CPCRN
Cancer Prevention and Control Research Network

March 1-3, 2026
Chapel Hill, NC

CPCRN 6 Year 2 Annual Meeting

Welcome Packet

PRC PREVENTION RESEARCH CENTERS

This report is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award with 100 percent funded by CDC/HHS (Cooperative Agreement Number U48DP006872. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

Welcome Packet

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TRAVEL AND LOGISTICS INFORMATION

LOCATION

Rizzo Conference Center Hotel
150 Dubose Home Lane, Chapel Hill, NC 27517
(919) 913-2098

CONTACTS

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- Cell phone number: (919) 323-5812
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TRANSPORTATION

Terminal Directory: https://www.rdu.com/maps-and-directions/inside-rdu/

Available Rideshare Options and Pickup/Dropoff Policies (Uber & Lyft):

- Ride share companies may drop passengers off on the Departures Curb at
  - Terminal 1
  - Terminal 2
- Ride share companies may pick up passengers on the Arrivals Curb at
  - Terminal 1
  - Terminal 2

Taxi Options from RDU to Rizzo Cnter

- **Locations:**
  - Walk Up Taxi Service – available at both terminals in the Taxi Zones
- **Contact:**
  - Taxi Taxi +1 (919) 333-333

Driving Directions from RDU to Rizzo Center

- Toll-free Route via I-40 (*est. trip duration = 20 min*): To drive to the Rizzo Center in from RDU, get on I-40 from Airport Blvd. Follow I-40 to NC-54 W in Durham County. Take exit 273A from I-40. Continue on NC-54 W. Turn right onto Meadowmont Lane and then turn right onto Dubose Home Lane. The Rizzo Center will be on your left.

Public Transportation from RDU to Rizzo Center

Public transportation from RDU to the Rizzo Center is limited, but there is a local bus option.

- **RDU to Rizzo Center** (*est. trip duration = 1 hr 15 min*): Walk 4 minutes to the RDU Airport Terminal 2 Regional Transit Center. Take the RDU Airport bus line 4 stops to the Regional Transit Center (TC). Take the 800 bus line from Regional Transit Center to UNC Hospitals and ride 24 stops. Get off at the NC 54 at Meadowmont Ln stop and walk 18 minutes to the Rizzo Center.

Shuttle Bus to/from RDU

- On **Sunday, March 1st**, shuttle bus service will **not** be provided from the airport to the hotel. Attendees are responsible for obtaining their own transportation to the hotel.
- At the conclusion of the meeting on **Tuesday, March 3rd**, shuttle bus transportation from the Carolina Inn to the airport will be provided by EcoStyle transportation services. The shuttle bus will be available for loading in front of the hotel at 1:45 PM ET. The shuttle bus will depart by 2:00 PM ET.

HOTEL CHECK-IN & REGISTRATION

- Members may check in to the Rizzo Center Hotel at the main lobby beginning at **3:00 PM**.
- Meeting materials and welcome kits will be available for pickup during check-in

HOTEL CHECK-OUT & LUGGAGE STORAGE

- Check-out will be **12:00 PM**. You may bring your luggage to store at the front desk or meeting rooms on March 3rd.

PARKING INFORMATION

- Parking is complimentary for overnight and day guests.

INTERNET ACCESS IN HOTEL

- Wi-fi access ("Rizzo Road Runner" Network) is available in the lobby, throughout the conference center, and in guest rooms for all meeting participants, *no password needed.* Follow the associated check-in prompts when connecting to Wi-fi.

MEETING ACTIVITIES

Sunday, March 1st

- 6:30 – 8:00 PM: Dinner at the Rizzo Conference Center
  - On Sunday evening, CPCRN will offer an informal pre-meeting dinner at the Dubose House at the Rizzo Center. Attendees are encouraged to wear their nametags.

Monday, March 2nd

- 8:45 – 9:00 AM: Mindfulness Practice Workshop with Claire Spears, *Georgia State University*
  - On Monday morning, attendees are invited to participate in a mindfulness practice workshop beginning at 8:45 AM and to be led by Claire Spears from Georgia State University.
  - Attendees are encouraged to wear their nametags; we will also provide temporary nametags for attendees.
- 6:30 – 8:30 PM: Dinner, Arcade and Karaoke Social at The Baxter Arcade
  - On Thursday evening, CPCRN will hold a dinner reception and arcade/karaoke social at 6:30 PM at The Baxter Arcade (108 N. Graham St., Chapel Hill)
  - Attendees are encouraged to wear their nametags; we will also provide temporary nametags.

-

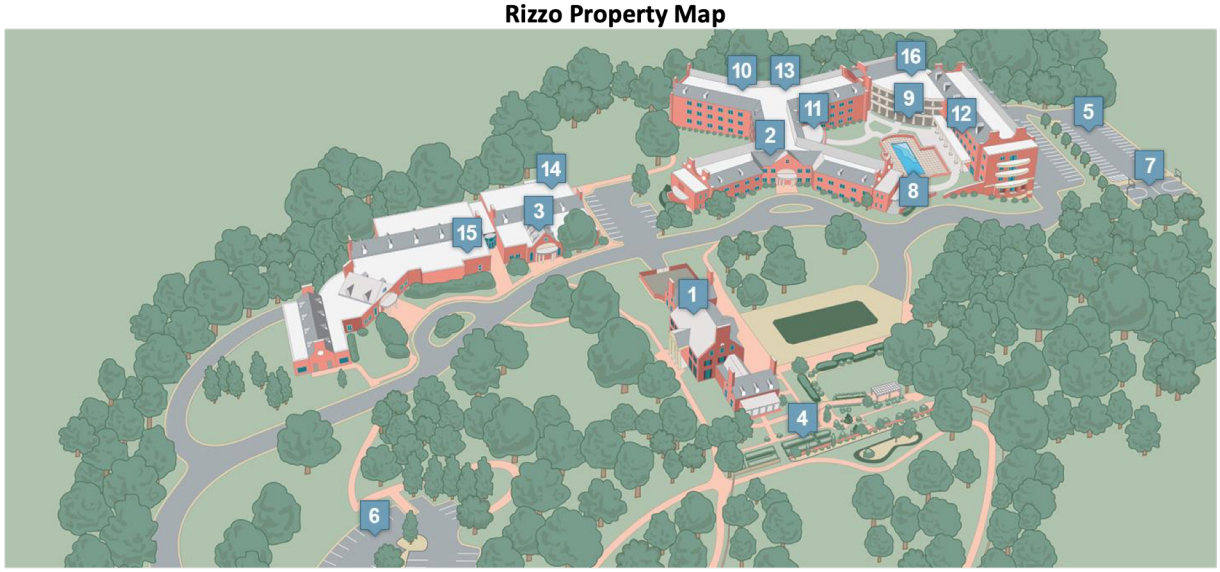
Tuesday, March 3rd

- 8:45 – 9:00 AM: Mindfulness Practice Workshop with Claire Spears, *Georgia State University*
  - On Monday morning, attendees are invited to participate in a mindfulness practice workshop beginning at 8:45 AM and to be led by Claire Spears from Georgia State University.
  - Attendees are encouraged to wear their nametags; we will also provide temporary nametags for attendees

EXPENSES

The CPCRN Coordinating Center will cover hotel rooms and meals throughout the event (breakfast, lunch, dinner, and snacks), as well as transportation to the RDU airport; however, attendees are responsible for transportation outside of the symposium, any meals outside of the above-mentioned list, and incidentals at the hotel (e.g., room service, video rentals etc.).

Rizzo Property Map

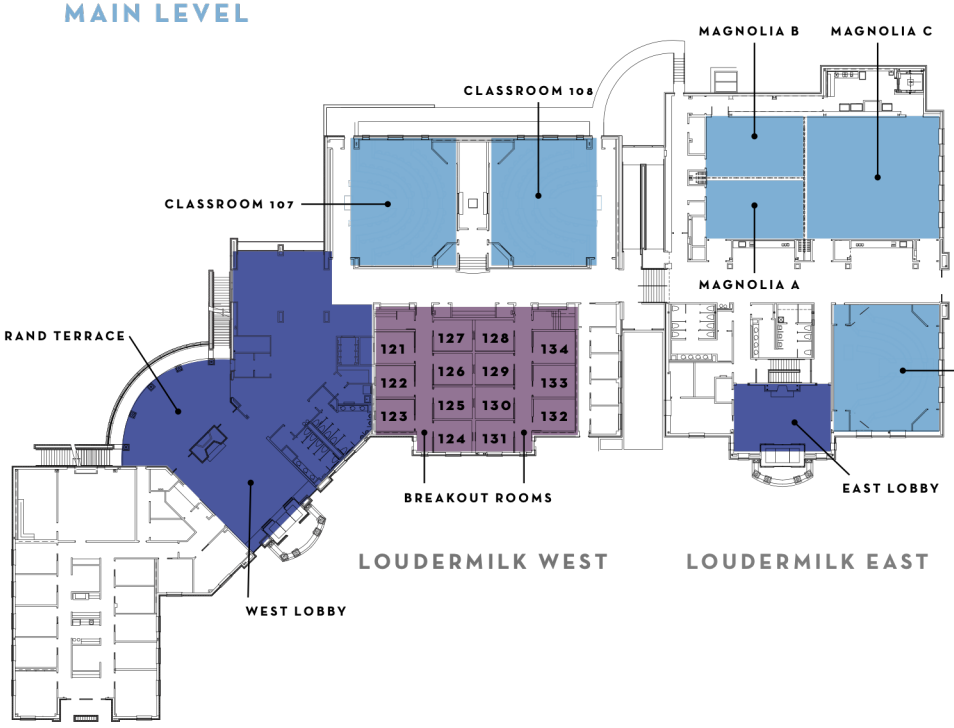


1	DuBose Home	9	Fitness Center
2	McLean Hall	10	Meadowmont Grill
3	Loudermilk Hall	11	Shaffer Kenan Lounge
4	Rizzo Gardens	12	Meeting Rooms 178 and 188
5	Parking	13	Meeting Rooms 240 and 340
6	Parking	14	Magnolia Room
7	Basketball Courts	15	Classrooms 107, 108, and 109
8	Swimming Pool	16	Board Rooms 274 and 374

LOUDERMILK HALL

RIZZO CENTER

MAIN LEVEL



LOWER LEVEL

	TOTAL SQ. FT.	ROOM SIZE	CEILING HEIGHT	TIERED	CONFERENCE	CLASSROOM	THEATER	TEAM	HOLLOW SQ	U—SHAPE	BQT/10	BQT/8	RECEPTION	C ROUNDS
Classroom 107	2116	46x46	11	64	—	—	—	—	—	—	—	—	—	—
Classroom 108	2116	46x46	11	64	—	—	—	—	—	—	—	—	—	—
Classroom 109	1258	34x37	11'6"	52	—	—	—	—	—	—	—	—	—	—
LM Breakouts 121–34	154	14x11	9	—	8	—	—	—	—	—	—	—	—	—
LM Breakouts 135–40	154	14x12	9	—	6	—	—	—	—	—	—	—	—	—
LM Breakout 141	154	14x13	9	—	8	—	—	—	—	—	—	—	—	—
Magnolia	3500	80x43	12	—	—	144	250	90	76	48	240	224	350	144
Magnolia A	689	32x21	12	—	—	30	60	24	24	20	50	48	75	24
Magnolia B	689	32x21	12	—	—	20	54	24	20	16	50	48	75	24
Magnolia AB	1378	32x43	12	—	—	60	120	42	36	28	100	96	150	42
Magnolia C	2100	48x43	12	—	—	84	200	72	44	32	120	128	200	72

MEETING AREA STUDY & BREAKOUT AREA FOOD & REFRESHMENTS FITNESS & RECREATION COMMON AREAS

RIZZO
CENTER

Restaurants Close to Rizzo

- Bartaco (Tacos & Rice Bowls) – 201 S Estes Drive, Suite E3
- Bin 54 Steak & Cellar (Premium Steaks & Cocktails) – 1201 Raleigh Road
- Bluebird (Classic French Bistro) – 601 Meadowmont Village Circle
- Hawkers Asian Street Food (Asian Street Eats) – 201 S Estes Drive, #400A
- Hawthorne & Wood (Sophisticated Eatery with Global Provisions) – 3140 Environ Way
- Lime & Lemon Indian Grill & Bar (Indian Fusion) – 100 Meadowmont Village Circle, #101
- Nantucket Grill (Burgers & Seafood) - 5925 Farrington Road

Downtown Chapel Hill Restaurants

- Blue's on Franklin (BBQ) – 110 W Franklin Street
- Carolina Brewery (Craft Beer & Burgers) – 460 W Franklin Street
- Crossroads (Modern Twists on Southern Foods) – 211 Pittsboro Street (located inside The Carolina Inn)
- Linda's Bar & Grill (Burgers & Wings) – 203 E Franklin Street
- Que Chula Craft Tacos (Fresh Mexican food with a twist) – 140 W Franklin Street
- Top of the Hill (Eclectic American Fare & Brewery) – 100 E Franklin Street

Meeting Agenda

Zoom Registration Information	
Virtual options for remote attendees are available for sessions marked with ※	
Zoom Link *Main, Room 240*	https://zoom.us/j/97319080870?pwd=FSDmMilr6MLy1SQLUIgHTD8EDI7Et5.1 **Passcode** - 603027

Day 1: Sunday, March 1st *All times are listed in EST	
6:30 – 8:00 PM	**Pre-Meeting Dinner at the Rizzo Center, (optional)**, *Dubose House*

Day 2: Monday, March 2nd *All times are listed in EST	
All Day	**CPCRN Poster Showcase,** *Room 240*
6:30 – 9:00 AM	**Breakfast Available,** *Meadowmont Grill*
8:00 – 9:00 AM	**Registration**, *Foyer outside Room 240*
8:00 – 8:45 AM	※ **CPCRN Orientation,** *optional, Room 240* Stephanie Wheeler, Becky Lee, Jingle Xu, Julianna Villarosa, *University of North Carolina*
8:45 – 9:00 AM	※ **Morning Mindfulness**, *Room 240* Claire Spears, *Georgia State University*
9:00 – 9:30 AM	※ **Welcome & Introductions**, *Room 240* Stephanie Wheeler, *University of North Carolina*
9:30 – 11:45 AM	※ **Collaborating Center Core Project Updates,** *Room 240* Moderated by: Natoshia Askelson, *University of Iowa* & Claire Spears, *Georgia State*

Time	Center
9:30	University of Utah
9:40	University of South Carolina
9:50	University of Pennsylvania
10:00	University of North Carolina
10:10	University of Iowa
10:20	Discussion
10:30	**Coffee/Snack Break**
10:45	New York University-CUNY
10:55	Harvard University

Day 2: Monday, March 2nd
**All times are listed in EST*

	11:05 Georgia State University 11:15 Emory University 11:25 Discussion
11:45 – 1:00 PM	※ **Workgroup & Core Work Session #1** **Room** | **Topic** | **Co-Chair(s)** | **Zoom Link** *240* | PharmCPC | Alison Brenner, *UNC* Parth Shah, *UW* | Link Passcode: 603027 *300* | Methods Core | Ryan Suk, *Emory* Maryam Kheirandish, *Emory* | Link Passcode: 510882
1:00 – 2:00 PM	**Lunch,** *Dubose House*
2:00 – 2:45 PM	※ **Planning for the Future of the CPCRN Scholars Program**, *Room 240* Stephanie Wheeler, *University of North Carolina*
2:45 – 3:00 PM	**Coffee/Snack Break,** *Foyer*
3:00 – 4:00 PM	※ **Workgroup & Core Work Session #2** **Room** | **Topic** | **Speaker** | **Zoom Link** 240 | Survivorship/Health Behaviors/Integrative Medicine Workgroup | James Hébert, *USC* Rachel Hirschey, *UNC* Claire Spears, *GSU* | Link Passcode: 603027 300 | Training Core | Mary Wangen, *UNC* | Link Passcode: 510882
4:00 – 4:15 PM	**Coffee/Snack Break,** *Foyer*
4:15 – 5:15 PM	※ **Workgroup & Core Work Session #3** **Room** | **Topic** | **Speaker** | **Zoom Link** 240 | Community Engagement Core | Rachel Hirschey, *UNC* | Link Passcode: 603027 300 | Lung Cancer Screening & Tobacco Control Workgroup | Claire Spears, *GSU* | Link Passcode: 510882
6:15 PM	**Shuttle Bus Departs for Dinner in Downtown Chapel Hill,** *Rizzo Center Lobby*
6:30 PM	**Dinner and Karaoke at The Baxter Arcade (108 N. Graham St., Chapel Hill)**
8:00 PM	**First Shuttle Bus Departs for the Rizzo Center**
8:30 PM	**Final Shuttle Bus Departs for the Rizzo Center**

**Continental breakfast will also be available in the foyer outside of meeting room 240*

<table>
<tr><th colspan="2">Day 3: Tuesday, March 3rd
*All times are listed in EST</th></tr>
<tr><td>All Day</td><td>CPCRN Poster Showcase, Room 240</td></tr>
<tr><td>6:30 – 9:00 AM</td><td>Breakfast Available, Meadowmont Grill</td></tr>
<tr><td>8:45 – 9:00 AM</td><td>※Morning Mindfulness, Room 240
Claire Spears, Georgia State University</td></tr>
<tr><td>9:00 – 9:30 AM</td><td>※ CDC & NCI Remarks, Room 240
Jaqueline Miller, Centers for Disease Control and Prevention
David Chambers, National Cancer Institute</td></tr>
<tr><td>9:30 – 9:35 AM</td><td>Transition</td></tr>
<tr><td>9:35 – 10:35 AM</td><td>※ Paper Work Session #1
<table>
<tr><th>Room</th><th>Topic</th><th>Lead Author(s)</th><th>Zoom Link</th></tr>
<tr><td>240</td><td>Evidence That Matters: CPCRN as a Trusted Voice</td><td>Heather Brandt, St. Jude
Alison Brenner, UNC
Rachel Hirschey, UNC
Stephanie Wheeler, UNC</td><td>Link
Passcode: 603027</td></tr>
<tr><td>250</td><td>Physical Activity, Neighborhood Context, and Chronic Inflammation Biomarkers Among African American Adults: Evidence from the HEALS and SISTAS Randomized Trials</td><td>Zenawi Hagos Gufue, USC</td><td>Link
Passcode: 117246</td></tr>
<tr><td>300</td><td>Unifying Lung Cancer Screening and Tobacco Cessation by Replacing Stigma and Nihilism with Empathy and Hope</td><td>Jamie Studts, CU
Mayuko Ito Fukunaga, UMass</td><td>Link
Passcode: 510882</td></tr>
</table></td></tr>
<tr><td>10:35 – 10:40 AM</td><td>Transition</td></tr>
<tr><td>10:40 - 11:40 AM</td><td>※ Paper Work Session #2
<table>
<tr><th>Room</th><th>Topic</th><th>Lead Author(s)</th><th>Zoom Link</th></tr>
<tr><td>240</td><td>Evaluation of the Putting Public Health Evidence into Action (PPHEIA) Community Pilot Funding Program (2021-2024)</td><td>Mary Wangen, UNC</td><td>Link
Passcode: 603027</td></tr>
<tr><td>300</td><td>Exploring Cancer Related Priorities Across our Communities: A Cross-Sectional Survey Study</td><td>Rachel Hirschey, UNC
*Note – Not currently seeking additional authors</td><td>Link
Passcode: 510882</td></tr>
</table></td></tr>
</table>

<table>
<tr><th colspan="2">Day 3: Tuesday, March 3rd
*All times are listed in EST</th></tr>
<tr><td>11:40 – 11:45 AM</td><td>Transition</td></tr>
<tr><td>11:45 – 12:45 PM</td><td>※ Paper Work Session #3
<table>
<tr><th>Room</th><th>Topic</th><th>Lead Author(s)</th><th>Zoom Link</th></tr>
<tr><td>240</td><td>Bundled Strategies for Cancer Screening and Prevention: A Scoping Review of the Literature from 1975-2022</td><td>Karen Glanz, UPenn
*Note – Not currently seeking additional authors</td><td>Link
Passcode: 603027</td></tr>
<tr><td>250</td><td>Dissemination and Implementation (D&I) Designs for use in Situations Where Evidence for Efficacy Exists and Randomized Control Trial (RCT) Designs are Impractical or Unnecessary</td><td>James Hébert, USC</td><td>Link
Passcode: 117246</td></tr>
<tr><td>300</td><td>Systematic Review of Integrative Medicine Services at NCI-designated Comprehensive Cancer Centers</td><td>Claire Spears, GSU
Rachel Hirschey, UNC
Camelia Gonzalez, GSU</td><td>Link
Passcode: 510882</td></tr>
</table></td></tr>
<tr><td>12:45 – 12:50 PM</td><td>Transition</td></tr>
<tr><td>12:45 – 1:00 PM</td><td>※ Planning Next Steps, Room 240
Natoshia Askelson, University of Iowa
Claire Spears, Georgia State University
Stephanie Wheeler, University of North Carolina</td></tr>
<tr><td>1:00 PM – 2:00 PM</td><td>Lunch, Dubose House</td></tr>
<tr><td>2:00 PM</td><td>Shuttle Departs to Airport, Rizzo Center Lobby
Shuttle will be available for loading beginning at 1:45 PM and will depart for RDU at 2:00 PM.</td></tr>
<tr><td>2:00 PM - 5:00 PM</td><td>Optional Meeting Time (Rooms 240, 250, and 300 available)</td></tr>
</table>

**Continental breakfast will also be available in the foyer outside of meeting room 240.*
***Hotel checkout time is 12:00 PM. Luggage can be stored in the bellstand closet in the hotel lobby.*

In-Person Attendee List

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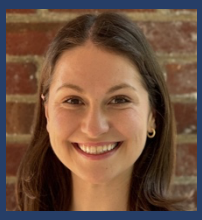

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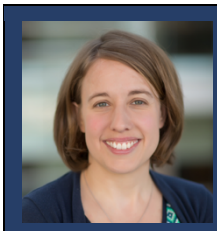

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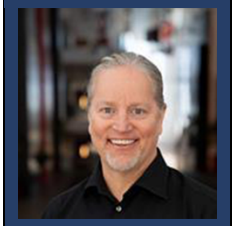

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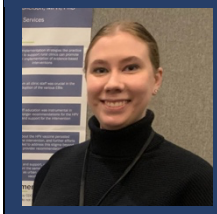

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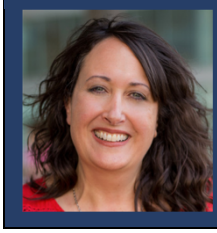

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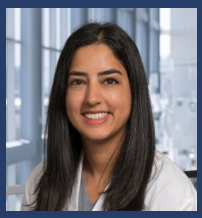

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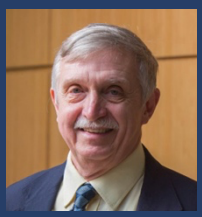

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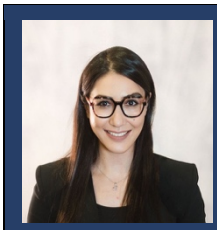

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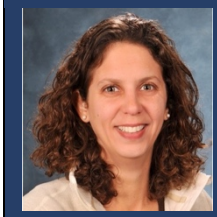

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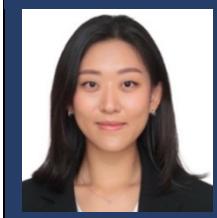

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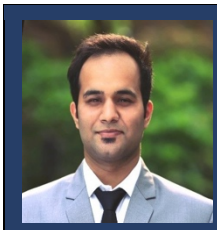

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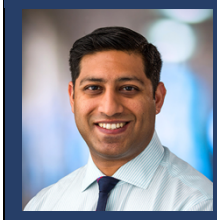

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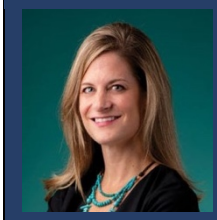

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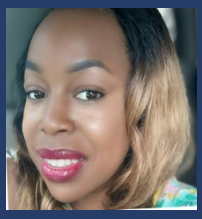

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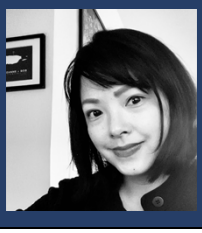

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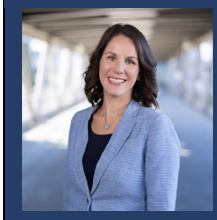

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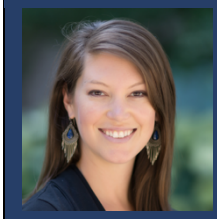

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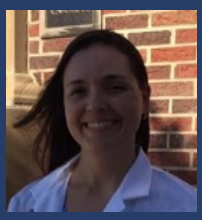

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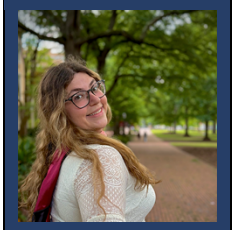

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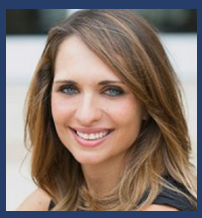

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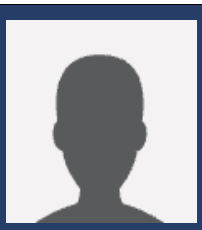

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CPCRN6 YEAR 2 SUPPLEMENT PITCHES
Updated 2/13/26

Table of Contents

Title/topic:
Participant Perspectives on Technical Assistance and Support for Success in Using Project ECHO and Patient Navigation to Improve Cancer Survivorship Across the National Comprehensive Cancer Control Program.

Lead author:
Prajakta Adsul & Rachel Hirschey

Additional authors *(if known)***:** Alison Brenner, Stephanie Wheeler, Mary Wangen, Jingle Xu, Renee Ferrari, Megan Oleary, Becky Lee

Summary: The inaugural Scaling What Works (SWW) program demonstrated that a tailored, multi-modal capacity-building approach can significantly improve confidence and readiness among NCCCP recipients to implement evidence-based interventions, including Project ECHO. While quantitative findings and session feedback indicate high satisfaction and meaningful gains in confidence, there is a critical opportunity to deepen our understanding of *how* and *why* the program supported ECHO implementation and areas for improved support. To maximize the impact of the next SWW iteration focused on ECHO, it is essential to systematically capture the lived experiences of SWW ECHO participants, particularly the barriers, facilitators, and contextual factors that influenced implementation during the pilot year. We propose to conduct interviews with SWW ECHO participants (26 individuals across 11 sites participated in the pilot) This proposed qualitative study will generate actionable, implementation-focused insights to directly inform the design, content, and technical assistance strategies of the next SWW ECHO program, while also contributing to the broader implementation science literature on scaling ECHO models in public health systems.

Is it workgroup related? Yes

Timeline*:*

	February	March	April	May	June
IRB and protocol development	X				
Data collection (interviews)		X	X		
Analysis and interpretation			X	X	
Writing					X

Title/topic

Health care providers attitudes and beliefs about off-label use of HPV vaccination- a national survey

Lead author
Natoshia Askelson

Additional authors
CDC (potentially) and members of the HAPPI team

Summary
The HAPPI team collected survey data to assist in ACIP decision-making over the last 5 years. In early 2025, the team was asked to collect data from pediatricians, family physicians, general internists, and ob-gyn to assess their attitudes and beliefs about moving to a “one dose” recommendation for the HPV vaccine.

Background
Many countries have moved to a “one dose” recommendation. The ACIP was supposed to consider this change in June 2025. The new childhood immunization schedule released in January 2026 outlines a “one dose” recommendation.

Methods
An online survey was launched using a Qualtrics panel of 2 million health care providers in early 2025. Inclusion criteria were specialty, spending at least 50% of time providing outpatient care, and seeing patients 9-45 years old. A total of 1,000 providers completed the survey.

Results
TBD

Conclusions
TBD

Is it workgroup related?
No

Timeline:
The survey data is collected, cleaned, and basic analyses have been conducted.
Feb: Form group, define research questions
March: Run analyses, outline paper
April: Draft paper
May: Revise paper
June: Submit

Title/topic

Community-tailored partnerships and practices to minimize heterogeneity in cancer prevention and control

Lead authors
Perla Chebli & Austin Waters

Additional authors

- Julie Kranick
- Nathaniel Woodard
- Mary Wangen
- Besty Risendal
- Rachel Hirschey
- Feyi Odebunmi
- Westly Lighthall
- Emily Bilenduke
- Catherine Rohweder
- Chau Trinh-Shevrin
- Stephanie Wheeler

Summary
This qualitative case study aims to understand how CPCRN health equity principles were operationalized in the CPCRN collaborating center's core projects. The findings from this qualitative case study have the potential to illustrate how health equity principles can be used to develop and evaluate community partnerships and practices without drawing unnecessary external attention away from the purpose of the research - reducing cancer burden and disparities.

Is it workgroup related?
Yes (previous WG: health equity and social determinants of health - might need to be reframed)

Timeline
Data collection and analysis completed, draft of manuscript under development (competed: introduction, methods, analysis, results; pending: discussion, limitations, implications)

Title/topic
Using Rural-Specific Frameworks to Deepen Understanding of Implementation Context

Lead author
Jen Cruz

Additional authors
Sarah Nash, Whitney Zahnd, Chelsey Schlechter, Michelle Shin, Catherine Nagawa

Summary:
Implementation science frameworks are increasingly used to guide the uptake of evidence-based cancer prevention interventions; however, many commonly applied frameworks provide limited attention to broader community context, particularly in rural settings. As interest in rural cancer prevention and control grows, there is a need to draw on theoretical frameworks developed with rural contexts explicitly in mind to better understand the systems, relationships, and structural conditions shaping implementation success.
This paper demonstrates how integrating the Community Capitals Framework, a rural-specific framework designed to capture interconnected community assets and constraints, can strengthen implementation science by providing a more robust, systems-oriented understanding of context. Using breast cancer screening as a case example, we draw on qualitative data from eight focus groups with rural community members (N = 30) and nine semi-structured interviews with practitioners and providers in South-Central Washington State. Data were analyzed to examine how rural context shapes experienced and perceived barriers and facilitators to screening, and to identify areas of alignment and disconnect between community and practitioner perspectives.

Findings will highlight how differing understandings of rural context may hinder the implementation of breast cancer screening interventions when community perspectives are insufficiently integrated. By demonstrating the added value of a rural-specific framework, this study offers insights for advancing implementation science approaches that are more responsive to rural realities and better positioned to support equitable cancer prevention efforts.

Is it workgroup related?
Yes, this coming from the Rural Workgroup

Timeline
Note: Our work group had already start this project in 2025, so we have made a ton of progress already

- January/February 2026- Finalize results, draft full manuscript
- March 2026- Finalize draft manuscript
- April 2026- Send out to workgroup for feedback
- May 2026- Incorporate feedback
- June 2026- Finalize and submit paper

Title/topic

Survey of Georgia healthcare providers to assess knowledge, attitudes, and practices around lung cancer screening in primary care settings

Lead author
Cam Escoffery, PhD, MPH, CHES

Additional authors:
Madeline Lynam, MPH, Tanmayee Kodali, MEcon, James Hotz, MD, Jocelyn Yanis, PhD, Sarah Dupont, MD, Shacoria Anderson, MPH, Regine Haardoerfer, PhD, MS, Med

Summary:
To inform lung cancer screening (LCS) practices in the state of Georgia, we conducted an online survey assessing providers' lung cancer screening knowledge, attitudes, practices, and recommendations for implementation strategies to increase LCS in primary care centers. The survey was designed and distributed in collaboration with a workgroup of Georgia-based providers and experts in cancer screening and prevention. In total, 112 healthcare providers from 29 counties in Georgia participated in the survey. We found that providers had moderately high knowledge and positive views of lung cancer screening (LCS). A strong majority of participating providers reported either offering LCS at their facility or having the ability to refer patients to an LCS program, though fewer reported engaging in shared decision-making, offering patients educational materials, and providing a referral to smoking cessation services. Providers felt that reminders and distribution of educational materials would be highly important and feasible strategies in implementing LCS programs. These findings can be used as a blueprint for future LCS interventions in primary care settings.

Please see Key Survey Findings section on the next page for an overview of our results.

Is it workgroup related? No – Emory core project.

Timeline *(Please note that to be included in the supplement, papers must be ready for submission for peer review on or before June 30, 2026.)***:** Paper is already drafted and co-authors will review in January/February. Will be ready for submission by March.

Key Survey Findings:

Knowledge

- 64.3% of providers answered at least 4 out of 5 questions correctly
- Significant correlation between professional training (e.g., physician vs. nurse) and knowledge score, not for any demographic groups

Attitudes

- 88.4% agreed or strongly agreed that low-dose computed tomography (LDCT) is efficient and effective in reducing lung cancer mortality
- 75.9% believe there is a need to develop and efficient tool to help providers identify patients eligible for LCS

Practices

- 44.6% do LCS at their facility and 50% refer patients to LCS
- 21.3% of those who do shared decision-making provide a patient decision aid
- 75.5% have strategies to follow-up with patients who have positive scans
- Only 22.6% refer patients who smoke to tobacco treatment services

Barriers and Facilitators to LCS

- Top 3 Barriers: Costs/lack of insurance coverage, lack of patient knowledge/interest, transportation
- Top 3 Facilitators: Cost assistance, patient education materials, patient navigation

Implementation Strategies (1= Very low to 5= Very high)

- Top 5 Feasibility:
  - Distributing patient educational materials (mean= 4.05)
  - Reminding clinicians about LCS (mean= 3.98)
  - Audit and feedback (mean= 3.81)
  - Train-the-trainer (mean= 3.66)
  - Developing and implementing tools for quality monitoring (mean= 3.63)
- Top 5 Importance:
  - Reminding clinicians (mean= 4.02)
  - Distributing patient educational materials (mean= 3.99)
  - Developing and implementing tools for quality monitoring (mean= 3.90)
  - Tailoring strategies to the patient population (mean= 3.79)
  - Preparing patients to be active participants in their care (mean= 3.78)

Title/topic

Bundled Strategies for Cancer Screening and Prevention: A Scoping Review of the Literature from 1975-2022

Lead author
Karen Glanz, PhD, MPH

Additional authors
Many contributed to review, additional authors TBD based on work on manuscript – including Allison T Brenner, David Chambers, Cam Escoffery, Prajakta Adsul, Susan Sabatino, Krista Scheffey, Collin Kather, [Cynthia Vinson, Jennifer Smith, Andrea Dwyer - probably]

Summary
This manuscript is a product of the Multiple Cancer Screening Workgroup from CPCRN beginning in 2018-2019. Due to staff turnover and Penn becoming an affiliate (unfunded) member of CPCRN in 2019-2024, the manuscript was not previously completed and submitted for publication. We propose to update the draft manuscript for submission.

Background: Cancer is the second leading cause of death in the United States. While screening and early detection contribute significantly to earlier diagnosis and disease prognosis, screening is less than recommended. Standard of care dictates single cancer screenings, but bundling multiple cancer screenings together in a single visit or with other preventive services (e.g., flu shots, cardiovascular screening) may help to increase screening update and adherence to guidelines. Despite projected merit, there is a paucity of literature exploring the efficacy of bundling cancer screening interventions.

Methods: A multi-database literature search was conducted using key cancer terms and filtered to include results from 1975 through 2022. Based on prespecified inclusion criteria, 6,485 records were examined and 42 articles were included and then coded, synthesized and thematically analyzed. Syntheses were then examined for trends in the literature.

Results: The literature is diverse and does not follow a clear trajectory over time. Synthesis of included studies suggests that studies of bundled cancer interventions tend to include a focus on sociodemographic factors, site bundling frequency, and temporal factors related to the interventions. {Note: This can be updated based on a refreshed review of the articles}

Conclusions: Several preliminary conclusions emerged from this scoping review. These findings included the importance of culturally tailored intervention strategies, cognizance of sociodemographic factors, and frequency regarding both type and cancer site combinations used in the interventions.

Is it workgroup related?
Multiple Cancer Screening Workgroup (CPCRN4)

Timeline:
February-March 2026: Updates to draft manuscript by UPenn authors (led by Dr. Glanz)
April-May 2026: Circulation to co-authors for revision and feedback (coordinated by UPenn staff)
June 2026: Final draft ready for peer review (led by Dr. Glanz)

Title/Topic

Proyecto Vida Sana ("Healthy Living;" Qualitative Interviews to Inform Cultural Adaptation of Digital Health Intervention for Smoking Cessation among Hispanic/Latino Adults)

Leads

Camelia Gonzalez & Claire Spears

Collaborators

Rodney Lyn, Shannon Self-Brown, Virmarie Correa-Fernandez, Mary Helen O'Connor, Leesly Fraire, Caitlyn Chilito, Yanna Fajardo Cedena, and partners from the Hispanic Health Coalition of Georgia (Bella Borghi, Rafael Bernal, Daniela Ramirez)

Summary

Smoking is responsible for 30% of all cancer deaths and 80% of lung cancer deaths in the United States. Hispanic/Latino ("H/L") communities experience high levels of tobacco-related morbidity and mortality. Among U.S. adults who smoke, H/L are less likely to receive advice to quit by health professionals and to use smoking cessation counseling and/or medication, despite their high interest in quitting. Barriers to smoking cessation among H/L include limited healthcare access; language barriers; stress, stigma and anxiety; and lack of culturally tailored programs. There is an urgent need to increase access to and use of culturally appropriate smoking cessation interventions that address barriers to cessation for H/L communities. Digital health interventions are a cost-effective way to increase access to smoking cessation treatment. Mindfulness-based interventions also show promise for promoting psychosocial functioning and smoking cessation. Our team developed a mindfulness-based text messaging intervention for smoking cessation, *iQuit Mindfully*, that produces strong quit rates. Offering this program in Spanish, with thoughtfully developed cultural adaptations for H/L communities, could greatly increase its reach and impact.

In this qualitative study to inform intervention adaptation, we conducted individual interviews with H/L adults (people who currently or formerly smoked) and other key informants (healthcare providers and medical translators). Participants were asked about barriers and facilitators to tobacco cessation, acceptability of mindfulness and text messaging for tobacco cessation, suggestions for increasing accessibility and cultural relevance, and suggestions for implementing the intervention in healthcare and community settings. They also provided feedback on example intervention messages. Interviews were audio recorded and transcribed verbatim.

We will conduct rapid qualitative analysis, a validated approach to accelerate intervention development/adaptation timelines and implementation processes while maintaining scientific rigor. Our analysis will be guided by specific, targeted intervention and implementation questions such as: *What are key barriers and facilitators to tobacco cessation among H/L?, What factors might increase the acceptability of text messaging for tobacco cessation in this population?, What factors might increase the acceptability of mindfulness?,* and *What are key barriers and facilitators to implementing a text messaging intervention for tobacco cessation in healthcare and community settings?* First, we will create a neutral domain name that corresponds with each question. Second, we will draft a summary template for use by the team, including space for important quotations. Third, the team will "test drive" the template for the same subset of transcripts. Fourth, after consistency has been established across the team, transcripts will be divided across the team to write brief summaries using the template. Fifth, the summary points will be copied and pasted into a matrix to organize and synthesize findings (e.g., this will organize

feedback from H/L who smoke vs. H/L who formerly smoked vs. other key informants). This matrix will directly inform cultural adaptations and implementation plans. Overall, results will be integral to the adaptation of the intervention to promote smoking cessation among H/L adults.

Workgroup-Related
No (this is part of the SIP at Georgia State University, but we welcome CPCRN collaboration).

Timeline:

- January – February 2026: Data cleaning, develop coding templates
- March – April 2026: Data analysis (and begin writing)
- May – June 2026: Writing
- June 2026: Submit manuscript for peer review

Title

Physical Activity, Neighborhood Context, and Chronic Inflammation Biomarkers Among African American Adults: Evidence From the HEALS and SISTAS Randomized Trials

Lead Author
Zenawi Hagos Gufue

Co-leads
Swann Arp Adams, PhD; James R. Hébert, ScD; HEALS/SISTAS investigator team)

Summary
Pooled individual participant data (IPD) analysis of community-based randomized lifestyle trials (HEALS and SISTAS) to estimate intervention effects on chronic inflammation biomarkers (CRP primary; IL-6 secondary) and physical activity at 3 and 12 months, including multilevel analyses and effect modification by neighborhood context (as data allow).

Is this workgroup related?
Yes: Survivorship/Health Behaviors/Integrative Medicine Workgroup; Methods Core

Timeline
Feb 2026 confirm data access/finalize analysis plan; Mar–Apr 2026 analyses; May 2026 manuscript draft; Jun 2026 revisions and submission by June 30, 2026

Needs
Confirmation of neighborhood context measures and harmonization approach across sites (if available and interested); analytic support for pooled IPD/multilevel modeling; and identification of additional sites with comparable lifestyle intervention data for potential inclusion.

Title/topic

Dissemination and Implementation (D&I) Designs for use in Situations Where Evidence for Efficacy Exists and Randomized Control Trial (RCT) Designs are Impractical or Unnecessary

Lead author
James R. Hébert

Additional authors
Swann Adams, Other Members of the Health Behaviors Workgroup Who are Interested in Design Issues as They Relate to Biobehavioral Interventions

Summary
We often are confronted with the paradox that:

1. On the one hand, observational studies and laboratory animal experiments indicate a strong effect of diet or physical activity on health outcomes and on intermediate variables such as inflammatory or metabolic markers. While:
2. On the other hand, results from RCTs, which are expensive and fraught with practical problems in terms of randomization, blinding, etc. often produce results that are more confusing than enlightening.

Here, we propose the alternative of conducting D&I research incorporating elements of pragmatic and adaptive designs that are well suited to estimate effectiveness in context where efficacy has been demonstrated on robust scientific grounds. Dissemination and Implementation (D&I) designs can and often do incorporate pragmatic and adaptive design elements that are increasingly seen as important for improving the real-world applicability, efficiency, and relevance of findings for real-world applications in public health and clinical settings. This approach allows interventions to be tested across a broad range of patients and providers in a wide variety of settings. Outcomes could include conventional biological endpoints (e.g., inflammatory and metabolic markers) as well as other products that are important to the stakeholders in populations we are here to serve. This would include things such as quality of life, satisfaction, and cost-effectiveness. In this context, interventions can be implemented in a manner adaptable to local context rather than relying on a rigid RCT design that often fails in practice. Results will tell us a lot more about real-world effectiveness than typically would derive from conducting a conventional RCT.

Is it workgroup related?
This is something that I had discussed previously in larger meetings. This includes the use of a D&I design in the context of an SBIR application that was submitted by our company, Connecting Health Innovations LLC (CHI).

Timeline
Writing Team Established: Early February
Outline: Mid-February
1st draft: Mid-March
2nd draft: Late-April
Final MS: Late-May/ Early June

Title/topic

Geospatial analysis of area-level and individual-level factors of HPV vaccination in Iowa reveal that population characteristics, not rurality, significantly influence likelihood of vaccine series completion

Lead author
Allison Hill (Geography PhD student at University of Iowa)

Additional authors
Natoshia Askelson, Margaret Carrel, Amanda Kahl, Iowa Health and Human Services

Summary

Purpose

This study examines how individual-level factors from the Iowa's Immunization Registry Information System and area-level population characteristics are associated with adolescent HPV vaccination completion in the rural state of Iowa. Understanding how these factors influence HPV vaccination completion may help improve HPV vaccination coverage and reduce cancer risk among adolescents.

Methods

We will analyze HPV vaccination data from 2013 to 2024 for adolescents aged 9 to 17 years old in 2024 residing in Iowa. Individual-level characteristics of gender, insurance type, race, and receipt of other recommended vaccines will be linked to area-level ZIP Code Tabulation Area measures from the Census, including rurality, poverty, education, language spoken at home, and housing characteristics. We will fit a Bayesian multilevel regression model with a conditional autoregressive (CAR) spatial random effect to account for geographic clustering across ZCTAs.

Findings

Preliminary results suggest that both individual-level and area-level population characteristics influence the likelihood of HPV vaccine completion for adolescents in Iowa. At the individual level, male sex, private insurance, and identifying as Black or another non-White race were associated with lower odds of HPV vaccine completion, while public insurance and receipt of other recommended adolescent vaccines were linked with higher odds. At the area level, higher percentages of renter-occupied housing and residents who primarily speak a language other than English were associated with lower odds of completion. Area level attainment of a bachelor's degree was associated with higher odds of completion. Although area-level poverty and rurality were not independently related to completion, higher rates of poverty in an adolescent's community reduced the odds of HPV vaccine completion among adolescents with public insurance. These findings suggest that HPV vaccine completion is shaped by individual-level and area-level factors, rather than rurality alone. Targeted interventions that address personal and community characteristics could promote adolescent vaccine uptake and reduce the risk of HPV-related cancers.

Is it workgroup related?
No

Timeline:
Feb: Meet to refine model, complete analyses
March: Outline paper, writing assignments
April: Initial full draft
May: Revise
June: final paper ready for submission

Title/topic

Using design thinking visual frameworks to contextualize and understand mental health needs and solutions among Asian and Asian American cancer patients

Lead author
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Additional authors
Terry T-K Huang, PhD, MPH, MBA

Summary
All cancer patients and survivors, regardless of racial background, experience mental distress from facing and treating their illness, which can contribute to poor health and treatment outcomes. Within the broader context of patients undergoing cancer treatment, Asian and Asian American cancer patients' day-to-day physical and psychosocial stressors are often intensified by cultural and systemic barriers to care—including shame and stigma associated with cancer (Wong-Kim, Sun, Merighi, & Chow, 2005), language barriers (Lee, Chen, Ma, Fang, 2012), patients' deference to authority (Fielding & Hung, 1996), a fear of burdening their families, and patients' reluctance to explicitly seek out social support (Kim, Sherman, & Taylor, 2008)—that can lead to poor health outcomes. Existing studies show that the increased administration of psychosocial interventions could improve outcomes for this population (Chou, Lee-Lin, Kuang, 2016); however, information on Asian and Asian American cancer patients' psychosocial health needs tends to be fragmented, examining their needs at different points of the cancer treatment process and focusing on specific aspects of this multifaceted problem. As a result, it can be challenging to understand how various cultural and systemic barriers to mental health care can interact with and exacerbate each other on top of the day-to-day stress of receiving cancer treatment.

This perspective piece describes how we've worked to address these challenges around understanding Asian and Asian American cancer patients' full experiences with experiencing mental distress and seeking care using a Human-Centered Design (HCD) approach to organize and synthesize a combination of secondary and primary research. While HCD can encompass an array of activities and frameworks, at the core it is a research approach that is meant to help practitioners create innovative solutions that include the perspective of and center the experiences of project stakeholders—the people who will be most affected by the final implementation (Vechakul, Shrimali, & Sandhu, 2015). We used HCD visual frameworks to better understand the holistic patient journey by synthesizing a large body of research insights into a visualization of patients' experiences with 1) receiving cancer treatment and 2) seeking out mental health resources using multilayered patient journey maps. After visualizing our research into patient journey maps, we then organized and consolidated the insights to define the stakeholders' underlying problems and articulate their needs in an actionable way using a modified version of Levesque's Conceptual Framework of Access to Healthcare (Cu, et al., 2021).

This work demonstrates one version of how a HCD lens can make public health research and implementations more empathetic and reframe our understanding of secondary research to center the patients', caregivers', and providers' perspectives. We hope that this perspective piece will help provide one model for how researchers can integrate HCD principles and frameworks into public health research projects to foster more creativity in developing patient-centered interventions. Furthermore, we hope that future studies will be able to use this work as a jumping off point for developing their own innovations within this space.

Is it workgroup related?
No

Timeline
We have finished the underlying Human-Centered Design work and are on track to finalize the perspective piece by mid-March 2026

Title/topic

Exploring Cancer Related Priorities Across our Communities: A Cross-Sectional Survey Study

Lead author
Rachel Hirschey

Additional authors
Order TBD: Veronica Carlisle, Stephanie Wheeler, Jingle Xu, Perla Chebli, Victoria Foster, Julie Kranick, Yufen Lin, Madeline Lynam, Nivedhitha Parthasarathy, Rashmi Sharma, Ryan Suk, Karen Wickersham, Tisha Felder, Camila Yepes, Yenan Zhu, Natoshia Askelson, Chelsey Schlechter, Claire Spears, Karen Glanz, Krista Scheffey, Rebekka Lee

Summary
Community engagement is foundational to effective cancer prevention and control research, yet limited national data describe community partners' priorities, perceptions of cancer research, and interest in participating in coordinated research networks, given the current disruptions to research, funding, and science. Community Advisory Board (CAB) members and community partners offer critical insight into community needs and the relevance and communication of research efforts. We are conducting a cross-sectional, web-based survey among community partners of CPCRN centers. Eligible participants include CAB members and other community partners engaged in cancer-related research or outreach of CPCRN members or their cancer centers. The 15-minute survey assesses community-identified cancer priorities, perceptions of the relevance and communication of cancer research, concerns about research funding and trust, and interest in joining CPCRN as a community affiliate. Descriptive statistics will summarize closed-ended responses, and open-ended responses will be analyzed using rapid qualitative methods to identify key themes.

Is it workgroup related?
Yes, Community Engagement Core.

Timeline

	February	March	April	May	June
Data collection	X	X			
Analysis and interpretation		X	X		
Writing				X	X

Title/topic

The impact of social determinants of health on cancer treatments and outcomes among cancer patients and survivors: a scoping review of reviews

Lead author
Julie Kranick

Additional authors
TBD - Jocelyn Hunyadi, Lori Crane, Nate Woodard, Arica Branford, Perla Chebli, Jessica Islam, Ari Korn, Gregory Laynor, Melissa Lopez-Pentecost, Jennifer May, Alex Morshed, Nive Parthasarathy, Antoinette Percy-Laurry, Kevin Pignone, Roger Robles, Aaron Seaman, Rashmi Sharma, Santana Silver, Jennifer Sukalski, Ryan Suk, Tara Kirstin Torres, Milkie Vu, Stephanie Wheeler, Jingle Xu, Yousra Yusuf, Yenan Zhu, Rachel Hirschey (senior author).

Summary
The social determinants of health (SDOH), defined by the World Health Organization as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life,” can have a profound impact on individual health and drive health disparities, including cancer disparities. SDOH, defined according to five domains (economic stability, education access and quality, healthcare access and quality, neighborhood and the built environment, and the social and community context), have been shown to impact cancer screening, receipt of treatment, and cancer outcomes. There is a need to explore the relationship between SDOH and cancer treatment and survivorship outcomes for individuals with cancer. To our knowledge, the landscape related to the SDOH and cancer treatment and survival is not well understood, though many studies have been conducted.

The objective of this review is to map the research landscape and identify research gaps and trends of review articles that explore the relationship between social determinants of health and treatment and outcomes among people diagnosed with and living with cancer.

Is it workgroup related?
Community Engagement Core subgroup

Timeline:

Activity	Jan	Feb	Mar	April	May	June
Full Text Review	*X*					
Data Extraction		*X*				
Data Synthesis		X	*X*			
Manuscript Development/Review			X	X		
Manuscript Submission					X	*X*

Project Status:
On 4/29/2024 & 11/10/2025 an initial and secondary search were run (Pubmed, Scopus, Web of Science, Cochrane, Embase, CINAHL) resulting in 1,533 title/abstract reviews, 179 full text reviews, and thus far 76 studies for extraction (58 complete). Preliminary review of the data found that the most common SDOH reviewed related to economics and healthcare and the most common cancer reviewed was breast cancer, however, many studies were inclusive of all cancers

Title/topic

Factors Associated with Lung Cancer Screening Behavior Among Patients at a NYC-Based Cancer Center: A Qualitative Exploration

Lead author
Deborah Min

Additional authors
Study team

Summary
Lung cancer is the leading cause of cancer death in the United States (US) and globally. Timely lung cancer screening can reduce lung cancer mortality but is still underutilized. NYU Langone's Laura and Isaac Perlmutter Cancer Center (PCC) is a National Cancer Institute (NCI)-designated Comprehensive Cancer Center and has been part of the NCI Early Detection Research Network since 2000. PCC is home to the NYU Langone Lung Cancer Screening Program, which offers lung cancer screening for patients at risk for developing lung cancer. The purpose of this study is to qualitatively explore and understand factors associated with lung cancer screening behavior among patients at the NYU Langone Lung Cancer Screening Program at PCC. Semi-structured individual interviews were conducted among referred patients (n=7) and referring providers (n=4) for lung cancer screening to assess experiences, barriers, and facilitators. Two focus groups were also conducted with the Lung Cancer Screening Program staff (n=3) at two time points to understand processes and workflows. Interviews and focus groups were audio-recorded and transcribed verbatim. Preliminary findings on strategies to support increased engagement were identified through thematic content analysis and include the following major multi-level themes: 1) the need for clear communication and adequate information—e.g., user-friendly and actionable information from providers, explanations in simple terms and patients' preferred languages; 2) trust in providers—e.g., patient trust in provider's recommendations; 3) address challenges to accessing screening—e.g., cost, insurance, and accessibility of the lung cancer screening appointment; 4) need for proactive outreach and tailored patient engagement—e.g., text messages or direct calls rather than flyers, shared decision-making is key however different cultural groups have different preferences for receiving health information; and 5) importance of system-level improvements to streamline screening—e.g., screenings integrated within regular healthcare system, better coordination between patient's care team. These findings identify opportunities to improve lung cancer screening uptake through a patient-centered approach that improves education, trust, accessibility, and system coordination.

Is it workgroup related?
No

Timeline

Task	Jan	Feb	Mar	Apr	May	Jun
Synthesize findings	X	X				
Develop first draft		X	X			
Co-author review/feedback				X	X	
Finalize draft					X	X

Title/topic

Organizational Factors Associated with the Adoption and Maintenance of Tobacco Use Screening and Cessation Services in Community Health Centers Over Time

Lead author
Catherine S. Nagawa

Additional authors
Karen Emmons, Lee Rebekka (and others TBD)

Summary
Tobacco use remains disproportionately prevalent among patients served by community health centers (CHCs), particularly those with co-occurring mental health conditions. This study will use longitudinal, publicly available data from the National Health Center Program Uniform Data System (UDS) to examine factors associated with the adoption and maintenance of high levels of tobacco use screening and the consistent provision of tobacco cessation services among community health centers (CHCs) over time. We will assess how patient population composition, mental health and substance use burden, organizational capacity, and the availability of on-site pharmacy and enabling services are associated with sustained tobacco service delivery.

Brief overview of methods: The primary outcomes will be 1) adoption of tobacco use screening and tobacco cessation services, and 2) maintenance of high levels of tobacco use screening among patients, and the consistent provision of tobacco cessation services measured using standardized UDS clinical quality measures capturing annual rates of tobacco screening and provision of cessation services. Adoption will be defined as initiation of reported tobacco screening and cessation services, and maintenance as sustained reporting of these services across multiple years.

Independent variables include:

1) aggregated patient population characteristics (age distribution, race/ethnicity, insurance status, poverty level, and special populations), diagnostic burden (prevalence of depression, anxiety disorders, serious mental illness, substance use disorders, and COPD), and organizational characteristics.
2) organizational factors of interest include staffing capacity (primary care, behavioral health, and substance use treatment), availability of on-site pharmacy services, and provision of other on-site services such as mental health care, substance use treatment, case management, outreach, transportation, and interpretation services.
3) contextual variables will include health center type, urban–rural location, number of service delivery sites, and payer mix.

Is it workgroup related?
No

Timeline

Month (2026)	Key Activities	Primary Outputs
January	• Finalize research questions and analytic framework • Obtain and verify access to secondary data (e.g., public-use files, documentation)	• Analysis-ready dataset • Final analysis plan
February	• Data cleaning and variable construction • Develop table shells • Conduct targeted literature review	• Final analysis plan • Final table shells
March	• Draft Introduction and Background sections • Draft Methods section (data source, measures, analytic approach)	• Draft Introduction • Draft Methods
April	• Conduct primary analyses • Generate final tables and figures • Draft results section	• Final analytic tables and figures • Draft Results
May	• Draft Discussion section • Assemble full manuscript draft • Share drafts with co-authors	Complete first full manuscript draft
June	• Revise manuscript based on co-author feedback • Align manuscript with target journal requirements • Submit manuscript for peer review	**Manuscript submitted by June 30, 2026**

Title/topic:

Repeated uptake of colorectal cancer screening with mailed fecal immunochemical testing: a randomized clinical trial

- **Topic**: Multiple rounds of FIT completion in a large pragmatic RCT in an FQHC population

Lead author
Meghan O'Leary

Additional authors
Anisha Ganguly, Lindsay Stradtman, Alexis Moore, Dan Reuland, Alison Brenner

Summary
Mailed FIT increases CRC screening uptake, but repeated uptake across multiple rounds of outreach remains unclear. Previous research has suggested that prior CRC screening predicts future CRC screening. Understanding FIT completion over time will inform future implementation strategies to improve CRC screening. In this secondary post-hoc analysis of RCT data collected among FQHC patients, we will examine CRC screening uptake across two rounds of mailed reminder+FIT outreach. Our primary objective is to compare CRC screening uptake in the second round of mailed reminder+FIT outreach among people who remain eligible for the outreach intervention versus usual care. We also have two secondary objectives. First, we will compare CRC screening uptake over both rounds of mailed reminder+FIT outreach versus usual care. Additionally, we will compare follow-up colonoscopy completion after a positive stool test in the second round versus usual care.

Outcomes:

- Percent rounds of CRC screening complete/rounds eligible
- CRC screening completion within 6 months of each round
    - FIT completion within 6 months of each round
    - Changes in FIT result from round 1 to round 2
    - Follow-up colonoscopy completion among those with positive FIT
- Biennial dichotomous outcome: any screening within 2 years

Testable hypotheses:

- Patients with FIT completion in round 1 will be more likely to complete CRC screening in round 2.
- Patients who were screening naïve prior to the trial will be less likely to sustain screening.

Is it workgroup related?
No

Timeline

	January	February	March	April	May	June
Data Collection	X	X				
Cohort development	X	X				
Data analysis			X	X		
Manuscript writing					X	X

Title/Topic

Systematic Review of Integrative Medicine Services at NCI-designated Comprehensive Cancer Centers

Leads

Claire Spears, Rachel Hirschey, & Camelia Gonzalez

Collaborators

Cam Escoffery, Mayank Sakhuja, Yufen Lin, Scotty Poston, Nathaniel Woodard, Julia Rowland, Jennifer May, Santana Silver, Haerim Lee, Jingxi Sheng, Ryan Suk

Summary

Cancer and its treatment create significant stress for survivors, caregivers, and healthcare providers. Survivors often face mental health issues like anxiety, depression, PTSD, and fear of recurrence, along with challenges like body image concerns, cognitive changes, and social isolation. Caregivers often struggle with anxiety, depression, and burnout. Healthcare providers in cancer care also face burnout and compassion fatigue. Within the field of integrative medicine (combining conventional treatments with evidence-based complementary therapies to promote overall health and well-being), mind-body practices like mindfulness meditation and yoga have been shown to improve mental health, pain management, and quality of life for cancer survivors, caregivers, and healthcare providers. In their systematic analysis of websites of NCI-designated comprehensive cancer centers, Yun et al. (2017) found an increase in integrative medicine services between 2009 and 2016. This project is updating that analysis with 2025 data. The CPCRN Survivorship and Integrative Medicine workgroup created a comprehensive integrative medicine modality coding scheme informed by NIH and NCI terminology, and we developed a standardized website search and data extraction protocol. The workgroup has completed data extraction, with two workgroup members assigned to independently extract data for each cancer center. The resulting publication will provide an updated, evidence-informed assessment of integrative medicine service availability, benefit communication, and online accessibility across comprehensive cancer centers. This has important implications for understanding and improving the ways that cancer survivors, caregivers, and cancer center staff can access and benefit from integrative medicine services to improve their quality of life.

Workgroup-Related

Yes (Survivorship/Health Behavior/Integrative Medine workgroup)

Timeline

- January – February 2026: Data cleaning
- March – April 2026: Data analysis (and begin writing)
- May – June 2026: Writing
- June 2026: Submit manuscript for peer review

Title/topic

Unifying Lung Cancer Screening and Tobacco Cessation by Replacing Stigma and Nihilism with Empathy and Hope

Lead authors
Jamie L. Studts & Mayuko Ito Fukunaga

Additional authors
Stephanie Land, PhD, Claire Adams Spears, PhD, Julie Kranick, MPhil, MA, Madeline Lynam, MPH, Shacoria Anderson, MPH, Megan A. Mullins, PhD, MPH, Lisa Carter-Bawa, PhD, MPH, APRN, ANP-C, FAAN, Simona Kwon, DrPH, MPH

Summary:
We propose an opinion paper aimed at increasing awareness of the impact of stigma and nihilism on lung cancer screening and tobacco cessation among clinicians and academic, public health, and community partners of CPCRN. Our goal is to promote an empathic and collaborative approach to assess lung cancer risk that meaningfully engages and empowers individuals eligible for lung cancer screening, by addressing the stigma and nihilism uniquely associated with lung cancer screening and tobacco cessation.

Stigma and nihilism remain critical psychological barriers to both lung cancer screening uptake and tobacco cessation. In this context, stigma refers to the negative beliefs, attitudes, and behaviors directed toward individuals who smoke or have a history of smoking, as well as toward those diagnosed with lung cancer. Nihilism manifests as a sense of hopelessness or futility about lung cancer prevention, screening, and treatment, often leading to the perception that early detection, treatment, or quitting smoking will not meaningfully improve outcomes. Stigma and nihilism often intersect with structural racism, classism, and historical mistrust, disproportionately affecting populations eligible for lung cancer screening.

Despite their significant impact, awareness of these issues and their mitigation remain limited in clinical, public health, and community settings. Because lung cancer screening eligibility is based on age and smoking history, obtaining a detailed smoking history is often the first step in the screening process. Additionally, tobacco cessation counseling and treatment are essential components of lung cancer screening, as quitting smoking significantly reduces the risk of developing lung cancer and of dying from other causes. However, conducting these conversations without sensitivity to the potential for stigma and nihilism can inadvertently reinforce these feelings, ultimately discouraging individuals from pursuing lung cancer screening or engaging in tobacco cessation efforts.

In this paper, we will first summarize current evidence on the impact of stigma and nihilism on lung cancer screening and tobacco cessation at the patient, provider, and community levels. Second, we will propose specific, patient-centered communication strategies for each step of the lung cancer screening process– from tobacco use assessment to determine eligibility, through shared decision-making, delivery of screening results, and tobacco cessation counseling. These strategies are designed to be practical and implementable across healthcare, public health, and community settings to address and reduce stigma and nihilism.
In summary, this paper will support CPCRN partners in fostering therapeutic alliances and creating supportive environments throughout the lung cancer screening process.

Complementing our ongoing workgroup project on the scoping review of the questions and methods to obtain smoking history, our recommendations for patient-centered communication aim to encourage

more individuals at risk to participate in tobacco use assessment, lung cancer screening, and tobacco cessation efforts, and ultimately, to reduce lung cancer mortality.

Is it workgroup related?
Yes, Lung Cancer Screening and Tobacco Cessation Workgroup.

Timeline
February 2026
- Develop the main narrative and key messages of the paper
- Identify potential target journals to reach a broad CPCRN audience
- Assign sections to co-authors

March 2026
- Literature search
- Draft the initial manuscript

April – May 2026
- Review and revise the manuscript collaboratively within the team

June 2026
- Finalize and submit the manuscript to the selected journal

Title/topic

Testing colorectal cancer screening distribution in two community pharmacies in North Carolina: Findings from the PharmFIT Study

Lead author
Mary Wangen

Additional authors
Catherine Rohweder, Austin Waters, Olufeyisayo Odebunmi, Ashley Duggins, Renée Ferrari, Macary Marcinak, Benessa Sutton, Ijeoma Uwakwe, Jenna Minser, Stephanie Wheeler, Parth Shah, Alison Brenner

Summary

Background: To develop and test a model for distributing fecal immunochemical tests (FIT) for colorectal cancer (CRC) screening in community pharmacies.

Methods: Working with two community pharmacies and two primary care clinics in North Carolina, we developed protocols for a pharmacy-based CRC screening program (PharmFIT™). We conducted collaborative process mapping exercises during project meetings with pharmacists and primary care providers (PCPs) to tailor the program to each pharmacy/primary care context.
Two PharmFIT™ models emerged (Model A and Model B). In Model A, one PCP identified eligible patients and sent e-scripts for patients to pick up FITs at the pharmacy. In Model B, a self-insured employer group notified beneficiaries of FIT availability at the pharmacy. Those interested called the pharmacy and eligibility was determined; those eligible picked up FITs at the pharmacy. In both Models, patients mailed completed FITs to labs for processing. Pharmacists and staff managed reminder calls, tracking (including FIT return), counseling, results reporting, and collected patient demographics. Implementation evaluation surveys were administered to patients, pharmacists, and PCPs.

Results: Patients from Model A were 83% black, 50% had at least some college education, and 56% had Medicaid or Medicare. Twenty-nine e-scripts for eligible patients were sent to the pharmacy, 24 patients picked up the FIT, and 21 completed and returned the FIT (72% response; 88% return). Patients from Model B were 93% white, 100% some college or more, and 93% privately insured. Twenty-five patients contacted the pharmacy of whom 15 were eligible for FIT. Fourteen picked up a FIT, all of whom completed and returned the FIT (93% response; 100% return). In both Models, all FIT results were negative. Pharmacists and PCPs shared considerations for future implementation and scale-up. Survey results from patients (*n*=30), pharmacy staff (*n*=3), and PCPs (*n*=2) indicated high acceptability and satisfaction with PharmFIT™.

Conclusions: Tailoring and implementing context-specific protocols for the PharmFIT™ program resulted in high FIT completion rates, acceptability, and satisfaction among participants, suggesting that it is feasible to expand CRC screening to the community pharmacy setting.

Is it workgroup related?
This work was competed as UNC's Core Project in the last cycle, however this work is relevant to the PharmCPC workgroup.

Timeline
The introduction and methods of this paper have been drafted, including all tables and figures. With just the results and the discussion write-ups left to complete, the June 30th deadline is extremely feasible.

Title/topic

Evaluation of the Putting Public Health Evidence into Action (PPHEIA) Community Pilot Funding Program (2021-2024)

Lead author
Mary Wangen

Additional authors
Stephanie Wheeler, Jennifer Leeman, Veronica Carlisle, Katie Johnson (others TBD)

Summary
Community-based organizations (CBOs) are uniquely positioned to identify and implement evidence-based interventions that align with local needs, priorities, and cultural contexts. However, despite their deep community knowledge and trusted relationships, many CBOs lack the time, personnel, and resources needed to locate, adapt, and implement evidence-based approaches. Strategic partnerships with academic institutions can help address these gaps by pairing community expertise with access to research evidence, training, funding, and technical assistance.

In 2021, the National Cancer Institute (NCI) funded administrative supplements to NCI-designated Cancer Centers' Offices of Community Outreach and Engagement (COE) to strengthen community–academic partnerships and accelerate the translation of research into practice. As one of nine awardees, the University of North Carolina Lineberger Comprehensive Cancer Center (UNC LCCC), in collaboration with the Cancer Prevention and Control Research Network (CPCRN), developed a community pilot grant program to support CBOs in planning and implementing evidence-based cancer prevention and control interventions through targeted funding, training, and technical assistance.

This paper reports evaluation findings from the first three years of the program, highlighting how structured academic–community partnerships can build CBO capacity, support evidence-based decision-making, and promote sustainable, community-driven implementation of cancer prevention and control interventions.

Is it workgroup related?
This paper is relevant to the Training Core and could be added as one of the Core's activities if there is sufficient interest.

Timeline
The evaluation data has been collected and included in a comprehensive evaluation report which can be used to inform most of the manuscript development. The manuscript has been outlined, and the introduction has been drafted. Therefore, the June 30th, 2026 due date is feasible for this manuscript.

Title/topic
Evidence That Matters: CPCRN as a Trusted Voice

This could be the overarching paper for this special issue.

Lead author
Stephanie Wheeler, Heather Brandt, Rachel Hirschey, Alison Brenner

Additional authors
Other CPCRN PIs and active affiliate investigators.

Summary
As cancer prevention and control researchers, we are accustomed to relying primarily on empirical evidence gathered through systematic observation and experimentation. This original, first-hand data, considered a primary source, is then rigorously tested, analyzed, and synthesized, often through the peer-review process and in secondary sources like scholarly, peer-reviewed journals and systematic reviews. Secondary analysis of existing data also contributes. It has been usual for policy- and guideline-related decisions regarding cancer screening, cancer treatment, and cancer prevention to be strongly grounded in this established and respected approach to evidence generation.

Current practices have not followed this usual consideration of evidence in a systematic manner. In fact, processes in place to ensure such systematism exists have been intentionally bypassed, including long-held as the holy grail Cochrane Reviews as one example of ignoring evidence. This compromises science, undermines public trust in science, and ultimately results in confusion – and paralysis in actions derived from evidence. One recent example is what has unfolded with the vaccination schedule. Publicly transparent processes have been long agreed upon as the best way to ensure all evidence is considered, evidence is reviewed by subject matter experts, and public comments are invited. In this most recent recommendation statement, there was a disregard of evidence and misinterpretation of most evidence. One counter measure for this dismissal of evidence is for researchers – diverse, inclusive, and experienced – who are part of collaborative research networks by providing evidence-based driven reviews and narratives in support of what we know through independent review of the totality of evidence. This is particularly important in cancer prevention and control to retain hard-earned gains in survival – and ensure everyone benefits from evidence put into practice. CPCRN is in a unique position serve in this role – we have a long history of evidence generation, geographically broad representation, and do not have hands as tied as traditional government sources.

Is it workgroup related? No

Timeline

	February	March	April	May	June
Co-Authors meet and outline	X				
Writing assignments	X				
CPCRN Data collation		X			
Writing		X	X	X	
Cleaning and editing for submission				X	X

Title/topic
A Narrative Review of Metamodeling in Healthcare

Lead author
Ashley Stanfield

Additional authors
Maria Mayorga, Kristen Hassmiller Lich, Meghan O'Leary, Clayton Ulm

Summary
This review will synthesize the literature on metamodeling applications in health care. Metamodels are simplified versions of more complex models. The review will describe common inputs and outputs used in health simulation metamodels, sampling approaches for their construction, and the types of analyses they enable. The goal is to provide a comprehensive overview of current methods, identify gaps in the literature, and propose directions for applying metamodels in decision-making contexts. We plan to include, at minimum, a section dedicated to describing applications to cancer prevention and control. Depending on the number of articles, we could limit the scope of the review to only those papers focused on cancer prevention and control.

Is it workgroup related? No, though it is somewhat related to the Modeling Workgroup from prior CPCRN cycles

Timeline:

	January	February	March	April	May	June
Conduct search	X	X				
Abstract screening	X	X	X			
Full text screening			X	X		
Data extraction/analysis				X	X	
Manuscript writing				X	X	X

CPCRN
Cancer Prevention and Control Research Network

March 1-3, 2026
Chapel Hill, NC

Thank you for attending!

PRC PREVENTION RESEARCH CENTERS

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