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# Putting Evidence Academies into action: Prostate cancer, nutrition, and tobacco control science

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## Abstract

A well-documented challenge in moving public health research into practice is the extended time it takes to implement findings in clinical practice and communities. The Evidence Academy model (Rohweder et al., 2016), developed and first used in North Carolina, is a pragmatic, action-oriented model that aims to shorten this timeline by communicating cutting-edge findings directly to those who can use them and convening individuals working in a single topic area to network and plan activities for the future. The University of Pennsylvania Collaborating Center of the Cancer Prevention and Control Research Network (CPCRN) held three conferences based on the Evidence Academy model: one about prostate cancer in 2015, a second on food access and obesity prevention in 2017, and a third about tobacco control science in 2018. A diverse planning committee of stakeholders helped shape the content, focus,and format of each conference. Local and national experts presented findings to regional audiences of researchers, practitioners, government leaders, and community members. Each Evidence Academy included collaborators and speakers from other Prevention Research Centers (PRCs) and CPCRN network sites. Evaluations and outcomes indicated that the events were successful in achieving their goals and fostered ongoing relationships among attendees. This paper illustrates how the Evidence Academy model was used in a different region and describes lessons learned and follow-up activities that were initiated via the Evidence Academy and with input from participants. Lessons learned may be helpful in developing and evaluating future adaptations of the Evidence Academy model and/or the effectiveness of its components.

### Keywords

Evidence-based interventions; Community stakeholders; Research to action; Cancer control

## 1. Introduction

Robust, adaptable models for engaging researchers, clinicians, advocates, and policymakers in joint efforts to address important community health priorities using available evidence are

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needed (Rohweder et al., 2016). Community-engaged initiatives, like the Cancer Prevention and Control Research Network (CPCRN), are well-positioned to facilitate the advancement of knowledge and application of cutting-edge science, thus accelerating knowledge translation, action, and partnerships.

One of the aims of the University of Pennsylvania Prevention Research Center's (UPenn PRC) CPCRN Collaborating Center is to expand community-based dissemination and implementation research on cancer prevention and control in Southeastern Pennsylvania and the surrounding region using Evidence Academies. Evidence Academies are designed to bring together researchers, health professionals, advocates, and policy makers to accelerate the process of integrating research findings into practice (Rohweder et al., 2016).

This paper illustrates how the Evidence Academy model was used in a different region and describes lessons learned and follow-up activities initiated via the Evidence Academies and with input from participants.

## 2. The Evidence Academy model

The “Evidence Academy” education model, developed in North Carolina, is a one-day, single-theme meeting focused on an important community health priority. The Evidence Academy (EA) model (Rohweder et al., 2016) was used as a guide to plan the UPenn PRC events; see Fig. 1 for an example of how the original EA process model was applied for the Prostate Cancer Evidence Academy and details about the unique features of EAs.

This model differs from a conventional conference model by creating co-learning experiences for a relatively small, well-defined, local or regional network of individuals who represent different sectors but share a collective interest in a specific health priority. The focus of presentations is cutting-edge research. EAs offer community, clinical, and policy tracks during the event; and focus on both short term outcomes such as knowledge transfer, awareness, and partnerships, and long term outcomes related to evidence adoption and implementation (Rohweder et al., 2016). Events are planned and held locally with the guidance of a planning committee. Planning committees should be multidisciplinary, representative of affected stakeholders at all relevant levels, and knowledgeable about the evidence for the EA topic. For the EA model to be adopted widely or individualized for specific user needs, it is important to share examples of how the model has been implemented outside where it was first pioneered (Rohweder et al., 2016).

## 3. Planning the UPenn PRC Evidence Academies

UPenn researchers used the EA model because it provided a template for engaging community and other partners in developing EA themes; sharing cutting edge study results on issues of importance to community partners; informing local experts and community partners of appropriate dissemination and implementation strategies; and framing discussions with participants at different community and health systems levels about ways to overcome challenges to high quality, consistent implementation of evidence. Specific examples of adaptations made to the model for these events include having a more narrow geographic focus (i.e., city/regional as compared to state) and creating tracks to reflect the

target participants and speaker expertise. Through these EAs, the UPenn PRC aimed to make successful community engagement the rule, rather than the exception, in implementing evidence-based cancer prevention and control in the communities surrounding UPenn (Michener et al., 2012).

Each EA began with the UPenn CPCRN team and community partners identifying the broad issue that would be the overarching topic. Issue selection was based on local epidemiologic assessments of cancer incidence and mortality, risk factors, and health disparities. The team then identified and convened a Planning Committee for each EA. Committee members were chosen based on their expertise in the content area and to ensure different groups' interests were voiced during the planning process. Membership included clinicians, researchers, advocates, and policy makers from local universities and health systems, the State Department of Health, and community health organizations. For the Food Access, Diet, and Obesity Evidence Academy, faculty and staff from across the Prevention Research Centers (PRC) network participated, including individuals from Tulane University, the University of Illinois at Chicago, University of Massachusetts Medical School, the CPCRN Coordinating Center, and the Nutrition and Obesity Policy, Research, and Evaluation Network (NOPREN). The Planning Committee provided recommendations and input for each Academy, including refining conference themes, proposing topics, nominating keynote speakers, identifying potential event venues, publicizing the event, and serving as session moderators.

With support from CPCRN staff, Planning Committee members fine-tuned plans for each EA and helped craft agendas and meeting formats, which were planned to maximize interaction among attendees. Transmission of new information, by using a combination of lectures by experts and small group discussions, was also an important goal. Separate “tracks” within each EA were intended to focus on community action, clinical practice, and policy as per the original EA model (Rohweder et al., 2016). Evaluation forms were used to collect immediate post-EA feedback.

EA registration fees were kept low to engage a diverse audience. Registration included breakfast, lunch, refreshments during breaks, and the course syllabus, but did not cover the full direct costs of the event (Table 1). Scholarships were offered to increase attendee access, especially among community partners and students.

Each event was held from 9:00 am to 4:30 pm on a Friday at a hotel event/meeting space near the University of Pennsylvania and convenient to public transportation. EA attendance targets were 50 to 100 people per event. For each EA, speakers received speaker fees/honoraria based on their role (keynote speaker, plenary speaker, breakout speaker, etc.) and all lodging and travel costs were paid for by the event sponsors.

All three EAs concluded with planning action and follow-up steps along with related action-oriented networking. The Planning Committee or a subgroup of the members then formed an implementation workgroup with the addition of new leaders and committed volunteers who emerged during the meeting. They discussed and reflected on the meeting, and with technical assistance from CPCRN staff, moved into action steps.

## 4. Three Evidence Academies: collaborations, structure, and responses

Using the Evidence Academy (EA) model (Rohweder et al., 2016), three EAs were held in Philadelphia, Pennsylvania between 2015 and 2018. EAs focused on prostate cancer, food access/diet and obesity, and tobacco control. These case studies illustrate the various ways that each EA was developed, the logistics involved (such as sponsoring partners, time for planning, and finances), whether and how we met our participation goals, and concrete outcomes. Table 1 provides a high-level overview of the three Evidence Academies. Details about each event are described below.

## 5. Prostate Cancer Evidence Academy, 2015

Prostate cancer is the second most common cancer and a leading cause of cancer death among men in the United States (Siegel et al., 2014). Further, African American men are about 60% more likely to be diagnosed with prostate cancer and more than twice as likely to die from prostate cancer than the general population (Siegel et al., 2014). The causes of these disparities are not completely understood but are likely the result of complex interactions including genetic, behavioral, environmental, and socioeconomic factors (Cooperberg, 2013; Kheirandish and Chinegwundoh, 2011). The community where UPenn is located has high proportions of African Americans, increasing the salience of both this condition and the impact of racial disparities.

The Prostate Cancer Evidence Academy (PCEA) Planning Committee identified the topics to be covered at the EA, including: prostate cancer prevention, early detection, and quality treatment; cutting edge technologies, treatment, and research; current best practices in prostate cancer prevention and screening; medical treatment decision making; epidemiology of prostate cancer; evidence-based interventions (EBIs) to increase screening; using data for prostate cancer prevention and control; future directions for public health practice and research in prostate cancer; policies, interventions, programs, and resources in the region; and prostate cancer activism, education, and survivorship.

A professionally-designed event brochure outlining the objectives, agenda, and featured speakers was developed, printed, and distributed through mailing lists to the American Urological Association and Oncology Nursing Society, and to physicians on a Marketing InFocus List. Local and regional organizations such as the African-Caribbean Cancer Consortium, Zero the End of Prostate Cancer, Sidney Kimmel Cancer Center at Jefferson, Malecare, Fox Chase Cancer Center, Prostate Cancer International, and the Philadelphia Corporation for Aging helped to publicize and promote the event. Electronic brochures were distributed widely through local hospital and university listservs, newsletters, and student organizations.

The PCEA was a Continuing Medical Education (CME) and Continuing Nursing Education (CNE) accredited conference. Those interested in attending were instructed to register for the event online through the Penn Medicine Continuing Medical and Interprofessional Education (CME-IPCE) Office.

The PCEA was held in November 2015 with the goals of having participants learn about the latest evidence and model programs that make a difference in prostate cancer prevention, control, and treatment, and identify follow-up projects to advance prostate cancer control in the region. The PCEA was hosted by the UPenn PRC, the CPCRN Collaborating Center, and the P60 Center of Excellence in Prostate Cancer Disparities (funded by the National Institute on Minority Health and Health Disparities). The CPCRN team led event coordination, with substantial assistance from Penn Medicine Abramson Cancer Center. A total of 94 people attended the PCEA.

The conference began with morning plenary sessions where speakers provided overviews of the latest science on clinical, epidemiological, and public health aspects of prostate cancer. The afternoon consisted of breakout sessions for three tracks – clinical, public health/policy, and survivorship/advocacy. A lunch keynote address focused on men's health and survivorship was followed by a panel discussion on improving prostate cancer outcomes through translating research to policy. The last session of the day included working groups for each track, which allowed attendees to focus on and discuss the most relevant and applicable information and tools for application after the event. All attendees reconvened for a group discussion about the working group sessions. Highlights and action items from the working groups are outlined in Table 2.

## 6. Food Access, Diet, and Obesity Evidence Academy, 2017

Obesity is one of the most important health problems of our time. More than one third of adults and 17% of children are obese (Hales et al., 2017). The increasing rates of obesity contribute to high rates of chronic diseases, such as heart disease and type 2 diabetes. Obesity also contributes to the high cost of healthcare. Rates of obesity are often higher in low-income and minority populations, and paradoxically, issues of hunger and food insecurity co-exist with overnutrition or excess consumption of low-nutrition value foods (Hernandez et al., 2017). In Philadelphia, more than 20% of children and 35% of adults are obese (City of Philadelphia Department of Public Health, 2018). Obesity is a complex issue and a variety of different factors such as home and work environments, the food industry, and neighborhood safety can influence obesity in a community – and can provide opportunities for healthful, innovative policy and environmental changes.

The EA on “Accelerating Policies and Research on Food Access, Diet, and Obesity Prevention” was held in April 2017. This event was hosted by the UPenn PRC and the CPCRN Collaborating Center. Additional funding came from the Office of the Vice Provost for Research at the University of Pennsylvania.

The goals of this event were to provide a platform to collaborate with leaders in the field to prioritize local/regional research and policy efforts to combat obesity, and to focus on the dual concerns of overnutrition and food insecurity.

A flyer advertising the event was created. It was distributed widely to the University of Pennsylvania, other local universities and public health programs, the Philadelphia Department of Public Health, the PRC network, CPCRN, NOPREN, and relevant

organizations like The Food Trust. Registration was handled online through a SplashThat registration page.

A unique element of this EA was a Public Health Pitch Competition that was held the afternoon before the conference. This was an opportunity for students to present their ideas about accelerating policies and research on public health and disease prevention. Since a goal of EAs is to engage stakeholders, this competition was an innovative way to reach early-career scholars and engage them in the EA. Students submitted their ideas and 14 undergraduate and graduate students were selected to present their ideas to the audience and a panel of judges in five minutes. Students presented on a wide range of public health issues, as it was determined that requiring the pitches to focus on nutrition or obesity would be too limiting. A panel of judges and the audience rated the brief talks using rating forms and clickers. Awards of a certificate and $100 were given to the top undergraduate and graduate presentations, and a “People's Choice” award was also presented. Winning pitches focused on expanding prescription drug take-back programs in pharmacies, resolving malpractice dilemmas, and navigating the student health system. Virtually all the audience members and student presenters attended the EA the following day.

The main EA event was held the next day with 100 people attending. The conference began with a keynote address about supporting healthy eating through nutrition policy and was followed by a panel on innovative policy ideas and four breakout sessions. The afternoon consisted of a keynote address about community transformation through action around hunger and food. The last panel session featured speakers from the PRC network focusing on translating research into high-impact policy. This event helped to strengthen current connections and build new collaborations between obesity researchers, policy makers, and community partners.

## 7. Tobacco Control Evidence Academy, 2018

Tobacco use is a leading cause of preventable disease and death in the United States, and is a concern for both adults and youth (Odani et al., 2018; Wang et al., 2018). The rise in e-cigarette use, or vaping, presents new challenges to battling a public health threat that had been declining in past decades (Prochaska, 2019). The fast-moving field of tobacco control science was identified as the top priority for the next Evidence Academy in a voting process by cancer control researchers at UPenn.

The goal of the Tobacco Control Science Evidence Academy (TCSEA) was to engage public health professionals, policy makers, researchers, and clinicians, to inform them of the most up-to-date research on tobacco, and to bridge the gap between research, policy, and practice. The TCSEA was hosted by the UPenn PRC, the CPCRN Collaborating Center, and the UPenn Abramson Cancer Center.

Publicity included digital flyers and registration information distributed via email and social media across the University, and to organizations in the greater Philadelphia area. The TCSEA was held in November 2018 and 77 people attended.

The conference began with three morning plenary sessions providing an overview of the latest about new tobacco product marketing, clinical and biobehavioral research, and tobacco cessation programs. Concurrent breakout sessions were held in three tracks: clinical, research, and policy/action. The lunch keynote address was about e-cigarettes, followed by a panel about tobacco control in Philadelphia. Afterwards, a flash talk session featured six-minute presentations by five speakers about their research, programs, or policy initiatives. Similar to the pitch competition at the previous EA, this session was meant to engage graduate students and early career scholars and give them an opportunity to both present their work and network with other researchers. Participants then attended three workgroups in the same tracks as the morning breakout sessions to discuss themes from the day. The day concluded with a large group session to share information from the workgroups and talk about next steps.

Across the three workgroup tracks (clinical, research, and policy/action), several common themes emerged during discussion sessions among attendees. First, there is significant interest in e-cigarettes, particularly because of their potential to be both helpful and dangerous. Second, technology, specifically smartphones, should be further integrated into research. Third, special efforts should be made to reach and study populations such as pregnant women, youth, and tobacco users who do not seek out cessation treatment. Fourth, links between tobacco and marijuana use should be better understood.

## 8. Evaluation and follow-up activities

Across all events, evaluations showed that at least 80% of attendees rated each session as “very good” or “excellent.” Attendees reported that they liked the multidisciplinary approach, the action-oriented presentations, the wide range of people in attendance, the variety and quality of the speakers, and the ability to network with others.

PCEA evaluations indicated that participants would be able to implement new ideas and practices learned at the EA. Additionally, attendees working in clinical settings shared that the content could be used to improve care. Food access EA attendees reported that they planned to use the information learned in educational settings and school-based programs, for program evaluation, to build new partnerships, and for advocacy and volunteer work. TCSEA participants reported learning cutting-edge information about emerging areas of public health concern and planned to integrate what they learned in their own work, including social media campaigns and future research. These responses suggest that the short-term outcomes of knowledge transfer, increased awareness, and the establishment of new partnerships were achieved. (A version of the evaluation form used is available upon request from the authors.)

Follow-up actions from the PCEA included convening interested participants and obtaining funding for a pilot study of active surveillance of men diagnosed with early-stage prostate cancer. In addition, new research collaborations emerged from the PCEA that led to two other studies of prostate cancer disparities and community-engaged action (McIntire et al., 2018). There were no specific follow-up projects initiated as a result of the food access EA, but initiatives in nutrition, food access, and food policy are ongoing at UPenn and with

community partners. Follow-up from the TCSEA included new partnerships and collaborative projects between UPenn and the City of Philadelphia.

## 9. Discussion

The development and conduct of each of the three Evidence Academies led to significant cumulative learning for our CPCRN Collaborating Center team (Michener et al., 2012). Here we highlight some “lessons learned” across the three EAs that other groups planning EAs can consider in their future endeavors. These points were determined by the planning team based on evaluations, notes taken during the EAs, and from in-person discussions among the team, with the planning committee, and with attendees.

### 9.1. Collaborating partners and planning committees are important and helpful

The EAs hosted at the University of Pennsylvania used the model originally developed by the CPCRN site at the University of North Carolina (UNC) (Rohweder et al., 2016). Our co-author, Cathy Melvin, developed the EA concept and led the UNC CPCRN when the EAs were first initiated and provided input, guidance, and advice during the planning processes for these EAs. She also attended the Prostate Cancer Evidence Academy in 2015 and led the afternoon group discussion. Her help was invaluable in applying the EA model to our local context.

Planning Committees for each EA included university faculty members, staff and students, and local public health leaders. For the 2017 “Food Access, Diet, and Obesity” EA, we invited colleagues from the national PRC network to serve on the planning committee, as judges, and as panel speakers at the meeting. While it can be challenging to convene Planning Committee meetings, it was our experience that the committee members shaped the EAs into more engaging and vibrant events than they would have been without their input. The planners were also key to attracting broad audiences to the events.

The original EA model emphasizes the importance of a local focus for the conference content, which the Planning Committee helps ensure. This aspect of the EA model is a significant strength, but can also be a limitation in that it makes planning difficult to scale or easily transfer to other sites. For example, partnerships and institutional ties are essential for almost every step of the planning and execution of the EA, including securing funding, assembling the planning committee, recruiting speakers, and publicizing the event. We found these relationships vital to successful events, but it is up to the team on the ground to leverage their specific partnerships.

### 9.2. Costs, CE credits and planning time

The cost of the Evidence Academies ranged from $26,772 to $45,551, which included speaker fees, speaker travel and accommodations, event space, AV expenses, catering, publicity and audience generation costs, and printing costs (programs, meetings materials, signage). Also, a Planning Committee/Speaker dinner was held at a local restaurant the night before each Evidence Academy. This further facilitated collaborations and connections in a more informal atmosphere. These direct costs do not include faculty and staff time, which were supported through the CPCRN, UPenn PRC, and other grants related to the foci of the

EAs. The registration fee revenue covered only a small part of the direct costs, so we identified funding from non-PRC grants and from co-sponsors on campus and in the region. No pharmaceutical or industry contributions were used for the EAs.

We offered CME/CNE credits for the Prostate Cancer Evidence Academy in 2015, to encourage attendance and participation from clinicians. Of the 94 people in attendance during this event, 24 attendees received CME/CNE credit. However, the costs and staff effort required to be a CME/CNE-certified course were high and the cost-to-benefit ratio was poor. Therefore, in consultation with the Planning Committees we decided not to offer CME/CNE credits for the next two EAs. Also, we purchased commercial mailing lists of clinicians for the PCEA and sent a professionally designed brochure to over 7000 people. For the other EAs, we found that targeted publicity and e-invites were equally effective and much less costly.

While we expected that planning for each EA would take four to six months, at least nine months lead time was a more realistic estimate. The tasks requiring the most advance notice were booking high-quality, flexible, and affordable conference spaces and scheduling plenary speakers.

### 9.3. Follow-up activities and collaborations

All three EAs attracted sizable audiences that exceeded our minimum goals of 50 participants. Further, each Evidence Academy led to new activities and collaborations. The most vigorous follow-up was after the PCEA (Table 2), when a Follow-up Planning Survey was conducted. Based on the results, we convened a Survivorship and Advocacy Workgroup to discuss action plans from the event and to brainstorm next steps. This work group decided to prioritize two areas – active surveillance and awareness about prostate cancer, specifically among African American men and women. Because of these conversations, we applied for and received internal pilot grant funds to study patient and provider perspectives around active surveillance. That project is now complete and manuscripts are under review. Follow-up Planning Surveys were not used with the other two EAs because existing structures and ongoing initiatives were already in place for these content areas.

## 10. Conclusion

The overarching goals of the Evidence Academies are to enhance knowledge transfer, awareness, and partnerships, and to promote adoption of EBIs and priorities for improved cancer prevention and control (Rohweder et al., 2016; Stamatakis et al., 2013). The long-term impact should be reduced morbidity, mortality, and health disparities in regions where EAs are held.

The three Evidence Academies described here were very highly rated and met their goals of bringing together different stakeholders to enhance knowledge transfer, awareness, and partnerships. The Evidence Academy events also contributed to collaborations on new and ongoing research projects, increased communication between University faculty/staff and state and local health department leadership/staff, and fostered connections among researchers, community organizations, and existing resources.

While positive outcomes were attained in this use of the EA model, the EA model overall, its components, and various adaptations of it have not been evaluated as to overall effectiveness in achieving stated goals compared to other types of educational, communication, dissemination, or implementation strategies. For example, comparing long-term outcomes (like the speed of translation of evidence into practice) from EAs to those from more traditional conferences that do not have the same discussion and networking emphasis would help identify the relative advantage of this aspect of EAs. Future research opportunities exist to use information such as that presented in this paper to advance our understanding of whether the EA model is a robust intervention strategy to move evidence into practice.

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## References

City of Philadelphia Department of Public Health, 2018 Philadelphia's community health assessment: health of the city. https://www.phila.gov/media/20190110163926/Health_of_City_2018_revise2.pdf.

Cooperberg MR, 2013 Re-examining racial disparities in prostate cancer outcomes. J. Clin. Oncol 31, 2979–2980. [PubMed: 23878300]

Hales CM, Carroll MD, Fryar CD, et al., 2017 Prevalence of Obesity Among Adults and Youth: United States, 2015–2016 NCHS Data Brief, No 288 National Center for Health Statsitics, Hyattsville, MD.

Hernandez DC, Reesor LM, Murillo R, 2017 Food insecurity and adult overweight/obesity: gender and race/ethnic disparities. Appetite 117, 373–378. [PubMed: 28739148]

Kheirandish P, Chinegwundoh F, 2011 Ethnic differences in prostate cancer. Br. J. Cancer 105, 481–485. [PubMed: 21829203]

McIntire RK, Keith SW, Boamah M, Leader AE, Glanz K, Klassen AC, Zeigler-Johnson CM, 2018 A prostate cancer composite score to identify high burden neighborhoods. Prev. Med 112, 47–53. [PubMed: 29625131]

Michener L, Cook J, Ahmed SM, Yonas MA, Coyne-Beasley T, Aguilar-Gaxiola S, 2012 Aligning the goals of community-engaged research: why and how academic health centers can successfully engage with communities to improve health. Acad. Med 87, 285–291. [PubMed: 22373619]

Odani S, Armour BS, Agaku IT, 2018 Racial/ethnic disparities in tobacco product use among middle and high school students - United States, 2014–2017. MMWR Morb. Mortal. Wkly Rep 67, 952–957. [PubMed: 30161103]

Prochaska JJ, 2019 The public health consequences of e-cigarettes: a review by the National Academies of Sciences. A call for more research, a need for regulatory action. Addiction 114, 587–589. [PubMed: 30347473]

Rohweder CL, Laping JL, Diehl SJ, Moore AA, Isler MR, Scott JE, Enga ZK, Black MC, Dave G, et al., 2016 Bridging research, practice, and policy: the “Evidence Academy” conference model. J. Public Health Manag. Pract 22, 200–203. [PubMed: 25723874]

Siegel R, Ma J, Zou Z, Jemal A, 2014 Cancer statistics, 2014. CA Cancer J. Clin 64, 9–29. [PubMed: 24399786]

Stamatakis KA, Norton WE, Stirman SW, Melvin C, Brownson RC, 2013 Developing the next generation of dissemination and implementation researchers: insights from initial trainees. Implement. Sci 8, 29. [PubMed: 23497462]

Wang TW, Asman K, Gentzke AS, Cullen KA, Holder-Hayes E, Reyes-Guzman C, Jamal A, Neff L, King BA, 2018 Tobacco product use among adults - United States, 2017. MMWR Morb. Mortal. Wkly Rep 67, 1225–1232. [PubMed: 30408019]

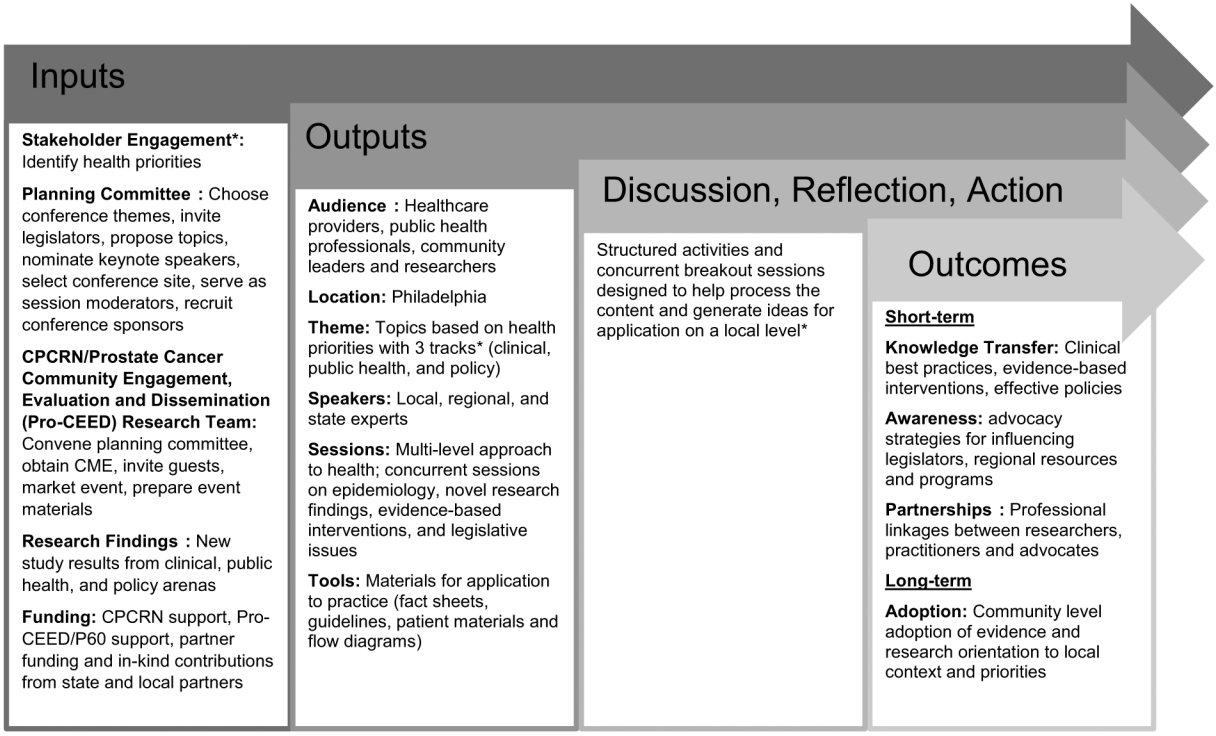


**Fig. 1. Prostate Cancer Evidence Academy logic model.**

*These are unique features of the Evidence Academy model.

(Adapted from: Rohweder, C., Laping, J., Diehl, S., Moore, A., Isler, M., Scott, J., … Melvin, C. (2016). Bridging Research, Practice, and Policy: The "Evidence Academy" Conference Model. Journal of Public Health Management and Practice, 1–4.)

**Table 1**

Evidence academies overview.

| | 2015 Evidence Academy | 2017 Evidence Academy | 2018 Evidence Academy |
|---|---|---|---|
| Theme | Prostate cancer | Food access, diet, and obesity | Tobacco control science |
| Target audience | Clinicians, public health professionals, policy makers, patients/ survivors | Public health professionals, policy makers, researchers, community organizations and stakeholders | Public health professionals, policy makers, researchers, clinicians |
| Reach/focus | Regional: Southeastern Pennsylvania | Regional and national: Southeastern Pennsylvania and PRC Network | Local: Philadelphia area |
| Number of attendees | 94 | 100 | 77[a] |
| CME/CNE certified course | Yes | No | No |
| Registration cost[b] | CME/CNE credit: $50 (physicians), $25 (nurses and other health professions)<br>Not seeking CME/CNE credit: $15 | $25, $15 student registration | $35 |
| Sources of funding | UPenn CPCRN[c]; UPenn PRC[d]; P60 Center of Excellence in Prostate Cancer Disparities (NIH) | UPenn CPCRN[c]; UPenn PRC[d]; University of Pennsylvania Office of the Vice Provost for Research | UPenn CPCRN[c]; UPenn PRC[d]; Population Science Program, Penn Medicine Abramson Cancer Center |
| Total costs[e] | $45,551 | $27,876 | $26,772 |

[a]There were more no-shows to this EA than the others, due to a major early-season snowstorm.

[b]Scholarships to cover registration costs were available upon request.

[c]CPCRN: Cancer Prevention and Control Research Network (funded by the CDC).

[d]Penn PRC: University of Pennsylvania Prevention Research Center (funded by the CDC).

[e]Total costs reflect total direct costs and do not include faculty and staff time for planning and managing the events.

**Table 2**

Working group discussion points and action items: Prostate Cancer Evidence Academy.

| Working group | Discussion highlights | Action items |
|---|---|---|
| Clinical | • Prostate cancer behaves differently than other cancers.<br>• Clinicians see the value of screening, the question is when to screen and how to fine-tune it. | • More genomic research is needed to determine which prostate cancers need to be treated.<br>• Physician perceptions of screening should be explored.<br>• Physicians need a list of advocacy groups and resources to refer patients to after a diagnosis. |
| Public health/ policy | • Although individual decision making related to prostate cancer is nuanced and complex, evidence-based information about prostate cancer should be made readily available to clinicians and patients. | • Decision-making tools and resources should be compiled and disseminated to health care providers<br>• More needs to be done to incorporate health literacy with informed decision making tools.<br>• Research findings should be aggregated into a public database. |
| Survivorship/ advocacy | • Low health literacy is a major concern.<br>• More conversations about post-treatment are needed.<br>• It is important to encourage men to talk about health and peer encouragement can be powerful. | • Prostate cancer survivors and advocates can be trained to be educators and navigators.<br>• The language difference between “screening” versus “testing” should be addressed. |