DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

DEPT. COMM. NO. 130

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:

December 19, 2017

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Twenty-Ninth State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Scott K. Saiki, Speaker
and Members of the House of
Representatives
Twenty-Ninth State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of the report, "Requesting the Department of Health to Convene a Working Group to Develop Recommendation to increase Colorectal Cancer Screening Rates in the State," as required by House Concurrent Resolution 129, Session Laws Hawaii 2017.

In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at:

http://health.hawaii.gov/opppd/department-of-health-reports-to-2018-legislature/

Sincerely,

Virginia Pressler

VIRGINIA PRESSLER
Director of Health

Enc.

c: Senate
House
Legislative Reference Bureau
SOH Library System (7 copies)
University of Hawaii

REPORT TO THE TWENTY-NINTH LEGISLATURE

STATE OF HAWAII

2018

PURSUANT TO HOUSE CONCURRENT RESOLUTION NO. 129, SESSION LAWS OF HAWAII 2017, REQUESTING THE DEPARTMENT OF HEALTH TO CONVENE A WORKING GROUP TO DEVELOP RECOMMENDATIONS TO INCREASE COLORECTAL CANCER SCREENING RATES IN THE STATE

PREPARED BY

STATE OF HAWAII
DEPARTMENT OF HEALTH, CHRONIC DISEASE PREVENTION AND
HEALTH PROMOTION DIVISION, CHRONIC DISEASE MANAGEMENT BRANCH
IN CONJUNCTION WITH THE
AMERICAN CANCER SOCIETY – HAWAII PACIFIC AND
AMERICAN CANCER SOCIETY CANCER ACTION NETWORK

NOVEMBER 2017

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1. INTRODUCTION

House Concurrent Resolution (HCR) 129, was adopted by both the Senate and House of Representatives of the Twenty-Ninth Legislature of the State of Hawaii, Regular Session of 2017. The concurrent resolution requested the Department of Health (DOH) to convene a working group, with the assistance of the American Cancer Society (ACS) – Hawaii Pacific and the American Cancer Society Cancer Action Network (ACS CAN) to develop recommendations to increase colorectal cancer screening rates in the State and submit findings and recommendations prior to the convening of the Regular Session of 2018.

Public health is vital to Hawaii's economy, culture, and people. Reducing the burden of cancer and chronic diseases takes a community effort to achieve this goal. Hawaii has made significant strides to reduce the burden of cancer through systems and environmental changes, as well as advances in public policy. Despite these accomplishments, cancer continues to affect individuals and their families physically, mentally, and financially.

The Hawaii Comprehensive Cancer Coalition, a group of diverse stakeholders including community partners and organizations, developed a 2016-2020 State strategic cancer plan. As part of the strategic plan, seven colorectal cancer strategies were provided as a guide to achieving the plan's goal of increasing Hawaii's screening rate from 70.5% to 80% for all eligible adults aged 50 to 75 by the year 2020. The HCR-129 focuses on these seven strategies to determine which specific actions are feasible and achievable within Hawaii's public health community to make an 80% screening rate for eligible adults a reality.

This report is a result of collaboration between public and private organizations and individuals in an effort to address the goals and objectives in HCR 129.

Colorectal Cancer – What is it?

Colorectal cancer is a cancer that starts in the colon or the rectum. These cancers can also be named colon cancer or rectal cancer, depending on where they start. Colon cancer and rectal cancer are often grouped together because they have many features in common.

Most colorectal cancers begin as a growth called a polyp on the inner lining of the colon or rectum. Some types of polyps can change into cancer over the course of several years, but not all polyps become cancer. The chance of changing into a cancer depends on the kind of polyp. The two main types of polyps are:

- Adenomatous polyps (adenomas): These polyps sometimes change into cancer. Because of this, adenomas are called a pre-cancerous condition.

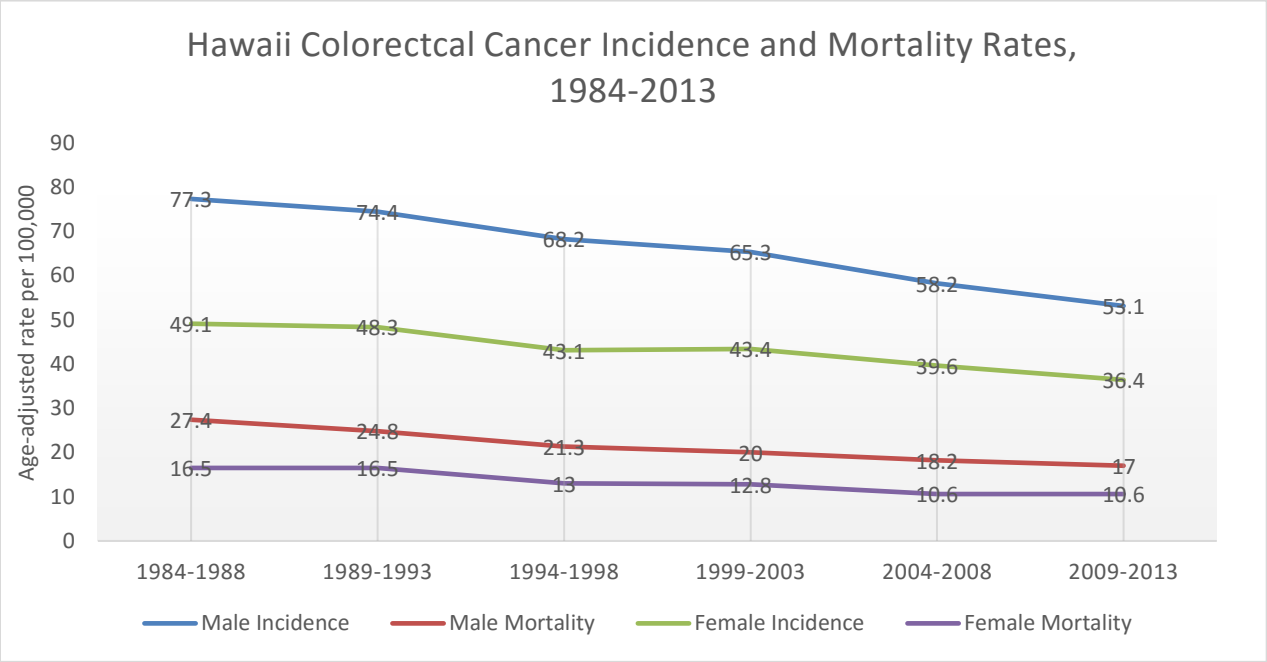
- Hyperplastic polyps and inflammatory polyps: These polyps are more common, but in general they are not pre-cancerous.

Other polyp characteristics that can increase the chances a polyp may contain cancer or increase someone's risk of developing colorectal cancer besides the type, include the size (larger than 1 cm), the number found (more than two), and if dysplasia is seen in the polyp after it is removed. Dysplasia, another pre-cancerous condition, is an area in a polyp or in the lining of the colon or rectum where the cells look abnormal (but not like true cancer cells).

If cancer forms in a polyp, it can eventually begin to grow into the wall of the colon or rectum. The wall of the colon and rectum is made up of several layers. Colorectal cancer starts in the innermost layer (the mucosa) and can grow outward through some or all the other layers. When cancer cells are in the wall, they can then grow into blood vessels or lymph vessels (tiny channels that carry away waste and fluid). From there, they can travel to nearby lymph nodes or to distant parts of the body. [1]

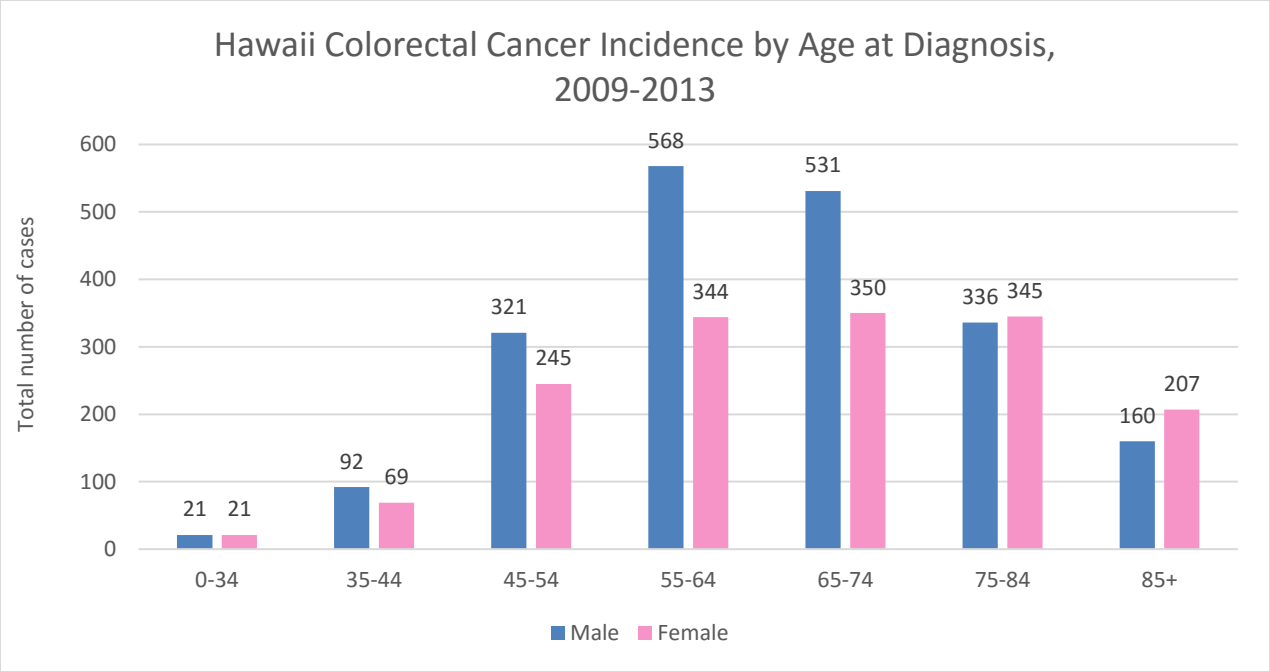
Colorectal Cancer in Hawaii

Colorectal cancer is the 3rd most frequently diagnosed cancer in Hawaii with approximately 720 new cases diagnosed each year. With approximately 220 deaths in Hawaii each year, it is the 2nd leading cause of cancer death in men, and the 3rd leading cause of death among women. Most colorectal cancers are diagnosed at ages 55 and older.



Source: *Hawaii Cancer at a Glance, 2009-2013*, Hawaii Tumor Registry, University of Hawaii Cancer Center

[1] American Cancer Society.



Source: *Hawaii Cancer at a Glance, 2009-2013*, Hawaii Tumor Registry, University of Hawaii Cancer Center

While Hawaii's colorectal cancer incidence and mortality rates have declined over nearly the last 30 years, colorectal cancer remains a serious health concern. As a cancer with few symptoms and warning signs, colorectal cancer is primarily diagnosed in late stages, making treatments options and long-term recovery more difficult. Screening and early detection saves lives. When colorectal cancer is diagnosed at the localized stage, the 5-year survival rate is 90%. However, many people live much longer than 5 years (and many are cured). Unfortunately, only 39% of cases are diagnosed at this localized stage. If the cancer is not detected until the late stage, the 5-year survival rates drops to 14%. Thus, efforts to screen as many people for colorectal cancer has the potential to significantly reduce premature death from cancer and lead to a more positive prognosis and quality of life.

2. HOUSE CONCURRENT RESOLUTION 129 WORKING GROUP

The HCR 129 was introduced in the House of Representatives on March 10, 2017, with a companion measure Senate Concurrent Resolution 112 introduced in the Senate. HCR 129 was adopted by the Legislature on May 5, 2017, and requested the DOH, with the assistance of the ACS and ACS CAN, to convene a working group to draft a report on ways to increase colorectal cancer screenings in the State. Specifically, the resolution requested the working group to evaluate the following criteria:

(1) Promote public education on colorectal cancer screenings in combination with other screenings;

(2) Identify barriers to colorectal cancer screening among underserved, hard-to-reach population groups, and develop effective strategies to overcome those barriers;

(3) Increase public knowledge about family history as a risk factor for colorectal cancer;

(4) Implement small media interventions;

(5) Utilize provider-client reminder systems to ensure timely compliance with screenings;

(6) Partner with community clinics and federally qualified health centers to implement evidenced-based screening interventions; and

(7) Partner with union organizations and employer groups to provide cancer screening education to members of unions and employer groups.

The working group was also requested to assess the following:

(1) Existing and potential state and community resources to address screening and awareness of colorectal cancer;

(2) The use of targeted models and methods to reach underserved populations within the State's unique social, cultural, and geographic diversity;

(3) Strategies to partner across health systems, providers, insurers, and community organizations to collaborate on reaching underserved populations; and

(4) Any other proposals that have the potential to increase colorectal cancer screening rates.

HCR 129 Working Group Members

The DOH's Comprehensive Cancer Control Program (CCCP) reached out to the ACS and the ACS CAN pursuant to HCR 129. To achieve the goals set forth in HCR 129, initial planning was conducted between the parties regarding scope and participants of the working group. To meet the goals of the resolution, the HCR 129 Working Group was comprised of a broad range of individuals and organizations from the public health community. The working group included:

- Hawaii State DOH
- ACS
- ACS CAN
- AlohaCare
- Hawaii Association of Health Plans
- Hawaii Medical Services Association
- Hawaii Primary Care Association
- Hawaii Pacific Health – Straub Medical Center
- Hawaii Tumor Registry
- Hawaii State Department of Human Services – Med-QUEST Division
- Kaiser Permanente Hawaii
- University of Hawaii John A. Burns School of Medicine
- The Queen's Medical Center
- Waimanalo Health Center

The HCR 129 Working Group agreed upon two meetings for the purposes of addressing the goals of the resolution. Accounting for the preparation of the legislative report, the working group agreed to complete the objectives set forth in HCR 129 within the time permitted; allowing for drafting and review of the final report by all members of the working group.

The working group convened its first meeting on July 12, 2017. At this initial meeting, the working group reviewed the goals and objectives of HCR 129. After review of the seven strategies listed in HCR 129, the working group categorized them into two separate discussion areas: communications strategies and community partnerships.

Communications Strategies	1. Promote public education of colorectal cancer screenings in combination with other screenings; 2. Identify barriers to colorectal cancer screening among underserved, hard-to-reach population groups and develop effective strategies to overcome those barriers; 3. Increase public knowledge about family history as a risk factor for colorectal cancer; 4. Implement small media interventions; 5. Utilize provider-client reminder systems to ensure timely compliance with screenings;
Community Partnerships	6. Partner with community clinics and federally qualified health centers to implement evidenced-based screening interventions; and 7. Partner with union organizations and employer groups to provide cancer screening education to members of unions and employer groups.

The working group then proceeded to align these two subject areas with existing recommendations and guidance from the *Community Preventive Services Task Force Findings - Increasing Cancer Screening: Multicomponent Interventions* guide.

Reviewing the Community Preventive Services Task Force Findings

The *Community Preventative Services Task Force Findings - Increasing Cancer Screening: Multicomponent Interventions* is an update to recommendations made by the Community Preventive Services Task Force (CPSTF) – a group established by the Centers for Disease Control and Prevention (CDC). The CPSTF guide recommends that two or more interventions maximize impact on cancer screenings for breast, cervical, and colorectal cancers.

Two or more intervention approaches from the following strategies:	• Interventions to increase community demand: provider-client reminders, client incentives, small media, mass media, group education, one-on-one education. • Interventions to increase community access: reducing structural barriers, reducing client out-of-pocket costs. • Interventions to increase provider delivery of screening services: provider assessment and feedback, provider incentives, provider-client reminders.
Two or more intervention approaches to reduce different structural barriers	

Note: Multicomponent interventions to increase cancer screening may be coordinated through healthcare systems, delivered in community settings, or both.[2]

[2] *See* Appendix B

Targeted strategies

After review of the *Community Preventive Services Task Force Findings - Increasing Cancer Screening: Multicomponent Interventions* guide, the working group decided to focus on two intervention actions pursuant to an effective multicomponent strategy most aligned with the seven strategies listed in HCR 129: small media interventions and provider-client reminder systems. Small media is defined as, videos and printed materials such as letters, brochures, and newsletters that educate and motivate people to get screened. These materials can be distributed through community settings or healthcare systems and do not have to be tailored to the recipients.

While the seven strategies in HCR 129 originated from the 2016-2020 Hawaii State Cancer Plan, the group felt strongly that with new information and data, national recommendations, and the time to complete a report before the start of the 2018 legislative session; the intent of the resolution could be addressed through a narrowly tailored and focused examination of proven intervention strategies.

The working group proceeded to analyze small media and provider-client reminders during small group breakout sessions. Working group participants were asked to provide input on ways to increase screening through small media and provider-client reminders.[3]

3. FINDINGS OF THE WORKING GROUP

The HCR 129 Working Group considered different colorectal cancer screening interventions based on recommendations by the CDC, National Colorectal Cancer Roundtable (NCCRT), and community partners. After extensive discussion on where the greatest needs are for increasing colorectal cancer screening rates in Hawaii, the working group presented the following findings and conclusions.

- With a current screening rate of 70.5% (2015 BRFSS data), the group determined that targeting specific populations is necessary to incrementally raise the state's screening rates to 80% by 2020. The group reviewed geographic distributions of colorectal cancer screening rates to identify communities with greater disparities to prioritize for interventions.
- There are insured individuals ages 50-75 (target population) who are not getting screened. Several working group members felt that this target population should be the initial focus because insurance coverage is not believed to be barriers to screenings for these individuals. Researching the reasons for going unscreened would provide insight into what areas the working group should focus on.
- There are uninsured populations that do not have access to screening services; however, the working group discussed treatment issues and medical ethics issues that arise if individuals are screened, but no treatment options or coverage for those who cannot afford it exist. Under these circumstances, the working group healthcare provider members felt it premature to reach out to those who cannot afford screening.
- After determining what target population would be the focus of a small media campaign, group members suggested utilizing messaging recommendations by the Asian American Network for Cancer Awareness, Research and Training (AANCART).[4]
- Specific data is needed to determine which specific populations the working group should focus efforts towards. Native Hawaiians and Filipinos have the lowest screening rates per ethnic group, although with the release of new data, these groups may have higher rates than the data from 2013 suggests.

[3] *See* Appendix C.

[4] *See* Asian American cancer health disparities, http://www.aancart.org/cancer-research (accessed on 9/8/17)

- Cancer screening patient navigation was a need identified by many of the working group members to increase one-on-one interactions. Patient navigation, an evidence-based intervention not included in the seven strategies, is an avenue to enhance provider-client reminders in communities with high rates of disparities in colorectal cancer screening.

At the close of the August 11, 2017 meeting, the HCR 129 working group agreed that more work would be needed to make successful recommendations and action steps to effectively increase the colorectal cancer screening rates in the state. The DOH's Chronic Disease Prevention and Health Promotion Division's Surveillance, Evaluation, and Epidemiology Office informed the working group that new data sets that shed further light on screening rates were being analyzed and processed in late 2017, which would provide stronger data on which groups of individuals to target for a campaign. The working group agreed that having the latest data would be beneficial to the planning process. As a result, the working group felt it prudent to establish further steps needed before making specific recommendations, so that efforts would be based on the most current data.

Determining the effectiveness of existing provider-client reminder systems

The working group recommended using existing provider-client reminder systems to target insured individuals who are not currently being screened to nationally recommended schedules. While these individuals have insurance coverage for a colorectal cancer screening, they are not actively making an appointment for screening or following up on their medical provider's recommendations. Working group members that have provider-client reminder systems expressed some hesitancy to use these systems in isolation to enhance screening rates in target populations with higher rates of disparities. The working group agreed to revisit existing provider-client reminder system after reviewing the latest screening data from the DOH.

Utilizing existing campaigns to develop a small media colorectal cancer campaign

The NCCRT, established by the ACS and the CDC in 1997, is a national coalition of:

- public organizations;
- private organizations;
- voluntary organizations; and
- invited individuals.

The NCCRT is dedicated to reducing the incidence of and mortality from colorectal cancer in the U.S., through coordinated leadership, strategic planning, and advocacy.

The NCCRT developed materials for campaigns including signage, fact sheets, advertisements, and media pieces.[5] The working group discussed the effectiveness of these materials developed for an audience different from Hawaii's demographics. For example, many of the demographics targeted by the NCCRT are Hispanics, Latinos, and African Americans. Some of the state's target populations based on historically low screening rates would be Filipinos and Native Hawaiians, along with low socioeconomic status populations that have insurance, but are not seeking screening. In addition, communities with low screening rates can be identified through maps (i.e., Geographic Information System (GIS)), providing opportunities to identify health systems serving these communities. The working group concluded that localized messaging tailored to specific Hawaii demographics would be vital to the success of any small media campaign including education and outreach.

[5] *See*: http://nccrt.org/tools/ (retrieved 8/18/17)

The DOH staff shared their experiences implementing the Prevent Diabetes campaign earlier in the year. Similar to outreach and awareness efforts with a potential colorectal cancer screening campaign, the Prevent Diabetes campaign had similar goals to raise awareness of screening for type 2 diabetes and pre-diabetes. After reviewing messaging examples from national health provider sources which focused primarily to a different demographic, department staff engaged in localized communication strategies. The Prevent Diabetes campaign created positive messaging by using local Hawaii actor and comedian Frank De Lima.[6] Hawaii focus group testing confirmed that this type of messaging resonates and engages Hawaii's diverse ethnic demographics.

With potential funding or resources, the DOH and HCR 129 Working Group partners could develop a campaign using existing goals and objectives. The working group recognized the usefulness of the Prevent Diabetes campaign in creating a small media campaign for colorectal cancer screening.

4. RECOMMENDATIONS AND CONTINUING WORK ON INCREASING COLORECTAL CANCER SCREENING RATES

The working group determined that for small media and provider-client reminders, the following actions are required to make effective recommendations. The following is designed to serve as a road map for future action by working group members. As new screening data becomes available, the working group can focus its efforts on individuals and target populations that represent the under screened.

Small Media Campaign

- The working group members should review the most recent colorectal cancer screening data, to be released in late 2017, and determine from the data which specific populations should be the target of a small media campaign.
- Reaching out to key organizations and individuals representing the target populations to engage in creating campaign messaging.
- Finding and testing target messages thereafter.

Provider-Client Reminder Systems

- Examine available clinical quality measures related to colorectal cancer screening and provider practices related to colorectal cancer screening. Assess successful clinical practices among providers achieving higher screening rates.
- Examine whether provider-client reminder tools are effective, and if so, in which populations.
- Assess ways to partner with health systems, particularly those serving communities with disparities, to implement effective electronic and non-electronic strategies (such as reminder systems and patient navigators as needed) to improve screening rates.

Other Identified Evidence-Based Interventions: Reducing structural barriers

- For colorectal cancer screening, strong evidence supports the benefits of removing other barriers to screening. Examples of these approaches include keeping flexible clinic hours, working in non-clinical settings, and offering on-site translation, transportation, patient navigators, and other administrative services.

All working group members agreed to continue with the work already completed in this report with the common goal of taking the necessary steps highlighted above. The working group would like to

[6] *See* Appendix E

acknowledge that although this report did not result in recommendations for the legislature and working group members to immediately pursue, HCR 129 provided the means to assemble the working group to focus on colorectal cancer screening rates as a community issue – one that will take more than one organization or healthcare provider to address.[7]

[7] For more information on future working group meetings and activities addressing colorectal cancer screening, please contact the DOH, CCCP at (808) 692-7480, or the ACS at (808) 595-7500.

HOUSE OF REPRESENTATIVES
TWENTY-NINTH LEGISLATURE, 2017
STATE OF HAWAII

H.C.R. NO. 129

HOUSE CONCURRENT RESOLUTION

REQUESTING THE DEPARTMENT OF HEALTH TO CONVENE A WORKING GROUP TO DEVELOP RECOMMENDATIONS TO INCREASE COLORECTAL CANCER SCREENING RATES IN THE STATE.

WHEREAS, colorectal cancer is the second leading cause of cancer deaths for men and the third leading cause of cancer deaths for women in the State; and

WHEREAS, approximately 660 Hawaii residents are diagnosed with colorectal cancer every year, and nearly 240 Hawaii residents die from the disease each year; and

WHEREAS, colorectal cancer has very few symptoms, making screenings vital to detection and treatment of the cancer in its early stages; and

WHEREAS, Hawaii currently has a screening rate of 70 percent, with a state goal of reaching an 80 percent screening rate by 2020; and

WHEREAS, in 2016 the Hawaii Comprehensive Cancer Coalition unveiled a five-year strategic plan to address early detection of colorectal cancer through education, outreach, and working with health systems and community partners; and

WHEREAS, with the uncertainty of the health insurance market and federal funding for existing cancer screening and prevention programs, it is prudent and reasonable for cancer control advocates to come together as a community to reevaluate these issues in the volatile healthcare landscape; and

WHEREAS, the Department of Health, American Cancer Society, American Cancer Society Cancer Action Network, and other community partners are all committed to reducing the burden of colorectal cancer in Hawaii; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twenty-ninth Legislature of the State of Hawaii, Regular Session of 2017, the Senate concurring, that the Department of Health is requested to convene a working group, with the assistance of the American Cancer Society-Hawaii-Pacific and the American Cancer Society Cancer Action Network, to develop recommendations to increase colorectal cancer screening rates in the State; and

BE IT FURTHER RESOLVED that the working group is requested to incorporate cancer control organizations including hospitals, healthcare associations, community health centers, insurers, and other interested public health groups; and

BE IT FURTHER RESOLVED that pursuant to the Hawaii State Cancer Plan 2016-2020, the working group is requested to examine and identify specific actions to:

(1) Promote public education on colorectal cancer screenings in combination with other screenings;

(2) Identify barriers to colorectal cancer screening among underserved, hard-to-reach population groups, and develop effective strategies to overcome those barriers;

(3) Increase public knowledge about family history as a risk factor for colorectal cancer;

(4) Implement small media interventions;

(5) Utilize provider-client reminder systems to ensure timely compliance with screenings;

(6) Partner with community clinics and federally qualified health centers to implement evidenced-based screening interventions; and

(7) Partner with union organizations and employer groups to provide cancer screening education to members of unions and employer groups; and

H.C.R. NO. 129

BE IT FURTHER RESOLVED that the working group is also requested to assess:

(1) Existing and potential state and community resources to address screening and awareness of colorectal cancer;

(2) The use of targeted models and methods to reach underserved populations within the State's unique social, cultural, and geographic diversity;

(3) Strategies to partner across health systems, providers, insurers, and community organizations to collaborate on reaching underserved populations; and

(4) Any other proposals that have the potential to increase colorectal cancer screening rates; and

BE IT FURTHER RESOLVED that the working group is requested to submit findings and recommendations, including any proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2018; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of Health; American Cancer Society Cancer Action Network; and Executive Director of the American Cancer Society-Hawaii-Pacific.

OFFERED BY: _____

MAR 1 0 2017

Community Preventive Services Task Force

Increasing Cancer Screening: Multicomponent Interventions

Task Force Finding and Rationale Statement
Ratified August 2016

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Task Force Finding and Rationale Statement

Intervention Definition

Multicomponent interventions to promote breast, cervical, or colorectal cancer screening combine two or more intervention approaches reviewed by the Community Preventive Services Task Force. Combinations may include the following.

- Two or more intervention approaches from the following strategies:
  - Interventions to increase community demand: client reminders, client incentives, small media, mass media, group education, one-on-one education
  - Interventions to increase community access: reducing structural barriers, reducing client out-of-pocket costs
  - Interventions to increase provider delivery of screening services: provider assessment and feedback, provider incentives, provider reminders
- Two or more intervention approaches to reduce different structural barriers

Multicomponent interventions to increase cancer screening may be coordinated through healthcare systems, delivered in community settings, or both.

Task Force Finding (August 2016)

The Community Preventive Services Task Force recommends multicomponent interventions to increase screening for breast, cervical or colorectal cancers, on the basis of strong evidence of effectiveness in increasing screening use. For colorectal cancer screening, evidence shows these interventions are effective in increasing screening with colonoscopy or fecal occult blood test (FOBT).

Findings suggest greater effects result from interventions that combine approaches to increase community demand and access, and the greatest effects come from interventions that combine these two approaches with interventions to increase provider delivery of services. When designed for and implemented among underserved populations, multicomponent interventions can increase screening use in these populations. If access to appropriate follow-up care and treatment are provided, these interventions may improve health for these groups.

Rationale

Basis of Finding

The Task Force recommendation is based on evidence from a systematic review of 88 studies (search period January 2004 - November 2013) that evaluated intervention effects on breast, cervical or colorectal cancer screening use—services recommended by the U.S. Preventive Services Task Force (USPSTF 2016a, 2016b, 2012). Included studies compared multicomponent interventions with no intervention (absolute effectiveness, 79 studies) or evaluated the effect of adding one or more components to another intervention (incremental effectiveness, 24 studies).

Compared with no intervention, multicomponent interventions increased breast cancer screening by a median of 6.2 percentage points (interquartile interval [IQI]: 0.9 to 14.5; 34 study arms), cervical cancer screening by a median of 6.1

percentage points (IQI: 1.1 to 11.6; 19 study arms), and colorectal cancer screening by a median of 15.4 percentage points (IQI: 6.0 to 21.6; 39 study arms). See table for effect estimates by screening and test type.

Table 1. Overall Cancer Screening Use (Absolute Effectiveness)

Outcome	Summary Effects
Breast cancer screening by mammography (34 study arms)	Median increase of 6.2 percentage points (IQI: 0.9 to 14.5 percentage points)
Cervical cancer screening by Pap test (19 study arms)	Median increase of 6.1 percentage points (IQI: 1.1 to 11.6 percentage points)
Colorectal cancer screening Any test* (39 study arms)	Median increase of 15.4 percentage points (IQI: 6.0 to 21.6 percentage points)
Colonoscopy (9 study arms)	Median increase of 10.2 percentage points (IQI: 5.0 to 12.5 percentage points)
FOBT (21 study arms)	Median increase of 7.7 percentage points (IQI: 2.3 to 21.1 percentage points)
Flexible Sigmoidoscopy (5 study arms)	Median decrease of 0.5 percentage points (IQI: -0.9 to 1.8 percentage points)

FOBT = Fecal occult blood testing

IQI = interquartile interval

*Clients screened by having any of the following tests: colonoscopy, FOBT, or flexible sigmoidoscopy

Given that multicomponent interventions can include approaches within the strategies of increasing community demand, increasing community access, or increasing provider delivery of screening, many of these interventions are also multilevel interventions that address needs across the individual, provider, community, or system levels.

The most commonly used intervention approaches were those that aimed to increase community demand for cancer screening. The largest screening increases were seen among multicomponent interventions that combined approaches from each of the three strategies (median increase of 24.2 percentage points [IQI: 8.8 to 39.0 percentage points], 5 study arms) or that combined approaches to increase community demand and access (median increase of 11.2 percentage points [IQI: 5.3 to 18.2 percentage points], 48 study arms).

Studies included in this review employed many different combinations of intervention approaches. Increases in screening use were seen across multicomponent interventions with different numbers of intervention approaches, though those with five or more intervention approaches showed a larger median increase. This was particularly true for multicomponent interventions aimed at increasing colorectal cancer screening.

Increases in cancer screening use were seen across multicomponent interventions, regardless of which individual approaches were used. One exception was multicomponent interventions that included provider assessment and feedback, which did not demonstrate an increase in screening across all three cancer types. Further examination revealed this finding was driven by two cervical cancer screening studies. For both breast and colorectal cancer screening, multicomponent interventions with provider assessment and feedback resulted in increases in screening use comparable to multicomponent interventions with other approaches.

When multicomponent interventions included approaches to reduce structural barriers, increases in screening were found for each type of structural barrier addressed, although none of the included studies provided child care. The largest increases in cancer screening rates were reported when transportation barriers were addressed (median increase 18.4 percentage points, IQI: 8.5 to 30.2 percentage points; 11 studies) or language translation services were provided (62.7 percentage points, range 11.6 to 71.2 percentage points; 4 studies).

Most studies that provided information about incremental effects evaluated the addition of 1 or 2 intervention approaches to single component interventions. When an intervention approach to increase community demand was added to a single component intervention, cancer screening use increased by a median of 4.9 percentage points (IQI: 0.4 to 12.0 percentage points; 14 study arms). When an intervention approach to increase community access was added to a single component intervention, cancer screening use increased by a median of 17.1 percentage points (range: 4.6 to 18.7 percentage points; 2 study arms).

Applicability and Generalizability Issues

The Task Force finding is considered applicable to a range of settings and populations within or outside the United States; in healthcare or community-based settings; and in urban or rural communities. Studies were conducted in the United States (76 studies), Canada (5 studies), Australia (2 studies), the United Kingdom (1 study), Italy (1 study), Taiwan (1 study), Singapore (1 study), and Israel (1 study). Studies evaluated interventions implemented in community and healthcare settings, including community health centers and Federally Qualified Health Centers, and in urban and rural environments.

Multicomponent interventions were effective for populations with different baseline screening use, and in groups that were age-eligible for screening. For colorectal cancer screening, findings should be applicable to men and women. Findings should also be applicable to different racial and ethnic groups. Many studies focused on one racial or ethnic group, and several studies provided within-study information about effects by race or ethnicity. No studies included only American Indian/Alaska Native populations and few had samples that were majority Native Hawaiian/Pacific Islander.

Many of the studies did not report enough information to conclude whether most participants were low-income. Other studies, however, reported increases in cancer screening use among participants who were likely low-income or who had no, or inadequate, insurance. Findings, therefore, are likely applicable to these populations.

Findings should be applicable across intervention characteristics, including the number and type of intervention approaches included. Findings should also be applicable across types of intervention deliverers, including patient navigators, community health workers, and clinician educators.

Data Quality Issues

Study designs included randomized control trials (41 studies), non-randomized trials (19 studies), pre-post (22 studies), cohort (3 studies), and time series (3 studies) designs. Stratified analyses found increases across different study designs, indicating robust findings.

Other Benefits and Harms

No additional benefits or harms were reported in included studies. One possible benefit of multicomponent interventions involving community health workers, however, is the potential for community health workers to address healthcare coverage.

Considerations for Implementation

Studies in this review included a large number of interventions with a heterogeneous mix of intervention combinations. Decision makers should consider the local population, needs, and context when selecting interventions to implement. Cost and resource requirements may also be considerations when implementing multicomponent interventions, particularly for intensive or large-scale interventions.

The current body of evidence shows that effects for colorectal cancer screening were often larger than those for breast or cervical cancer screening. This may be due in part to lower colorectal cancer screening uptake in the general population (Sabatino et al., 2015). It also may be that participants in colorectal cancer screening studies have lower baseline screening rates compared with participants in breast or cervical cancer screening studies.

Evidence suggests that it is important to address needs related both to community demand for, and access to, screening services, and that multicomponent interventions are most effective when they address both of these needs and provider delivery.

The large effect estimate for interventions that included language translation services for non–English speaking study participants was based on 4 studies. All 4 of the studies included predominantly Asian American populations, and three of them evaluated similar interventions. In addition to these 4 studies, a number of included studies involved language translation activities, including translation of intervention components (e.g., education). These studies also showed an increase in screening use, although smaller in magnitude. Interventions that addressed transportation barriers also resulted in large increases in screening use. Most of the studies that addressed transportation or language needs recruited majority low-income study participants, suggesting that these may be effective intervention approaches for low-income groups.

People with low incomes or lacking insurance are less likely to be up-to-date with cancer screening (Sabatino et al., 2013; Brown et al., 2014). Targeting multicomponent interventions to these populations can increase their screening use. It is important, however, to ensure access to timely and appropriate follow-up and treatment for all populations. Lack of available, financially accessible, and appropriate follow-up care could lead to missed opportunities to improve health and potentially reduce the benefits of screening.

Many interventions in this review were targeted to population subgroups. For interventions targeted to specific populations, appropriateness of materials is important (Slater et al., 2005). Technology infrastructure may be a consideration for some intervention approaches. Technology may increase efficiency and reduce maintenance costs (Flight et al., 2012; Mosen et al., 2010), but it also may require upfront costs and resources (Taplin et al., 2008; Leffler et al., 2011). In addition, some groups many not have equal access to or use of these technologies (Flight et al., 2012).

Evidence Gaps

Several areas were identified as having limited information. Additional research would help answer remaining questions or strengthen findings in these areas.

- What are intervention effects on repeat cancer screening rates?
- How effective are interventions that only include strategies to increase community access and provider delivery?
- What is the magnitude of effect for multicomponent interventions that provide language translation services, and does it vary across population subgroups?
- What are effects of specific combinations of intervention approaches?
- How well do interventions work among people who have low health literacy?
- How cost-effective are these interventions?

More consistent terminology and reporting of study details would help improve future assessments of intervention effectiveness. For example, more detailed reporting about intervention activities, barriers addressed, study participants (including income and health insurance status), and those delivering interventions would improve understanding and characterization of intervention approaches and intervention effectiveness in different populations.

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Disclaimer

The findings and conclusions on this page are those of the Community Preventive Services Task Force and do not necessarily represent those of CDC. Task Force evidence-based recommendations are not mandates for compliance or spending. Instead, they provide information and options for decision makers and stakeholders to consider when determining which programs, services, and policies best meet the needs, preferences, available resources, and constraints of their constituents.

Document last updated April 11, 2017

APPENDIX C

HCR 129 Colorectal Cancer Working Group Meeting
July 12, 2017

Overview of HCR 129 – Cory Chun
(American Cancer Society Cancer Action Network (ACS CAN))

- ACS CAN Hawaii-Pacific recently helped to pass HCR 129, a concurrent resolution that allows for the formation of a workgroup including ACS, ACS CAN, the Department of Health and community partners to convene meetings to develop a plan to increase colorectal cancer screening rates and foster collaboration between community partners.
- The Working Group will look at the 7 strategies in the cancer plan and also at:
  - Existing and potential state and community resources to address screening and awareness of colorectal cancer;
  - The use of targeted models and methods to reach underserved populations within the State's unique social, cultural, and geographic diversity;
  - Strategies to partner across health systems, providers, insurers, and community organizations to collaborate on reaching underserved populations; and
  - Any other proposals that have the potential to increase colorectal cancer screening rates.

U.S. Preventive Services Task Force (USPSTF) Recommendations – Julian Lipsher (Hawaii State Department of Health)

- The proven strategies that work include small media education, provider-client reminders, one-on-one education and reducing structural barriers like out-of-pocket costs, including the extra charge for anesthesia during colonoscopy.
- The main emphasis should be focused around MULTI-COMPONENT interventions to increase the rate of colorectal cancer screening. It must be done in a coordinated way in a healthcare setting. No single policy can solve these problems.

Challenges in Reaching Underserved Populations – Dr. Neal Palafox (John A. Burns School of Medicine)

- The results of primary prevention may take years to show. If you get everything correct and get the screening right, the results may be seen many years down the road.
- Cancer patient navigation is clearly evidence-based.
- Evidence-based interventions should be for physicians, hospitals, and healthcare systems as a whole.
- Cultural dimensions are an integral component as there are some cultures in which patients do not want to know about the diagnosis of cancer.

APPENDIX C (continued)

Colorectal Cancer Data– Lance Ching (Hawaii State Department of Health)

- Cancer is the second leading cause of death in Hawaii after cardiovascular disease.
- Approximately 720 new cases of colorectal cancer (CRC) occur each year. The Hawaii incidence rate for CRC is 43.4 % as compared to 39.8% for US.
- 59% of late stage CRC are diagnosed in Native Hawaiian populations and they have the highest mortality with CRC. Data does show that the overall incidence and mortality is decreasing by 1% per year in the last 10 years.
- Stage wise, if detected early, at stage-1, the 5-year survival is 90%. Unfortunately, only 39% of CRC are found that early. When diagnosed in stage-4, the 5-year survival is only 14%.
- "80% by 2018" is a movement to close the screening gap and reduce the incidence of late stage CRC. Nationally 277,000 cases can be prevented by 2030, if this screening target is reached and 203,000 colon cancer deaths will be averted.
- Currently, Hawaii has 71% CRC screening rate as per 2015 data. A few years ago it was 59%.
- Yes, we can reach 80%. But disparities exist by social status and race. Filipino populations are significantly less likely to be screened as compared to Japanese and Caucasians. As a result, Filipinos have the highest rate of late stage cancer and cancer mortality.
- The 5 largest health plans in the state of Hawaii perform differently when it comes to CRC screening. Variability is from 25% to 71%. Some system level change and changes at the level of healthcare providers are needed.
- The Roadmap to 80% will require cooperation from everybody. The specific actions to increase screening are:
  - Promote public education for CRC screenings.
  - Identify barriers to screening among underserved populations.
  - Increase public knowledge about family history as a risk factor.
  - Implement small media interventions.
  - Utilize provider-based client reminder system to ensure compliance.
- Changes are needed at the health policy level by encouraging physicians to participate in programs that provide incentives to physicians via the merit based incentive payment system (MIPS) and Medicare Access and CHIP Reauthorization Act (MACRA) act signed by President Obama and MPQH.
-

Group Stakeholder Sharing

(What stakeholders are doing OR can do under the seven strategies in HCR 129)

(1) Promote public education on colorectal cancer in combination with other screenings.

- *ACS CAN*: Advocating for colorectal cancer screening and education/awareness program from 2012-2017.
- *John A. Burns School of Medicine*

  - Instruct and evaluate medical students and resident physicians re: cultural competency, population health, specific cancer & health screenings.
  - Teach CRC screening methods.
  - Dept. of Native Hawaiian Health: Work with Native Hawaiians health re: cancer risk reduction including screenings.
  - Research: Special population in Pacific cancer reduction.
- Increase rates by 2020:
  - Promote public education on colorectal cancer screening in combination with other screenings.
  - Implement small media interventions.
  - Practice with community clinics and federally qualified health centers.

(2) Identify barriers to colorectal cancer screening among underserved, hard-to-reach population groups, and develop effective strategies to overcome those barriers.

- Payer of healthcare that does cover cancer screenings.
- Provide services through contracts with 5 managed care programs statewide.
- Look at quality measures to ensure recipients getting quality care.
- Ensure access to medical care.

(3) Increase public knowledge about family history as a risk factor for colorectal cancer.

(4) Implement small media interventions.

- Sending out postcards to targeted members and letting them know that if they get screened, we'll send them an AlohaCare T-shirt, Long's $10 gift card (member incentive).

(5) Utilize provider-client reminder systems to ensure timely compliance to screening

- Implement provider-client reminders in various forms.
- Train providers to use these systems to view screening rates in their patient populations and flag patients who are eligible and due or overdue for screening.
- Capitalize on current opportunities to enhance screening rates, as providers are also incentivized because of 1) value based transformation to improve screening rates in general; and 2) target patients with higher disparities and associated costs to provide focused interventions.
- Implement reminder systems that provide strategies for outreach to patients due for screening in multiple ways, including reminder flags during the patients' visit, patient emails, text messages, letters, and calls, and other opportunities to provide 1:1 education using such resources such as the Imi Hale patient education. Specific strategies explored will include:
  - RN students providing 1:1 education.
  - Patient portals to send reminders to patients overdue for screenings to schedule appointments.
  - Patient-focused mailings of blue cards (postcard reminders) and auto generated reminder letters at appointment times to assist with recall.
  - Flagging patients with overdue screenings so that interventions can be provided at the point of care.
  - Setting up additional reminders directed to physicians to screen and refer patients for screening.

- Target focused reminder-based strategies to key populations selected by age, previous screening history, and populations with disparities as opportunities arise.
- Provider training to healthcare providers on CRC screening.
- Work with health plans to increase colorectal cancer screening and explore strategies to enhance reporting of colorectal cancer screening related clinical quality measures.
- Increase participation and engagement in colorectal cancer screening efforts by Medicaid serving providers.
- Provide public education through public education outlets.
- Waimanalo Health Center utilized a CRC screening navigator to successfully increase CRC screening and would like to reinstate the program.

(6) Partner with community clinics and federally qualified health centers to implement evidence-based screening interventions.

- Promote awareness of the colonoscopy based cancer screening program at the Queen's Medical Center.
- Utilize opportunities to educate the public, for example via activities during annual colon cancer awareness month.
- Promote available opportunities for cancer screening, including colorectal cancer, in Molokai (the community with the lowest screening rate in the state), with patient navigation used to target difficult to reach populations.
- Promote local education for providers on best practices in colorectal cancer screening (for example, visiting Professor Dr. Gray - OSU at QMC Punchbowl, West and Molokai to address disparities and community activities – 2016).
- Sharing evidence-based strategies and technical assistance to systems to implement reminder systems.

HPCA

- Working through our Quality Improvement groups to share best practices around CRC screening across Hawaii FQHCs.
- Work together to understand and address barriers in unique communities.
- By 2020:
  - Provider education to FQHC providers.
  - Support & disseminate CRC education materials from Imi Hale to our FQHCs.
  - Find opportunities to support navigation & CRC outreach.
  - Support provider-client reminders & recall systems across different CRC platforms.

(7) Partner with union organizations and employer groups to provide cancer screening education to members of unions and employer groups.

APPENDIX C (continued)

Group Activity - NOTES

Identifying Specific Actions with a focus on the two evidenced-based strategies listed in HCR 129

(*) = number of dots the strategies received when the participants were asked to prioritize.

Small media is an evidenced-based intervention recommended by the Community Preventive Services Task Force (Task Force). **Small media.** Videos and printed materials such as letters, brochures, and newsletters can educate and motivate people to get screened. These materials can be distributed through community settings or healthcare systems and do not have to be tailored to the recipients.	**Utilize provider-client reminder systems to ensure timely compliance with screenings.** **Provider-client reminders**. Strong evidence supports sending patients provider-client reminders (such as letters, postcards, e-mails, or phone messages) to increase screening rates. Evidence also suggests that there is an added benefit to combining provider-client reminders with other intervention strategies recommended by the Task Force to promote screening.
• Communications/Media: Bring in partners in the discussion who can focus on communications (i.e., DOH Communications Team) who have experience conducting/testing media campaigns/strategies (i.e., radio, FB, Twitter, focus groups, etc.). Explore what works for CRC by looking at data. Also need to make sure to inform providers if there is a media campaign. Message (written materials) need to be culturally appropriate. **(15)** • Sustainability: Ensure messages will continue and are multi-modal, age-specific, and population-specific. Important to reinforce the message. **(5)** • Should be population specific. **(2)** • Training: Important to train entire care team on small media interventions. • Messaging: Create a positive tone and identify various forms of media outlets. • There will be more buy-in if the community develops the message.	• Partner with non-traditional partners to create a robust network (faith-based, pharmacists). **(17)** • Collaborate with other evidence-based programs like Flu/FIT to increase (CRC) screening rates. **(10)** • Identify cost barriers and transportation barriers, especially for neighbor island patients. **(8)** • Assist primary providers with screening protocols. **(6)** • Train users of provider-client reminder systems to be able to update client address/contact information. **(4)** • Remove prior authorization barriers for providers in obtaining approval for their patients to get screened. **(2)** • Use other tests than colonoscopy to start with (FIT, FOBT). • Utilize combinations of patient reminders and provider reminders to improve screening rates. Use multiple approaches including reminders at the point of care and reminders via patient portals and other outreach efforts to enhance screening rates.
Other Identified Actions	
• Identify local/statewide champions specific to different populations (i.e., Filipinos). **(16)** • Identify existing resources are available (i.e., AANCART, Imi Hale) and increase knowledge of the resources. **(12)** • Partner/connect w/CBO, resource centers, faith-based settings, gyms such as cross-fit and other non-traditional partners. **(12)** • Utilize text reminders. **Reducing structural barriers:** For breast and colorectal cancer screening, strong evidence supports the benefits of removing other barriers to screening. Examples of these approaches include keeping flexible clinic hours, working in non-clinical settings (e.g., mobile mammography vans), and offering on-site translation, transportation, **patient navigators,** and other administrative services. • Funding for screening navigators. **(15)**	

APPENDIX D

HCR 129 Colorectal Cancer Working Group Meeting
August 11, 2017

Welcome and Overview of July 12th Meeting – Lola Irvin

- Recapped July 12 meeting including USPSTF Recommendations, the presentation from Dr. Palafox on addressing priority populations that have lower screening rates, and Lance Ching's presentation on the current screening data.
- Underlying message is that we cannot be doing the same thing if we want to increase the screening rate from 70% to 80% by 2020, and that we need to have continued dialogue and discussion about how we reach out to demographics including Native Hawaiians to boost our overall screening rate.
- The group will submit the proposal and findings, including any proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2018, where, if approved, it will be made into a law.

Continue Discussion of Potential Recommendations to the Legislature – Cory Chun

Small Media – Joint Stakeholder Comm. Plan

- Need for general consistent messaging from all partners, regardless of the health plan. At the same time, there may need to be tailored messages focusing on specific populations (NHPI, lower socio-economic status, Filipinos).
- Even though there's a high rate of awareness, still a low rate of screening. Need to understand why there's a lack of engagement.
- Need to gather people who have never been screened for focus groups and find out what the actual barriers to screening.
- Identify the demographics of individuals not being screened – i.e., Filipinos and Native Hawaiians.
- Able to do something similar to Prevent Diabetes Campaign – conduct focus groups with target populations such as Filipinos, NHPI and Lower SES to ensure that the message is received. For example, CDC messaging regarding diabetes was not well received by target populations.
- Some messaging and studies exist already:
  - AANCART – conducted similar study on Filipino Americans regarding mammograms.
  - Materials available by the National Colorectal Roundtable on their website for Asian Americans.
- Important to ensure that focus groups are not just comprised of individuals within these target populations but are the ones that are not being screened.
- Participants were encouraged to consider contributing support from their organizations towards joint-stakeholder messaging.

- Request for any graphic design talent or anyone that can help.
- Need to engage leaders in target communities – who is held in high regard.
- Client touches throughout the community would help in getting individuals to get screened.

Provider-Client Reminder Systems

- Need to be focusing on how to assist providers to reach out to clients with reminders about screenings.
- On provider surveys – are they doing it and if they're not, is there a way to track their patients – it's a way to see what providers are doing and how messages can be better focused.
- HMSA has a tool for providers to remind clients about screenings – the tools are there, but are they effective? And if so, for what populations? There may be a need to figure out where the weaknesses exist for these tools.
- Need to separate individuals that have never come in for screenings versus individuals that are past due for a screening.
- Provider survey is still on-going, data still needs to be collected. What is known now is that there is a huge range between what types of reminders are being provided. Some are smaller practices that are using faxes while others are huge systems that are still trying to figure out if they're optimizing tool usage.
- They do know that all FQHCs have EHR's, but there is still a great degree of variance among the FQHCs.
- There is an expectation and understanding that payment transformation is incentivizing providers to push screening. There is some agreement that this is the way to move forward, but at the same time the burden of turning out patients and getting patients screened shouldn't necessarily be up to the PCP. There is a concern from providers about the need for patient responsibility and a desire from doctors about ensuring that there are tools to help reach out to patients.
- There needs to be a decision made about the actionable message and whether it should be to contact their physicians, due to an expectation for a higher workload. One way may be training provider staff on how to address basic questions regarding screenings rather than solely having PCP handle them.
- Within worksites, there is a general incentive for promoting general healthy living and healthy lifestyle habits for employees versus a specific message on colon cancer screenings. Cancer screenings are concrete and may have a different feeling than healthy lifestyle, long-term trends. A message may be: screenings and taking care of that may be a feel-good way to promote healthy lifestyle trends.
- Once information is available and a small media campaign can begin, it can be up to organizations/community partners like ACS/ACS CAN to assist in trying to obtain funding to reach out to the gap group.

APPENDIX D (continued)

Moving Forward to Implementation – Tenaya Jackman

- To continue to build upon the ongoing progress made on these discussions, there is going to be a kick-off to continue the working group's discussions.
- Possibility of creating smaller sub-groups to address specific issues that come along and develop processes.
- Kick-off event to be held in late October and early November.

Specific Actions (Led by Cory Chun)

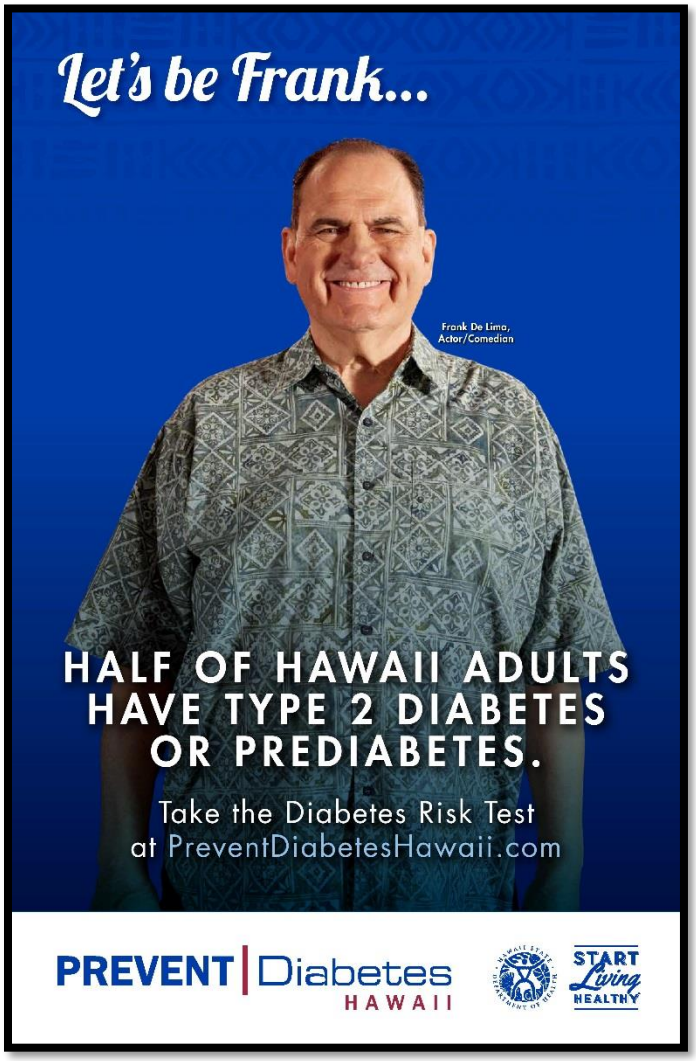
Roadmap to Small Media Campaign

- Looking at data and seeing which specific populations need to be targeted.
- Getting gap populations into focus groups then creating targeted messages.
- Finding and testing target messages thereafter.

Roadmap to Provider-Client Reminder Systems

- Examine provider survey data, once completed, and figure out what high-screening rate providers are doing that other providers are not.
- Examine whether provider tools are effective, and in which populations they are effective.
- Reach out to groups that are not covered as well as those that are insured but have never been screened.
- Working with community partners to address gaps/issues as they arise.

APPENDIX E

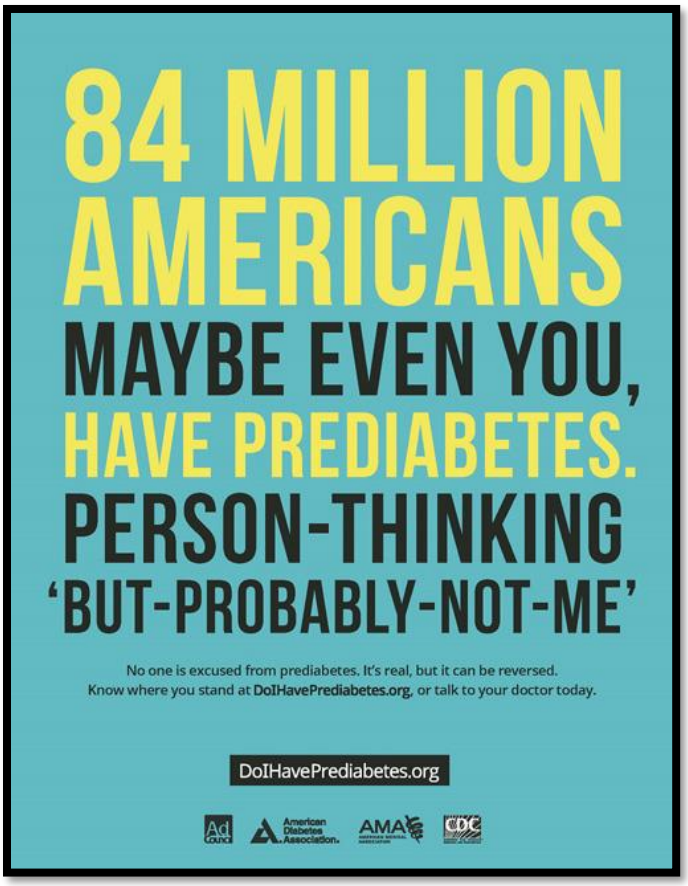


For the Prevent Diabetes Campaign, the Department of Health localized messaging for early detection by using Hawaii entertainer Frank De Lima. The test messaging was extremely successful and received positive feedback from focus groups.

The campaign utilized Mr. De Lima in print and video messaging stressing the overall importance of early detection for diabetes. A similar strategy could be used to target Hawaii populations for colorectal cancer screening.

Many other campaigns focused on statistics and other messaging that might resonate with audiences in other parts of the country, but not as much with Hawaii's ethnically diverse populations.

Using the success of the Prevent Diabetes 2017 campaign, any new media campaigns for colorectal cancer could model this campaign to make sure that any messaging has significant impact.



APPENDIX F

HCR 129 Working Group Participant List	
Organization	**Representative**
AlohaCare	Rachel Wilkinson
American Cancer Society, CAN	Cory Chun
American Cancer Society, Hawaii Pacific	Alaina Cunningham, Tenaya Jackman, and Davin Aoyagi
Consultant (Hawaii Association of Health Plans)	Beth Giesting
Kaiser Permanente Hawaii	Daryl Kurozawa, M.D. and Jill Shinno
Hawaii Medical Services Association	Kara Kitazaki-Chun, Doug Jeffs, and Andrew Breton
Hawaii Pacific Health – Straub Medical Center	Julio Zamarripa
Hawaii Primary Care Association	Jermy Domingo
Hawaii Tumor Registry	Michael Green
Hawaii State Department of Human Services – Med-QUEST Division	Leslie Tawata
Hawaii State Department of Health	Lola Irvin, Julian Lipsher, Lance Ching, Christina Teel, and Florlyn Taflinger
University of Hawaii John A. Burns School of Medicine	Neal Palafox, M.D.
The Queen's Medical Center	James Grobe, M.D. and Shane Morita, M.D.
Waimanalo Health Center	Christina Lee, M.D.

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