Symposium Report

Pacific Island Jurisdiction
Comprehensive Cancer Control
Policy and Practice Summit

Waikiki Beach Marriott Resort & Spa, Honolulu, HI

September 14, 2009

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Executive Summary

The purpose of the Pacific Island Jurisdiction (PIJ) Comprehensive Cancer Control (CCC) Policy and Practice Summit, held September 2009 in Honolulu, Hawaii, was to: (1) engage in a dialogue with leaders from PIJ CCC Coalitions on identified priority CCC areas and potential policy approaches to address those areas; (2) share and discuss PIJ CCC program and coalition experiences, successful strategies, challenges encountered, and new approaches on how to affect policy change within the CCC priority issues; (3) assist PIJ Coalition leaders to identify the policy approaches that they can consider for their own CCC efforts; (4) identify a set of policy-related actions for CCC National Partners to support and assist PIJ CCC Coalitions to build their capacity affecting policy change; (5) identify a set of policy-related actions for CCC National Partners to address at a national level that support PIJ CCC Coalitions in their priority policy-related efforts; and (6) provide information and materials that PIJ CCC Coalitions can use in their CCC plan implementation efforts.

Following the welcome, opening blessing, and overviews of the Summit and the CCC National Partnership, Dr. Stevenson J. Kuartei, Palau Minister of Health, provided the keynote address. His address focused on five management areas that must be addressed to move forward the agenda of cancer care in the Pacific region, including: (1) managing and reorienting the model of cancer care and other chronic illnesses, (2) managing health versus disease, (3) managing health disparities, (4) managing "data cemeteries", and (5) managing partnerships and regionalism. To address the first management area, an environmental model of chronic disease care should supersede the current biomedical model that treats people as patients and disregards their humanness. Using the environmental model would include the important physical, natural, social, emotional, behavioral, spiritual, and sacredness spheres that surround each individual. To address the second management area, protection of health and treatment of chronic disease must coexist, and the environmental model helps address this balance. In terms of the third management area, there must be a balance between intentions and expectations so that the individual and the community own the power of real health choices. Surveillance data, addressed under the fourth management area, must be used to move from individual to system performance. To address the fifth management area, partnerships must be managed for long-term, sustainable gains in health through "prenuptial" agreements so that the benefits and consequences of remaining as partners or separating are known and can be considered. Ultimately, an integrated environmental model allows for the protection of health.

Discussion Area I: Reduce Cancer-Related Behavioral Risk Factors. Participants identified a number of possible policy areas to reduce cancer-related behavioral risk factors related to tobacco, nutrition, and physical activity:

- Encourage community enforcement and ownership of policies.
- Examine how government agencies are held accountable for enforcing tobacco policies.
- Focus on tobacco prevention that targets children.
- Investigate the costs of importing tobacco versus the cost of prevention.
- Link organizational policies to the environment/church.
- Lead by example.
- Include tobacco cessation messages in sporting league events.
- Examine mechanisms for limiting the influence of the tobacco industry.
- Engage the church and other communities in changing nutrition practices.
- Encourage "healthy start" breastfeeding campaigns.
- Remove junk food from vending machines in schools.
- Offer subsidies to offset the costs of healthy food items.
- Implement food guidelines at government agency meetings.
- Partner with grocery stores to promote healthy and affordable items and products.

- Implement a "wellness center" model.
- Implement restrictions on food stamps similar to the Special Supplemental Nutrition Program for Women, Infants, and Children Program (commonly known as the WIC Program).
- Encourage the government to issue a healthy community challenge.
- Utilize cultural activities to promote physical activity.
- Create a commission (possible via executive order) to create/enhance/examine policies regarding physical activity.
- Engage/implement "cultural norms" in risk reduction strategies.
- Make exercise convenient.
- Create a spiritual health department within jurisdictional departments of health.
- Encourage government employees to "get moving" during time off.
- Increase flexibility of funds to allow jurisdictions to better allocate funding to priorities.

Discussion Area II: Increase the Availability and Quality of Cancer Screening and Treatment Services. Participants identified a number of possible policy areas to increase the availability and quality of cancer screening and treatment services:

- Eliminate caps for Medicaid.
- Define the economic costs of providing cancer screening and treatment by jurisdiction/region (systems or individual screening and treatment).
- Increase insurance company coverage caps for cancer care services for later stage cancers.
- Increase the number of participants enrolled in insurance plans.

Discussion Area III: Increase the Available Cancer Workforce. Participants identified a number of possible policy areas to increase the available cancer workforce:

- Implement minimum standards/credentials for all health agency workers.
- Approach legislators and advocate for education training.
- Sustain existing education and training initiatives.
- Share ideas/materials/curricula for cancer-related education programs.

The ideas from each discussion area were consolidated into a final list so that the participants could vote for the top five items overall that they thought were important to improve PIJ access to cancer care. The straw poll was intended to provide guidance to the National Partners, not a definitive priority-setting process. The National Partners may act on any of the ideas once they determine how to best use their areas of expertise to advance the ideas identified during the Summit. The items identified as promising areas in which to begin, in order from most votes to least, were to increase the flexibility of funds to allow jurisdictions to better allocate funding to priorities, implement minimum standards/credentials for all health agency workers, eliminate caps for Medicaid, encourage community enforcement and ownership of policies, and engage the church and other communities in changing nutrition practices.

Summit Proceedings

The purpose of the Pacific Island Jurisdiction (PIJ) Comprehensive Cancer Control (CCC) Policy and Practice Summit, held September 2009 in Honolulu, Hawaii, was to: (1) engage in a dialogue with leaders from PIJ CCC Coalitions on identified priority CCC areas and potential policy approaches to address those areas; (2) share and discuss PIJ CCC program and coalition experiences, successful strategies, challenges encountered, and new approaches on how to affect policy change within the CCC priority issues; (3) assist PIJ Coalition leaders to identify the policy approaches that they can consider for their own CCC efforts; (4) identify a set of policy-related actions for CCC National Partners to support and assist PIJ CCC Coalitions to build their capacity affecting policy change; (5) identify a set of policy-related actions for CCC National Partners to address at a national level that support PIJ CCC Coalitions in their priority policy-related efforts; and (6) provide information and materials that PIJ CCC Coalitions can use in their CCC plan implementation efforts.

Welcome

Mr. Gary Gurian, C-Change Program Director, welcomed participants to the Summit and thanked them for their attendance.

Opening Blessing

Mr. Anthony Laʻakapu-a-Kawailani Lenchanko, a master exponent of oli (Hawaiian chant), provided the opening blessing, which included four chants. The first chant describes the original settlement of the Hawaiian islands and brings to mind commonality, particularly the sea. The sea offers Pacific Islanders, and the rest of the world, discovery based on a foundation of research, methodology, practices, and the opportunity to grow. The second chant honors the Kamehameha Dynasty and symbolizes unity for the summit. The third chant portrays the new beginnings of a new day and symbolizes the welcoming of new friends and old friends not seen for some time. The fourth chant is a prayer to the ancestors, who support all current endeavors. Mr. Lenchanko welcomed the participants to Hawaii, and each PIJ representative received a gift of a kukui nut necklace, which represent enlightenment. Mr. Lenchanko performed a final chant, which expressed his wish for a enthusiastic return home for the Summit participants.

Overview of Summit

Mr. Gurian thanked the Summit planning committee, which was comprised of members of the PIJ community and the CCC National Partnership. He also thanked the organizations and National Partners for providing their support. The Summit participants include PIJ coalition chairs, program directors, and/or their designees; representatives from PIJ stakeholder organizations; and CCC National Partners. The planned discussions will benefit from the broad experience of the varied participants. Mr. Gurian noted that the Summit will focus on three discussion areas that were identified by the jurisdictions, and he asked participants to be candid during these discussions. Workshops designed for CCC programs and a Marketplace of Ideas will be part of the 3-day Summit. This marketplace will feature tools that will help jurisdiction-level efforts to advance CCC. The ultimate goal is to identify three or four distinct CCC action areas that can be addressed by Coalitions or at the regional and/or national levels.

Overview of the CCC National Partnership

Ms. Madeline La Porta of the National Cancer Institute (NCI) explained that CCC is a collaborative process through which a community works together to pool resources to reduce the cancer burden, resulting in reduced cancer risk, earlier detection, better treatment of cancer, and increased quality of life. The CCC National Partnership is an unprecedented collaboration of 13 leading cancer organizations that

works to empower states, tribes, and territories, such as the PIJs, to build capacity for cancer control and provide direction and guidance as these entities move forward with their cancer control efforts. The collaboration creates networks and forums to discuss relevant issues. The National Partnership sponsors a number of CCC activities: initiatives, such as CCC leadership institutes, which are designed to examine specific issues; technical/planning assistance team visits, which provide targeted assistance to entities that experience unique challenges in their CCC efforts; policy summits, such as this effort; and budgeting and resources workshops for CCC Coalitions. Two Web-based tools have been developed, CancerPlan.org and Cancer Control P.L.A.N.E.T. (http://cancercontrolplanet.cancer.gov). The tools provide robust methods to connect with national colleagues. The National Partners combine their common strengths and contribute unique resources and abilities to provide technical assistance, training, resources, advocacy, expertise, and leadership, which have enabled states, tribes, and territories to develop and implement CCC plans. The dramatic increase in the number of states, tribes, and territories with CCC plans is an impressive display of what collaboration can accomplish.

National Partnership efforts tailored to PIJs include CCC Leadership Institutes (CCCLIs) that focus on issues specific to territories and jurisdictions. Each of the three prior CCCLIs brought together 10 PIJs to discuss partnerships, data collection and evaluation, best practices, the process of planning through implementation, and standardization of training. The National Partners are advised by a PIJ Advisory Workgroup that provides input to the CCCLIs and efforts to advance PIJ CCC.

The National Partnership is strong and will continue its successful efforts and support the success of CCC Coalitions by fostering the implementation of CCC plans at the local level, identifying and supporting policy initiatives, building capacity, facilitating real-time communication with CCC Coalitions, developing a Phase IV CCCLI, and documenting CCC outcomes to evaluate efforts. The whole truly is greater than the sum of its parts, and the National Partnership will continue its efforts to leverage resources, coordinate expertise, provide guidance, and utilize its strengths to change the trajectory of the cancer burden in the United States.

Keynote Speaker: Minister Stevenson J. Kuartei, M.D.

Dr. Stevenson J. Kuartei, Palau Minister of Health, thanked the National Partners for the opportunity to address the Summit participants and speak as a clinician who also struggles with policy issues. He also thanked the National Partners for advocating for those with cancer in the Pacific region. For every timely diagnosis of cancer in the region, many more go undiagnosed or are diagnosed too late. Some of the diagnosed individuals cannot receive treatment because of government agreements. Efforts must continue for a positive landscape of cancer care in the Pacific region; it cannot be a job—it must be a calling.

Dr. Kuartei identified management areas that should be discussed at the Summit to ultimately move forward the agenda of cancer care in the region. The first management area is managing and reorienting the model of cancer care and other chronic illnesses. It sometimes is taken for granted that the biomedical model must be accepted; in this model, the person is seen as a patient and not as a person with a medical condition; the humanness of the individual is disregarded. A psycho-social model must be added to the biomedical model; an environmental model would be even more advantageous. Adopted and modified by the World Health Organization, the definition of the total environment includes the physical, natural, social, emotional, behavioral, spiritual, and sacredness environments, all of which envelope each individual. The model of cancer care must address these environments when dealing with people with cancer. A complete environmental assessment must be completed for each unique individual that allows insight into the environmental spheres surrounding him or her; this will present an opportunity for mitigation of the disease and alignment of the spheres, creating harmony.

The second management area is managing health versus disease. Often treatment efforts occur at the expense of preventive efforts. For example, increasingly more resources are spent on tobacco-related can-

cers than on primary prevention of tobacco use in children. There is a persistent attitude that more competent personnel are needed in hospitals but not in the public health arena; such thinking must change. Protection of health and treatment of chronic disease must coexist; the environmental model helps address this balance. The third management area is management of health disparities. Eliminating health disparities is a noble goal of the health system, but noble intentions do not define the problem—economics do. There is a disparity between intentions and expectations, and there must be a balance between the two so that the individual and the community own the power of real health choices. The fourth management area involves managing "data cemeteries". A problem in the region is that many healthcare workers believe that individual performance is preferable to system performance. Although good workers may be present, if there are no medications, laboratory reagents, or medical supplies, then the system cannot perform. Using surveillance data is the only way to move from individual to system performance. The fifth management area is managing partnerships and regionalism. Partnerships must be managed for long-term, sustainable gains in health through "prenuptial" agreements so that the benefits and consequences of remaining as partners or separating are known. This Summit allows for partnerships to be managed and cancer reduced in the next generation. Another goal is to manage applied strategic regionalism via regional mandates. Dr. Kuartei closed by stating that an integrated model allows for the protection of health, and those at the Summit should celebrate the opportunity to achieve through common purpose.

Introductions to Policy Discussions

Mr. Tom Kean, C-Change Executive Director, thanked the PIJ coalition members for their touching gestures of friendship at the Cultural Night Reception the previous evening. He reminded attendees that although there are many languages and cultures represented among them, everyone has the same common enemy: cancer. The diversity of the group is its strength, and change starts with each individual. Policy involves some level of leadership and authority; policy will set the stage, but it is up to everyone to make change happen. As Dr. Kuartei alluded to, the system must be a balance between treatment and prevention. People tend to be rescue-oriented, but this mindset must be altered. Policy occurs at the legislative level, and implementation includes creation of legislation. Organizations write legislative and regulatory policies, but internal organizational policies also can be powerful tools. Skills are needed to persuade and educate policymakers, who need to knew the facts of disease and economics to create beneficial policies.

Policy implementation also has challenges; skills, resources, and enforcement mechanisms must be identified and considered. The vehicle(s) for implementing and enforcing policies must be ascertained. Without this knowledge, a decrease in cancer incidence will not be achieved. Common threads can help PIJs, tribes, and states in implementing CCC policies. During the Summit, attendees will develop a list of possible actions; after the list is developed, each of the participants should consider each of the items in terms of what they can do as an individual, with their coalition, and in their region. The National Partners want to identify areas in which they can help that will be most useful for the PIJs in terms of policies to reduce cancer-related behavioral risk factors, increase the availability and quality of cancer screening and treatment services, and increase the available cancer workforce.

Policy Discussion Area I

Policies to reduce cancer-related behavioral risk factors, such as tobacco use, poor nutrition, and lack of physical activity.

Mr. Kean described the potential solutions for tobacco, nutrition, and physical activity that were identified in the pre-Summit survey and were provided to the attendees (Appendix XX) and asked for ideas and current challenges in this area.

Ms. Doris Crisostomo, Office of the Governor of Guam, stated that the governor of Guam signed an executive order to ban tobacco use in all government offices, but enforcement has been the primary chal-

lenge. Dr. Maxine Hayes, Association of State and Territorial Health Officials (ASTHO), noted that it was good that the first issue mentioned involves government; many policies can start within the government itself. In terms of enforcement, those in government cabinets can be held accountable and lead by example to motivate others, especially as the largest PIJ employer is government. It also is helpful to recognize that policy is action. Examples of actions that can encourage enforcement are to offer smokeless insurance benefits and provide tobacco cessation resources to employees. Dr. John Taitano, Guam CCC Coalition, added that departmental directors need to lead by example to promote a healthy workforce. Actions such as educating children early about the dangers of tobacco and drug use and offering the human papilloma virus vaccine to males in addition to females should be implemented; targeting youth will improve the health of future generations. Additionally, it is against the law to provide tobacco and alcohol to children and second-hand smoke is just as or more detrimental to children's health; therefore, smoking near children also should be outlawed.

A participant noted that policy is method to affect behavior; environmental connections, such as those mentioned in the keynote address, are more motivational than government policies. Policies should be linked to church and traditional leaders; the environment organically includes community involvement.

Ms. Amy Howard-Sasser, Republic of Marshall Islands National CCC Program Office, shared an example of tobacco cessation being included in sports leagues to educate youth about the dangers of tobacco. Young athletes must sign contracts that they will provide a good example to the community and refrain from drinking and smoking in public, particularly at sports venues. Feedback indicates that the program has been effective in reducing alcohol use by, drunk and disorderly incidences of, and cigarette sales to youth. Mr. Kean noted similar bans on smoking by parents and other adults during children's sporting events.

Mr. Clarence (Bud) White, Commonwealth Cancer Association of the Commonwealth of the Northern Mariana Islands (CNMI), emphasizes the importance of physical activity to his employees; each day he asks each employee how much physical exercise they participated in the previous day. He leads by example and ensures that he is able to report that he also participated in physical activity. This motivates his employees to increase their physical activity.

Dr. Victor Tofaeono, Lyndon Baines Johnson Tropical Medical Center, explained that his center implemented focus groups and screening programs for prostate cancer. During these events, the tobacco group is invited to share their information. Implementing this type of information sharing among all of the programs will broaden the message. Tobacco control legislation was passed the previous year in American Samoa but not signed by the governor; this year, the governor supports the program, and the new legislation is expected to be passed into law. Representative Taotasi Archie Soliai, American Samoa House of Representatives, thanked the National Partners for lobbying to help draft the legislation. In terms of enforcement, since the community began speaking of banning smoking in public places, the legislature as been inundated with support from the general public; the community should be given ownership for enforcement, outreach, and education. There has been discussion about increasing tobacco taxes, but without earmarking the revenue for specific healthcare programs, it will be a wasted resource. Some of the revenue should be used for education and cessation programs.

Senator Bob Skilling, Kosrae State Legislature, shared his experience with cessation programs. It is difficult to pass legislature completely banning tobacco; small steps must be taken, such as targeting single tobacco sales first. Dr. Dileep Bal, District Health Officer for the State of Hawaii, noted that the issue of enforcement is key. He cautioned that, in terms of making gradual changes, the tobacco industry buys innocence and interferes with the genesis of policy. He noted an example of an executive order that was issued that protects public workers better than the general public. Targeting only single cigarette sales will produce minimal change. The private sector must change for change to occur. Mr. Kean noted that each

community needs to decide the best strategy for itself, whether it be to start small or large. He agreed that it is necessary to examine what the tobacco industry is doing within the community.

A participant noted that tobacco is not a native product of any of the PIJs, and it would be beneficial to examine the collective cost of importing tobacco and determine what could be accomplished in terms of cancer prevention if this money instead was spent on CCC.

Ms. Jane Elymore, Federated States of Micronesia (FSM) Department of Health and Social Affairs, noted that FSM created a number of tobacco-related laws and regulations, but no reinforcement of positive behaviors was provided. Support was eventually granted for smoking cessation, which has been implemented. Reinforcement is a challenge.

Mr. Kean shifted the discussion to the next area of focus within healthy behaviors, nutrition. Ms. Joanne Ogo, Commonwealth Cancer Association of CNMI, explained that the local bishop banned all food except for water at church functions, and vending machines and junk food were removed from all public schools. The schools also began providing portioned serving sizes. Ms. Crisostomo described a recently implemented program in which her office partnered with grocery stores to identify affordable and nutritious foods that are branded with a specially designed logo. The logo allows shoppers to easily identify healthy, affordable food items. The stores are recording sales of logo items to determine the effectiveness of the program.

Dr. Marie Lanwi-Paul, Government of the Marshall Islands Assistant Secretary of Health, described a wellness center model, funded by a U.S. Department of Defense grant, that focuses on a healthy lifestyle and nutritious foods. As diabetes is common, the goal was to decrease the disease burden by implementing a comprehensive approach to increasing physical activity, improving diet, and so forth. The program has shown that a healthy lifestyle can prevent disease. The grant is finishing, so the current challenge is to continue the comprehensive approach with available resources. The plan is to work with a community college that receives a certain portion of the tobacco tax to leverage resources to support the diabetes wellness center. Mr. Kean noted that healthy lifestyle programs impact cancer and other chronic diseases, and cancer organizations should work with other chronic disease organizations to advance common efforts and leverage resources. Dr. Taitano commented that one challenge to eating healthy is the cost. He wondered if there were efforts to subsidize farmers to produce increased amounts of fruit and vegetables at lower cost.

Representative Soliai explained that constant communication to the public has been effective in decreasing diabetes-related eye disease by 60 percent during the previous 5 years. The incentive for sugar-free foods has decreased the tax base from the sugar tax. It also important to remember that McDonald's Corporation, a source of unhealthy food, is a major contributor to the Coalition. Mr. Kean agreed that balancing the economic and health interests in a community is an important issue.

Mr. Michael Epp, Pacific Island Health Officers Association (PIHOA), noted resource policy must recognize the need for the PIJs to provide policy guidance so that when support is received by the jurisdictions, they can use the resources effectively to meet their specific needs. The ability of a community to respond to the cancer burden is dependent on resource flexibility.

Dr. Tofaeono suggested a policy that includes restrictions on the use of government funds (e.g., providing food at government meetings and functions). Dr. Hayes noted the scientifically proven importance of breastfeeding in increasing an individual's health over the course of his or her life; policies should support breastfeeding. Dr. Kuartei described a program in northern Mississippi that prescribed food instead of money to be redeemed at the social department. Ms. Elymore noted that FSM has a policy regarding nutritious diets that ensures that all governmental departments serve healthy food.

The discussion moved to physical activity. Ms. Angelina Mummert, Guam Department of Public Health and Social Services, explained that Guam created the Healthy Guam Initiative, in which public employees negotiate physical fitness activities for better insurance rates. The success of the program will be determined after the first program year ends on September 30, 2009. Administrative leave is provided for employees to pursue physical fitness activities. Conditions had to be met to enroll in the program, including completion of a lifestyle survey and initial screening. Program participants were screened 6 months later to determine whether any health improvements were seen. A previous program, Get Up and Move, is defunct but appeared to decrease cholesterol levels in participants. Mr. Kean described a somewhat-related example in which a chief executive officer pays his employees for each pound lost and negotiated with the insurance company to support this effort.

Dr. Johnny Hedson, Pohnpei State Department of Health Services, noted that risk reduction programs have been a convenient method to engage nongovernmental organizations and the private sector to work with the government. An important question is how much education and empowerment (faith/cultural) are necessary for communities to take responsibility and ownership of risk reduction programs.

Ms. Crisostomo explained that one effort on Guam is a project with faith-based organizations, village mayors, and the Outrigger Guam Canoe Club to encourage children to explore physical fitness through cultural activities, such as paddling. More than 100 children enrolled; the winners will compete in the Micronesia Cup outrigger canoe race.

Ms. Ogo noted that physical fitness programs in her jurisdiction are threatened by decreasing funding and resources, but attempts to leverage resources are being made. Dr. Lanwi-Paul stated that administrative leave granted to hospital employees to attend aerobics classes was possible because of the understanding and support of policymakers. Ms. Elymore commented that an FSM policy to allow administrative leave for 1 hour of physical activity did not succeed.

Policy Discussion Area II

Policies to increase the availability and quality of cancer screening and treatment services.

Mr. Kean described the potential solutions for screening and treatment that were identified in the pre-Summit survey and provided to the participants (Appendix XX) and noted that a number of them require intervention at the U.S./federal level. Many of the potential solutions are programs; the policies behind the programs must be identified.

Ms. Roselie Zabala, Guam Department of Public Health and Social Services, noted that a significant problem is lack of funding for treatment following screening and diagnosis. The National Partners could advocate for Guam to eliminate certain Medicaid requirements that hinder treatment of cancer; many patients opt to go to the Philippines for treatment, and there is little or no followup available for these individuals. Ms. Elymore explained that FSM has a government insurance program, MiCare, that is mandatory for government employees, but the challenge is to increase nongovernment participation in the program. A participant from FSM added that MiCare coverage is limited to $25,000. The challenge is to increase this level and add coverage for terminal cancer by identifying additional resources. After a patient reaches $25,000 in medical expenses, it is at the hospital's discretion whether to continue care. Mr. Peter Tairuwepiy, Chairman of the Yap Cancer Coalition, explained that the situation in Yap is very different; 100 percent coverage is provided.

Dr. Bal stated that one issue is research being translated to public policy. Using clinical trials as the standard for interventions has caused a decline in this translation. The current approach is "high tech/low touch", but a "high touch/low tech" approach would yield better results. Mr. Kean noted that at the core is a research allocation issue. It necessary to know the cost of cancer treatment in the PIJs collectively and individually to advocate for additional resources. Dr. Kelley Daniel, American Cancer Society Cancer

Action Network, added that knowledge of capacity also is necessary. Dr. Giuseppe Cuboni, Fiji School of Medicine, was interested in knowing average treatment costs by jurisdiction. Mr. Kean agreed that this knowledge would be beneficial, but how much it would cost to obtain this information is unknown. Utilizing the federal government in answering this question would involve increased paperwork and time; the information must be credible, however, so that the Centers for Disease Control and Prevention (CDC), NCI, and U.S. Congress respect the quality of the study and respond. The cost of those not treated also must be calculated and included. Mr. White explained that organizations that deal with patients who are medically referred off-island keep records of cancer diagnosis, treatment and travel costs, and so forth; these organizations may be useful resources. Mr. Epp commented that the Cancer Council of the Pacific Islands also could be a resource. A participant commented that determining the cost of individual treatment may be overwhelming, and a systems approach could be more manageable. How many systems have the screening types to alleviate the burden? Is it acceptable for jurisdictions to make difficult decisions when funds are limited (e.g., choosing between cancer treatment or immunizations)? Mr. Kean noted that the universal issue appears to be resources, and some jurisdictions have issues in their current detection programs. Even systems that have insurance in place have issues with coverage, participation, and so forth. What would the economic burden be if additional patients are treated?

Representative Soliai asked about mandatory screening policies and whether there is a study that examines the cost of mandatory cancer screening. Mr. Kean explained that population demographics can be used to estimate screening costs. Dr. Lee Buenconsejo-Lum, Pacific Regional CCC Program, asked Ms. Charlotte Hewitt, Native American Cancer Research Corporation, about tribal and/or Indian Health Service (IHS) mandates. Ms. Hewitt replied that some cost analysis has been performed, and the costs of treatment processes are known within IHS. Funding levels are established based on known resources. The IHS has strong healthcare initiatives for prevention. For example, IHS has approximately 30 years of tracking data regarding smoke-free offices because the agency decided to become smoke-free in 1980. The IHS works with underfunded cultural communities that must find resources to provide treatment services; communities should be able to access all available resources. Dr. Buenconsejo-Lum added that IHS may be a resource for templates or models the PIJs may wish to implement.

Mr. Epp wondered whether any of the discussed issues were negotiated by the jurisdictions with the CDC and/or federal government. Are there actual opportunities to pursue these items? Dr. Phyllis Rochester, CDC, explained that the Breast and Cervical Cancer Project (BCCP) was tightly written, but the colorectal screening program may have more flexibility. High-level decisionmakers within CDC divisions struggle with this issue, which must be balanced with the stringency of the BCCP legislation. Ms. Sharon Sharpe, CDC, added that newer programs are heading in a slightly different direction, with increased emphasis on systems changes and screening the overall population instead of only specific populations. Mr. Epp noted that agreements are negotiated at multiple levels, and PIHOA is working with the CDC on a strategic management agreement in which the hope is that a consultation process is identified and described. Dr. Bal noted that policy changes occur quicker within the CDC compared to the NCI.

Ms. Hewitt stated that additional opportunities occur during certain presidential administration changes. Healthcare reform issues, such as resource issues, need to be defined and communicated within these opportunities. One policy issue that should be prioritized is mobilization so that PIJ healthcare reform issues are heard, particularly from a legislative perspective. The American Indian/Alaska Native community mobilizes with policy organizations when healthcare issues arise to ensure that their specific issues enter the discussion stream.

Mr. Kean asked whether the jurisdictions were working with any policy groups on healthcare reform issues. Mr. Epp responded that discussions are beginning in this area. It is important for the jurisdictions to have a direct voice on Capitol Hill and develop relationships with their representatives; groups such as ASTHO can assist with this. Mr. Kean suggested asking Hogan & Hartson, a *pro bono* lobbying firm with

which C-Change works, to determine whether any of the current healthcare reform discussions include PIJs and issues that are important to them.

Mr. Amato Elymore, FSM Department of Health and Social Affairs, commented that policies to increase the quality of cancer screening are important. He described breast and cervical cancer standards that have been endorsed by the FSM Secretary of Health; the policy would greatly improve the quality of screening services and covers the entire continuum of care.

Policy Discussion Area III

Policies to increase the available cancer workforce.

Mr. Kean described the potential solutions for workforce and training that were identified in the pre-Summit survey and provided to the participants (Appendix XX). Dr. Greg Dever, PIHOA, stated that PIHOA and the Association of Pacific Island Legislatures met in 2006 and made recommendations regarding training using a local community college as a pilot home for health careers training. PIHOA is working with the college to develop a nursing school and midlevel dental health training. An associative sciences degree program in public health has been created at the College of Micronesia–FSM. A generic curriculum was established and formally recognized and accredited by the Western Association of Schools and Colleges. The program is directed at the current workforce, many of whom do not have formal training, and is expected to expand to other jurisdictions. Discussions have been initiated with the CDC and University of Hawaii to use the program as a formal platform for cancer training to develop the capacity of the regional workforce. The program is examining how to work with regional partners to develop this training, as well as mental health and disaster preparedness training, under the umbrella of the associative sciences degree program. The program already is working with the University of Hawaii to offer college credit for these types of training and with other regional schools of public health, such as the University of Guam, to develop a distance bachelor's degree in public health. Dr. Cuboni added that Dr. Dever had presented broad information on the widespread framework of the program and stated that delivering educational material for the cancer program will be a long and labor-intensive process. There is a great deal of information that will need to be conveyed to Coalitions and staff. Possible faculty for the program include cancer program personnel labeled as adjunct faculty, clinicians diagnosing and treating cancer within the jurisdiction, and/or graduates of the program. Once the cancer training program has been established, it will be easier to convince academic institutions to offer this relevant umbrella course.

Ms. Ogo provided information about a palliative care course conducted in the CNMI. There is community interest, but the program currently is on hold while determination is made whether it is sustainable. It is an important program that benefits the people, and support from the National Partners or other groups in the region to sustain the program would be appreciated.

Dr. Neal Palafox, Pacific Regional CCC Program, noted that there are content issues in developing courses and wider pipeline issues to ensure that an adequate workforce is being trained; training the current workforce is another issue. He asked whether the intent was to develop broad or narrow policies. Ms. LaPorta explained that, in terms of content issues, the NCI is assembling its current cancer education programs to create "NCI University", which will have several tracks, including a public health cancer control planner track. To aid in this effort, the NCI is examining medical and nursing school curricula and guidance from the American Public Health Association Cancer Forum. Dr. Armin Weinberg, Intercultural Cancer Council, noted that the National Association of Social Workers and American Association of Colleges of Nursing have established curricula and could be used as additional resources. He asked whether work was being continued on the initiative on developing core quality measures for end-of-life care. Dr. Rochester explained that CDC and other partners worked with the Lance Armstrong Foundation regarding public health options that encourage survivorship, such as training, education, and outreach. There is not a current initiative to use this as broadly as possible, however.

Mr. Epp commented that a number of people in his jurisdiction have worked for decades on health education and have developed a body of helpful principles, including training programs and data and quality assurance systems. Any developed policies should focus on: (1) external training and education resources that will build around and bypass local educational capacity and (2) education and training that will be delivered in the context of the health system as much as possible. The associative sciences degree is one platform by which to accomplish this. Dr. Dever described another innovative platform that has been developed, the Pacific Association of Clinical Trainers. The group mapped the current health work-force and organized continuing professional development. Palau has taken these activities a step further and developed a "College of Health" to organize continuing professional development and licensing within the Ministry of Health for every employee. Continuing education units are needed for employees to continue to be employed within the system; health administrators now will be licensed and will need to be re-licensed periodically, which requires continuing education. A participant noted that it is time for the administrative side of healthcare to be held to similar credentialing requirements as the clinician side.

Dr. Buenconsejo-Lum stated that each jurisdiction is in the process of strengthening its registries, and a regional registry is in development. The North American Association of Central Cancer Registries (NAACCR) listened to the needs of the jurisdictions to tailor software for training. Ms. Betsy Kohler, NAACCR, added that there will be information about Webinars and other training at the Marketplace of Ideas.

Mr. Kean described that the C-Change Cancer Core Competency Initiative Pain and Palliative Care Grant, a small grants program for palliative care core competencies. The competencies are aimed at nonprimary care health workers and nononcology professionals serving at various places in the community. More information is available at http://www.cancercorecompetency.org. C-Change staff continue to educate members about jurisdictional issues, and some members are interested in exploring whether they possess skill sets that could be made available, electronically or otherwise, that may be useful to jurisdictions. Dr. Weinberg suggested that it might be helpful to engage in as-needed consultations with colleagues via telephone or e-mail. Webinars also may be beneficial.

Dr. Palafox asked whether discussions regarding regional and/or jurisdictional core colleges of health should include the National Partners. Mr. Kean responded that the National Partners want to find methods to share their expertise, but they do not necessarily have funding to offer for such efforts. Some organi-zations may be interested in being included in the discussion if the jurisdictions are specific in what they need.

Dr. Dever noted that there are many regional volunteers who are frustrated at the various levels of technologies among the jurisdictions. Mr. Epp stated that jurisdictions appreciate all volunteer efforts and support, but the jurisdiction must have the absorptive capacity, and the volunteer must fit into priorities of the jurisdiction. Not every resource is appropriate, and jurisdictions must have the capacity to refuse in these situations. Ms. Hewitt agreed that is it important to define a protocol for volunteers. Organizations that can bring medical volunteers into the community should be explored as a method of increasing the workforce. The organizations can develop a policy and procedure manual to determine needs.

Dr. Weinberg commented that there are opportunities to learn the realities of what PIJ colleagues face. Member organizations may have expertise that can assist with PIJ CCC plans. Mr. Kean agreed and stated that there are many opportunities for connection; organizations can be stronger advocates if they under-stand the specific challenges, issues, and needs of the jurisdictions. Ms. Karin Hohman, President of Strategic Health Concepts, stated that many of these and similar issues will be included in the Resources Workshop convening the next day.

Mr. Kean summarized the discussion, which included information and ideas regarding an associative sciences degree in public health, implementing credentialing and continuing education for all healthcare workers, and examining capacities in which available resources and expertise can be incorporated.

Group Discussion: Identifying Priority Actions

Mr. Kean asked participants to consider all of the summarized concepts that had been discussed during the three discussion sessions and vote for the top five items overall that they thought were important to improve PIJ access to cancer care. He noted that this was a straw poll that would provide guidance; it was not a definitive priority-setting process. The National Partners may act on any of the concepts once they determine how to best use their areas of expertise to advance the ideas identified during the Summit, but the poll provides an indication of where to begin.

The results of the voting were as follows:

Discussion Area I: Reduce Cancer-Related Behavioral Risk Factors

Tobacco

- **Encourage community enforcement and ownership of policies—*16 votes*.**
- **Examine how government agencies are held accountable for enforcing tobacco policies—*11 votes*.**
- Focus on tobacco prevention that targets children—*8 votes*.
- Investigate the costs of importing tobacco versus the cost of prevention—*6 votes*.
- Link organizational policies to the environment/church—*2 votes*.
- Lead by example—*2 votes*.
- Include tobacco cessation messages in sporting league events—*1 vote*.
- Examine mechanisms for limiting the influence of the tobacco industry—*0 votes*.

Nutrition

- **Engage the church and other communities in changing nutrition practices—*16 votes*.**
- Encourage "healthy start" breastfeeding campaigns—*8 votes*.
- Remove junk food from vending machines in schools—*3 votes*.
- Offer subsidies to offset the costs of healthy food items—*2 votes*.
- Implement food guidelines at government agency meetings—*2 votes*.
- Partner with grocery stores to promote healthy and affordable items and products—*1 votes*.
- Implement a "wellness center" model—*1 vote*.

- Implement restrictions on food stamps similar to the Special Supplemental Nutrition Program for Women, Infants, and Children Program (commonly known as the WIC Program)—*1 vote*.

- Encourage the government to issue a healthy community challenge—*0 votes*.

Physical Activity

- **Utilize cultural activities to promote physical activity—10 votes.**

- Create (possibly by executive order) a commission to create/enhance/examine policies regarding physical activity—*7 votes*.

- Engage/implement "cultural norms" in risk reduction strategies—*5 votes*.

- Make exercise convenient—*3 votes*.

- Create a spiritual health department within jurisdiction departments of health—*2 votes*.

- Encourage government employees to "get moving" during time off—*0 votes*.

Other

- **Increase flexibility of funds to allow jurisdictions to better allocate funding to priorities—*26 votes*.**

Discussion Area II: Increase the Availability and Quality of Cancer Screening and Treatment Services

Screening/Treatment

- **Eliminate caps for Medicaid—*18 votes*.**

- Define the economic costs of providing cancer screening and treatment by jurisdiction/region (systems or individual screening and treatment)—*7 votes*.

- Increase insurance company coverage caps for cancer care services for later stage cancers—*3 votes*.

- Increase the number of participants enrolled in insurance plans—*1 vote*.

Discussion Area III: Increase the Available Cancer Workforce

Workforce/Training

- **Implement minimum standards/credentials for all health agency workers—*19 votes*.**

- Approach legislators and advocate for education training—*8 votes*.

- Sustain existing education and training initiatives—*6 votes*.

- Share ideas/materials/curricula for cancer-related education programs—*4 votes*.

Wrap Up and Adjourn

Mr. Kean thanked the Summit attendees for their participation in identifying certain areas of interest on which the National Partners can focus. Obviously, any jurisdiction is welcome to use any of the ideas that it finds useful. He asked for confirmation that the items captured what the jurisdictions intended. Mr. Epp clarified that the item to "increase flexibility of funds to allow jurisdictions to better allocate funding to priorities" was more broad and involved how funds are negotiated.

Mr. Kean asked participants to consider the following questions: (1) Are there items on the list I can do better? (2) Are there items on the list that my Coalition can accomplish? (3) Are the items appropriate to regional agencies? (4) Are there items on the list with which the National Partners can assist? The National Partners will examine their capacities to assist with the identified priority areas.

Mr. Gurian thanked Mr. Kean for facilitating the meeting, those who helped with survey information and identifying best practices, and his C-Change colleagues for handling the logistics of the meeting. This is the third in a series of CCC Policy and Practice Summits focusing on states, American Indian/Alaska Natives, and PIJs. The National Partners will review the issues identified during all of the Summits to move forward with CCC plans. Additionally, the Partners will advance policy areas that allow PIJ CCC efforts to evolve. He encouraged participants to attend the post-Summit reception and the Marketplace of Ideas, which was designed to provide examples of CCC program strategies to assist PIJ CCC Coalitions in enhancing their cancer control program efforts.

Appendices