NEBRASKA CANCER PLAN

2017 - 2022

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Executive Summary

Executive Summary

What is Comprehensive Cancer Control?

Comprehensive cancer control is an approach that brings together key organizations and community members to write a plan to reduce the impact of cancer on a community. Comprehensive cancer control coalitions are groups of diverse partners that work together to address cancer in their community. The Centers for Disease Control and Prevention (CDC) funds all fifty state governments to run a Comprehensive Cancer Control (CCC) program. No program is able to implement the plan alone; so the CDC tasks programs with forming and supporting a coalition.

The Nebraska Department of Health and Human Services began receiving funding from the CDC for the CCC program in 2002. During the next eight years the Nebraska CCC program ran the coalition. In 2010, the coalition decided to incorporate and filed paperwork to become a 501 c 3 organization. The nonprofit coalition is now known as Nebraska Cancer Coalition or NC2.

What is a Comprehensive Cancer Control Plan?

A cancer plan uses information unique to each state, such as the cancer type with the highest burden, the health behaviors that lower the risk of cancer, and the health behaviors that increase the risk of cancers. Each program and coalition is required to have a plan, and they are usually updated every five years with the help of a self an assessment tool. The plans are organized around six priority areas chosen by the CDC:

- Encourage people to make healthy choices.
- Educate people about cancer screening tests.
- Increase access to good cancer care and reduce health disparities.
- Make sure people who survive cancer live well.
- Implement policy, systems and environmental changes.
- Demonstrate outcomes through evaluation.

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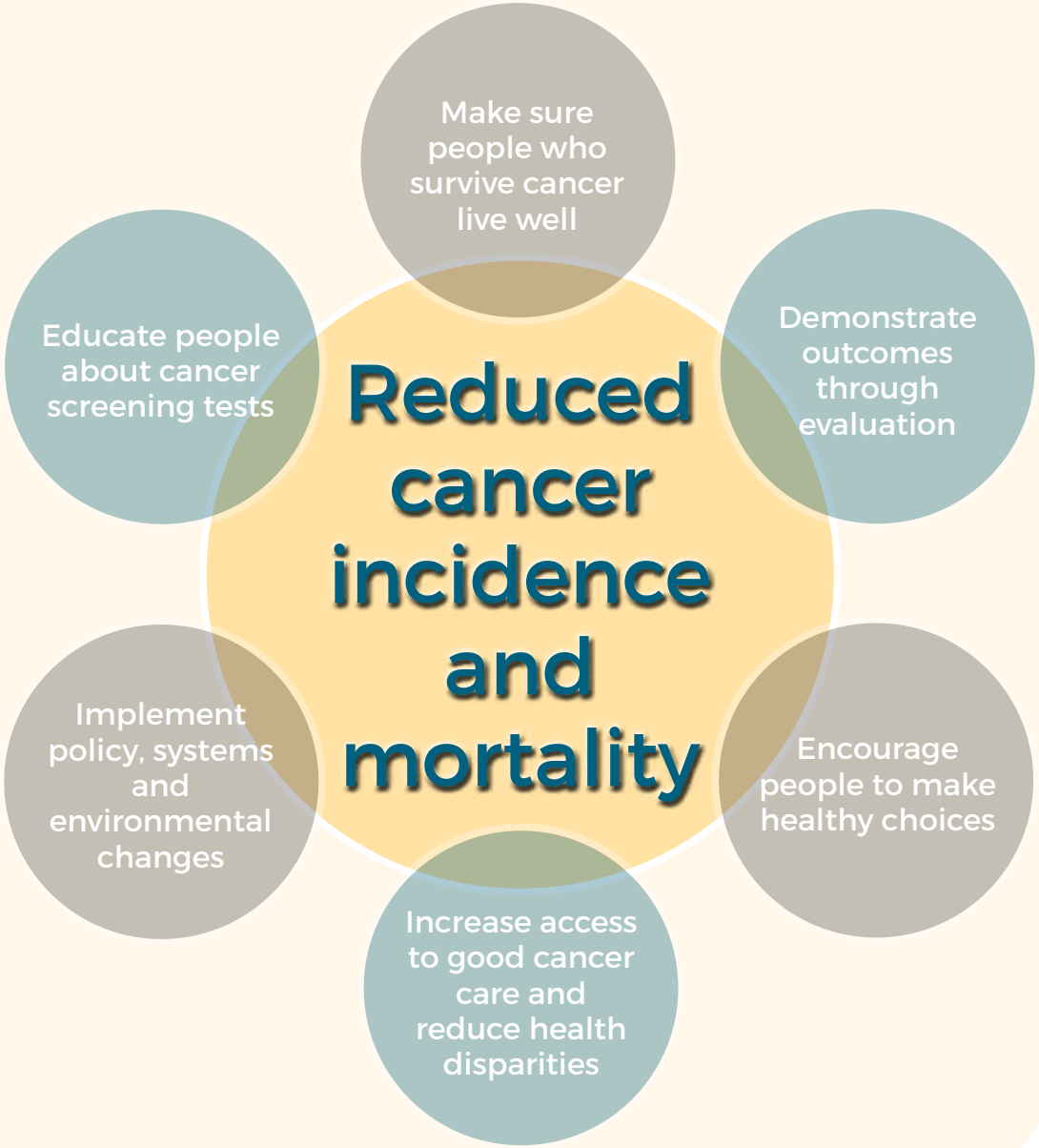
Executive Summary

CDC Cancer Control Priorities



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Self-Assessment

Results of the Self-Assessment Tool

The results of the Nebraska Cancer Plan self-assessment showed several things that the last plan did well and some things the next plan could include to be more robust.

What Nebraska's Last Cancer Plan Did Well:

The goals and objectives were clearly laid out. They covered a multi-year period, and they described a state-wide effort. They also addressed each of the six priority areas and addressed each part of the continuum of care. The goals and objectives showed a relationship to other statewide strategic plans. Nebraska's objectives were specific, measurable, attainable, results-oriented and time-phased (S.M.A.R.T.), and focused on multiple levels of action. In other words, the previous plan made the logical case for cancer control in Nebraska.

The previous cancer plan did a good job of presenting all the data available on the current burden of Cancer in Nebraska, as well as risk factors, demographic information, and the disease burden of diverse populations.

Improve On:

While the plan did present good data, the group of volunteers revising the plan found the volume of information to be burdensome and observed that this information was widely available elsewhere. The data-heaviness prevented stakeholders from using the plan when writing grants or planning activities. The core leadership team for the 2017-2022 Nebraska Cancer Plan decided to include in the data section only information not available elsewhere and to link to other reports so all the information necessary is available, but not regurgitated in the cancer plan document. Using hyperlinks to appropriate web pages and limiting physical copies of the plan also means the plan will remain up-to-date with minimal effort.

This assessment revealed the need to improve the process of updating the State plan. The last updating process was very informal, and feedback was gathered over a series of small group and individual conversations. The plan did not assign responsibility for implementing strategies, describe the process for prioritizing, or include a resource plan. The 2017-2022 plan includes detailed objective tables that clearly assign responsibilities, describes the process for prioritizing the annual work plans, and the necessary resources.

Additionally, while the last State plan listed strategies to reach objectives it did not clearly identify the population or setting, nor did it list the criteria for selecting the strategies. This information is now present in the detailed tables in the last section. Also present in the detailed tables are evaluation responsibilities, as well as short, intermediate, and long term indicators.

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As a group, the core leadership team set several goals; to always collaborate and coordinate, never duplicate. Secondly, the group decided the plan needed to contain enough flexibility to adapt to future changes. Lastly, the group decided to choose only the highest priority items for NC2 members to address while supporting and complementing the strategic plans of other DHHS programs.

The feedback from the volunteers working on the 2017-2022 plan was that the previous plan was bulky, contained duplicative goals from other programs, and was difficult to use. Every effort was made to keep this plan streamlined, include only essential content, and keep documents on the web only, as well as linking to other data sources to facilitate ease of use and ensure data is current. As a result, the plan is streamlined, action oriented and more user friendly.

The tracking system for five year indicators will be housed on the Nebraska Department of Health and Human Services Scorecard Dashboard, and will be easily updated. The tracking system will also be used to produce reports and will be easily modified.

Process to Write Nebraska Cancer Plan

In July of 2015, an initial group met to discuss the revision of the cancer plan. This group included representatives of the Comprehensive Cancer Control Program, Nebraska Cancer Coalition and the American Cancer Society. The group determined the plan's scope and exclusions. The group agreed on a few key goals:

- Increase manageability (limit duplication)
- Align with partners
- Utilize a user friendly format
- Increase opportunities for collaboration

The group also set some exclusions for the process. Excluded from this plan are goals with no preexisting data source, goals added late in process without a formal review, duplicating the work of other DHHS programs, non-high burden/priority items, items unrelated to cancer and, non-evidence based or promising practice items.

After the meeting, the group worked to identify volunteer facilitators to lead workgroups based around the six CDC priority areas. Facilitators included representatives from the Nebraska Cancer Coalition Advisory Committee, the CCC Program staff and contractors, and volunteers. The CCC Program Manager held a training for facilitators and discussed both the project scope and the results of the cancer plan self-assessment.

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Self-Assessment

The Nebraska Cancer Coalition Executive Director invited coalition members to participate in the revision process. Over 40 coalition members volunteered, including representatives from the Nebraska Medical Association, local health departments, University of Nebraska Medical Center (UNMC), UNMC College of Public Health, American Cancer Society, American Cancer Society Cancer Action Network, Department of Health and Human Services, and physicians (including the Physician Liaison from the American College of Surgeon's Commission on Cancer).

On August 6th, 2015 the CCC Program hosted a webinar featuring Nebraska Cancer Registry Epidemiology Surveillance Coordinator Bryan Rettig, who updated the cancer plan revision volunteers on the most recent cancer data and trends. The CCC Program Manager updated all the volunteers on the process to revise the plan, expectations, project scope and exclusions.

Over the next six months the work groups met individually. They set five year objectives, short, intermediate and long term indicators, and identified identified a one-year objective to reach that five-year goal. They set a one-year budget, and identified other resources needed. The groups cited their evidence base, and tied their objectives to a national level action plan. All these elements are detailed in the tables in the last section.

The work groups submitted tables to the CCC Program. The program manager condensed all the items into a logic model, checking for duplication, adding in evidence base items, and adjusting the budget.

After reviewing the objective tables, the CCC program manager then met with DHHS stakeholders to introduce them to the Nebraska Cancer Plan and to ensure that strategies were not duplicative. These meetings increased buy-in for the plan from DHHS staff who all responded positively to the plan.

Process to Implement

The process to implement the plan will be similar to writing the plan. Each objective identifies the lead organization to implement and evaluate the objective, evaluate the objective, and to collaborate with other organizations. Each year the work group will review the objective, plan the following year's objective, assign indicators and submit the plan for approval to the Nebraska Cancer Coalition and the Nebraska Comprehensive Cancer Control program. If an objective needs to be added to the plan, the same process will be used. The CCC program evaluator will track the evaluation measures for the plan via the DHHS web-based score-card dashboard and deliver annual evaluation reports to the stakeholders and the CDC.

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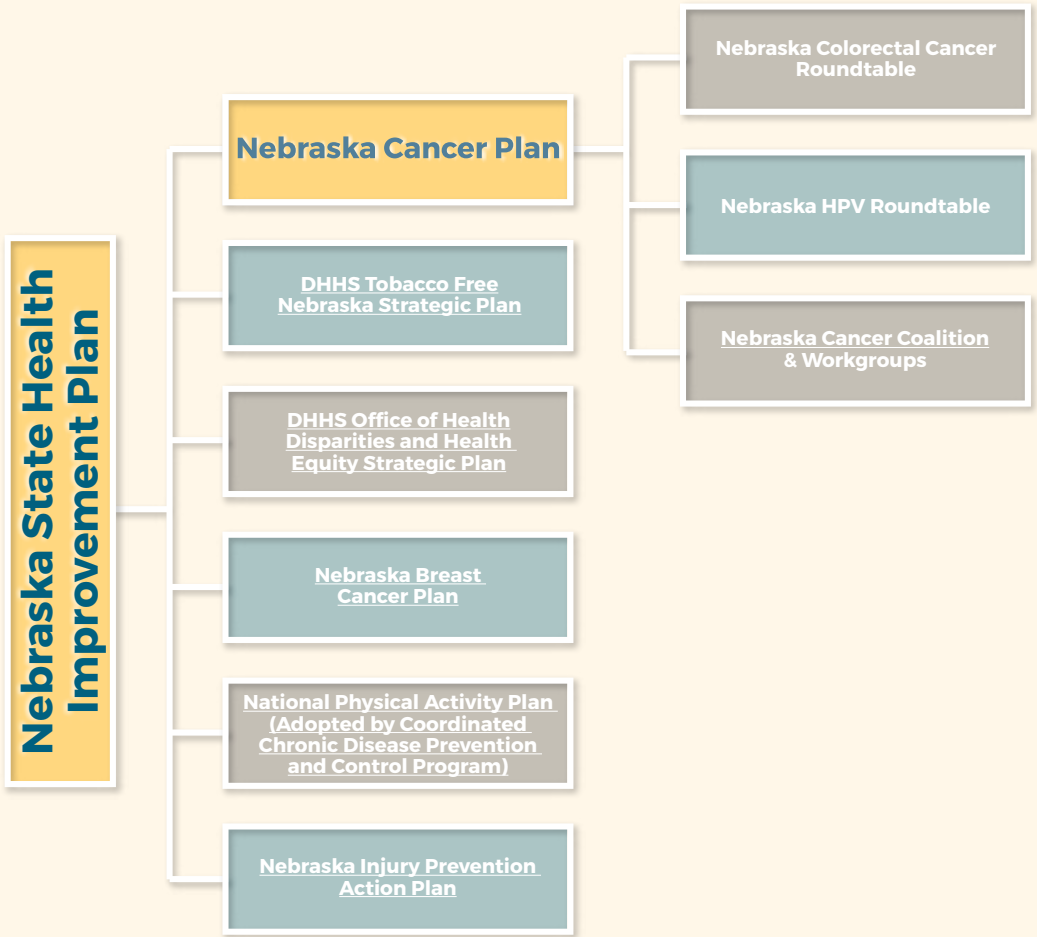
Self-Assessment

Conclusion

A cancer plan depends upon the time and talents of many individuals and organizations. One organization cannot develop or implement the plan alone. The Comprehensive Cancer Control Program depends upon the reach and influence of the coalition just as the coalition depends upon the technical expertise of the program. Together the two serve cancer survivors, caregivers and the public at large only through the purest egoless collaboration.

Below is a flow chart mapping out the Nebraska Cancer Plan within the overall Nebraska Health Improvement Plan. The underlined items represent hyperlinks to Nebraska strategic plans on associated risk factors and chronic diseases and showing the extensive collaborative input provided to the Cancer Plan.



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How to Use the Nebraska Cancer Plan

If You're Writing a Grant

Please refer back to the request for proposals for specific requirements, such as award limits, eligibility, dates and other requirements. To write a proposal, you can find a link to the most recent cancer registry report in the Cancer Data section, as well as a link to Cancer Registry website, along with links to other helpful data sources.

As you are designing your project, it will be helpful to know the history of the Nebraska Comprehensive Cancer Control Program and Nebraska Cancer Coalition. Those can be found in the Executive Summary. If you are looking for other similar strategic plans for the State of Nebraska, or for other potential collaborators on your project, view the State Plan flow chart on page 6.

As you design your project, remember to review the six priority areas designated by the Centers for Disease Control and Prevention, all the objectives and strategies within this plan fall into those priorities. Current year strategies are represented in a graphic for easy identification. The last section of the plan contains detailed tables with five year goals; evidence based intervention sources; short, medium and long term indicators; and data sources to assist in your grant writing process.

You are strongly encouraged to reach out to the awarding entity for technical assistance on your proposal, if allowable.

If You're Looking for Information on Cancer in Nebraska

Information about cancer incidence and mortality are located in the Cancer Data section, where you will find a link to the Nebraska Cancer Registry web page. Reading the Executive Summary will give you an overview of what the CDC funded cancer programs and the strategies partners are working on, as well as investigating the various logic models provided. There are many people working to prevent cancer, find it early, treat it, and care for survivors. This plan seeks to include the work of as many as possible, but doesn't capture all.

If You're a Member of the Community Looking to Get Involved

The history of the Nebraska Comprehensive Cancer Control Program and Nebraska Cancer Coalition appears in the Executive Summary and the six areas the CDC has chosen as a priorities for comprehensive cancer control programs are described there. Nebraska's current strategies are highlighted in this section. We are always in need of people with passion and would love to hear from you. Our contact information is NE CCCP NC2.

If You're a Provider Looking to Understand CDC Priorities Around Cancer Prevention and Control

The six priority areas designated by the Centers for Disease Control and Prevention are described in the executive summary. All the objectives and strategies within this plan fall into the priority areas. You will find the current year's strategies in a graphic for easy identification. The last section of the plan contains detailed tables with five year goals; evidence based intervention sources; short, medium and long term indicators; and data sources.

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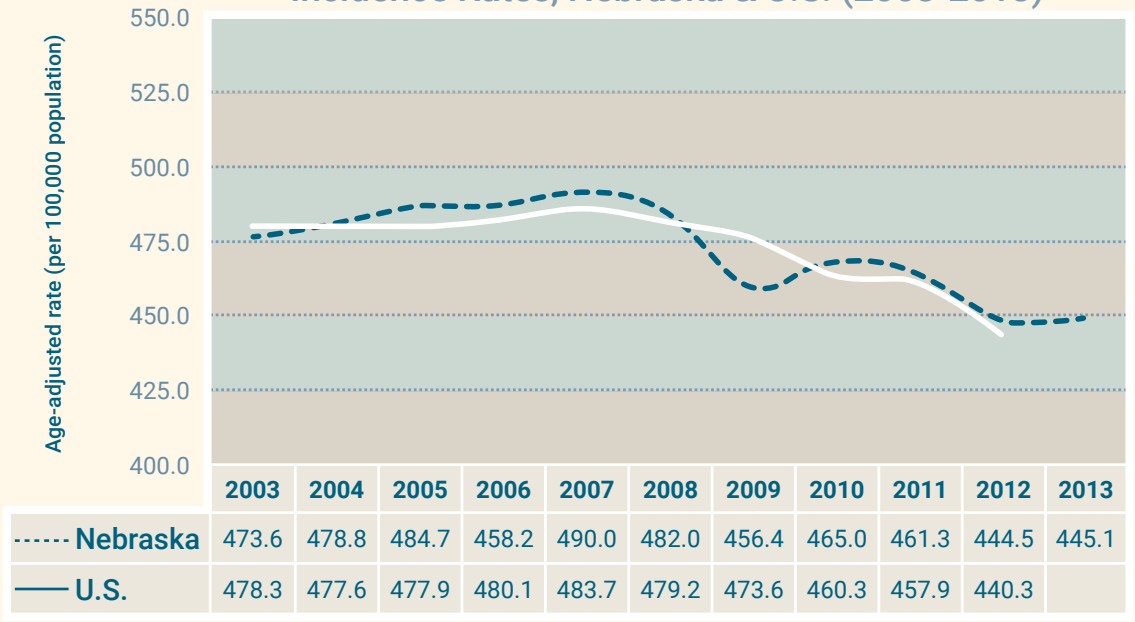
Cancer Incidence in Nebraska

The Nebraska Cancer Registry recorded 9,338 diagnoses of cancer among Nebraska residents in 2013, an increase from the 9,208 diagnoses recorded in 2012. The 2013 number translates into an incidence rate of 445.1 cases per 100,000 population. By primary site, cancers of the lung, breast, prostate, colon and rectum occurred most frequently, accounting for about half (49.1%) of all diagnoses. Recent registry experience suggests that as the registry continues to record cases, the final count for 2013 will probably increase by 100 to 300 cases.

Comparison of the most recent state and national incidence rates for the past five years shows significant differences ($p<.01$) for cancers of the prostate, lung, stomach, liver, and ovaries and in situ female breast (Nebraska rates lower than the U.S.) and for non-Hodgkin lymphoma, invasive brain tumors, and cancers of the colon and rectum, endometrium, and testes (Nebraska rates higher than the U.S.). The graph below presents the annual incidence rates for all cancers for Nebraska and the United States since 2003.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
------ Nebraska	473.6	478.8	484.7	458.2	490.0	482.0	456.4	465.0	461.3	444.5	445.1
—— U.S.	478.3	477.6	477.9	480.1	483.7	479.2	473.6	460.3	457.9	440.3	

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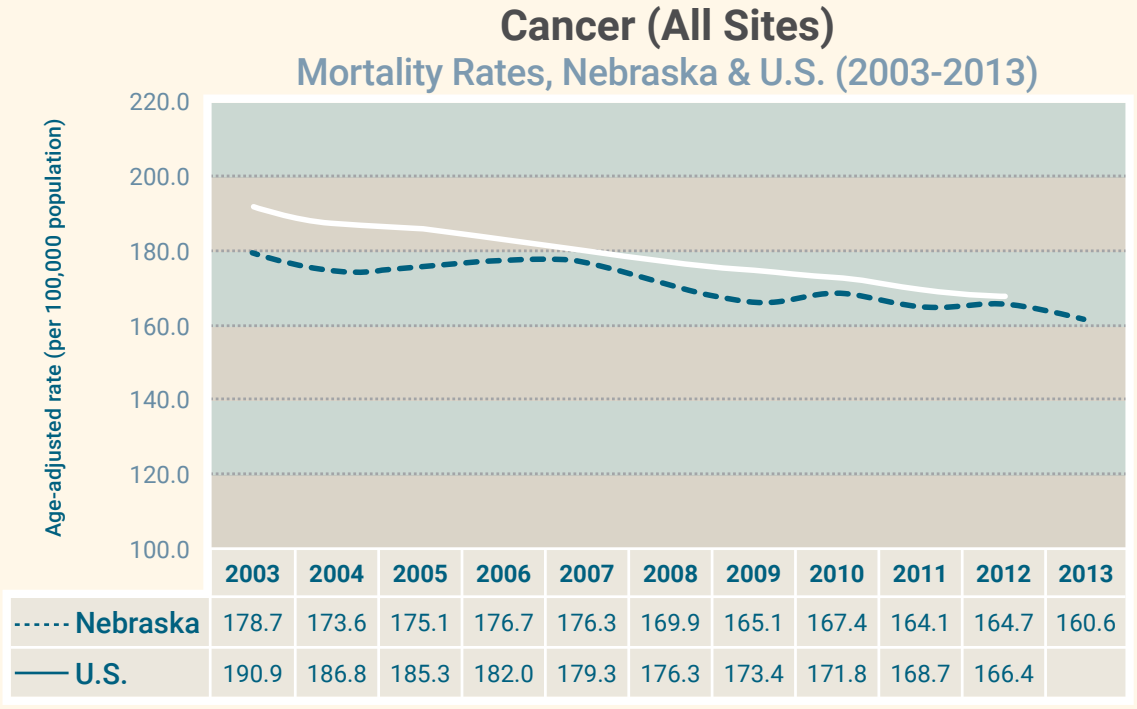
Cancer Mortality in Nebraska

In 2013, 3,458 Nebraska residents died from cancer, a number that translates into a rate of 163.0 cancer deaths per 100,000 population. These figures represent an increase from the state's 2012 figures of 3,481 (cancer deaths) and 164.7 (cancer mortality rate). For the fifth consecutive year, cancer was the leading cause of mortality among Nebraska residents in 2013, surpassing heart disease by 80 deaths. By primary site, cancers of the lung, breast, prostate, colon and rectum accounted for just under half (48.4%) of Nebraska's cancer deaths in 2013.

Comparison of the most recent state and national mortality rates for the past five years shows significant differences ($p<.01$) for cancers of the stomach, lung, liver, and female breast (Nebraska rates lower than the U.S.) and for cancers of the kidney and renal pelvis and brain and central nervous system tumors (Nebraska rates higher than the U.S.). The graph below shows annual mortality rates for cancer for Nebraska and the U.S. since 2003.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
------ Nebraska	178.7	173.6	175.1	176.7	176.3	169.9	165.1	167.4	164.1	164.7	160.6
—— U.S.	190.9	186.8	185.3	182.0	179.3	176.3	173.4	171.8	168.7	166.4	

More detailed information and analysis of cancer registry data may be found on the Nebraska Cancer Registry page, including the most up-to-date annual report.

Additionally more information and data regarding the Nebraska Behavioral Risk Factor Surveillance System (BRFSS), including the most current information on many cancer risk factors such as nutrition, physical activity, alcohol intake and other behaviors may be found there.

Nebraska State Demographics

According to the 2015 Nebraska Health Disparities Report, Nebraska's population is increasingly diverse although the overall proportions of minority groups remains smaller than United States as a whole. Approximately 9% of Nebraska's 2010 population was Hispanic, 4.4% Black, 1.7% Asian, 0.8% American Indian, and 1.6% identified as two or more races. 82.1% of Nebraska's population identified as white.

The minority population has been increasing much more rapidly than the white population. Between 2000 and 2010, according to the same report, Nebraska's total population increased by about 6.7%. While the racial and ethnic minority population grew by 50.7%, the growth rate in the white population was 0.4%. Within the racial and ethnic minority populations, the Hispanic population grew by 77.3%, the Native Hawaiian Pacific Islander population grew by 53% and the Asian population grew by 47%.

The Nebraska Health Disparities Report also found that Nebraska's Hispanic population reported the highest percentage of people not having a personal physician, American Indians and African Americans living in Nebraska reported similar numbers. The Hispanic population were also the most likely to report not having health insurance, and to be unable to see a doctor due to cost.

According to that same report, Nebraska's African American population had the highest death rate due to cancer over the years 2006-2010, 238.3 of every 100,000 compared to 171.8/100,000 of the white population. Almost 100 of every 100,000 Asians and Hispanic Nebraskans died of cancer.

For more in depth analysis of these issues and many others facing Nebraska's racial and ethnic minorities please examine the Nebraska Health Disparities Report.

Health Literacy

Health literacy is a complex issue with three levels to the definition.

1. According to the CDC anyone who needs health information and services also needs health literacy skills to find information and services, communicate their needs and preferences, process the meaning and usefulness of the information and services and understand the choices, consequences and context of the information and services.

2. Anyone who provides health information and services to others needs health literacy skills to help people find information and services, communicate about health and healthcare, process what people are explicitly and implicitly asking for, understand how to provide useful information and services and decide which information and services work best for different situations and people to help them to act.

3. Lastly organizational health literacy is how organizations decide on health information and services. Organizations that remove health literacy barriers are health literate, such as adopting the Ten Attributes of Health Literate Health Care Organizations from the Institutes of Medicine.

The 2014 Nebraska BRFSS survey reveals some staggering statistics regarding people's understanding of the health care information they receive and provide.

- 34.3% of Nebraskans reported lacking confidence in their own ability to fill out health forms
- 26.6% of Nebraskans reported they had difficulty understanding written health information
- 50.2% of Nebraskans reported they regularly get help reading health information
- Nebraskan African Americans, Hispanics, American Indians, Asians/Pacific Islanders are all more likely to report difficulty understanding written health information.
- Nebraskans with less than a high school education, those who make less than $25,000 a year, and Nebraskans who live in rural areas are also more likely to report difficulty understanding written health information

Prioritization Process

Health literacy affects half of Nebraskans and disproportionately affects racial and ethnic populations as well as rural populations. The health equity strategies in the Nebraska cancer plan have been targeted towards health literacy efforts, and have, as much as possible been combined with system and organizational changes to affect the maximum number of Nebraskans possible.

Years One and Two Action Plan

On the following page are the selected strategies for years one and two, removed from the detailed tables and sorted into the relevant priority areas. These are the strategies listed under the 1 year SMART objective in the detailed tables. These strategies will be carried out by a variety of organizations, require different funding levels and cover the first two years of the Nebraska Cancer Plan. All these details are contained within the tables.

The policy systems and environmental changes and the reducing cancer disparities priorities have been combined because the relevant strategies are crosscutting. During the planning process every effort was made to fill gaps rather than to duplicate existing strategies or to replicate the work of existing programs.

Educate people about cancer screening tests

- Provide support to cancer centers seeking to become lung-cancer centers of excellence.
- Increase number of worksite wellenss projects related to cancer screening.
- Increase channels of communication to the public on the importance of cancer screening.
- Increase number of staff trained in CLAS.
- Increase number of funded projects with FQHCS working to improve their colorectal screening rates.

Make sure people who survive cancer live well

- Develop and implement needs assessment targeted to Nebraska cancer survivors.
- Conduct key informant interviews with cancer stakeholder groups to identify resources available for survivors in Nebraska.
- Form ad hoc committee to study requirements to raise Pain Policy Studies grade from B+ to an A.
- Establish collaborative relationships with two entities interested in partnering with NC2 to evaluate the highest priorities in survivorship research.

Encourage people to make healthy choices

- Social marketing campaign on the dangers of radon targeted to Nebraska homeowners.
- One year educational series on cancer risk and alcohol targeted to health professionals. Support sun safe work environment and public attractions.
- Collaborate on a social marketing campaign on HPV vaccination targeted toward adolescents emphasizing cancer prevention.

Increase access to cancer care and reduce health disparities and implement policy systems and environmental changes

- Collaborative efforts to educate Nebraskans who experience health disparities on tobacco and cancer risk via the CDC TIPS campaign.
- Support cancer centers, local health departments, and 501 c 3 organizations in implementing health literacy action plans.
- Coordinate and assist communities in forming coalitions around walking.

Nebraska Cancer Plan Objective Tables

On the following pages are the objectives and strategies for the Nebraska cancer plan. Please note that the crosscutting strategies of Policy, systems, and environmental changes and promoting health disparities and health equity do not appear in separate priority areas, but are built into each area as is noted in the top row of each table. After the objective section there is an overall logic model for the first two years of the period.

Definitions to Note:

Objective-Specific, quantifiable targets that measure the accomplishment of the plan, there are 5 year objectives and one year objectives in this plan. Strategy-Specific, discrete activities, designed to achieve the objective. There are one year strategies contained in this plan.

Early Detection and Screening

**Note the Screening section is organized into several 5 year objectives and then into cross-cutting one year objectives focused on colorectal cancer to mobilize around the 80% by 2018 nationwide initiative, as well as state-wide interest. In years 2-5 the coalition and program plan to take lessons learned to other forms of screenable cancers. An exception to this is lung cancer, because while there are recommendations for screening, they are for a subset of the population, thus lung cancer strategies are listed separately.*

PRIORITY AREA: Screening and Early Detection			
5 year SMART objective A: increase the number of women aged 21-65 up to date on cervical cancer screening from 81.7% to 91.7% according to the BRFSS			
What will be measured: percent increase	**Baseline:** 81.7% of women aged 21-65 up to date on cervical cancer screening	**Data source:** 2014 BRFSS	**Timeframe:** by 2021
Continuum of care: ⧈ Screening/early detection	**Level of action:** ⧈ Individual ⧈ Families	**Criteria:** ⧈ Stakeholder interest ⧈ Available resources	**Population:** adults of screening age **Setting:** communities, clinics
Evidence base: USPSTF/HP2020	**Lead organization:** NE CCCP	**Lead workgroup:** screening	
Short-term indicators (1st and 2nd year): reported changes in knowledge, attitudes and beliefs, web analytics	**Intermediate indicators (3rd to 4th year):** reported changes in knowledge, attitudes and beliefs, web analytics, changes in clinical systems	**Long-term indicators (4th to 5th year):** increase in women up-to-date on cervical cancer screening	
Evaluation methods: tracking BRFSS data, program and process evaluations		**Lead evaluating organization:** NE CCCP	
Estimated budget: $100,000		**Other resources needed:** subject matter expertise	

PRIORITY AREA: Screening and Early Detection			
5 year SMART objective B: increase the percent of men over 40 who had ever had a doctor, nurse or other health professional talk to them about the advantages of the PSA test from 56.1% to 66.1% according to the BRFSS			
What will be measured: percent increase	**Baseline:** 56.1% of men never had a doctor, nurse or other health professional talk to them about the advantages of the PSA test (men 40+)	**Data source:** BRFSS 2014	**Timeframe:** by 2021
Continuum of care: ⧈ Screening/early detection	**Level of action:** ⧈ Individual ⧈ Families	**Criteria:** ⧈ Burden ⧈ Environmental scan ⧈ Stakeholder interest ⧈ Available resources	**Population:** adults of screening age **Setting:** communities, clinics
Evidence base: USPSTF/HP2020	**Lead organization:** NE CCCP	**Lead workgroup:** screening	
Short-term indicators (1st and 2nd year): reported changes in knowledge, attitudes and beliefs, web analytics	**Intermediate indicators (3rd to 4th year):** reported changes in knowledge, attitudes and beliefs, web analytics, changes in clinical systems	**Long-term indicators (4th to 5th year):** increases in men who have had this important conversation with a health care professional	
Evaluation methods: tracking BRFSS data, program and process evaluations		**Lead evaluating organization:** NE CCCP	
Estimated budget: $100,000		**Other resources needed:** subject matter expertise	

PRIORITY AREA: Screening and Early Detection			
5 year SMART objective C: increase the percent of adults aged 50-75 who are up to date on colorectal cancer screening from 64.1% to 80% according to the BRFSS			
What will be measured: percent increase	**Baseline:** 64.1 % of adults aged 50-75 up to date on colorectal cancer screening	**Data source:** 2014 BRFSS	**Timeframe:** by 2021
Continuum of care: ☐ Screening/early detection	**Level of action:** ☐ Individual ☐ Families	**Criteria:** ☐ Burden ☐ Environmental scan ☐ Stakeholder interest ☐ Available resources	**Population:** adults of screening age **Setting:** communities, clinics
Evidence base: USPSTF/HP2020	**Lead organization:** NE CCCP		**Lead workgroup:** screening
Short-term indicators (1st and 2nd year): reported changes in knowledge, attitudes and beliefs, web analytics, attendance at CLAS trainings, requests for technical assistance, creation of channels of communication, reported applicability, number of funded projects	**Intermediate indicators (3rd to 4th year):** reported changes in knowledge, attitudes and beliefs, web analytics, changes in clinical systems, attendance at CLAS trainings, requests for technical assistance, creation of channels of communication, reported applicability, number of funded projects		**Long-term indicators (4th to 5th year):** increases in screening rates
Evaluation methods: tracking BRFSS data, program and process evaluations		**Lead evaluating organization:** NE CCCP	
Estimated budget: $100,000		**Other resources needed:** subject matter expertise	

PRIORITY AREA: Screening and Early Detection			
5 year SMART objective D: increase the percent of women aged 50-74 up to date on breast cancer screening from 76.1% to 86.1% by 2021			
What will be measured: percent increase	**Baseline:** 76.1 % of women aged 50-74 up to date on breast cancer screening	**Data source:** 2014 BRFSS	**Timeframe:** by 2021
Continuum of care: ☐ Screening/early detection	**Level of action:** ☐ Individual ☐ Families	**Criteria:** ☐ Burden	**Population:** adult women of screening age **Setting:** communities, clinics
Evidence base: USPSTF/HP2020	**Lead organization:** NE CCCP		**Lead workgroup:** screening
Short-term indicators (1st and 2nd year): reported changes in knowledge, attitudes and beliefs, web analytics	**Intermediate indicators (3rd to 4th year):** changes in clinical systems		**Long-term indicators (4th to 5th year):** increases in screening rates
Evaluation methods: tracking BRFSS data, program and process evaluations		**Lead evaluating organization:** NE CCCP	
Estimated budget: $100,000		**Other resources needed:** subject matter expertise	

Screening Crosscutting Issues: ACCESS

PRIORITY AREA: Screening and Early Detection

1 year SMART objective C1: increase the number of projects designed to increase Nebraskan's access to Cancer screening services done in collaboration from 0 to 2

Strategy (specific discreet activities designed to achieve the objective) used: support Chronic Disease Prevention and Control Program in its current worksite wellness efforts related to cancer screening, reduce the burden of transportation on Nebraskans trying to access screening services

What will be measured: increase in projects	**Baseline:** 0	**Data source:** CCC program records	**Timeframe:** by 2018
Continuum of care: ☐ Screening/early detection	**Level of action:** ☐ Institutions ☐ Communities ☐ Systems ☐ Policy	**Criteria:** ☐ Burden ☐ Environmental scan ☐ Stakeholder interest ☐ Available resources	**Population:** adults of screening age **Setting:** communities, clinics, worksites
Evidence base: The Community Guide, ACS CDC Worksite Wellness Scorecard, NE DHHS Worksite Wellness Toolkit, Research Tested Intervention Programs from the National Cancer Institute, National Colorectal Roundtable 80% by 2018		**Lead organization:** NE CCCP/NC2/ Colorectal Roundtable	**Lead workgroup:** early detection and screening
Indicators: reported changes in knowledge attitudes beliefs, web analytics, reported uptake in transportation programs			
Evaluation methods: process and program evaluations		**Lead evaluating organization:** NE CCCP	
Estimated budget: $100,000		**Other resources needed:** technical assistance from partners	

Years 2-5 Strategies:

☐ Take lessons learned and apply to other screenable cancers

Screening Crosscutting Issues: EDUCATION

1 year SMART objective C2: increase the channels of communication to the public on the importance of cancer screening developed and disseminated in collaboration from 0 to 2 by June 2018.

Strategy (specific discreet activities designed to achieve the objective) used: support the creation of webinar training for nonclinical team members on the importance of colorectal cancer screening, support the creation of speaker's bureau on colorectal cancer.

What will be measured: creation and dissemination	**Baseline:** creation of channels of communication	**Data source:** program records	**Timeframe:** by June 2018
Continuum of care: ☐ Screening/early detection	**Level of action:** ☐ Institutions ☐ Communities ☐ Systems ☐ Policy	**Criteria:** ☐ Burden ☐ Environmental scan ☐ Stakeholder interest ☐ Available resources	**Population:** adults of screening age **Setting:** clinics
Evidence base: The Community Guide, ACS Research Tested Intervention Programs from the National Cancer Institute, National Colorectal Roundtable 80% by 2018		**Lead organization:** NE CCCP/ NC2/Colorectal Roundtable	**Lead workgroup:** screening and early detection

Indicators: creation of webinar modules, number of speaker, variety of speakers	
Evaluation methods: dissemination strategies, focus group testing results for webinar, speaker's bureau recruitment strategy, and request numbers	**Lead evaluating organization:** NE CCCP
Estimated Budget: $10,000	**Other resources needed:** technical assistance from partners

Years 2-5 Strategies:

- ☐ Take lessons learned and apply to other screenable cancers

Screening Crosscutting Issues: HEALTH DISPARITIES AND HEALTH EQUITY

1 year SMART objective C3: increase the number of NC2 partner organizations, clinics, and federally qualified health centers who have had staff participate in culturally and linguistically appropriate standards trainings in the past 12 months to 50 by June 2018			
Strategy (specific discreet activities designed to achieve the objective) used: support the Office of Health Disparities and Health Equity in wide dissemination and promotion of the culturally and linguistically appropriate standards trainings, communicate to high risk and vulnerable populations in many different ways the current screening guidelines for cancer, and the available tests, update NC2 communication and media plan to include sample messages for partners on communicating to the public on screening. Include at least one webinar in the monthly series on each screenable cancer before the relevant awareness month			
What will be measured: staff participated in CLAS trainings	**Baseline:** unknown	**Data source:** program records	**Timeframe:** by June 2018
Continuum of care: ☐ Screening/early detection	**Level of action:** ☐ Institutions ☐ Communities ☐ Systems ☐ Policy	**Criteria:** ☐ Burden ☐ Environmental scan ☐ Stakeholder interest ☐ Available resources	**Population:** adults of screening age, high risk and vulnerable populations **Setting:** communities, clinics, workplaces
Evidence base: The Community Guide, ACS, Research Tested Intervention Programs from the National Cancer Institute, National Colorectal Roundtable 80% by 2018, LGBT Best and Promising Practices Throughout the Cancer Continuum	**Lead organization:** NE CCCP/NC2	**Lead workgroup:** screening and early detection	
Indicators: reported changes in knowledge attitudes and beliefs, web analytics, attendance at events			
Evaluation methods: pre/post tests, process evaluations, program evaluations	**Lead evaluating organization:** NE CCCP/other partners as appropriate		
Estimated budget: $10,000	**Other resources needed:** technical assistance from partners		

Years 2-5 Strategies:

- ☐ Take lessons learned and apply to other screenable cancers

Screening Crosscutting Issues: HEALTH SYSTEMS CHANGES

1 year SMART objective C4: increase the number of partner clinics or federally qualified health centers working to increase their colon cancer screening rates from 0 to at least 2 by June 2017			
Strategy (specific discreet activities designed to achieve the objective) used: support the creation of a colonoscopy registry using the Nebraska Health Information Initiative, support the creation of medical neighborhoods, support individual clinics and federally qualified health centers in increasing their cancer screening rates through evidence based interventions			
What will be measured: number increase	**Baseline:** 0 FQHCS	**Data source:** program records	**Timeframe:** by 2017
Continuum of care: ☐ Primary Prevention	**Level of action:** ☐ Institutions ☐ Communities ☐ Systems ☐ Policy	**Criteria:** ☐ Burden ☐ Environmental scan ☐ Stakeholder interest ☐ Available resources	**Population:** adults of screening age **Setting:** communities, clinics
Evidence base: "How to Increase Screening Rates in Practice", Research Tested Intervention Programs from the National Cancer Institute, National Colorectal Roundtable 80% by 2018, Addressing Chronic Disease Through Community Health Workers		**Lead organization:** NE CCCP/ACS/Colorectal Roundtable	**Lead workgroup:** screening and early detection
Indicators: increased knowledge, reported changes in beliefs or attitudes about screening, improved screening rates at individual clinics, improved system wide supports at clinics, improved staff buy in at clinics			
Evaluation methods: process and program evaluation		**Lead evaluating organization:** NE CCCP	
Estimated budget: $20,000		**Other resources needed:** technical assistance from partners	

Years 2-5 Strategies:

☐ Take lessons learned and apply to other screenable cancers

PRIORITY AREA: Early Detection & Screening			
5 year SMART objective E: increase the number of American College of Surgeons Commission on Cancer Accredited (ACoS CoC) Cancer Centers who are Lung Cancer Screenings of Excellence from 1 to 13 by 2021			
What will be measured: number of ACoS CoC Cancer Centers who are Lung Cancer Screenings of Excellence	**Baseline:** 5	**Data source:** American Cancer Society, Lung Cancer Alliance	**Timeframe:** by 2021
Continuum of care: ☐ Screening/early detection	**Level of action:** ☐ Individual	**Criteria:** ☐ Burden ☐ Environmental scan ☐ Stakeholder interest ☐ Available resources	**Population:** qualified NE residents who meet USPSTF Lung CA screening guidelines
			Setting: community
Evidence Base: USPSTF, ACoS CoC	**Lead organization:** NC2		**Lead workgroup:** early detection & screening
Short-term indicators (1st and 2nd year): requests for technical assistance, number of cancer centers accredited	**Intermediate indicators (3rd to 4th year):** number of cancer centers accredited		**Long-term indicators (4th to 5th year):** number of Nebraskans appropriately screened for lung cancer
Evaluation methods: process evaluation of assistance, tracking numbers			**Lead evaluating organization:** NE CCCP
Estimated Budget: $100,000		**Other resources needed:** technical expertise	

1 year SMART objective E1: improve access to safe, responsible screening by increasing the number of lung cancer screening programs in Nebraska from 1 to 5 that comply with best practice standards by June 2018			
Strategy (specific discreet activities designed to achieve the objective) used: form ad hoc committee with representation from ACS and Physician Liaison of ACoS CoC and members of Survivorship group to study best way forward. Provide action plan for providing technical assistance moving forward at the end of year one			
What will be measured: number of CoC Cancer Centers who are Lung Cancer Screenings of Excellence	**Baseline:** there are currently 5 of the 13 CoC Cancer Centers who are Lung Cancer Screenings of Excellence through the Lung Cancer Alliance	**Data source:** Lung Cancer Alliance	**Timeframe:** by 2018
Continuum of care: ☐ Screening/early detection	**Level of action:** ☐ Institutions	**Criteria:** ☐ Burden ☐ Environmental scan ☐ Stakeholder interest ☐ Available resources	**Population:** Nebraskans eligible for lung cancer screening **Setting:** Nebraska Cancer Centers
Evidence base: USPSTF, ACoS CoC	**Lead organization:** NC2	**Lead workgroup:** early detection & screening	
Indicators: requests for technical assistance, number of cancer centers accredited			
Evaluation methods: process evaluation of assistance, tracking numbers	**Lead evaluating organization:** NE CCCP		
Estimated budget: $20,000	**Other resources needed:** technical expertise		

Emphasize Primary Prevention

PRIORITY AREA: Primary Prevention			
5 year SMART objective F: increase the number of Nebraska homes tested for radon from 73,280 to 80,000 by 2021			
What will be measured: Nebraska homes tested	**Baseline:** 73,280	**Data source:** office of Indoor Air Quality	**Timeframe:** by 2021
Continuum of care: ☐ Primary Prevention	**Level of action:** ☐ Families ☐ Communities	**Criteria:** ☐ Burden ☐ Environmental scan	**Population:** Nebraska property owners **Setting:** communities
Evidence base: Environmental Protection Agency National Radon Action Plan	**Lead organization:** NE CCCP	**Lead workgroup:** Primary Prevention	
Short-term indicators (1st and 2nd year): number of homes tested, number of homes mitigated for radon	**Intermediate indicators (3rd to 4th year):** number of homes tested, number of homes mitigated for radon, number of communities with Radon Resistant New Construction Codes (RRNC)	**Long-term indicators (4th to 5th year):** number of homes tested, number of homes mitigated for radon, statewide coverage of RRNC	
Evaluation methods: tracking numbers of homes tested, number of homes mitigated numbers of communities with RRNC	**Lead evaluating organization:** NE CCCP		
Estimated budget: $500,000	**Other resources needed:** TBD		

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1 year SMART objective F1: increase the number of Nebraska homes tested for radon from 73,280 to 74,280 by June 2018

Strategy (specific discreet activities designed to achieve the objective) used: increase demand for radon testing and mitigation through increased public awareness with social marketing campaign targeted toward property owners

What will be measured: number of homes tested | **Baseline:** 73,280 | **Data source:** office of Indoor Air Quality | **Timeframe:** by June 2018

Continuum of care:
- ☐ Primary Prevention

Level of action:
- ☐ Families
- ☐ Institutions
- ☐ Communities
- ☐ Systems
- ☐ Policy

Criteria:
- ☐ Burden
- ☐ Environmental scan

Population: Nebraska property owners

Setting: communities

Evidence base: Environmental Protection Agency National Radon Action Plan

Lead organization: CCCP

Lead workgroup: Primary Prevention

Indicators: numbers of homes tested, reported knowledge, attitudes and beliefs through electronic survey, campaign analytics

Evaluation methods: tracking numbers of homes tested, campaign analytics | **Lead evaluating organization:** NE CCCP

Estimated budget: $100,000 | **Other resources needed:** technical expertise of partners

Year 2-5 strategies:

1. Support communities in adopting radon resistant new construction codes
2. Support local health department staff in being trained to test for radon
3. Create toolkit to outreach to child care providers and schools on radon testing
4. Support research on the cost-effectiveness of mitigation
5. Create toolkit to outreach to property owners of rentals on radon testing
6. Seek funding source for radon mitigation for low income Nebraskans
7. Support statewide coverage of radon resistant new construction codes

PRIORITY AREA: Primary Prevention

5 year SMART objective G: decrease the percentage of adults 18 and older who report having five or more alcoholic drinks for men/four or more alcoholic drinks for women on at least one occasion during the past 30 days from 19.5% to 17.5% by June 2021

What will be measured: percent decrease | **Baseline:** 19.5% | **Data source:** BRFSS | **Timeframe:** by June 2021

Continuum of care:
- ☐ Primary Prevention

Level of action:
- ☐ Communities
- ☐ Policy

Criteria:
- ☐ Burden
- ☐ Stakeholder interest

Population: adults of drinking age

Setting: communities

Evidence base: The Community Guide, CDC Cancer and Alcohol Infographic, CDC Alcohol Frequently Asked Questions

Lead organization: NC2

Lead workgroup: Primary Prevention

Short-term indicators (1st and 2nd year): increased knowledge, changed attitudes and beliefs

Intermediate indicators (3rd to 4th year): changed community and organizational policies, continued Increased knowledge, changed attitudes and beliefs

Long-term indicators (4th to 5th year): changes in BRFSS indicators

Evaluation methods: BRFSS tracking, process and program evaluations | **Lead evaluating organization:** NE CCCP

Estimated budget: $50,000 | **Other resources needed:** content expertise

1 year SMART objective G1: implement a one year educational program on the health risks of alcohol consumption related to cancer by June 2018

Strategy (specific discreet activities designed to achieve the objective) used: partner with other local organizations to educate Nebraska Cancer Coalition members and medical community (physicians, nurses, PAs, office staff) at large on the health risks of alcohol consumption, review current literature for most accurate science and dissemination methods and produce recommendations, assemble a toolbox of organizational no alcohol fundraising and alcohol free event policies

What will be measured: implementation | **Baseline:** no program | **Data source:** program records | **Timeframe:** by 2018

Continuum of care:
- ☐ Primary Prevention

Level of action:
- ☐ Communities

Criteria:
- ☐ Burden
- ☐ Stakeholder interest

Population: adults of drinking age

Setting: communities, clinics

Evidence base: The Community Guide, CDC Cancer and Alcohol Infographic, CDC Alcohol Frequently Asked Questions

Lead organization: NC2, NE CCCP

Lead workgroup: Primary Prevention

Indicators: changes in knowledge attitudes, beliefs , pre/post tests

Evaluation methods: process, knowledge, dissemination

Lead evaluating organization: NE CCCP

Estimated budget: $10,000

Other resources needed: content expertise

Years 2-5 Strategies

1. Sponsor a Cancer Summit speaker
2. Targeted distribution of alcohol policy toolkit
3. Sponsor a speaker on the health risks of alcohol at injury prevention conference
4. Invite members of the injury prevention community to join the Nebraska Cancer Coalition

PRIORITY AREA: Primary Prevention-Health Disparities and Health Equity

5 year SMART objective H: reduce the percentage of low income (less than $35,000 annual income) adults that currently smoke from 25.5% to 21% by 2021

What will be measured: percent decrease | **Baseline:** 25.5% | **Data source:** BRFSS | **Timeframe:** by 2021

Continuum of care:
- ☐ Primary Prevention
- ☐ Survivorship

Level of action:
- ☐ Individual
- ☐ Families
- ☐ Communities

Criteria:
- ☐ Burden
- ☐ Environmental scan
- ☐ Available resources

Population: Nebraskans who experience health disparities

Setting: communities

Evidence base: CDC Tips Campaign, CDC Tobacco Related Disparities, The Community Guide

Lead organization: tobacco Free Nebraska/ Nebraska Comprehensive Cancer Control Program

Lead workgroup: Primary Prevention, Health Disparities and Health Equity, Survivorship

Short-term indicators (1st and 2nd year): increased calls to Quitline, increased requests for available resources, increased connection to stakeholder groups, campaign analytics

Intermediate indicators (3rd to 4th year): rate decreases, increased reported quit attempts, Increased calls to Quitline, increased requests for available resources, increased connection to stakeholder groups, campaign analytics

Long-term indicators (4th to 5th year): rate decreases, increased reported quit attempts, Increased calls to Quitline, increased requests for available resources, increased connection to stakeholder groups, campaign analytics

Evaluation methods: process, Program, data tracking

Lead evaluating organization: Tobacco Free Nebraska, Nebraska Comprehensive Cancer Control Program

Estimated budget: $750,000

Other resources needed: technical expertise

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1 year SMART objective H1: reduce the percentage of low income (less than $35,000 annual income) adults that currently smoke from 25.5% to 25% by June 2018

Strategy (specific discreet activities designed to achieve the objective) used: leverage TIPS campaign between Tobacco Free Nebraska and Nebraska Comprehensive Cancer Control Program. Increase connections between tobacco community organizations and cancer control organizations

What will be measured: increased calls to Quitline, campaign analytics, increased requests for available resources, increased connections to stakeholder groups

Baseline: 25.5%

Data source: Nebraska Quitline

Timeframe: by 2018

Continuum of care:
- ☐ Primary Prevention
- ☐ Survivorship

Level of action:
- ☐ Individual
- ☐ Families
- ☐ Communities

Criteria:
- ☐ Burden
- ☐ Environmental scan
- ☐ Stakeholder Interest
- ☐ Available rescources

Population: Nebraskans who experience health disparities

Setting: communities

Evidence base: CDC Tips Campaign, CDC Tobacco Related Disparities, The Community Guide

Lead organization: Tobacco Free Nebraska/ Nebraska Comprehensive Cancer Control Program

Lead workgroup: Primary Prevention, Health Disparities and Health Equity, Survivorship

Indicators: increased calls to Quitline, increased requests for available resources, increased connection to stakeholder groups, campaign analytics

Evaluation methods: campaign analytics, process, tracking

Lead evaluating organization: Tobacco Free Nebraska, Nebraska Comprehensive Cancer Control Program

Estimated budget: $150,000

Other resources needed: technical expertise

PRIORITY AREA: Eliminate Health Disparities/Policy, Systems and Environmental Changes

5 year SMART objective I: increase the number of Nebraskans who consider written health information always or nearly always easy to understand from 73.4% to 80% by 2021

What will be measured: percent increase

Baseline: 73.4% of Nebraskans

Data source: Nebraska BRFSS

Timeframe: by 2021

Continuum of care:
- ☐ Primary p revention
- ☐ Screening/early detection
- ☐ Diagnoses
- ☐ Treatment
- ☐ Palliation
- ☐ End of life care
- ☐ Survivorship

Level of action:
- ☐ Institutions
- ☐ Systems
- ☐ Policy

Criteria:
- ☐ Burden
- ☐ Environmental scan
- ☐ Stakeholder interest
- ☐ Available rescources

Population: individuals with low health literacy/ unique cultural and linguistic needs in clinical settings.

Setting: Nebraska Cancer Centers, local health departments, 501 c 3 organizations, and Federally Qualified Health centers

Evidence base: National Action Plan to Improve Health Literacy, CDC Learn About Health Literacy

Lead organization: Nebraska Comprehensive Cancer Control Program, Nebraska Association of Local Health Directors, Nebraska Cancer Coalition, Office of Health Disparities and Health Equity

Lead workgroup: Health Disparities and Health Equity, policy, systems and environmental changes

Short-term indicators (1st and 2nd year): creation of action plans, buy in from upper level administration, and broad support across departments

Intermediate indicators (3rd to 4th year): number of plans in implementation, broad support across organization

Long-term indicators (4th to 5th year): improvement in selected BRFSS indicators

Evaluation methods: action plan evaluation reports, key informant interviews, signatures of administration on all plans

Lead evaluating organization: Nebraska Comprehensive Cancer Control Program

Estimated budget: $60,000

Other resources needed: technical expertise

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1 year SMART objective I1: increase the number of Nebraska Cancer Coalition partner organizations implementing health literacy action plans and participating in CLAS trainings by 2, by 2017

Strategy (specific discreet activities designed to achieve the objective) used: contract with Nebraska Cancer Coalition to provide financial support to two partner organizations (Nebraska Cancer centers, Local health departments, 501 c 3 organizations, and Federally Qualified Health centers) to implement health literacy action plans and to participate in up to 4 CLAS sessions provided by the DHHS Office of Health Disparities and Health Equity. Contract with Nebraska Association of Local Health Directors to provide technical assistance to the selected organizations on health literacy action planning

What will be measured: number of partner organizations participating in action planning for health literacy

Baseline: 0

Data source: program and partner records

Timeframe: by 2018

Continuum of care:
- ☐ Primary Prevention
- ☐ Screening/early detection
- ☐ Diagnoses
- ☐ Treatment
- ☐ Palliation
- ☐ End of life care
- ☐ Survivorship

Level of action:
- ☐ Institutions
- ☐ Systems
- ☐ Policy

Criteria:
- ☐ Burden
- ☐ Environmental scan
- ☐ Stakeholder interest
- ☐ Available rescources

Population: individuals with low health literacy/unique cultural and linguistic needs in clinical settings

Setting: Nebraska Cancer Centers, local health departments, 501 c 3 organizations, and Federally Qualified Health centers

Evidence base: National Action Plan to Improve Health Literacy, CDC Learn About Health Literacy

Lead organization: Nebraska Comprehensive Cancer Control Program, Office of Health Disparities and Health Equity, Nebraska Cancer Coalition, Nebraska Association of Local Health Directors

Lead workgroup: Health Disparities and Health Equity, policy, systems and environmental changes

Indicators: creation of action plans, buy in from upper level administration, and broad support across departments

Evaluation methods: action plan evaluation reports, key informant interviews, signatures of administration on all plans

Lead evaluating organization: Nebraska Comprehensive Cancer Control Program

Estimated budget: $12,000

Other resources needed: technical expertise, partnership

PRIORITY AREA: Primary Prevention/Policy, Systems, Environmental Changes

5 year SMART objective J: increase statewide coverage of Complete Streets policies from 4 to statewide by 2021.

What will be measured: number of complete streets policies

Baseline: 4

Data source: American Cancer Society/American Association of Retired Persons, DHHS Chronic Disease Prevention and Control Program

Timeframe: by 2021

Continuum of care:
- ☐ Primary Prevention

Level of action:
- ☐ Communities
- ☐ Policy

Criteria:
- ☐ Burden
- ☐ Environmental scan
- ☐ Stakeholder interest
- ☐ Available rescources

Population: Nebraskans

Setting: communities

Evidence base: Surgeon General's Call to Action To Promote Walking and Walkable Communities, CDC Guide to Strategies to Increase Physical Activities in the Community

Lead organization: American Cancer Society Cancer Action Network, American Association of Retired Persons, DHHS Chronic Disease Prevention and Control Program

Lead workgroup: Primary Prevention

Short-term indicators (1st and 2nd year): number of local coalitions, BRFSS physical activity & walking data	**Intermediate indicators (3rd to 4th year):** number of local policies, BRFSS physical activity & walking data	**Long-term indicators (4th to 5th year):** statewide coverage
Evaluation methods: tracking, program and process evaluations	**Lead evaluating organization:** DHHS Chronic Disease Prevention and Control Program	
Estimated budget: $60,000	**Other resources needed:** subject matter expertise	

1 year SMART objective J1: increase number of walking coalitions statewide from 7 to 12 by June 2018			
Strategy (specific discreet activities designed to achieve the objective) used: coordinate and assist communities in forming coalitions around walking			
What will be measured: number of coalitions	**Baseline:** 12	**Data source:** DHHS Coordinated Chronic Disease Prevention and Control program	**Timeframe:** by June 2018
Continuum of care: ☐ Primary Prevention	**Level of action:** ☐ Communities ☐ Policy	**Criteria:** ☐ Burden ☐ Environmental scan ☐ Stakeholder interest ☐ Available rescources	**Population:** Nebraska communities **Setting:** communities
Evidence base: Surgeon General's Call to Action To Promote Walking and Walkable Communities, CDC Guide to Strategies to Increase Physical Activities in the Community		**Lead organization:** ACS CAN/AARP/NC2	**Lead workgroup:** Primary Prevention
Indicators: number of coalitions, BRFSS physical activity data, requests for technical assistance			
Evaluation methods: partnership evaluation data, BRFSS tracking, tracking number of communities		**Lead evaluating organization:** DHHS Chronic Disease Prevention and Control program	
Estimated budget: $12,000 to host coalition building trainings		**Other resources needed:** subject matter expertise	

Years 2-5 Strategies:

1. Continue to expand walking coalitions across the state to complement existing funding
2. Support partner organizations efforts to achieve state wide coverage

PRIORITY AREA: Primary Prevention

5 year SMART objective K: increase female and male HPV vaccination rates from 43.3 (females) and 22.8 (males) to 48 and 27, respectively by 2021			
What will be measured: rate increase	**Baseline:** 43.3 (female) 22.8 (males)	**Data source:** DHHS Immunization Program	**Timeframe:** by 2021
Continuum of care: ☐ Primary Prevention	**Level of action:** ☐ Individuals ☐ Families	**Criteria:** ☐ Burden ☐ Available rescources	**Population:** vaccination age Nebraska youth and parents **Setting:** communities
Evidence base: NACCHO Statement of Policy, Centers for Disease Control and Prevention, The Community Guide, The National HPV Vaccination Roundtable	**Lead organization:** Department of Health and Human Services Comprehensive Cancer Control Program (DHHS Immunization Program and American Cancer Society provide technical assistance)		**Lead workgroup:** Primary Prevention

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Short-term indicators (1st and 2nd year): Nebraska State Immunization Information System, vaccine orders, changes in knowledge attitudes and beliefs.	**Intermediate indicators (3rd to 4th year):** Nebraska State Immunization Information System, vaccine orders	**Long-term indicators (4th to 5th year):** vaccination coverage rates, vaccine orders
Evaluation methods: monitoring vaccine orders and coverage rates, individual program evaluation	**Lead evaluating organization:** DHHS Immunization Program, Comprehensive Cancer Control Program	
Estimated budget: $150,000	**Other resources needed:** technical assistance, subject matter expertise	

1 year SMART objective K1: increase the knowledge of and change beliefs about the HPV vaccine in targeted area of Nebraska by June 2018			
Strategy (specific discreet activities designed to achieve the objective) used: social media campaign targeted towards vaccine age Nebraska youth			
What will be measured: implementation of campaign	**Baseline:** no campaign	**Data source:** Immunization Program	**Timeframe:** by June 2018
Continuum of care: ☐ Primary Prevention	**Level of action:** ☐ Communities	**Criteria:** ☐ Burden ☐ Stakeholder interest ☐ Available rescources	**Population:** Nebraska youth of vaccine age **Setting:** communities
Evidence base: NACCHO Statement of Policy, Centers for Disease Control and Prevention, The Community Guide, The National HPV Vaccination Roundtable	**Lead organization:** DHHS Immunization Program (DHHS Comprehensive Cancer Control Program provides technical assistance)	**Lead workgroup:** Primary Prevention	
Indicators: survey respondents reporting increased knowledge and a change in beliefs, increased demand for vaccine			
Evaluation methods: media campaign analytics, electronic survey	**Lead evaluating organization:** Immunization Program		
Estimated budget: $30,000	**Other resources needed:** technical assistance, leveraged networks, evaluation assistance		

Year 2-5 strategies:

1. Reduced missed opportunities and increase HPV vaccine series completion through assessment and system-based changes using AFIX visits to enrolled clinics
2. Support and continue participation in the Nebraska HPV Roundtable
3. Support efforts to require reporting vaccinations to a vaccination registry
4. Continue to disseminate knowledge and best practices via NC2 webinars and summit presentations

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Objective Tables

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Address the Public Health Needs of Cancer Survivors

PRIORITY AREA: Address Public Health Needs of Cancer Survivors

5 year SMART objective L: by 2021, collaborate with cancer stakeholders across the state to identify supportive care, rehabilitative needs of caregivers and cancer survivors in the following phases: a.) diagnosis and treatment; b.) post-acute treatment phase; c.) long-term survival; d.) living with metastatic disease; and e.) palliative care/end of life

What will be measured: knowledge of needs of cancer survivors and caregivers	**Baseline:** no needs assessment exists	**Data source:** questionnaires and Interviews	**Timeframe:** ongoing over the 5 year plan

Continuum of care: ☐ Survivorship	**Level of action:** ☐ Individuals ☐ Families	**Criteria:** ☐ Stakeholder interest ☐ Available rescources	**Population:** cancer survivors in one of the 4 phases: a. diagnosis & treatment b. post-acute treatment c. long-term survival	d. living with metastatic disease e. palliative care/end of life **Setting:** will vary

Evidence base: in 2014, cancer survivors totaled 14.5 million. That number is predicted to reach 19 million by 2024 (ACS Cancer Treatment & Survivorship Facts & Figures). Understanding the needs and desires of the cancer survivor and their caregivers will be imperative as the need for services increases	**Lead organization:** NC2	**Lead workgroup:** A Time to Heal will lead the first year's efforts to do the statewide survey of needs and resources *Survivorship Workgroup of NC2 will decide leadership for following years*

Short-term indicators (1st and 2nd year): identify survivor and caregiver supportive and rehabilitation resources across the state, develop a needs assessment to survey at least 300 NE cancer survivors, develop an initial resource guide of survivorship resources already in existence in NE	**Intermediate indicators (3rd to 4th year):** data analysis of cancer survivors' need survey. Determine if further assessment is needed to uncover the needs of populations that may have been under-represented in the original survey. If so, make concerted efforts to get input from those survivors. Continue to update the resource guide of resources across the state.	**Long-term indicators (4th to 5th year):** use the data analysis of cancer survivors' needs and priorities identified for each phase of cancer. Begin pilot survivorship program in one or more of the top needs.

Evaluation methods: process evaluation for assessment, tracking data from assessment	**Lead evaluating organization:** NE CCCP
Estimated budget: $100,000	**Other resources needed:** support of cancer advocacy groups and cancer centers; phone conferencing capability; technological support to put written, audio, and video information online and/or into CD/DVD format

1 year SMART objective L1: By the end of 2018 plan year,

a) Establish and identify collaborative relationships with at least five cancer stakeholder groups interested in partnering with the NE State Comprehensive Cancer Control Program to identify survivor and caregiver supportive and rehabilitation resources across the state.
b) Develop and implement a needs survey targeted to identifying the needs of NE cancer survivors
c) Collect survey data from at least 300 NE cancer survivors
d) Produce a preliminary resource guide listing currently available survivorship programs in NE

Strategy (specific discreet activities designed to achieve the objective) used:

- ☐ Personal contact with key cancer stakeholders to identify at least 5 entities willing to help with a needs survey
- ☐ Identify existing supportive and rehabilitative resources the state
- ☐ With input from cancer care professionals, develop a needs survey that can be available both online and in paper and pencil formats
- ☐ Distribute the survey to cancer survivors across the state via cancer centers, advocacy groups, and direct contact with survivors

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What will be measured: number of collaborative relationships with stakeholder groups, existence of a needs survey, resource guide, dissemination tactics and results	**Baseline:** to be established with this survey	**Data source:** cancer survivors in NE	**Timeframe:** by 2018
Continuum of care: ☐ Survivorship	**Level of action:** ☐ Individual ☐ Families	**Criteria:** ☐ Burden ☐ Available rescources	**Population:** mixed diagnoses- children and adults **Setting:** throughout the state
Evidence base: in 2014, cancer survivors totaled 14.5 million. That number is predicted to reach 19 million by 2024 (ACS Cancer Treatment & Survivorship Facts & Figures). Understanding the needs and desires of the cancer survivor and their caregivers will be imperative as the need for services increases		**Lead organization:** A Time to Heal NC2	**Lead workgroup:** survivorship
Indicators: partnership assessments, process evaluation of resource guide creation, number of guides dissemination, dissemination strategies			
Evaluation methods: partnership assessments, process evaluations, dissemination strategies		**Lead evaluating organization:** Dept. of Health and Human Services Division of Public Health, Health Promotion Unit	
Estimated budget: $19,000	**Other resources needed:** underwriting for a brainstorming conference to develop the survey, technology to distribute the survey to survivors in different settings, collaboration with on-site care providers to encourage survivor participation in the survey		

1 year SMART objective L2: by June 2018 form working group to address raising Pain Policy Studies Group grade from B+ to A			
Strategy (specific discreet activities designed to achieve the objective) used: form ad hoc committee to study requirements and create action plan to raise grade. Committee to include representatives from cancer centers, American Cancer Society Cancer Action Network, AARP, Injury Prevention Overdose Prevention Coordinator			
What will be measured: output of committee	**Baseline:** no current plan or timeline	**Data source:** "Achieving Balance in Sate Pain Policy" Painpolicy.wisc.edu	**Timeframe:** by June 2018
Continuum of care: ☐ Palliation ☐ End of life care ☐ Survivorship	**Level of action:** ☐ Policy	**Criteria:** ☐ Burden ☐ Environmental scan ☐ Stakeholder interest	**Population:** Nebraska cancer survivors **Setting:** statewide
Evidence base: "Achieving Balance in State Pain Policy a Progress Report Card" Pain & Policy Studies Group and "How Do You Measure Up?" American Cancer Society Cancer Action Network		**Lead organization:** American Cancer Society Cancer Action Network, Nebraska Cancer Coalition	**Lead workgroup:** survivorship; policy, systems and environmental changes
Indicators: creation of realistic action plan and timeline			
Evaluation methods: partnership evaluation, process evaluation		**Lead evaluating organization:** NE CCCP	
Estimated budget: $1,000	**Other resources needed:** staff time to lead group, technical assistance regarding suitable policies		

Years 2-5 strategies:

1. Support increased access to care and insurance for all Nebraskans
2. Support creation and maintenance of opioid prescription database for Nebraska pharmacies
3. Support lung cancer support group organized by American Lung Association

PRIORITY AREA: Address Public Health Needs of Cancer Survivors

5 year SMART objective M: by 2021, collaborate with researchers at state and university levels to increase the quality and reach of cancer survivorship research projects/grants relevant to the different phases of cancer survivorship (diagnosis and treatment, post-acute treatment, palliative care, and end of life)

What will be measured:	Baseline:	Data source:	Timeframe:
1. Collaborative relationships developed 2. Research projects in progress	1. Informal relationships with accredited cancer centers that currently conduct research 2. None known	environmental scan	by 2021

Continuum of care:	Level of action:	Criteria:	Population: cancer survivors in one of the 4 phases:	Setting: research will be conducted in a variety of settings dependent pon project
☐ Survivorship	☐ Institutions	☐ Environmental Scan	a. diagnosis & treatment b. post-acute treatment c. palliative care d. end of Life	

Evidence base:	Lead organization:	Lead workgroup:
in 2014, cancer survivors totaled 14.5 million. That number is predicted to reach 19 million by 2024 (ACS Cancer Treatment & Survivorship Facts & Figures). Understanding the needs and desires of the cancer survivor and their caregivers will be imperative as the need for services increases	NC2	Survivorship Workgroup

Short-term indicators (1st and 2nd year):	Intermediate indicators (3rd to 4th year):	Long-term indicators (4th to 5th year):
☐ 2 relationships established ☐ 2 funded projects/grants in process	☐ 5 relationships established ☐ 5 funded projects/grants in process	☐ 8 relationships established ☐ 8 funded projects/grants in process

Evaluation methods:	Lead evaluating organization:
routine environmental scan, key informant interviews	NE Comprehensive Cancer Control Program

Estimated budget:	Other resources needed:
$75,000	designated ombudsman (or team) to meet with and build collaborative research relationships

1 year SMART objective M1: by June 2018, establish a collaborative relationship with at least two entities interested in partnering with the Nebraska Cancer Coalition to evaluate the highest priorities for cancer survivorship research

Strategy (specific discreet activities designed to achieve the objective) used:
- ☐ Identify current survivorship research being conducted at the accredited cancer centers via key informant interviews
- ☐ List entities with research expertise that could be potential partners in conducting survivorship research through work group
- ☐ Explore funding opportunities focused on cancer survivors, both who are well and those receiving EOL care through work group

What will be measured:	Baseline:	Data source:	Timeframe:
number of formal, collaborative relationships developed	0 formal relationships	environmental scan	by 2018

Continuum of care:	Level of action:	Criteria:	Population:	Setting:
☐ Survivorship	☐ Institutions	☐ Environmental scan	mixed diagnoses - children and adults	throughout the state

Evidence base: in 2014, cancer survivors totaled 14.5 million. That number is predicted to reach 19 million by 2024 (ACS Cancer Treatment & Survivorship Facts & Figures). Understanding the needs and desires of the cancer survivor and their caregivers will be imperative as the need for services increases. Research is the evidence based way to determine which services effectively meet the needs without wasting valuable resources	**Lead organization:** NC2	**Lead workgroup:** Survivorship Workgroup
Indicators: 2 formal research relationships developed		
Evaluation methods: routine environmental scan, key informant interviews	**Lead evaluating organization:** NE Comprehensive Cancer Control Program	
Estimated budget: $10,000	**Other resources needed:** designated ombudsman (or team) to meet with and build collaborative research relationships	

Year 2-5 strategies:

1. Continue to build formal research relationships
2. Publish at least three peer reviewed articles
3. Release one white paper a year

Inputs	Activities Year ONE & TWO	Short-term Indicators	Intermediate Indicators	Long-term Indicators
Nebraska Comprehensive Cancer Control Program Staff & Funding	**Early Detection and Screening:** 1. Provide support to cancer centers seeking to become lung cancer screening centers of excellence. 2. Increase the number of transportation or worksite wellness projects related to screening. (Crosscutting issue ACCESS) 3. Increase the channels of communication to the public on the importance of cancer screening (webinar training for nonclinical staff, creation of speaker's bureau). (crosscutting issue EDUCATION) 4. Increase the number of staff trained on CLAS. (Crosscutting issue HEALTH DISPARITIES HEALTH EQUITY) 5. Increase the number of funded projects with partner clinics or FQHCS working to improve their CRC screening rates (Crosscutting issue	**Early detection and Screening:** 1. Number of requests for technical assistance, number of cancer centers accredited 2. Reported changes in knowledge, attitudes, beliefs, uptake in transportation programs. (Crosscutting issue ACCESS) 3. Creation of channels of communication, documented reach, number, variety of speakers. (crosscutting issue EDUCATION) 4. Attendance at CLAS trainings, number of staff trained, reported applicability. (Crosscutting issue HEALTH DISPARITIES HEALTH EQUITY) 5. Number of funded projects and results of project evaluations, clinic screening rates. (Crosscutting issue HEALTH SYSTEMS CHANGES)	**Early detection and Screening:** 1. Number of cancer centers accredited. 2. Reported changes in knowledge, attitudes, beliefs, uptake in transportation programs. Changes in clinical systems. (Crosscutting issue ACCESS) 3. Documented reach of channels of communication. (crosscutting issue EDUCATION) 4. Attendance at CLAS trainings, number of staff trained, reported applicability. (Crosscutting issue HEALTH DISPARITIES HEALTH EQUITY) 5. Number of funded projects and results of project evaluations, clinic screening rates. (Crosscutting issue HEALTH SYSTEMS CHANGES)	**Early detection and screening:** 1. Number of Nebraskans appropriately screened for lung cancer. 2. Increase in the number of Nebraska women up to date on cervical cancer screening. 3. Increase in the number of Nebraska men who have talked with their health care provider about the PSA test. 4. Increase in the number of adults up to date on colorectal cancer screening

	HEALTH SYSTEMS CHANGES			
Data (Nebraska Cancer Registry, Behavioral Risk Factor Surveillance System and others) State Health Improvement Plan Nebraska Cancer Coalition	**Emphasize Primary Prevention:** 1. Social marketing campaign on the dangers of radon targeted to home owners. 2. One-year educational series on cancer risk and alcohol targeted to health professionals. 3. Collaborative efforts educate Nebraskans who experience health disparities via the CDC TIPS campaign on tobacco and cancer risks. (Cross cutting issue HEALTH DISPARITIES HEALTH EQUITY) 4. Support cancer centers, hospitals, FQHCs, 501c3 orgs, and local health departments in implementing health literacy action plans. (Crosscutting issue HEALTH DISPARITIES HEALTH EQUITY, POLICY AND SYSTEMS CHANGES) 5. Coordinate and assist communities in forming coalitions around walking in collaboration with DHHS Chronic Disease Prevention and Control Program. (Crosscutting issue POLICY AND SYSTEMS CHANGES).	**Emphasize Primary Prevention:** 1. Number of homes tested for radon, number of homes mitigated for radon. 2. Reported changes in knowledge, attitudes and beliefs. 3. Increased calls to Quitline, increased requests for available resources, increased connection to stakeholder groups, campaign analytics. (Cross cutting issue HEALTH DISPARITIES HEALTH EQUITY) 4. Creation of plans, buy in from administration. (Crosscutting issue HEALTH DISPARITIES HEALTH EQUITY, POLICY AND SYSTEMS CHANGES) 5. Number of local walking coalitions. (Crosscutting issue POLICY AND SYSTEMS CHANGES) 6. Reported changes in knowledge, attitudes and beliefs. 7. Nebraska State Immunization Information System, vaccine orders, changes in knowledge attitudes and beliefs.	**Emphasize Primary Prevention:** 1. Number of homes tested for radon, number of homes mitigated for radon, number of communities with radon resistant new construction. 2. Changed organizational policies, reported changed knowledge attitudes and beliefs. 3. Rate decreases, increased reported quit attempts, Increased calls to Quitline, increased requests for available resources, increased connection to stakeholder groups, campaign analytics (Cross cutting issue HEALTH DISPARITIES HEALTH EQUITY) 4. Number of plans in implementation, broad support across organization. (Crosscutting issue HEALTH DISPARITIES HEALTH EQUITY, POLICY AND SYSTEMS CHANGES) 5. Number of local policies, BRFSS physical activity and walking data. (Crosscutting issue POLICY AND SYSTEMS CHANGES)	**Emphasize Primary Prevention:** 1. Number of homes tested for radon, number of homes mitigated for radon, state wide radon resistant new construction codes 2. Changes in BRFSS indicators 3. Rate decreases, increased reported quit attempts, Increased calls to Quitline, increased requests for available resources, increased connection to stakeholder groups, campaign analytics (Cross cutting issue HEALTH DISPARITIES HEALTH EQUITY) 4. Improvement in selected BRFSS indicators. (Crosscutting issue HEALTH DISPARITIES HEALTH EQUITY, POLICY AND SYSTEMS CHANGES) 5. Statewide coverage of Complete Streets (crosscutting issue POLICY, SYSTEMS AND ENVIRONMENTAL CHANGES) 6. Changes in selected BRFSS indicators.

15 Objective Tables

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NC2 Nebraska Cancer Coalition www.necancer.org

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	6. Support sun safe work environments and public attractions 7. Collaborate on a social marketing campaign on HPV vaccination targeted towards adolescents emphasizing cancer prevention in collaboration with DHHS Immunization Program.		6. Changes in the built environment, reported changes in knowledge, attitudes and beliefs 7. Vaccination Coverage rates, vaccine orders.	7. Vaccination Coverage rates, vaccine orders, Vaccination Coverage rates, vaccine orders
Evidence Base **Other Program Plans (See executive summary)**	**Address the Public Health Needs of Cancer Survivors:** 1. Develop and implement needs assessment targeted to Nebraska cancer survivors 2. Conduct key informant interviews with cancer stakeholder groups to identify resources available for survivors in Nebraska. 3. Form ad hoc committee to study requirements to raise Pain Policy Studies grade (Cross cutting issue POLICY AND SYSTEMS CHANGE) 4. Establish collaborative relationships with two entities interested in partnering with NC2 to evaluate the highest priorities in survivorship research.	**Address the Public Health Needs of Cancer Survivors:** 1. Survey at least 300 survivors 2. Establish relationships with at least five stakeholder groups. 3. Creation of action plan. (Cross cutting issue POLICY AND SYSTEMS CHANGE) 4. Two relationships established, and two projects funded.	**Address the Public Health Needs of Cancer Survivors:** 1. Establish baseline of unmet needs in Nebraska. 2. Pain Policy Studies Group Grade. 3. Five relationships established and fiveprojects funded.	**Address the Public Health Needs of Cancer Survivors:** 1. Use the data analysis of cancer survivors needs and priorities identified for each phase of cancer. 2. Begin to plot survivor-ship program in or more of the top needs. 3. Pain Policy Studies grade. 4. 8 relationships established and projects funded. **Ultimate Indicator:** Reduced Incidence and Mortality

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