Published in final edited form as:

Cancer Causes Control. 2018 December ; 29(12): 1173–1180. doi:10.1007/s10552-018-1118-9.

Collaborating to conquer cancer: the role of partnerships in comprehensive cancer control

Cynthia A. Vinson¹, Citseko Staples², Sarah Shafir³, Leslie Given⁴, and Nina Miller⁵

¹Division of Cancer Control and Population Sciences, National Cancer Institute, 9609 Medical Center Dr., Bethesda, MD 20892, USA

²American Cancer Society Cancer Action Network, 555 11th St., NW, Ste 300, Washington, DC 20004, USA

³American Cancer Society, 250 Williams St., Atlanta, GA 30303, USA

⁴Strategic Health Concepts, 660 Allen Rd, Earlysville, VA 22936, USA

⁵American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611, USA

Abstract

Comprehensive cancer control celebrated its twentieth anniversary in 2018. A dedicated group of national partners formed the Comprehensive Cancer Control National Partnership (CCCNP) at the same time that CDC's National Comprehensive Cancer Control Program was formed. The CCCNP has supported the development and growth of comprehensive cancer control from its inception. The CCCNP mirrors how coalitions function at the state, tribe, territory, and Pacific Island Jurisdiction level. We provide a national example of how 19 leading cancer organizations work together with a unified vision to support cancer control efforts in the United States (U.S.). What follows is an overview of the CCCNP, its vision, mission, and structure and a description of how this partnership has evolved over the past 20 years. The importance of collaboration is highlighted. Two states, South Dakota and Kansas, provide examples of how working with partners through the cancer coalition has advanced their state's cancer control agenda. Closing thoughts on the future work of the CCCNP are provided, including a continued focus on supporting health equity; better engagement and support of CCC coalition leaders; and informing efforts to develop a national cancer control plan for the United States.

Keywords

Coalition; Partnership; Collaboration; Cancer control

Introduction

Since 1994, comprehensive cancer control (CCC) has been an accepted, integrated approach where partners from organizations representing the diversity of the cancer control continuum collaborate to address the burden of cancer [1]. The CCC approach was put into action by

the Centers for Disease Control and Prevention (CDC) in 1998, with funding for the National Comprehensive Cancer Control Program (NCCCCP). The Comprehensive Cancer Control National Partnership (CCCNP) was formed in 1999 as a collaborative group of diverse organizations working together to build and strengthen comprehensive cancer control efforts across the nation [2]. Today, the CCCNP is an influential group of 19 leading cancer organizations (<https://www.cccnationalpartners.org/about-us>) that utilize their combined strengths and resources to coordinate national cancer control efforts and to support and facilitate the efforts of state, tribe, territory, and Pacific Island Jurisdiction (PIJ) cancer control coalitions to ultimately change the trajectory of the cancer burden in the U.S.

The network of partners engaged in the CCCNP includes organizations from a variety of sectors: government and non-profit, large and small, with direct and indirect connections to the coalitions working at the state or local level. Some of the national partner organizations have a major responsibility to support the work of the coalitions where others are contracted to support the work and still others bring specific expertise or resources to the table. Bringing partners together provide opportunity to share resources, identify gaps in resources, and plan activities to fill those gaps. It also provides for shared responsibility from multiple organizations to disseminate the information and resources to coalitions to incorporate into their cancer plans.

The CCCNP has evolved, like all CCC coalitions have, over the past 20 years. Between 1999 and 2013, the primary focus of the CCCNP was supporting the development and implementation of state, tribe, territory, and PIJ cancer control plans and supporting coalition development. Over the years, the work and the structure of the CCCNP have evolved. During this time, the partnership did not have a formalized leadership structure but relied on various partners to step in and lead efforts as they were able. Partners have joined, with varied activity level and some have left or become inactive in the partnership as organizational priorities have changed over time.

In 2014, the CCCNP modified its approach to providing states, tribes, territories, and PIJs with technical assistance and training to support successful implementation of comprehensive cancer control plans. The CCCNP identified specific priority areas that its member organizations could focus on to support coalitions in developing, implementing, executing, and evaluating a wide range of evidence-based interventions. To aid and assist the CCCNP with this new approach, the partners also established a formalized leadership group, which includes a Chair and Vice-Chair as well as workgroup leaders to serve in an advisory leadership capacity, providing guidance, direction, and support to the CCCNP as they deepened investment in the issue priority areas. Through the establishment of the priority areas and related workgroups, the CCCNP was able to convene a diverse group of subject matter experts, researchers, thought leaders, and other cancer and tobacco control professionals from the CCCNP member organizations to invest resources and to support coalition efforts. The partnership actively seeks input from CCC coalitions and conducts both qualitative and quantitative evaluations on all technical assistance and training that help refine the activities of the priority workgroups.

The flexibility of the CCCNP structure has and continues to serve the needs of the CCC coalitions, while also taking advantage of the diverse and unique contributions of the members of the CCCNP to strengthen and sustain cancer control efforts at the state, tribe, territory, PIJ, and local level.

CCCNP goals, objectives, and organizational structure

The CCCNP mission supports a national movement of states, tribes, territories, U.S. Pacific Island Jurisdictions, and local communities working together to reduce the burden of cancer for all people. The partnership is currently focusing on two goals: (1) coordinate national comprehensive cancer control efforts and (2) facilitate and provide support to comprehensive cancer control coalitions.

To discuss how the CCCNP coordinates national comprehensive cancer control efforts, it is important to review its structure. The national partnership is structured around three components: (1) member organizations, (2) leadership group, and (3) workgroups (Fig. 1).

CCCNP member organizations

There are currently 19 organizations who are members of the CCCNP. Member organizations are asked to actively participate in CCCNP membership meetings, conference calls, and workgroups. Membership meetings are typically held each month with in-person meetings held twice a year. Monthly calls allow time for partner spotlights to inform the CCCNP of the unique contributions of each organization. In-person meetings allow for networking, idea sharing, planning, and building strong partnerships, networks of diverse partners, working together to accomplish their goals. Other responsibilities of being an organizational member of the CCCNP include accountability for commitments made to partnership work, information sharing, and identification of opportunities to align organizational priorities with CCCNP efforts. Alignment may include fiscal, in-kind, staff expertise, and travel expenses to CCCNP meetings and events, designation of a senior level staff representative to the CCCNP, and adherence to the CCCNP guiding principles (Table 1).

CCCNP leadership group

Established in 2014, the role of the leadership group is to ensure the CCCNP member organizations are actively involved in implementing CCCNP priorities as outlined in the strategic plan. Specifically, the leadership group identifies opportunities to coordinate across workgroups and member organizations, ensures the CCCNP structure is optimally set to implement its priorities, sets meeting agendas, provides recommendations to the full membership regarding priority issues, addresses membership requests and opportunities, and resource needs and allocations.

CCCNP workgroups

Workgroups serve an important role in helping to meet the identified needs of the NCCCCP and CCC coalitions. The CCCNP gathers information about the needs of CCC coalitions

through a variety of mechanisms. The CDC brings information to the CCCNP about coalition needs gathered from program consultants that provide technical assistance to NCCCP grantees. Additionally, CDC funds two organizations, currently the American Cancer Society (ACS) and the George Washington University Cancer Center, to provide technical assistance and training to the NCCCP programs and their CCC coalitions. These two organizations collect information about CCC programs and coalitions on a regular basis through needs assessments including surveys and key informant interviews, and feedback on technical assistance and training activity evaluations. Other partners, including the National Association of Chronic Disease Directors which serves the chronic disease directors across the country, bring information to the CCCNP about needs identified through their networks.

There are currently several workgroups that members can participate in that address priority issues, including (1) colorectal cancer screening, (2) HPV vaccination uptake, (3) healthy behaviors for cancer survivors, (4) sustaining coalitions, and (5) evaluation. In addition, there are two volunteer leads who work on CCCNP communications including maintenance of the CCCNP website. Work-groups are the primary method for the CCCNP to organize, develop, and implement important work of the partnership. Generally, workgroups are comprised of national partner members and representatives from other national organizations who have expertise and experience in the focus area of the workgroup. Workgroups are formed and dissolved based on the current and upcoming needs and priorities of the CCCNP. Typically, workgroups meet by conference call or virtual technology platforms. The CCCNP establishes ad hoc workgroups, such as those focused on membership and policy when issues or opportunities arise.

Each workgroup is led by a chair or co-chairs that facilitate development of a 1-year action plan. The chair helps ensure implementation of the plan. Workgroups meet regularly to assess and recruit additional members, provide information on progress to the evaluation workgroup, report workgroup updates and progress to the CCCNP membership, identify newsworthy information that can be shared with cancer coalitions, and identify issues needing full membership input.

Each year the CCCNP reviews and revises its strategic plan. During planning discussions, care is taken to address current trends in cancer control, critical needs of coalitions, and resources to address challenges. The needs assessment data collected from CCC coalitions, along with promising practices and evidence-based interventions, inform development of workgroups action plans.

Details of current CCCNP work groups formed to address these critical national needs while also addressing how coalitions are supported are described below.

Increasing HPV vaccination uptake

Studies have shown that HPV vaccination can prevent cancers (cervical, oropharyngeal, anal, penile, vulvar, and vaginal) and several other diseases. While progress has been made since the original President's Cancer Panel report on Accelerating HPV Vaccine Uptake: Urgency for Action to Prevent Cancer was published in 2013, vaccine coverage in U.S. adolescents has not reached its full public health potential [3].

The HPV workgroup began in 2014, by sharing information about activities that each partner organization was implementing around HPV vaccination. Sharing this information was helpful because it provided a picture of what areas were being addressed and existing gaps. Based on a review of this information, the HPV workgroup identified an opportunity to support the NCCCP programs and CCC coalitions in their efforts to address HPV vaccination rates.

The HPV workgroup, with funding support from CDC, NCI and ACS, implemented a model of training and technical assistance that included in-person intensive workshops on evidence-based and promising practices in HPV vaccination, followed up with post-training-tailored technical assistance in direct response to the needs of cancer coalitions [4]. The first HPV workshop was held in 2016 and reached 11 states. Two more trainings were held in 2018 for an additional 22 states. Each state team included four individuals representing (1) state health department comprehensive cancer control program; (2) state immunization program; (3) ACS health systems manager; and (4) an HPV champion such as a healthcare provider or community organization. The focus of the workshops was on disseminating and implementing effective evidence-based strategies and promising practices on HPV vaccination uptake, and to support the state teams in development of action plans. The HPV workgroup played a critical role in planning the workshops by developing training curricula that included a mix of didactic and small group teamwork. Workgroup members served as faculty and state team facilitators at the training. Following the training, ACS coordinated the follow-up technical assistance delivered to state teams on implementation of their action plans. The HPV workgroup members were called upon to support the follow-up technical assistance by identifying resources to help state teams implement their action plans and serving as faculty on technical assistance webinars.

Increasing colorectal cancer-screening rates

Colorectal cancer (CRC) is the second most common cause of cancer death in the U.S. when men and women are combined [5]. In 2018, an estimated 97,220 new cases of colon and 43,030 cases of rectal cancer are expected to be diagnosed and an estimated 50,630 deaths from CRC are expected to occur [5]. With CRC screening, many of these cancer cases and deaths could be prevented.

In support of the National Colorectal Cancer Roundtable's (NCCRT) shared goal of screening 80% of adults aged 50 and older for colorectal cancer by 2018 (80% by 2018), the CCCNP signed the 80% by 2018 pledge and formed the CRC-Screening workgroup (CRC workgroup). This was an important area of focus because many of the CCC programs and coalitions prioritized CRC screening in their cancer plans, and the NCCRT reported that more than 60 coalitions had signed the 80% by 2018 pledge [6]. The CRC workgroup provides an opportunity for national partners to share information and resources to better coordinate efforts to support CCC programs and coalitions across the country.

One purpose of engaging in CCCNP efforts is to hear about work being done by partner organizations. In 2014, it was discovered through various conversations that the CCCNP and the NCI were planning to engage states in separate training opportunities to address colorectal cancer. The CCCNP training was focused on connecting state coalitions with ACS

health systems staff to improve CRC screening. The NCI efforts were focused on improving state CRC-screening activities with clinicians in Health Resources and Services Administration (HRSA) Federally Qualified Health Centers (FQHC). Efforts were made to bring these initiatives together to plan one event collaboratively. The two efforts joined forces and established one planning committee to undertake the convening of training for state coalitions. The CCCNP and its partners offered 3 CRC forums from 2015 to 2018 that provided an opportunity for 33 state coalitions to learn from national experts about evidence-based interventions, connect with staff at FQHCs in their respective states, and develop collaborative action plans to increase CRC-screening rates [7].

Addressing gaps in services that promote healthy behaviors for cancer survivors

The CCCNP Tobacco Cessation for Cancer Survivors workgroup was formed under the leadership of a partner representative from the Truth Initiative (<https://truthinitiative.org/>). The workgroup developed a matrix of resources and provided technical assistance to coalitions addressing tobacco cessation for cancer survivors. Various national partners engaged in supporting and presenting webinar topics. The workgroup raised awareness of the issue, provided key messages, materials, toolkits, and other evidence-based information to coalitions on issues such as tobacco cessation referral, reimbursement, and billing.

Annually, the CCCNP engages in a strategic planning process including discussion of emerging issues in cancer control and review of the areas of focus for the partnership in the coming year(s). At the Spring 2017 meeting of the CCCNP it was discussed and agreed upon that based on trends, needs, and gaps, it would be advantageous for the Tobacco Cessation for Cancer Survivors workgroup to expand its scope. This would include a more comprehensive approach focused on promotion of healthy behaviors for cancer survivors that are known to impact patient outcomes. Some areas for consideration included not only tobacco cessation but also nutrition and physical activity, psychosocial/mental health and support, early detection for survivors, alcohol use, delivery of survivor care plans, and patient navigation. One key accomplishment of the workgroup is the collection of resources and dissemination of a tool to CCC coalitions regarding tools and information they can use to address priorities related to healthy behaviors for cancer survivors (<http://bit.ly/HealthyBehaviorsTool>).

By expanding the workgroup focus, the CCCNP engaged additional partners interested in topics. Each member of the workgroup brings unique expertise that can assist coalitions as they embark on important work to address the needs of cancer survivors.

Sustaining effective CCC coalitions

Since a well-functioning cancer coalition is integral to the successful implementation of cancer plan priorities, the CCCNP recommitted efforts to help maintain and sustain strong coalitions by forming a workgroup dedicated to this topic. The workgroup focuses initiatives around the core tenets of the Nine Habits of Successful Comprehensive Cancer Coalitions: A Guide for an Effective and Efficient Coalition [8]. In August 2017, the CCCNP conducted a Nine Habits workshop for all cancer control program directors and coalition leaders during the CDC's National Cancer Conference. The training provided an opportunity for coalitions

to reacquaint themselves with the Nine Habits and develop an action plan on how to strengthen their coalitions over the coming year.

State CCC coalitions collaborating to conquer cancer

The CCCNP is only one example of how a coalition functions but we can learn more from how state, tribe, territory, and PIJ coalitions operate. These CCC coalitions face many of the same challenges and opportunities. Coalitions vary in how they organize and operate but all have a dedicated leadership that include coalition and workgroup chairs, steering committees and workgroups that maintain a focus on implementing action plans that address priority issues from their cancer plans. Each coalition aims to include a diverse membership group that represents various populations. The following two case studies provide a snapshot of how states have created strong, diverse CCC partnerships and how their leaders view the future of comprehensive cancer control.

South Dakota

The South Dakota Cancer Coalition (SDCC) (<https://www.cancersd.com>) is chaired by Mary Milroy, MD, FACS. In a recent interview, Dr. Milroy described how the coalition has been able to engage partners in initiatives that have impacted the residents of South Dakota. In the early years of the coalition, a team of dedicated professionals representing many aspects of healthcare began to explore approaches to cancer control in South Dakota by visiting nearby states. The team also attended a regional Leadership Institute sponsored by the CCCNP. SDCC began partner engagement, formed committees, and began work on their first cancer plan, delivered to CDC in 2005. According to Dr. Milroy, the coalition benefited from looking to the current groups working in breast and cervical cancer and incorporating those groups into the cancer coalition “because they already had the convening nature down pat.” The breast and cervical cancer-screening subgroup worked on addressing resource gaps and providing patient information, including a book titled, “Straight Talk About Breast Cancer” by Suzanne Braddock, MD et al. to hundreds of South Dakota women. One of the first initiatives brought the American Cancer Society, the South Dakota affiliate of Susan G. Komen, and Wellmark Blue Cross Blue Shield to the table as critical partners to expand breast and cervical cancer screening to women aged 40–49. To address the screening age controversy, the coalition brought partners together to create a video and paper for providers to encourage personalized risk assessment when talking with patients about whether to be screened.

Dr. Milroy describes their coalition as the “little organization that could.” The coalition receives limited funding from the South Dakota Department of Health (SC DOH) through a cooperative agreement with the CDC. The CCC work is housed in the Office of Chronic Disease Prevention and Health Promotion. South Dakota State University (SDSU) Population Health Evaluation Center provides data analysis and evaluation services for the coalition through an agreement with the SD DOH. The state’s Cancer Registrar became an integral part of the coalition’s work and use of data for planning. Critical partner groups joined forces to address other plan objectives.

The SDCC made a formal decision in a strategy session to discuss and determine just who should be at the table and serve on their steering committee. Partners were invited to serve, and the representation was strategically determined using formal group decision-making. Representation today includes the following partners: healthcare providers, the SD Department of Health, representatives from the state's three major health systems, a SD legislator, American Cancer Society, Great Plains Tribal Health Board, a cancer survivor, and Susan G. Komen Great Plains. Similar strategic methodology is utilized to determine areas of focus for the coalition's work. Starting with the 15 priorities outlined in the state cancer plan, a scoring system was applied that listed points for:

- Is the issue pressing?
- Can the coalition make an impact?
- Is no one else doing this?
- Do we have the partners/resources to accomplish the task?

Initiatives were proposed and the top five or six scored initiatives were sent out to the entire coalition for a vote. The top three areas of focus determined by group consensus are currently (1) increase HPV vaccination rates; (2) early detection health equity; and (3) promote patient-centered care that enhances quality of life for all cancer survivors. Three task forces were formed in these areas, chairs assigned, and coalition partners invited to participate. Cross-cutting committees engage additional partners. Through this exercise, the coalition was able to explore and recognize work that is occurring in the state that is addressing the cancer-related goals of the cancer plan. The coalition was then able to focus on other efforts while recognizing the good work being done by other organizations.

Dr. Milroy concluded the interview with a reflection on her greatest accomplishment as chair of the coalition. She cites her connection with the American College of Surgeons as a Fellow and the Commission on Cancer (CoC) where she served as a commissioner and representative of South Dakota as State Chair and reflected on how that has benefitted the SD Cancer Coalition. She set the stage to engage the State Chair, a leader representing the provider community, as a mandatory member of the steering committee from her time as State Chair and moving forward. As that leader with the knowledge of the work of the CoC she was able to bring a quality framework to the table, engage the state's provider community and hospital systems in coalition work, and inject quality and evidence-based initiatives into the cancer plan called for in the CoC's patient-centered accreditation framework, e.g., implementation of distress screening, navigation processes, and delivery of survivorship care plans.

Kansas

Dr. Gary Doolittle is a medical oncologist at the University of Kansas Cancer Center specializing in melanoma. He is also the immediate past chair of the Kansas Cancer Partnership (KCP) (<http://kscancerpartnership.org/>). The Kansas Cancer Partnership was convened in 1999 by the Kansas Department of Health and Environment and published "Part I" of the Kansas plan in April 2002. The initial partnership included 70 members

representing organizations and agencies from across the state. The initial plan focused on five key strategies: (1) foster collaboration for primary, secondary, and tertiary/palliative care; (2) identify gaps in services and optimized resources; (3) reduce disparities in cancer screening and management; (4) enhance access to quality treatment and support services; and (5) identify and implement priorities and strategies to evaluate outcomes. Workgroups were formed around six priority cancer areas and included lung, skin, colorectal, breast, cervical, and prostate. Since 2002, the Kansas Cancer Control plan has been updated three times; modifying strategies and priorities based on data and needs specific to Kansas. The structure of the partnership has also evolved over the years and shifted from cancer-specific workgroups to workgroups focusing on policy, early detection, survivorship, prevention, health equity (social inequities), financial burden, and health systems change. The partnership has also expanded to include additional regional coalitions as well as tobacco and immunization coalitions. Dr. Doolittle has been a member of the KCP from the beginning and kindly shared his perspective on how to build and maintain an effective comprehensive cancer control coalition.

According to Dr. Doolittle, membership diversity is very important. The KCP includes a wide variety of organizations involved in cancer and chronic disease. The partners include the American Cancer Society, Midwest Cancer Alliance, Chronic Disease Alliance of Kansas, Susan G. Komen, Kansas Department of Health and Environment, academia, healthcare systems and providers, patient advocates, and private citizens. Diversity is a challenge and an opportunity. Each member comes to the table with their own agendas. For example, the American Cancer Society brings national priorities and diffuses them to the coalition. Native American organizations bring tribal priorities to the attention of the coalition. Interacting with partners across the state allows grass root issues to emerge and viewpoints from many populations to be represented. Bringing together diverse groups allows you to find “common ground” that you can work on collectively. An example of a common-ground issue was identified when everyone agreed to focus on clean indoor air which included a partnership with the Kansas American Heart Association. Collectively, they helped pass the Kansas Indoor Clean Air Act in 2010.

Building a diverse partnership can be challenging. Kansas is not known as having a particularly diverse population. However, there are pockets of diverse populations within the state such as American Indian and Hispanic populations and various communities that are living in poverty. The KCP has made a concerted effort to recruit members from across the state to learn about the needs of all Kansas citizens. Since 2013, three Regional Cancer Coalitions have been established to help identify local cancer priorities, provide support to local level partners, assure that the Kansas cancer plan is informed by local communities, and increase participation in KCP and implementation of plan priorities at the local level.

When Dr. Doolittle was asked about the benefits of engaging partners in the implementation of cancer plan goals he responded:

Engaging with partners allows for a diversity of ideas and a broader perspective on how to accomplish a common goal. As partners, we work together during coalition meetings to gain consensus while at the same time moving our agenda forward. I

find that when our coalition gets together we bring each other up, reminding ourselves that the work we are doing is really important. I always leave a meeting with a strong sense of purpose, more inspired for having met as a coalition.

The KCP has formalized their operating guidelines and defined their structure. They have a steering committee that consists of a chair, co-chair, immediate past chair, secretary, workgroup, and ad hoc committee chairs and up to three other individuals from the general membership. The steering committee meets at least quarterly and there are two full membership meetings each year. The workgroups develop and implement work plans and provide opportunities for engagement with local communities. When Dr. Doolittle was asked what accomplishment he is most proud of as chair, he responded quickly that it was the creation of regional coalitions. While he does not take credit for the idea of regional coalitions, he feels “they are a genuine attempt to bring areas of the state into the coalition and he is really proud of what that has done for the coalition as a whole.”

When thinking about the future of cancer control, Dr. Doolittle reflected on the importance of CCC coalitions for keeping the agenda moving forward. Public health is not always a priority. Cancer coalitions, like the KCP, help keep cancer control issues at the forefront by telling stories that put a face to cancer control that policymakers can respond to.

CCCNP future directions

In 2016, the Cancer MoonshotSM refocused national efforts in cancer control. The primary goal of the MoonshotSM is to accelerate progress in cancer, including prevention and screening as well as encourage greater cooperation and collaboration within and between academia, government, and the private sector [9]. This is a natural area for the CCCNP to play a role.

While the CCCNP has been leading efforts to support the development and implementation of cancer control plans, the effort has not yet led to the development of national comprehensive cancer control plan for the United States. In 2017, the CDC, ACS, and NCI commissioned the National Academies of Sciences, Engineering, and Medicine (NASEM) to convene an ad hoc committee to develop a National Strategy for Cancer Control in the United States (<https://www8.nationalacademies.org/pa/projectview.aspx?key=49923>). The CCCNP has been supportive of this effort by recommending committee members and presenting to the committee on the role that state, tribe, territory, and PIJ coalitions can play in refining and supporting implementation of a national strategy. The report from the committee is expected to be released in 2019 and the CCCNP stands ready to collaborate on recommendations.

With a focus on accelerating cancer control through comprehensive cancer control efforts, the partnership will continue to work through its workgroups with a renewed attention on health equity for hard to reach populations and improved access to cancer control for all. In 2019, the partnership will assist with updating the Nine Habits [8] document to incorporate health equity and will build health equity into all workgroup activities to encourage and support all CCC coalition to do the same. The partnership is also identifying ways to support cancer control efforts in rural areas where populations are small and access to care is

challenging. The partners are working with the CDC NCCCP staff to query coalitions about the activities currently underway in rural communities. Partner activities in the coming years will work to connect workgroup activities with additional national networks such as the National Association of County and City Health Officials Forum and the National Association of Community Health Centers.

The CCCNP remains an organization dedicated to collaborating to support CCC coalitions in their efforts to address cancer burden in states, tribes, territories, and PIJs. In the coming years, the partners will continue to engage and support CCC coalition leaders, identify collaborative priorities that reduce the burden of cancer in our populations, and support the implementation of CCC plans across the United States.

References

1. Given L, Black B, Lowry G, Huang P, Kerner J (2005) Collaborating to conquer cancer: a comprehensive approach to cancer control. *Cancer Causes Control* 16(0):3–14 [PubMed: 16208570]
2. Hohman K, Rochester P, Kean T, Belle-Isle L (2010) The CCC National Partnership: an example of organizations collaborating on comprehensive cancer control. *Cancer Causes Control* 21(12):1979–1985 [PubMed: 20872239]
3. President's Cancer Panel (2018) HPV vaccination for cancer prevention: progress, opportunities, and a renewed call to action. A Report to the President of the United States from the Chair of the President's Cancer Panel https://prescancerpanel.cancer.gov/report/hpvupdate/pdf/PresCancerPanel_HPVUpdate_Nov2018.pdf. Accessed 14 Nov 2018
4. Comprehensive Cancer Control National Partnership. Increase human papillomavirus (HPV) vaccination uptake workgroup page. <https://www.cccnationalpartners.org/increase-human-papillomavirus-hpv-vaccination-uptake>
5. American Cancer Society (2018) Cancer facts & figs. American Cancer Society, Atlanta
6. National Colorectal Roundtable (2018) All pledges. NCCRT web-site. <http://nccrt.org/all-pledges/>. Accessed 14 Nov 2018
7. Comprehensive Cancer Control National Partnership Forum Teams Report 80%: 80% by 2018 Forum. https://smhs.gwu.edu/cancercontroltap/sites/cancercontroltap/files/80%20by%202018%20Forum%20Teams%20Report_0.pdf
8. American Cancer Society (2014) Nine Habits of successful comprehensive cancer control coalitions. Comprehensive Cancer Control National Partnership website. <https://www.cccnationalpartners.org/new-resource-9-habits-successful-comprehensivecancer-control-coalitions>. Accessed 14 November 2018
9. Biden J (2016) Cancer moonshot. Official Medium Account of the Vice President's Cancer Moonshot. <https://medium.com/cancer-moonshot>. Accessed 14 Nov 2018

Fig. 1.
CCCNP organization chart

Table 1

CCCNP guiding principles

The members of the CCCNP are committed to working together by adhering to the following guiding principles:	
1	We value and respect each CCCNP member
2	We engage in direct and honest communication with each other
3	We are transparent regarding decision-making, roles, and interests
4	We participate in shared decision-making
5	We think and act as a unified collaborative
6	We trust each other to remain true to our mission
7	We agree to think and act comprehensively on cancer control
8	We value and respect diversity

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript