmielewski, MD HMDC
Chief, Palliative Care Clinical Services-Beaumont Health
Angela.chmielewski@Beaumont.edu

Beaumont

View this presentation
(Clicking this link will open an Adobe Acrobat PDF copy of the slides from this session.)
According to the Centers for Disease Control and Prevention, more than 30,000 people in the United States are affected by HPV-associated cancers each year. While the HPV vaccine provides safe, effective and lasting protection against HPV infections that most commonly cause cancer, vaccination rates for children in Michigan have been slow to climb.

This breakout session shed light on ways to improve HPV vaccine uptake through policies and systems change at provider offices. It also examined current Michigan HPV vaccination rates and related data and helped provide a better understanding of why the HPV vaccine is so important for cancer prevention.
## Top 10 Tips for HPV Vaccination Success

**Attain and Maintain High HPV Vaccination Rates**

<table>
<thead>
<tr>
<th>1</th>
<th>Appreciate the significance of achieving high HPV vaccination rates.</th>
<th>By boosting HPV vaccination rates among your patients, you will be preventing cancer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Acknowledge the importance your recommendation has when it comes to parents choosing to get their children vaccinated.</td>
<td>Clinician recommendation is the number one reason parents decide to vaccinate. This is especially important for HPV vaccination.</td>
</tr>
<tr>
<td>3</td>
<td>Use an effective approach by bundling your vaccine recommendation.</td>
<td>Recommend the HPV vaccine the same day and the same way you recommend all other vaccines. For example, “Now that Danny is 11, he is due for vaccinations to help protect against meningitis, HPV cancers, and whooping cough. We’ll give those shots during today’s visit. Do you have any questions about these vaccines?”</td>
</tr>
<tr>
<td>4</td>
<td>Motivate your team and encourage their immunization conversations with parents.</td>
<td>Starting with your front office, ensure each team member is aware of HPV vaccine’s importance and is educated on proper vaccination practices and recommendations, ready to answer parents’ questions, and/or regularly remind and recall parents. Be sure staff regularly check immunization records, place calls to remind families about getting vaccines, and let you know if parents have additional questions.</td>
</tr>
<tr>
<td>5</td>
<td>Implement systems to ensure you never miss an opportunity to vaccinate.</td>
<td>Establish a policy to vaccinate at every visit. Create a system to check immunization status ahead of all visits. Before seeing the patient, staff should indicate if the patient is due for immunization, with special consideration to HPV vaccination. Use standing orders.</td>
</tr>
<tr>
<td>6</td>
<td>Use your local health department’s resources.</td>
<td>Use the resources of the local health department to achieve your goals of protecting your patients.</td>
</tr>
<tr>
<td>7</td>
<td>Know your rates of vaccination and refusal.</td>
<td>Deputize your staff to assist you with knowing your actual vaccination rates and learning more about why some patients are behind on their vaccines. They can also help you facilitate solutions on how to bring these patients in and get or keep immunization rates up.</td>
</tr>
<tr>
<td>8</td>
<td>Maintain strong doctor-patient relationships to help with challenging immunization conversations.</td>
<td>It is extremely gratifying when parents who initially questioned immunization agree to get their child vaccinated on time. It’s always nice to hear: “Okay, that makes sense and I trust you!”</td>
</tr>
<tr>
<td>9</td>
<td>Learn how to answer some of parents’ most common questions about HPV vaccine.</td>
<td>Be prepared to answer parents’ questions succinctly, accurately, and empathetically by using terms that they understand. A parent will often accept your explanations if presented with their children’s best interests in mind.</td>
</tr>
<tr>
<td>10</td>
<td>Use personal examples of how you choose to vaccinate children in your family.</td>
<td>Providing personal examples shows you believe in the importance of immunizations, especially HPV vaccine. These examples—combined with an effective recommendation—can help parents better understand the benefits of HPV vaccination for cancer prevention.</td>
</tr>
</tbody>
</table>

Get the go-to-guide for health care professionals and systems to increase HPV vaccination rates. The experts of the National HPV Vaccination Roundtable have assembled the most effective interventions and promising strategies into short, easy to implement guides. Each guide has tips and strategies that will impact your immunization rates.

Each Clinician and System Action Guide has role-specific actions along with:

- best practice actions, interventions and promising strategies
- interactive links including links for Continuing Education
- rationale for prioritizing HPV vaccination
- detailed appendix of resources
- facts about HPV cancers and vaccination

**DOWNLOAD the FREE National HPV Roundtable’s Clinician and System Action Guides Today!**

» hpvroundtable.org/action-guides
By using these guides to improve HPV vaccination, your practice or health system can lower costs associated with treatment, reduce future suffering, and ultimately help save patients’ lives.

"We hope clinicians and health systems across the county can use this information to raise HPV vaccination rates. The guides represent our best current knowledge to help promote the prevention of HPV cancers. There is so much potential in sharing this knowledge," said Margot Savoy, MD, chair of the National HPV Vaccination Roundtable Provider Training Task Group.

Let us know what your system is doing to increase HPV vaccination rates through our “We’re In” Story Collector at hpvroundtable.org/were-in.

Questions about the guides? Reach us at hpv.vaccination.roundtable@cancer.org.
CANCER PREVENTION  
THROUGH HPV VACCINATION

AN ACTION GUIDE FOR PHYSICIANS, PHYSICIAN ASSISTANTS, AND NURSE PRACTITIONERS

You have the power to reduce the incidence of human papillomavirus (HPV) cancers and pre-cancers among patients in your care. HPV cancer prevention starts with you.

Make it your goal for every patient you care for to be vaccinated against HPV before the age of 13. Every member of a practice plays a critical role in advocating for HPV vaccination as cancer prevention and should work together as a team.

TAKE THESE ACTIONS TO INCREASE HPV VACCINATION WITHIN YOUR PRACTICE TODAY.

Make a presumptive recommendation
Your recommendation is the #1 reason parents choose to vaccinate their children.

Answer parents’ questions
Let parents know the vaccine is safe, effective and prevents cancers.

Minimize missed opportunities
Use every opportunity to vaccinate and keep patients up-to-date. Use EHR prompts to help.

Take the team approach
Empower every member of the team to be a HPV vaccination champion. Provide in-service training. Discuss vaccination status at huddles. Practice messaging “HPV vaccination is cancer prevention.”

Evaluate and sustain success
Implement quality improvement strategies to drive up HPV vaccination rates to be on par with your Tdap and MenACWY rates.

DOWNLOAD the full Action Guide at hpvroundtable.org/action-guides.

To review the entire guide and citations, visit hpvroundtable.org/wp-content/uploads/2018/04/PROVIDERS-Action-Guide WEB.pdf
Screening won’t protect your patients from most HPV cancers. 

Protect your preteen patients today with HPV vaccine.

Cervical Cancer
Just the tip of the iceberg.

Even with screening, in the United States 12,000 women are diagnosed with cervical cancer each year.


Cervical Precancers
While cervical precancers are routinely screened for, these precancers may require invasive testing and treatment.


Other HPV Cancers
Cases Every Year

~216,000 High Grade Cervical Lesions

~468,700 Low Grade Cervical Precancers

Recommended cancer screening tests are not available yet for these cancers. These cancers may not be detected until they cause health problems.

Over 90% of HPV cancers are preventable through HPV vaccination.

OVER 90%

Don’t rely on screening to catch it later. Protect them now with HPV vaccination.

https://www.cdc.gov/hpv/hcp/more-than-screening/index.html
Michigan HPV Immunization Data Update

Presenter: Stephanie Sanchez, AFIX Quality Improvement Coordinator, Division of Immunization, Michigan Department of Health and Human Services, Lansing, MI (email: sanchezs@michigan.gov)

About the presenter: Stephanie Sanchez has worked at the Michigan Department of Health & Human Services, Division of Immunization for 25+ years. She currently coordinates the statewide Immunization Quality Improvement program, referred to as AFIX (Assessment, Feedback, Incentives, and eXchange).

Sanchez is an active member of several national-level immunization workgroups, including many with an HPV focus. She is a recognized subject matter expert in immunization quality improvement strategies, with a passion for HPV.

Sanchez continuously collaborates with several Michigan immunization partners, with the primary goal of increasing immunization coverage levels through timely vaccination of people in Michigan.

She has a degree in social work from Michigan State University.

References cited in this presentation:


Michigan HPV Immunization Data Update

November 2018

Stephanie Sanchez
Immunization Quality Improvement Coordinator
Bureau of Child & Family Services, Division of Immunization
Email: SanchezS@Michigan.gov

View this presentation
(Clicking this link will open an Adobe Acrobat PDF copy of the slides from this session.)
You are the Key to HPV Cancer Prevention

**Presenter:** Marcus DeGraw, MD, St. John Hospital and Medical Center, Detroit, MI (email: marcus.degraw@ascension.org)

About the presenter: Marcus DeGraw, MD is medical director of the Child Protection Team and medical director of Outpatient Pediatric Subspecialty Services at St. John Hospital and Medical Center in Detroit. A board-certified pediatrician and a board-certified child abuse pediatrician, he practices in both private and academic settings, as well as both outpatient and inpatient settings.

Dr. DeGraw earned his medical degree from Wayne State University in Detroit. He completed a residency in pediatrics at William Beaumont Hospital in Royal Oak, MI, followed by a fellowship in child abuse pediatrics/emergency medicine at Cincinnati Children’s Hospital in Cincinnati, OH.

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References cited in this presentation:


Cancer Prevention in the Dental Office

Presenter: Cristiane H. Squarize, DDS, MS, PhD, Associate Professor (with tenure), Department of Periodontics and Oral Medicine, School of Dentistry, University of Michigan, Ann Arbor, MI (email: csquariz@umich.edu)

About the presenter: Dr. Squarize is a DDS and a clinician-scientist. She currently serves as an associate professor with tenure at the University of Michigan, a member of the Michigan Medicine Rogel Cancer Center, and the Brazilian division leader for the UM School of Dentistry Global Initiative. In addition, she is the head and principal investigator of the UM School of Dentistry’s Squarize Lab, which investigates the function of the key signaling pathways and stem cells in epithelial regeneration and disease.

Prior to joining the UM School of Dentistry in 2010, she spent five years at the National Institute of Dental and Craniofacial Research in a fellowship studying oral and pharyngeal cancer.

Dr. Squarize earned both a master’s degree and a PhD in oral pathology from the University of Sao Paulo, Brazil. She is the recipient of the prestigious Edward Hatton Award from the International Association for Dental Research’s Brazilian division for her head and neck cancer research.

References cited in this presentation:


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• Cincinnati Children’s Hospital Medical Center. Research and Discoveries. Preventing Infection: An Update on the HPV Vaccine. [https://blog.cincinnatichildrens.org/research-and-discoveries/hpv-vaccine-update/](https://blog.cincinnatichildrens.org/research-and-discoveries/hpv-vaccine-update/)
Cancer Prevention in the Dental Office

Cristiane Squarize DDS, MS, PhD
Associate Professor
UM School of Dentistry
csquariz@umich.edu

View this presentation
(Clicking this link will open an Adobe Acrobat PDF copy of the slides from this session.)
The Gynecologic Consequences of HPV Infection or Why We Should Encourage Vaccination

Presenter: Carolyn M. Johnston, MD, FGCPS, Gynecological Oncology, Rogel Cancer Center, Michigan Medicine, Ann Arbor, MI (email: johnstob@umich.edu)

About the presenter: Carolyn M. Johnston, MD, FGCPS, is recognized as an excellent surgeon and clinician and an outstanding teacher. She is the principal investigator for Gynecologic Oncology Group (GOG) clinical research trials available at the University of Michigan.

Dr. Johnston has served as a board member and officer of the Michigan Cancer Consortium (2005-2017) and a board member of the American Cancer Society, American Cancer Society, North Central Region.

She is actively involved in training physicians in Ghana and is the recipient of the Society of Gynecologic Oncology Humanitarianism and Volunteerism Award, which is awarded to individuals who have displayed exemplary volunteer and outreach efforts in women’s cancer care in local, national or international settings. She also is actively involved with clinical education of fellows.

Dr. Johnston received her MD degree from Yale University. She completed an obstetrics and gynecology internship and an obstetrics and gynecology residency and also served as the obstetrics and gynecology chief resident at the University of Chicago Hospitals and Clinics. She completed a gynecologic oncology fellowship at Mount Sinai Hospital in New York.

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THE GYNECOLOGIC CONSEQUENCES OF HPV INFECTION
or
WHY WE SHOULD ENCOURAGE VACCINATION

Carolyn Johnston, MD, FGCP
Michigan Medicine
November 2018

View this presentation
(Clicking this link will open an Adobe Acrobat PDF copy of the slides from this session.)
Using Virtual Care to Address Health Disparities among Cancer Patients

Moderator: Maria George, MPH
Michigan Department of Health and Human Services

Virtual care, also known as telemedicine, is described as the use of technology to overcome barriers that prevent patients from receiving optimal health care. Virtual care is becoming an increasingly popular tool in the care of oncology patients throughout their cancer treatment.

This session explored Michigan’s rules and regulations related to virtual care, including how Medicaid and insurance companies reimburse for these services. Content included a discussion of ways in which health systems are implementing virtual care programs, including clinic-to-clinic and clinic-to-home programs, which provide pre- and post-treatment access for hard-to-reach cancer patient populations.
Telemedicine and Telehealth in Context

Presenter: Becky Sanders, MBA, Director of Operations, Indiana Rural Health Association, and Program Director, Upper Midwest Telehealth Resource Center, Terre Haute, IN (email: bsanders@indianarha.org)

About the presenter: As director of operations for the Indiana Rural Health Association (IRHA), Becky Sanders works with healthcare providers throughout the state of Indiana. She maintains close ties with the Indiana Office of Community and Rural Affairs and other state agencies to foster public/private partnerships on behalf of the IRHA.

Sanders also serves at the program director for the Upper Midwest Telehealth Resource Center (UMTRC), a federally funded program of the IRHA. In this role, she works with our UMTRC consortium partners to provide a single point of contact for telehealth resources throughout Indiana, Illinois, Ohio, and Michigan.

The UMTRC provides educational and outreach presentations, as well as individualized technical assistance, facilitation, and connections to resources via its website and project staff.

Prior to her current positions, Sanders served IRHA as director of the Indiana Telehealth Network, where she administered the creation and construction of the Indiana Telehealth Network.

Sanders has been with the IRHA since 2008, during which time she completed a Lean Healthcare Black Belt Certification from Purdue Healthcare Advisors. She serves on the Advisory Committee for the National Rural Health Resource Center’s Technical Assistance and Services Center.

References cited in this presentation:

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• National Consortium of Telehealth Resource Centers. www.telehealthresourcecenter.org/

• U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. Medicare Learning Network resources:

• Center for Connected Health Policy resources:

**Michigan Cancer Consortium Annual Meeting**

**(November 7, 2018)**

Becky Sanders, Program Director

Upper Midwest Telehealth Resource Center

[View this presentation](#) (Clicking this link will open an Adobe Acrobat PDF copy of the slides from this session.)
Virtual Care Offerings for Oncology

**Presenter:** Marie Lee, M Ed, PMP, Coordinator, Virtual Care Program, Henry Ford Health System, Detroit, MI (email: mlee4@hfhs.org)

About the presenter: Marie Lee is a program coordinator for the Virtual Care Program at Henry Ford Health System (HFHS), deploying telehealth programs throughout the health system. She started her career with HFHS more than a decade ago as the training coordinator for the Contact Center, the centralized appointment scheduling hub for more than 600 of the system’s providers.

Lee was part of the project team to roll out the system electronic medical record (Epic), which had a project scope of three years and $300 million. She joined the Virtual Care team in 2017, enabling her to utilize her project management, training, and telecommunications background to effectively implement new programs.

Lee is a part-time faculty lecturer at Eastern Michigan University in the College of Technology. She has a bachelor’s in communications technology from Eastern Michigan University and a master's of education in instructional technology from Wayne State University. She earned her Project Management Professional (PMP) certification in 2015.

References cited in this presentation:

Advanced Technology in Caring for Cancer Patients Remotely

Presenter: Geralyn Roobol, LMSW, RN, BS, CMAC, Director, Cancer Services, Spectrum Health Cancer Program, Grand Rapids, MI (email: gerri.roobol@spectrumhealth.org)

About the presenter: Geralyn Roobol is the director of cancer services at Spectrum Health Cancer Program, employed at Lemmen-Holton Cancer Pavilion (LHCP) since 2008. Roobol has developed and implemented disease-site nurse navigator services in outpatient cancer programs, including lung, breast, melanoma, and autologous bone marrow transplantation (ABMT). She is responsible for the planning, development and daily operations of multiple clinics and oversees the psycho-social and integrative therapies at LHCP. She has extensive background in program development.

References cited in this presentation:


Advanced Technology in Caring for Cancer Patients Remotely

Geralyn Roobol, LMSW, RN, CMAC
Director Cancer Services, Spectrum Health Cancer Center

Michigan Cancer Consortium Annual Meeting
November 7, 2018

View this presentation
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Awards Presentations
Michigan Cancer Consortium

Champion Award

The MCC Champion Award honors an individual who has demonstrated leadership, excellence, success, and impact in the fight against cancer. This individual has, through his/her proven efforts, reduced the burden of cancer, championed initiatives to prevent and control cancer, and improved the lives of those living with cancer.

The MCC Champion is someone who is looked up to as a leader in cancer prevention and control. An MCC champion displays exemplary leadership and mentorship and extraordinary dedication. An MCC champion is a tireless advocate who has made significant contributions in cancer prevention and control.

To be honored, a nominee must:

• be on the staff of, or formally affiliated with, a current MCC member organization;
• be experienced in cancer prevention and control;
• have demonstrated success and impact in the fight against cancer; and
• have made measurable and significant contributions.

This is the third year for presentation of the MCC Champion Award.

2018 Champion Award Winner:
Carolyn M. Johnston, MD, FGCPS

Congratulations to Carolyn M. Johnston, MD, FGCPS, the recipient of the 2018 Michigan Cancer Consortium Champion Award.

Dr. Johnston graduated from the Yale University School of Medicine and completed an obstetrics and gynecology residency at the University of Chicago Hospitals & Clinics and a fellowship at Mount Sinai Hospital in New York City.

She joined the faculty of the University of Michigan in 1990 and now provides gynecologic oncology clinical care at both the University of Michigan and St. Joseph Mercy Hospitals.

Board certified in gynecologic oncology and obstetrics and gynecology, Dr. Johnston is the principal investigator for Gynecologic Oncology Group (GOG) clinical research trials available at the University of Michigan. GOG is a non-profit organization funded by the National Cancer Institute with the purpose of supporting research for the prevention and treatment of all gynecologic cancers.

Dr. Johnston has received a number of awards and honors in recognition of her long-time work teaching and mentoring residents, fellows and medical students in Michigan, as well as in Ghana and Ethiopia.
In 2013, U-M Medical School residents awarded Dr. Johnston the Silver Speculum Teaching Award, presented to the faculty member who best exemplifies in deed and thought, and possesses the attributes of, the enlightened obstetrician gynecologist. She received the Society of Gynecologic Oncology’s Humanitarianism and Volunteerism Award in 2015, presented by the Society to recognize exemplary local, national or international volunteer and outreach efforts in women’s cancer care, research or training. In 2016, the Ghana College of Physicians and Surgeons awarded her an Honorary Fellowship in recognition of her work in that nation.

Dr. Johnston has numerous certifications and licensures in surgical obstetric and gynecologic and medicine. She is highly regarded by her patients, as evidenced by the positive comments they leave on healthgrades.com and other online review sites.

Consider, for instance, this comment from February 2018: “I trust this woman with my life!!! If you have to have an oncologist, she is THE one. She gives the most pain-free, comfortable exams you could imagine and is straight to the point. She tells you what you need to hear but also explains why you need to hear it. I cannot ever put in to words what a wonderful doctor she is. She genuinely cares about her patients and I feel very fortunate to have her as my oncologist.”

Dr. Johnston has been active with the Michigan Cancer Consortium for more than a decade and a half. She was a Board member for 12 years, serving as Board co-chair for three of those years. She also has been chair of the MCC Cervical Cancer Early Detection Workgroup for 16 years, and has served on a number of other workgroups and committees. Throughout those years, she also has been a truly valued expert clinical resource for both the state health department’s Cancer Prevention and Control Section and the Michigan Breast and Cervical Cancer Control Navigation Program.

Dr. Johnston’s contributions to research, teaching, mentorship, and leadership have had—and will continue to have—a positive ripple effect on improving the lives of women today and over the next several generations.

Dr. Carolyn M. Johnston is a true leader and advocate, and it is an honor for the Michigan Cancer Consortium to present her with the 2018 Michigan Cancer Consortium Champion Award.
National Comprehensive Cancer Control Program

Carol Friedman Award

The Carol Friedman Comprehensive Cancer Control Award was established in 2011 and is presented each year by the Centers for Disease Control and Prevention (CDC) Comprehensive Cancer Control Branch to a true champion and leader in cancer control.

Dr. Carol Friedman was a dedicated physician who first joined CDC in 1991. Over the subsequent years, she rose to a captain in the U.S. Public Health Service, and led numerous disaster response teams as a highly decorated officer.

Dr. Friedman joined CDC’s Cancer Division in 2003. She first served in the Cancer Surveillance Branch, and then as the first branch chief for the newly created Comprehensive Cancer Control Branch. Her efforts in these positions helped CDC’s National Program of Cancer Registries and National Comprehensive Cancer Control Program become important and critical forces for cancer control in the United States.

Dr. Friedman was loved and admired by many, as she touched many hearts in her public health career. She always put the populations served by CDC first, especially those who were marginalized or were in greater need of assistance. In her honor, the Comprehensive Cancer Control Branch awards its highest recognition in her name.

In keeping with priorities of the National Comprehensive Cancer Control Program and Dr. Friedman’s public health and medical service, the 2018 award recognized excellence in addressing cancer disparities. Cancer disparities were defined as adverse differences in a given population in pathways to a cancer diagnosis, screening rates, burden (incidence, morbidity and mortality), survivorship, and quality of life after diagnosis. Populations who experience disparities could be characterized by race, ethnicity, disability, gender and sexual identity, geographic location, income, education, and other characteristics.

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2018 Carol Friedman Award Winner:

Hiam Hamade, BSN, MA, MPH, PTA

Congratulations to Hiam Hamade, BSN, MA, MPH, PTA, recipient of the 2018 Carol Friedman Comprehensive Cancer Control Award for Excellence in Addressing Cancer Disparities.

Hiam is supervisor of the Chronic Disease Prevention Programs for the Arab Community Center for Economic and Social Services (ACCESS) and is a member of the Michigan Cancer Consortium Health Equity Committee. As an established, long-time community leader and a cancer survivor herself, she has made it her personal and professional mission to improve cancer screening among the men and women in Michigan’s Arab American community.
She builds bridges between programs and community members by meeting with men and women at community centers, in their homes, and at mosques, churches, schools, and stores to educate them about cancer screening. In addition, she trains community health educators to work with Arab community members, as well as with Asian American refugees to increase cancer screening.

To ensure her work is addressing the ongoing needs, she also conducts regular surveys with community members to assess their cancer knowledge and screening barriers and uses what she learns to plan focused interventions.

A cancer survivor herself, Hiam Hamade takes great care to provide substantial peer support to others diagnosed with cancer. She has established culturally appropriate support groups that allow for privacy among members, she frequently provides transportation and other instrumental needs, and she always visits cancer patients with a bouquet of flowers following their surgery, often being the first person to see them after surgery.

While she’s only one individual, Hiam consistently performs the tasks of many, including acting as a clinician, scientist, community health worker, educator, peer supporter, and friend to all, especially to those with the greatest need.

The Michigan Cancer Consortium is pleased to add its congratulations to Hiam Hamade, recipient of the 2018 Carol Friedman Comprehensive Cancer Control Award for Excellence in Addressing Cancer Disparities and a living embodiment of the true spirit of this award.
Michigan Cancer Consortium

Inspiration Award

Courageous. Determined. Resolute. Faithful. These are the faces of cancer survivors. The Consortium presents its annual MCC Inspiration Award to a cancer survivor who exemplifies these words and has lifted up others in the face of his or her own diagnosis.

To be nominated, an individual must be a Michigan resident, a cancer survivor, and an advocate for cancer survivors in the community and/or in a healthcare institution, as demonstrated by one or more of the following:

- Significant participation in community cancer events, education to cancer survivors, and/or education to medical practitioners about cancer survivorship through written or verbal activities;
- Commitment to reducing the burden of cancer in Michigan through cancer control and prevention;
- Facilitation of, or active participation in, cancer support groups;
- Demonstration of outstanding leadership and empowerment of cancer survivors and advocates; and/or
- Support of state and/or federal public policy efforts.

This is the third year for presentation of the MCC Inspiration Award for survivors.

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2018 Inspiration Award Winner:

Erika Lojko

Congratulations to Erika J. Lojko, the recipient of the 2018 MCC Inspiration Award for cancer survivors.

Erika’s personal cancer journey began in 2015, after discovering a lump in her breast while in the shower. At the time, she was still grieving the loss of her husband in a motorcycle accident the year before.

Upon the death of her husband, Erika had instantly become a single mother and was now caring for her four-year-old son Caleb while also working full time as a public health educator for the Macomb County Health Department. After she found the lump, Erika quickly reacted, reaching out to her doctor and beginning a round of testing that soon led to a diagnosis of stage 3 triple-negative breast cancer. She was 35 years old.

What followed was many months of intensive treatment and surgery that included 12 biopsies, multiple surgeries, intravenous and oral chemotherapies, and radiation therapy. Erika experienced a host of side effects from her treatments. Along with her appetite, cancer took away Erika’s confidence, her hair, her endurance, and her ability to bounce back after a virus or common cold. Despite this, she
endured the treatments and made it to all her appointments—and she continued working full-time, paying her bills, picking her son up from daycare, and keeping her house in order. Her comprehensive team of physicians and specialists from Henry Ford Health System was there for her each step of the way.

In spite of the intensity of her personal journey, Erika’s spirit persevered. She constantly gave herself pep talks, telling herself, “Pull it together,” and “You’ve got this!” The one thing that kept her focused and fighting through it all was her son.

“I’m still here for a big reason—to raise my son and to be a good mom,” she has explained. “I’m all he’s got.”

Today, Erika is a fierce advocate for cancer prevention and cancer survivorship, and she has evolved into an advocate for patients. She has worked with her healthcare team at Henry Ford Health System, readily providing feedback regarding programs and services for breast cancer patients. She persistently has urged members of the health and medical community to consider the long-term effects of cancer treatments when engaging with survivors.

Erika is an active member of the Colorectal Cancer Awareness Network (CRAN) of Southeastern Michigan, a multidisciplinary coalition dedicated to promoting and increasing awareness of colorectal cancer through public education. She chairs the CRAN Screening Initiatives Subcommittee, working to find new and innovative ways to build screening partnerships. In fact, she is a primary member of the team that introduced the Southeast Michigan FluFIT Screening Initiative, which won a 2017 MCC Spirit of Collaboration honorable mention award.

Erika actively seeks opportunities to educate the community about cancer prevention, treatment and survivorship issues, and she frequently is invited to speak at regional events. In the fall of 2017, she was the survivor speaker at the American Cancer Society’s Making Strides Against Breast Cancer event in Macomb County, delivering a message of hope to all survivors in the county. Her motto? “I’m still here to help others. Use me. Use my story.”

Erika knows that “survive” is a verb, an action. She knows the importance of getting through each day, of waking up and living, one day at a time.

“If you want your life back, you need to be a warrior.”

Erika Lojko lives that mantra. She exemplifies the true spirit of inspiration, courage, hope, and advocacy, and the Consortium is proud to recognize her with its 2018 Michigan Cancer Consortium Inspiration Award.
Michigan Cancer Consortium

Spirit of Collaboration Awards

Collaboration is defined as the action of working together with others to produce or create something or accomplish a goal. On the organizational level, collaboration can occur internally between staff members within an organization, or it can occur externally between two or more organizations.

From the beginning, collaboration has formed the essence of the Michigan Cancer Consortium, which focuses on what can be accomplished by organizations working together to accomplish comprehensive cancer control goals for Michigan.

Since 2001, the MCC Spirit of Collaboration Award has exemplified the spirit of the Consortium by recognizing outstanding collaborative projects that have significantly moved comprehensive cancer control activities forward in our state.

To be considered, a project must focus on one or more MCC cancer plan goals and also address one or more MCC cancer plan pillars.

2018 Spirit of Collaboration Awards Winner:

Karmanos Cancer Institute Michigan Cancer HealthLink for Equity in Cancer Care Initiative—Cancer Action Councils

MCC goal addressed:  
**Quality of life** (Optimize the quality of life for every person affected by cancer)

MCC pillar addressed:  
**Promote health equity**

How this collaboration addressed it:  
Cancer Action Councils are groups made up of community members and representatives from community-based organizations who apply their knowledge about local cancer issues to improving the lives of cancer patients, survivors, and caregivers within their communities. The council members represent the various ethnic and social groups living in their neighborhoods.

Collaborating partners:  
• Barbara Ann Karmanos Cancer Institute/Wayne State University  
• Detroit HealthLink Voices of Detroit Initiative/Conner Creek  
• Western Wayne Family Health Center/Inkster  
• Cancer Action Council  
Robert Johnson, Maria Jones, Gaylotta Murray, Ekanem Obong, Jean Overman, Gennifer Williams

Staff: Hayley Thompson, PhD, Voncile Brown Miller, Carie Francis, Knoll Larkin

Project description/outcomes:
The Karmanos Cancer Institute (KCI) Michigan Cancer HealthLink for Equity in Cancer Care Initiative is a region-wide coalition that addresses cancer-related needs in the Metropolitan Detroit area. Several cancer action councils (including Western Wayne, Conner Creek, KCI, ACCESS (Arab Community Center for Economic and Social Services), and LGBT Detroit) have been developed to empower cancer patients, caregivers, survivors and community members to address cancer issues in their communities through increased engagement in cancer research.

Cancer Action Councils are groups made up of community members and representatives from community-based organizations who apply their knowledge about local cancer issues to improve the lives of cancer patients, survivors, and caregivers within their communities. The council members represent the various ethnic and social groups living in their neighborhoods.

The project aims for KCI Michigan Cancer HealthLink for Equity in Cancer Care are:

• increase capacity among community stakeholders;

• build trusting and collaborative relationships between community stakeholders and cancer researchers; and

• identify cancer-specific, patient-centered outcome research priorities, based upon the Cancer Action Councils input.

In order to recruit members, nominations were solicited through Karmanos Cancer Institutes’ partnering community-based organizations; self-nominations also were accepted. A Detroit HealthLink website was created (www.DetroitHealthLink.org) to provide an online presence through which interested individuals could apply.

Individuals were formally invited to become a CAC member based upon their expressed interest in advancing cancer research, demonstration of prior community participation or activism, understanding of the role of a CAC member, and willingness/ability to attend CAC meetings over the course of 18 months.

Two types of CAC members were established: core and associate. Core members were expected to be fully involved in all meetings and activities over an 18-month period and were eligible for a $1,000 stipend. Associate members were expected to play a role in setting cancer care and research priorities in their communities, but were not necessarily able to attend all activities and meetings. Associate members also could be employees of nonprofit agencies with goals aligned with HealthLink goals, such as the American Cancer Society.

The CACs participated in a process of evidence prioritization in which they identified and prioritized research topics. This process began with the identification of critical needs along the cancer care continuum that they observed in their communities, and was consistent with the steps in the Tufts Clinical and Translational Service Institutes Engaging Stakeholders in Comparative Effectiveness Research program, specifically, the identification
of the mission, vision and objectives for research. This step was followed by the identification and prioritization of research topics and research questions.

A key strategy in this process was concept mapping. Steps in concept mapping included: 1) starting with a main topic or idea in the center of the map; 2) adding an idea that connects to the main topic; 3) taking these ideas to branch off even more; and 4) using one branch of inquiry on the map to help form a question. CAC members worked in small groups to collaboratively generate concept maps.

The program started with three CAC locations: Karmanos Cancer Institute; Conner Creek (hosted by Voices of Detroit Initiative); and Inkster (hosted by Western Wayne Family Health Centers). The KCI CAC identified seven research domains, Conner Creek CAC identified 10 research domains, and Inkster CAC identified 11 research domains. Each CAC then selected four research domains that had been identified as the leading priorities for their group, after which each CAC developed specific patient-centered outcome research questions relative to the leading priorities.

The efforts of Detroit HealthLink are housed within KCI’s newly established Office of Cancer Health Equity & Community Engagement. Detroit HealthLink for Equity in Cancer Care is now a part of Michigan Cancer HealthLink, which covers KCI’s 46-county service area in the state of Michigan. New CAC members are currently being recruited for the next phase.

Funded by: Patient-Centered Outcomes Research Institute Engagement Award, Contract #s 2971 and 6252, Detroit Medical Center (DMC) Foundation

For more information, contact: Knoll Larkin, Barbara Ann Karmanos Cancer Institute/Wayne State University (ph: 313-576-9691; email: larkink@karmanos.org)

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2018 Spirit of Collaboration Honorable Mention:
The Colorectal Cancer Awareness Network of Southeastern Michigan

**MCC goal addressed:**
**Early detection** (Promote early detection of cancer using modalities that have been shown to reduce mortality)

**MCC pillar addressed:**
**Implement policy, systems, and environmental changes**

**How this collaboration addressed it:**
Through cross-collaboration, the Colorectal Cancer Awareness Network (CRAN) encourages policy and systems change by encouraging the implementation of evidence-based strategies shown to improve cancer screening rates; assisting the dissemination of up-to-date information on colorectal cancer and screening mechanisms; and identifying methods to increase survivor engagement.

**Collaborating partners:**
- Henry Ford Health System
- Beaumont Health System
- Ascension
Project description/outcomes:
CRAN is a community-based coalition of individuals and representatives of health system organizations, universities, community agencies, and survivors who share a common mission to raise awareness to—and prevention of—colorectal cancer. The long-range goal of CRAN is to raise awareness through education and increase colorectal screening rates, therefore preventing colorectal cancer.

Initially formed to raise awareness about the need for colorectal cancer screenings in Macomb County, this group has expanded to include: the American Cancer Society; four hospital systems (Henry Ford Health System, Ascension, Beaumont Health System, and Michigan Medicine); four universities (Wayne State University, Oakland University, University of Detroit Mercy, and University of Michigan); three county-level health departments (Macomb County Health Department, Oakland County Health Department, and Wayne County Health Department); federally qualified health centers; and other community agencies, such as the Detroit Area Agency on Aging and the Breast and Cervical Cancer Control Program.

Past coalition activities include educational forums; annual colon health awareness events; and the development and coordination of regional screening initiatives, such as the FluFIT program, which entails a partnership between health departments and health systems for the provision, processing and tracking of fecal immunochemical test (FIT) kits to improve access to screening services for those who may not otherwise receive colorectal cancer screenings. (The FluFit program received a 2017 MCC Spirit of Collaboration Honorable Mention.)

Current projects include expanding the FluFIT program to include faith-based initiatives and corporate/employee wellness partnerships, and the consideration of new innovations to combine FIT screening with the provision of other health services, such as Hepatitis A vaccinations. CRAN has also established a small steering committee of sub-committee leads to further guide initiatives that will lead to increased survivor engagement and educational outreach.

Also serving as an advocacy or action coalition, CRAN has worked alongside the American Cancer Society’s Cancer Action Network (ACS CAN) to advocate for oral chemotherapy parity, increased funding for the Michigan Tobacco Quitline, and other tobacco prevention initiatives. CRAN also feverishly advocates for the closing of the Medicare loophole that permits additional cost sharing for patients when polyps are removed during colonoscopies (Bill H.R. 1017—Removing Barriers to Colorectal Cancer Screening Act of 2017). (Although colonoscopies are provided at no cost-sharing to Medicare patients, the removal of polyps is not a covered benefit,
resulting in undue economic hardship for patients who often face significant barriers to care and prevention services.)

CRAN exemplifies public health in action: Through the collaboration of private, public and non-profit sectors, public health concerns are being addressed in our community. This creative collaboration brings agencies together to promote health and well-being within our community, with an unwavering commitment to work together to achieve a world without cancer.

Key outcomes of this collaboration include: Colorectal Cancer Awareness Month events; a regional FluFIT screening program (2016-current); and a Colorectal Cancer Awareness Month in a Box toolkit for clinical, corporate and community partners.

For more information, contact: Megan Landry, American Cancer Society, Inc., North Central Region (ph: 248-663-3509; email: megan.landry@cancer.org)

2018 Spirit of Collaboration Honorable Mention: HPV Vaccine as Cancer Prevention

MCC goal addressed:
Prevention (Prevent cancer from occurring)

MCC pillar addressed:
Implement policy, systems, and environmental changes

How this collaboration addressed it:
Changes to system education and reminders for the human papillomavirus (HPV) vaccine

Collaborating partners:
• Ascension Michigan
• Michigan Department of Health and Human Services
• American Cancer Society

Project description/outcomes:
The HPV Vaccine as Cancer Prevention is an initiative supported by Ascension Michigan leadership. The initiative is a collaborative effort, led by Vilma Drelichman, MD, and Joanne Shamoun, RPh, with a common goal of raising HPV vaccination rates throughout Ascension Michigan. Ascension Michigan serves individuals in multiple counties, but the focus was on Oakland, Macomb and Wayne counties.

The HPV working committee originated in the summer of 2017, following an educational meeting with Melinda Wharton, MD, MPH, director of Immunization Services Division at the Centers for Disease Control and Prevention. Following the 2017 meeting with Dr. Wharton, Dr. Drelichman and Ms. Shamoun, along with Megan Landry from the American Cancer Society and Stephanie Sanchez from the Michigan Department of Health and Human Services (MDHHS) Immunization Division, received support from Ascension Michigan’s leadership to form a working committee and to take this on as a system-wide priority.

The initiative is being carried out by the HPV working committee of Ascension Michigan, which includes family medicine, internal medicine, and infectious disease physicians, pediatricians, and hospital staff from the departments of Quality,
Marketing and Oncology. Megan Landry, health systems manager, American Cancer Society, and Stephanie Sanchez, AFIX quality improvement coordinator, MDHHS Immunization Division, are also active members of the committee. The HPV working committee members were identified as HPV vaccination champions within Ascension Michigan, and all accepted the invitation to participate.

This committee was tasked with creating and rolling out a strategic plan to help increase HPV vaccination rates across the system, with the end goal of reducing HPV cancers. To begin the process, the committee members studied the current data trends related to HPV vaccinations and vaccination rates. In June of 2017, the HPV series completion for 13-year-olds at Ascension Michigan was 24.62 percent.

Two main goals were developed by the committee:
1. To educate all staff at physician offices on how to make a strong recommendation for the HPV vaccine to patients and parents. Members of the committee volunteered to lead the effort in providing the education.
2. To increase community outreach efforts to inform community members and parents about the importance of preventing HPV-related cancers through timely HPV vaccination.

Since the June 2017 initiation of the HPV working committee, there has been a 6-percent increase in the completion of the HPV vaccination rate for 13-year-olds within the Ascension Michigan Health System, with the current June 2018 rate being 30.72 percent.

For more information, contact: Megan Landry, American Cancer Society, Inc., North Central Region (ph: 248-663-3509; email: megan.landry@cancer.org)

2018 Spirit of Collaboration Honorable Mention:
Michigan HPV Cancer Summit: The Road to Prevention

MCC goal addressed:
Prevention (Prevent cancer from occurring)

MCC pillar addressed:
Implement policy, systems, and environmental changes

How this collaboration addressed it:
We know that a provider recommendation is the number one reason for vaccinations. The summit focused on helping providers to make that recommendation and to create office policies that support the vaccine.

Collaborating partners:
• American Cancer Society
• Michigan Department of Health and Human Services, Division of Immunization
• Michigan Medicine Rogel Cancer Center
• Barbara Ann Karmanos Cancer Institute
• Michigan Association of Physicians of Indian Heritage
Project description/outcomes:
Human papillomavirus (HPV) is a recognized cause of cancer. Although most HPV infections are asymptomatic and clear spontaneously, persistent infections can progress to precancer or cancer. HPV causes most cervical cancers, as well as some cancers of the vagina, vulva, penis, anus, and oropharynx (cancers of the back of the throat, including the base of the tongue and tonsils).

Cancer registries do not routinely collect information about HPV status, so in this report, HPV-associated cancers are defined as those that occur in parts of the body where HPV is often found. In the United States, 31,500 men and women get HPV-related cancers each year. The HPV vaccine has a 97-percent effectiveness at preventing infection, yet the series completion rate of Michiganders getting the vaccine is below 50 percent. To change this, the collaborating partners planned and developed a summit to increase rates.

Learning objectives included:
- current Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices HPV vaccine recommendations;
- HPV coverage rates for Michigan and the United States;
- HPV cancer occurrence for Michigan and the United States;
- reasons to vaccinate 11- and 12-year-olds with HPV vaccine;
- communication approaches for making a strong HPV vaccine recommendation; and
- evidence-based preventive strategies to reduce HPV cancers.

Aimed primarily at providers, the summit featured presentations from national, state and local HPV vaccination champions. These included:
- Dr. Melinda Wharton, director, CDC Immunization Services Division;
- Dr. Basel Khatib, Dearborn pediatrician;
- Dr. Shelly Seward, gynecologic oncologist, Barbara Ann Karmanos Cancer Institute;
- Dr. Marcus DeGraw, St. John Hospital and Medical Center;
- Dr. Melissa Gilkey, assistant professor, University of North Carolina;
- Bob Swanson, director of immunization, Michigan Department of Health and Human Services; and
- a cervical cancer survivor.

Eighty-one people attended the summit, including doctors, nurses, social workers, health plan staff, researchers, and others. While it is too early to determine empirical results (i.e., whether and how much HPV vaccination rates improved), the interest generated by the presenters was overwhelming. Attendees heard first-hand the methods physicians in the state of Michigan used to raise their HPV vaccination completion rates; that it could be done in their practices demonstrated that like results could be achieved elsewhere. The feedback from the attendees was excellent. The participant evaluations showed quite favorable impressions and interest in future summits.

For more information, contact: Tom Rich, American Cancer Society, Inc., North Central Region (ph: 517-664-1422; email: thomas.rich@cancer.org)
Acknowledgements
2018 MCC Poster Abstract
Peer Review Board

The Michigan Cancer Consortium leadership and staff would like to express their sincere appreciation to the following comprehensive cancer control professionals who volunteered to serve as peer reviewers and gave unselfishly of their time and expertise to make this edition of our annual publication a reality. Thank you.

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Consultant
2018 MCC Annual Meeting
Program Committee

The Michigan Cancer Consortium leadership and staff would like to express their sincere appreciation to the following comprehensive cancer control professionals who volunteered their time and shared their expertise as members of the 2018 Annual Meeting Program Committee. Together, they helped develop the programming and the speakers for the 2018 gathering. The success of this meeting would not have been possible without their contributions. Thank you.

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2018 MCC Financial Contributors

Thank you to the following organizations for their financial contributions during 2018, which helped support the annual and business meetings of the Michigan Cancer Consortium. Their investments in the Consortium and its work allowed us to keep a modest registration fee, support needed scholarships, and offer program support throughout the year.

ACCESS Community Health & Research Center
www.accesscommunity.org/

American Cancer Society, Inc., North Central Region
www.cancer.org/

Barbara Ann Karmanos Cancer Institute
www.karmanos.org/

Beaumont Health System
http://cancer.beaumont.edu/

Blue Cross Blue Shield of Michigan
www.bcbsm.org/

District Health Department #10
www.dhd10.org/

Henry Ford Health System
www.henryfordhealth.org

Inter-Tribal Council of Michigan, Inc.
www.itcmi.org

Mercy Health Saint Mary’s
www.mercyhealth.com/

Michigan Department of Health and Human Services
www.michigan.gov/cancer

Michigan Medicine Rogel Cancer Center
www.mcancer.org/

Michigan Osteopathic Association
www.mi-osteopathic.org/

Michigan Public Health Institute
www.mphi.org/

Michigan Society of Hematology and Oncology
www.msho.org

Sparrow Health System Herbert-Herman Cancer Center
www.sparrow.org/cancer/

Spectrum Health Cancer Program
www.spectrumhealth.org/cancer

West Michigan Cancer Center
www.wmcc.org/

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