Comprehensive Cancer Control

Evaluation Report:

Maine Comprehensive Cancer Control Program
Maine Cancer Consortium
Maine Cancer Plan

August 2006
Final Report

Prepared for:

Maine Comprehensive Cancer Control Program
Division of Chronic Disease
Maine Center for Disease Control and Prevention
Department of Health and Human Services

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Background

The Maine Center for Disease Control and Prevention, Department of Health and Human Services contracted with the Maine Center for Public Health to evaluate the statewide Comprehensive Cancer Control (CCC) Initiative. This report provides information on three major areas of the initiative that have similar goals and objectives. They include the:

1) Maine Comprehensive Cancer Control Program
2) Maine Cancer Consortium
3) Maine Cancer Plan

In relation to these areas, this report provides an overview of findings related to the implementation of the 2001-2005 Cancer Plan, the planning process of the new 2006-2010 Cancer Plan, and Program accomplishments.

Moreover, the report includes evaluation data from the following initiatives implemented by the Skin Cancer and Colon Cancer Task Forces of the Cancer Consortium:

1) *Sun Safety Kits* for Middle-Schools
2) *No Sun for Babies,* Hospital Initiative
3) *Screen ME!* Colon Cancer Social Marketing Campaign

Purpose of the Report

The report is intended to be used to inform Consortium members, program staff, and other governmental and nongovernmental stakeholders about the progress, achievements, gaps, and limitations of the initiative, to date. This evaluation report is issued in that spirit.

It is our hope that information provided herein will be seen as an invitation to celebrate the successes and that it will serve as the impetus to make improvements that will ultimately strengthen the initiative. The findings of this evaluation should be viewed as a learning opportunity and one of several tools utilized to ultimately help strengthen the collective efforts of those seeking to decrease the burden of cancer in Maine.

Results: At-a-Glance

Cancer Consortium, New Cancer Plan Planning Process Findings

During March and April of 2006, an evaluation of the planning process of the new Cancer Plan was conducted. The evaluation included a survey with Consortium members and telephone interviews with Workgroup chairs. Overall, 57.4% of respondents stated they were satisfied with the planning process. Respondents were asked to rate their level of satisfaction with five aspects of the planning process. All ratings were 4 or above, indicating a high level of satisfaction. Strengths of the planning process included having an "open process," inclusion of "various perspectives" and the Annual Meeting. These findings were supported through the interviews as well, with all seven respondents noting their satisfaction with the planning process.

Comprehensive Cancer Control Program Results

During 2005 cycle, the Maine Comprehensive Cancer Control Program (MCCCP) and Maine Cancer Consortium updated the Maine Cancer Plan to reflect emerging needs and new issues in cancer prevention, detection, and care. Moreover, the MCCCP awarded over $54,000 mini-grant funds to support various cancer control efforts around the state including hospitals and Consortium Workgroup. Additional MCCCP accomplishments can be found in *Results Part II.*

2001-2005 Maine Cancer Plan Implementation Findings

This evaluation report provides information on select goals, objectives, and strategies delineated in the Maine Cancer Plan. A modified *Activity-Monitoring Tool* was developed to track progress, to date, with regard to implementation for all strategies listed in the 2001-2005 Maine Cancer Plan. Overall, the results suggest that some progress has been achieved for approximately 76% of the strategies assessed, an increase from 57% last year.

Outcome data, when available, was also included as part of this report. The findings indicate that improvements were noted in several areas. The final results section of this report details the findings.

Recommendations

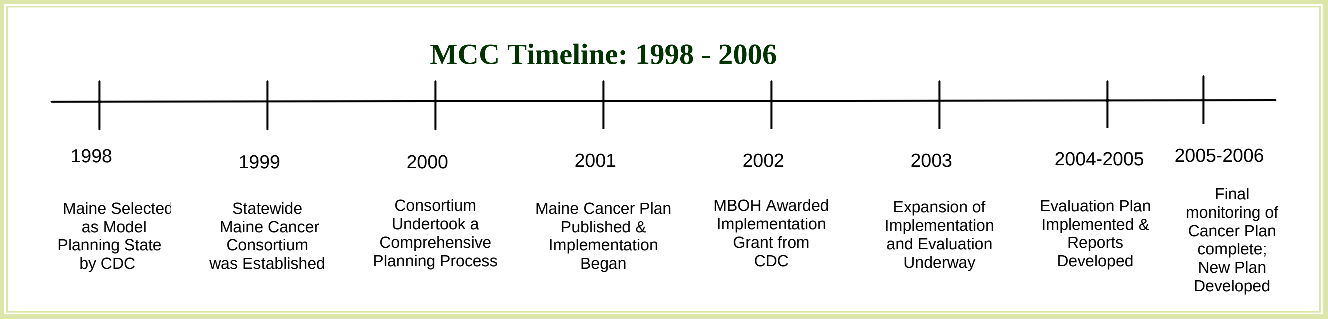
The following recommendations have been provided.

1. Enhance the Consortium's membership and participation.
2. Reach consensus on the various functions of the Workgroups, Board, and Program, as well as the role of Consortium members and potential staff.
3. Narrow the Consortium's focus to select priorities.
4. Enhance Communication.
5. Engage Consortium Workgroups in the Evaluation.

BACKGROUND

The Maine Center for Disease Control and Prevention (ME-CDC, previously the Bureau of Health) contracted with the Maine Center for Public Health (MCPH) to evaluate the statewide Comprehensive Cancer Control Initiative. The first phase of this evaluation involved the development of a comprehensive plan outlining the design, components, and strategies to be accomplished. The comprehensive evaluation plan (available upon request) was completed in June 2003. This report details the results of the final phases of the evaluation otherwise known as implementation and impact of the plan. Figure 1 depicts the timeline.

Figure 1. *Maine Comprehensive Cancer Control Initiative Timeline, 1998-2006*



As depicted in the figure above, the actual implementation of the Maine Cancer Plan has been underway since 2001. This report attempts to capture activities, successes, and challenges that have occurred, to date, related to three major areas of the initiative. They include: 1) the Maine Comprehensive Cancer Control Program housed within the ME-CDC; 2) the Maine Cancer Consortium and related Workgroups or Task Forces; and 3) the Maine Cancer Plan. These three areas complement one another and many of the activities overlap.

Maine Comprehensive Cancer Control Program

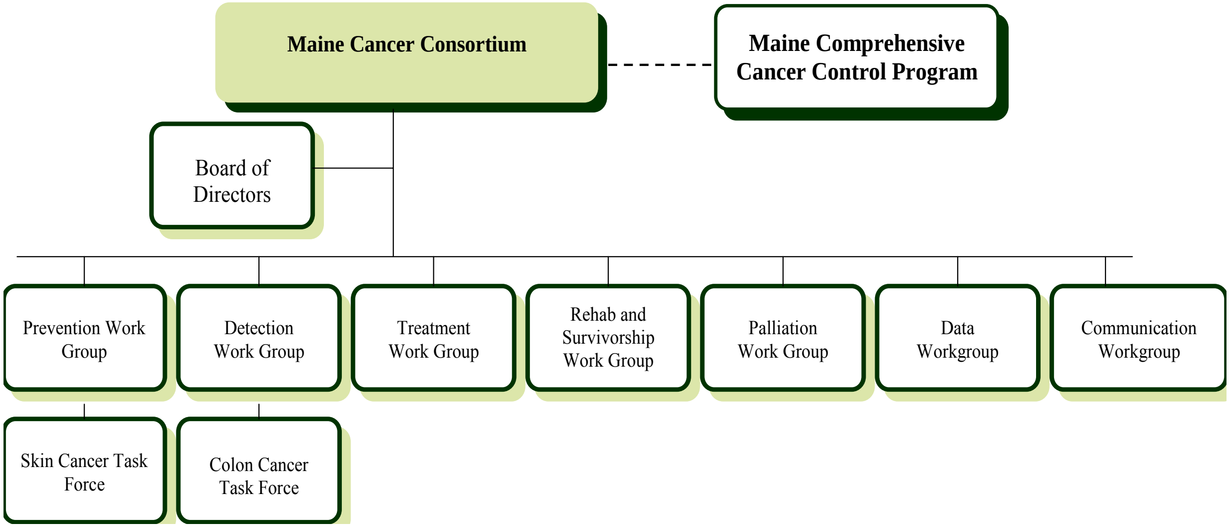
The Maine Comprehensive Cancer Control Program (MCCCP) is a state-run program funded by the U.S. Centers for Disease Control and Prevention. The program provides leadership for, and coordination of, Maine’s statewide comprehensive cancer control efforts and is guided by the goals and objectives delineated in the Maine Cancer Plan. The long-term goal of the program is to reduce the burden of cancer in Maine through the coordinated efforts of the Maine Cancer Consortium (Consortium), a statewide partnership. The programmatic objectives are:

- Improve and expand the collaborative efforts already in place through the Maine Cancer Consortium among stakeholders working on cancer control in Maine.
- Increase the use of the Maine Cancer Plan as the statewide document directing cancer control efforts.
- Provide technical assistance to organizations working on state and local efforts.
- Conduct collaborative public awareness and education projects.
- Evaluate the efforts and impact of the Consortium and CCC Program.

Maine Cancer Consortium

The Maine Cancer Consortium was created in 1999 and includes representatives from public and private organizations involved in all aspects of cancer prevention, control, and care. There are over 130 organizations involved in the Consortium. An organizational chart is provided below. Currently, all of the Workgroups are active with the exception of the Treatment and Communication Workgroups.

Figure 2. *Maine Cancer Consortium Organizational Chart*



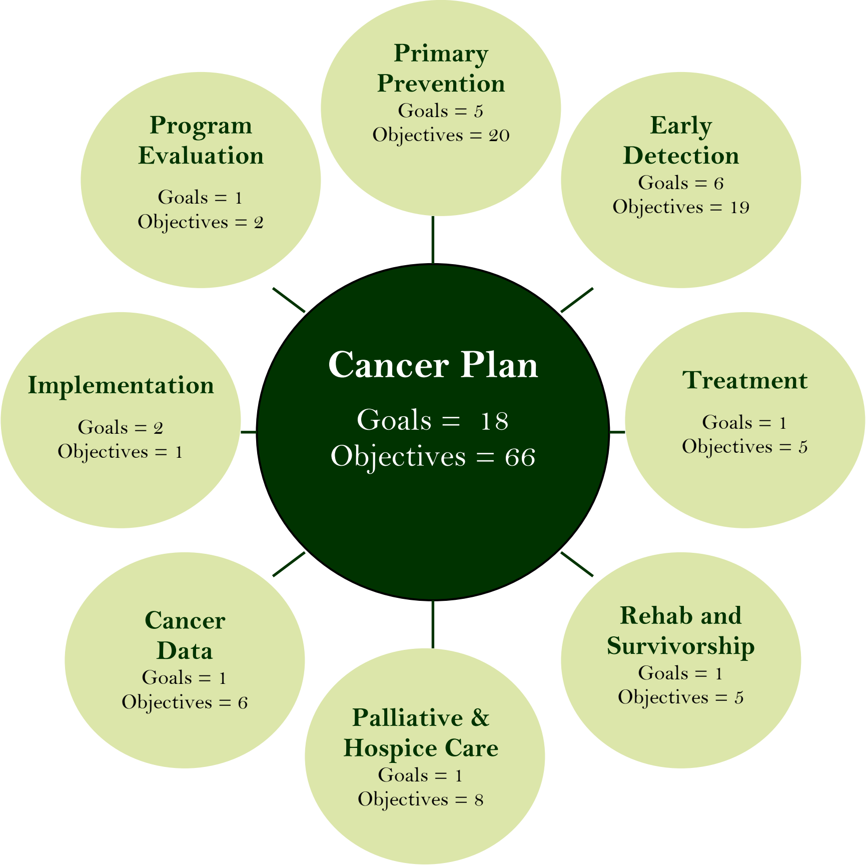
The mission of the Consortium is to reduce the burden of cancer in Maine by working collaboratively to optimize quality of life by improving access to care, prevention, early detection, treatment, rehabilitation, survivorship, palliation, and end of life care. The Consortium seeks to:

- Increase statewide integration, coordination, and provision of quality prevention, treatment, palliative, and end of life care services in Maine.
- Increase access to high quality cancer prevention, treatment, palliative, and end of life care information and services for all Maine residents regardless of geographic, financial, and other demographic factors.
- Increase the proportion of residents who appropriately utilize screening, follow-up, treatment, rehabilitation, survivorship, hospice, and palliative care services.
- Improve the quality and coordination of cancer surveillance and other data systems and the extent to which these and other evaluation data are used for comprehensive cancer control programming and management.
- Increase support from policy and grant makers for comprehensive cancer control in Maine.

Maine Cancer Plan

The Consortium and CCC Program worked collaboratively to create the *Maine Cancer Plan*, published in 2001. The purpose of the Plan was to provide a template for what should be done to provide statewide coordination of cancer control efforts in Maine through 2005. The eight components of the Maine Cancer Plan are depicted below in Figure 3.

Figure 3. *Maine Cancer Plan Components, Goals, Objectives: 2001-2005*

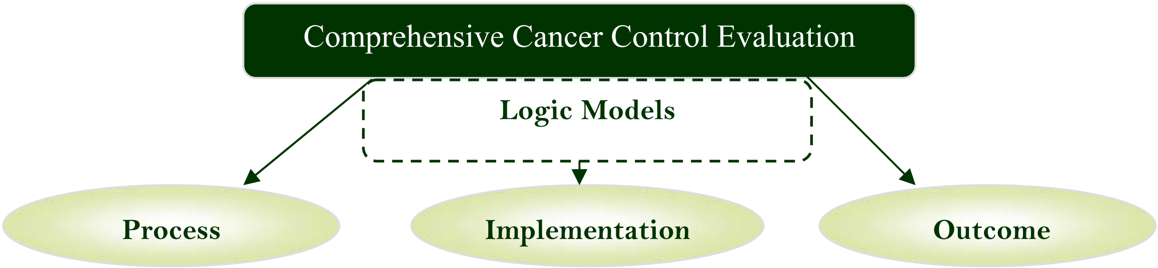


This evaluation report focuses on all strategies identified in the Maine Cancer Plan. The strategies pertaining to active Workgroups are included in this report.

EVALUATION DESIGN

As seen in Figure 4, this evaluation framework includes three components. The first component was designed to assess the process of the initiative. The second component focuses on the implementation of activities that collectively and theoretically result in improvements in health outcomes and other programmatic objectives. The third component attempts to determine the outcomes or impact of the initiative. For more information about the evaluation design, please refer to the *Comprehensive Cancer Control Evaluation Plan*. This plan delineates the steps and includes the overarching program evaluation framework consistent with the Centers for Disease Control and Prevention's approach.

Figure 4. *Comprehensive Cancer Control Evaluation Design*



Data Collection Methodology

Quantitative and qualitative information were collected as part of this evaluation. Table 1 depicts the data sources for each component of the evaluation during the 2005 cycle year.

Table 1. *Data Sources*

Evaluation Component	Source
Process Evaluation	
• **Cancer Plan Planning Process Surveys** - On-line - Paper/pencil evaluation at Annual Meeting	• Developed by the Maine Center for Public Health
• **Key Informant Interviews** - Telephone (13 items, 6 domains)	• Developed by the Maine Center for Public Health
Implementation Evaluation	
• **Modified Activity Monitoring Tool** - Paper and pencil tracking tool	• Developed by the Maine Center for Public Health
• **Interviews with Staff** - In person, program accomplishments updates	• Developed by the Maine Center for Public Health
• **Sun Safety Kit evaluation survey** - Paper/pencil distributed to Middle Schools	• Developed by the Maine Center for Public Health
• **No Sun for Babies evaluation surveys** • Parent postcard • Hospital paper/pencil survey	• Developed by the Maine Center for Public Health

• **Social marketing surveys** • Maine residents, 50 & older: Telephone, Pre/Post (30 items) • Physicians: Telephone/fax (5 items)	• Developed by Digital Research, Inc.
Outcome Evaluation	
• **Maine Cancer Registry, CDC Wonder** - Secondary data (incidence and mortality)	• Maine-CDC • CDC
• **Youth/Behavioral Risk Factor Surveillance System** - Secondary data (behaviors)	• Maine-CDC • CDC

RESULTS PART I: PROCESS

Understanding the contextual factors (e.g., environmental, organizational, human, etc.) that either hinder or facilitate a program's success provides important information that can be used for program replication and decision-making. At this stage of the CCC initiative, implementation of the current Cancer Plan and planning for the new Cancer Plan occurred simultaneously. Therefore, this component of the evaluation focused on two important areas: 1) an assessment of the Consortium's planning process of the new 2006 Cancer Plan; and 2) a review of potential Program and Consortium-specific internal and external factors potentially related to the implementation of the 2001-2005 Cancer Plan.

Cancer Consortium Findings

In the spring of 2005 the Consortium participated in the *Partnership Self-Assessment* (see September 2005, final report) that measured the collaborative process and effectiveness (i.e., synergy) of the Consortium. A clear area for improvement emerging from this assessment was the need to enhance communication among Consortium members. In response to this finding, the Consortium developed a Communications Workgroup. Moreover, in an effort to enhance the involvement of and communication among the membership, the MCCCP with the assistance of Consortium Workgroups Chairs designed a planning structure for the new Cancer Plan that would further engage and retain its membership

To hone in on the effectiveness of the partnership, a process evaluation component was designed to evaluate a specific way in which the partnership functions -- the effectiveness of the planning process for the Maine Cancer Plan, a critical aspect of the Comprehensive Cancer Initiative. A survey and telephone interview protocol were developed to capture Consortium members' satisfaction with the planning process for new 2006-2010 Maine Cancer Plan.

Cancer Plan Planning Process Evaluation

The process evaluation for the new Cancer Plan was conducted in March – April of 2006 and included a survey with Consortium members and telephone interviews with Workgroup chairs. Results from both are summarized below.

Methods

Survey

The on-line survey included a total of 21 items under six domains (see Appendix A for text-only version). The purpose of the survey was to measure Consortium members' satisfaction with the planning process and their initial assessment of the Cancer Plan.

Interviews

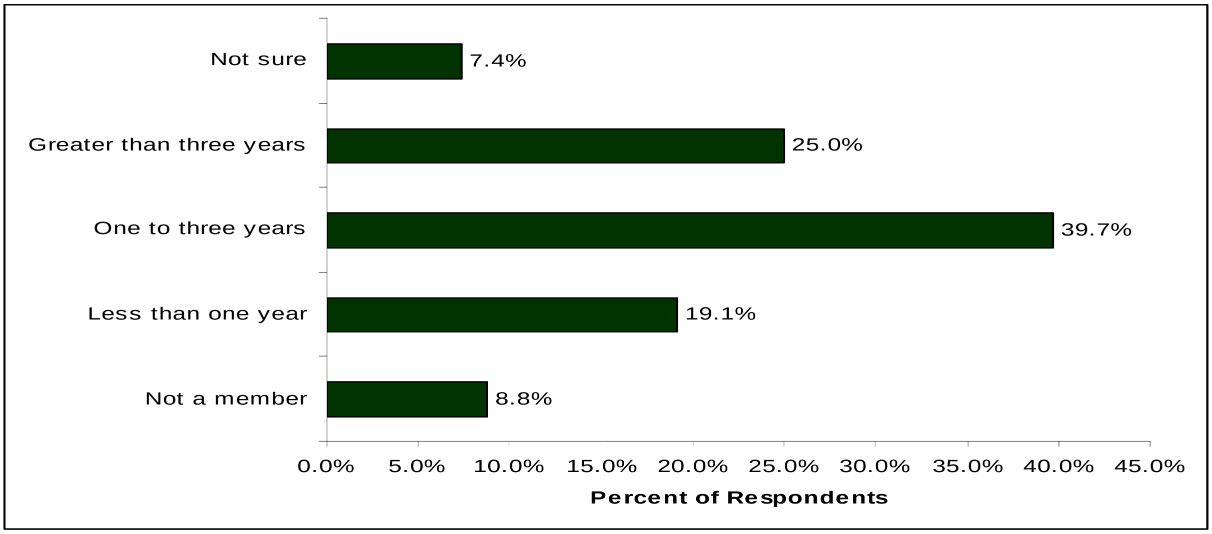
Telephone interviews were designed to understand the process of the Workgroups, particularly the time commitment, strengths, and potential challenges the Workgroups faced when writing their goals, strategies, and objectives for the new Cancer Plan (see Appendix B for interview protocol). In addition, Workgroup chairs were asked to identify contextual factors that may relate to the implementation of the Cancer Plan.

Seven Workgroup chairs and one Workgroup member were interviewed, representing all but two Workgroups. *The communication Workgroup was not included, as it was not involved in the Cancer Plan process.*

Participant Characteristics

Out of the 202 members contacted, 66 completed a survey, for a response rate of 33%. As shown in the following chart, most respondents to the survey had been a member of the Consortium from 1 – 3 years (40%). Less than 10% of respondents indicated that they were *not* a member.

Chart 1. *Length of Involvement in the Consortium*

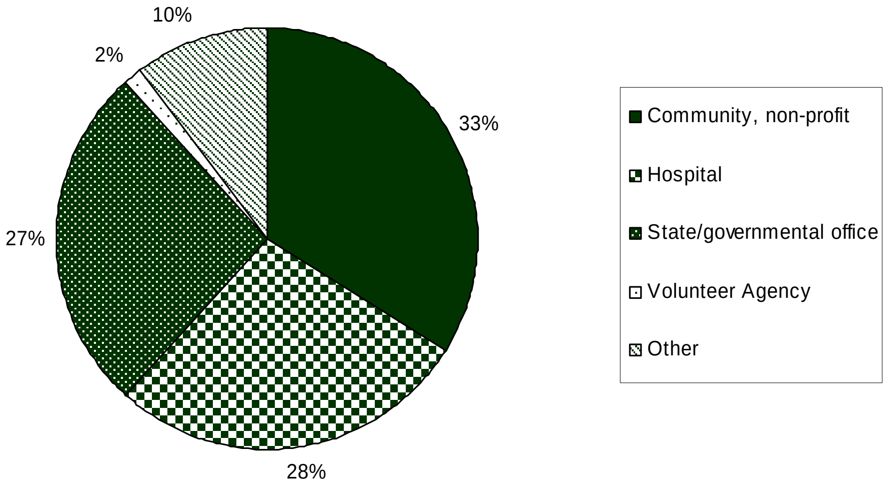


All but one of the interview participants had been involved with the Consortium for over 3 years.

Representation

Most respondents represented a community organization/non-profit (33.8%), hospital (27.9%), or state/governmental office (26.5%).

Chart 2. *Sector Representation*

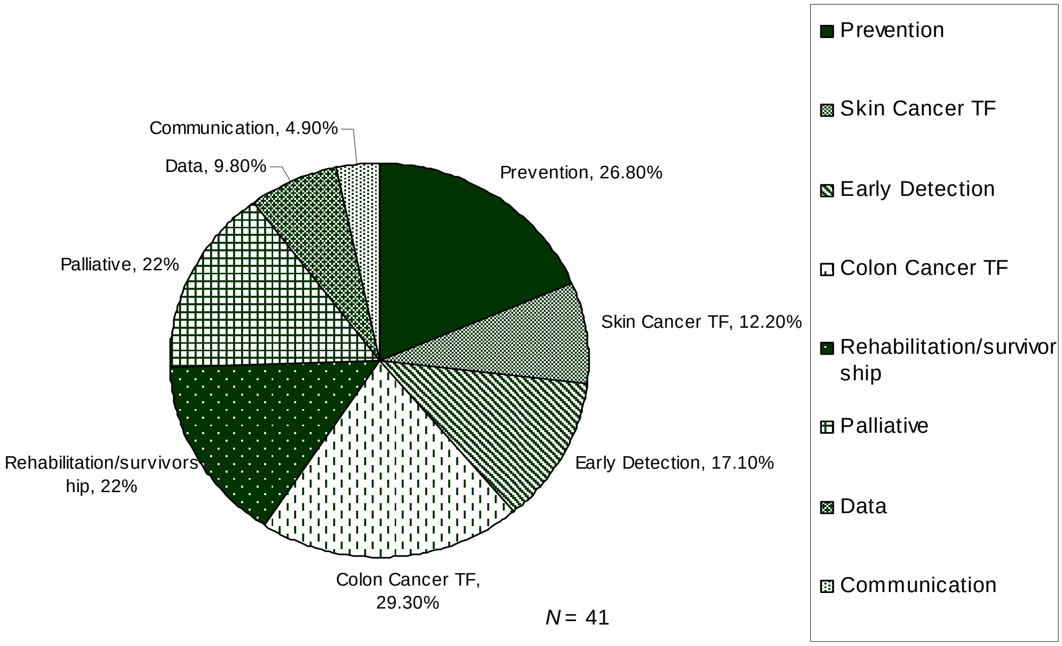


Those who listed “other” represented a range of sectors including, healthcare system, student, academic-community partnership, hospice, and the Medical Association.

Workgroup Membership

Thirty-nine respondents (57.4%) were a member of a Workgroup, with five respondents stating they “used to be” a member. Of these members who identified a Workgroup, all of the Workgroups were represented. As shown in Chart 3, the four most represented Workgroups included the Colon Cancer Task Force, Prevention, Rehabilitation/Survivorship, and Palliation.

Chart 3. *Workgroup Representation*



Level of Involvement in Consortium

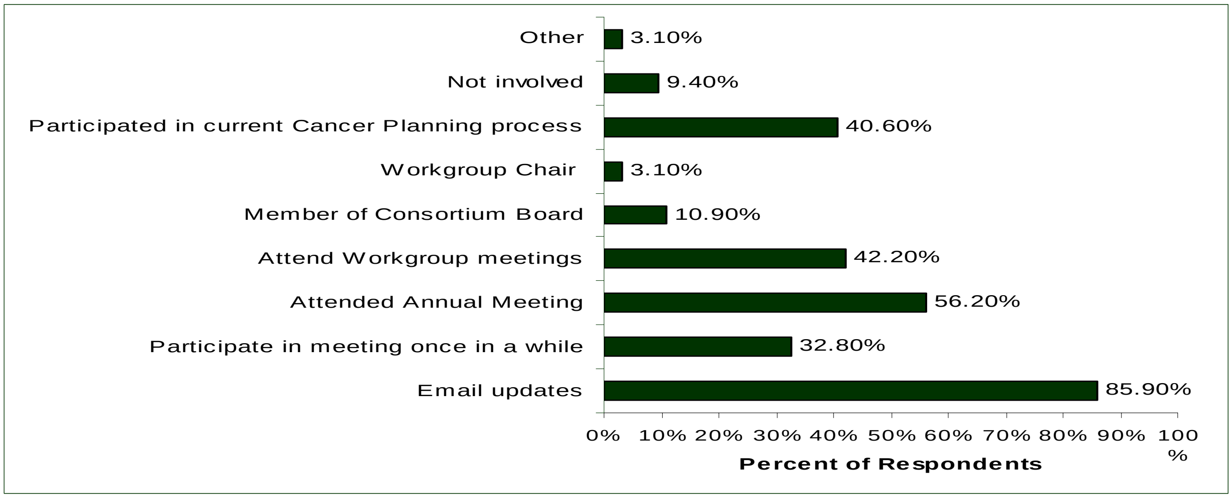
Respondents were asked to rate their level of involvement on a 5-point scale (1 = not at all; 5 = extremely involved). The average response was 2.84, indicating that respondents felt they were only "somewhat involved" with the Consortium.

Table 2. *Level of Involvement in Consortium*

Level of Involvement	Frequency	Percentage
Not at all involved	11	16%
Somewhat uninvolved	18	26%
Somewhat involved	18	26%
Involved	11	16%
Extremely involved	9	13%
Total responses	**67**	

The majority of respondents (86%) indicated that they stay involved with the Consortium through email updates, and over half (56.2%) attended the Annual Meeting. Other responses are included in Chart 4.

Chart 4. *Description of Involvement in Consortium*



Finally, participants were asked to rate their satisfaction (1 = not at all; 5 = extremely satisfied) with their level of participation. The average rating was 3.5, indicating that respondents were fairly satisfied with their level of participation. In fact, the majority of respondents (86%) rated their satisfaction as 3 (somewhat satisfied) or higher (29% noted that they were "extremely satisfied"). Not surprisingly, those who indicated they were somewhat to extremely involved were significantly[1] more satisfied (*mean* = 3.91) than those who indicated they were not at all involved or somewhat uninvolved (*mean* = 2.76).

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[1] Significantly indicates a difference that would be expected to occur by chance alone less than 5 times in 100. Significance level, ($p < .05$).

Satisfaction with Consortium

Using the same 5-point scale, participants were asked to rate their satisfaction with various aspects of the Consortium. Participants were also given the option of indicating they, "don't know." A summary of these responses (*n* = 56) are located in the following table. As indicated in Table 3, there is some room for improvement on various aspects of the Consortium with most areas receiving a rating of 3.5 or more. The two areas showing the most room for growth are efforts in getting and providing funding, and the use of media to promote awareness. It should be noted that issues related to funding were the most unclear to respondents with approximately 40% indicating they "did not know" about the Consortium's efforts in getting and providing funding.

Table 3. *Average Satisfaction Ratings of Consortium*

Aspect of Consortium	Mean response	# of respondents
Strength and competence of leadership	4.20	44
Contribution to health/well-being of Maine	3.84	43
Progress in meeting objectives and strategies	3.84	42
Participation of influential people from key sectors	3.84	40
Willingness of members to take leadership role	3.68	35
Communication among members	3.68	50
Clarity of roles	3.64	41
Capacity to advocate effectively	3.52	45
Use of media to promote awareness	3.40	41
Efforts in providing funding for community efforts	3.16	32
Efforts in getting funding	2.76	31

Note: Averages do not reflect those respondents who indicated "Don't Know" or "other."

Cancer Plan Process

Fifty-four participants in the survey responded to the following questions regarding the Cancer Plan planning process. The findings are summarized in the following sections.

Involvement in Process

Respondents' level of involvement varied with the average level being 2.76 on a 5-point scale (1 = not at all; 5 = extremely involved). Responses were relatively evenly distributed along the scale. Responses are summarized in the following table.

Table 4. *Level of Involvement in Cancer Plan Process*

Level of Involvement in Cancer Plan	Frequency	Percent of responses
Not at all involved	12	22%
Somewhat uninvolved	13	24%
Somewhat involved	11	20%
Involved	12	22%
Extremely involved	6	11%
Total responses	**54**	

The most common areas of involvement in the Cancer Plan planning process included participation in the Annual Meeting (61%), developing goals, objectives and strategies within a Workgroup (53.7%), and providing feedback on revised goals and objectives (50%). Other areas of involvement included: providing feedback on draft Cancer Plan (38.9%) and providing feedback at Board of Director's meetings (11%). Twenty-six percent of respondents (*n* = 14) noted "no involvement" in the planning process[2].

Satisfaction with Process

Overall, 57.4% of respondents stated they were satisfied with the planning process. Respondents were asked to rate their level of satisfaction with five aspects of the planning process. Most ratings were approximately 3.6 or above, indicating a fairly high level of satisfaction. Moreover, those areas with lower average responses, (e.g., decision-making process) had higher frequencies of respondents indicating they "did not know" about their satisfaction, therefore decreasing their average mean response. Refer to Table 5 for a summary of responses. Average responses (*n* = 54) are summarized in Chart 5.

Table 5. *Summary of Satisfaction Ratings of the Planning Process*

Aspect of Planning Process	Not at all satisfied	Somewhat unsatisfied	Somewhat satisfied	Satisfied	Extremely satisfied	Don't know
Components/focus areas	--	6%	22%	24%	24%	11
Diverse representation	2%	7%	17%	31%	17%	22%
Decision-making process	4%	6%	19%	24%	20%	24%
Information sharing/communication	2%	9 %	21%	30%	21%	13%
Timeline for the process	--	2%	20%	26%	20%	28%
Total responses	**4**	**16**	**53**	**73**	**68**	**58**

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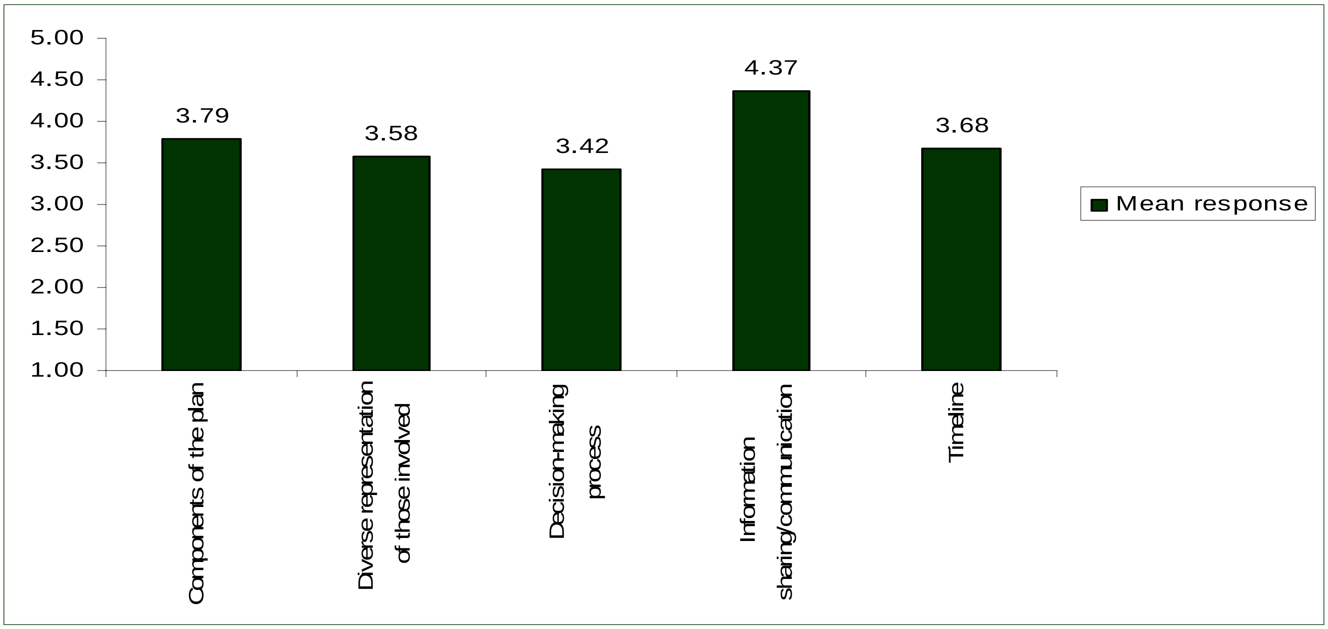
[2] This number varied slightly from the previous question asking respondents to rate their level of involvement in the Cancer Plan planning process.

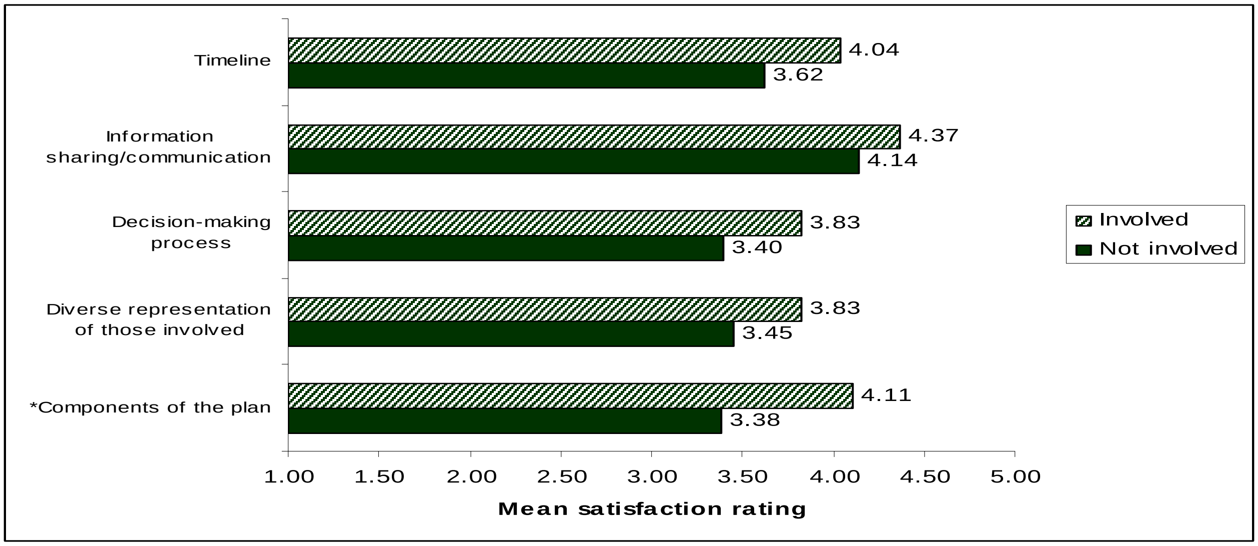
Chart 5. *Average Satisfaction Ratings of Cancer Plan Process*



These findings were supported through the interviews as well, with all seven respondents noting their satisfaction with the planning process.

Finally, slight differences were found between respondents describing a low level of involvement (i.e., ratings of “1” or “2”) and those indicating a higher level of involvement in the planning process (i.e., “3” – “5”). These findings are presented in Chart 6. Due to the small number of respondents in the “not involved” category, the findings should be interpreted with some caution.

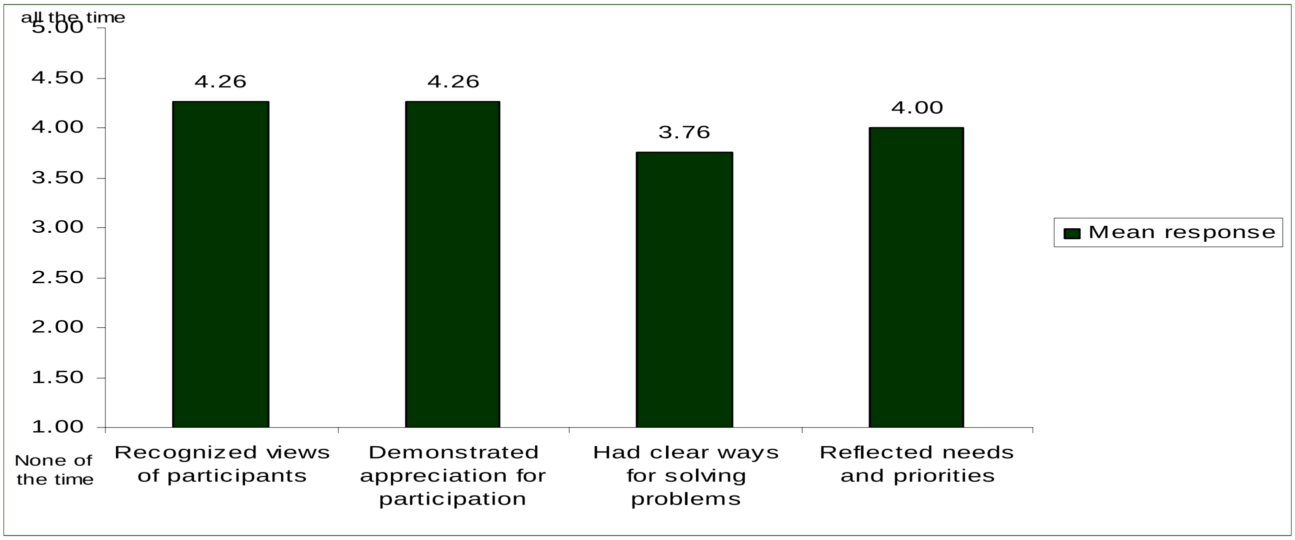
Chart 6. *Average Satisfaction Ratings by Planning Process Involvement Level*



* *Note.* Indicates a significant difference, p < .01

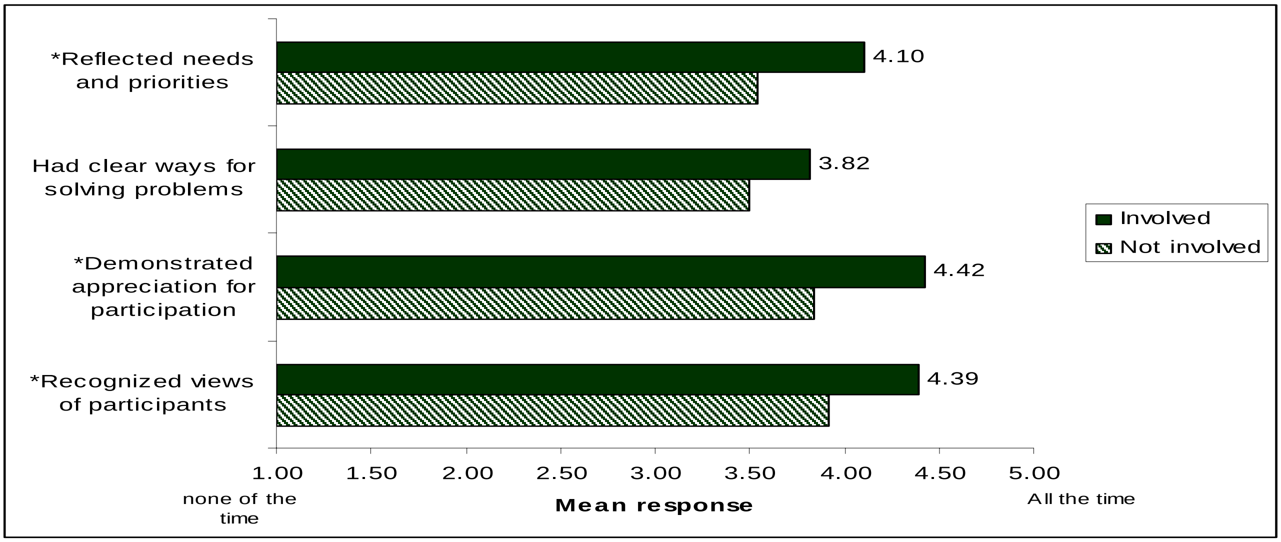
Survey participants were asked to rate the extent to which the planning process recognized the views of and demonstrated appreciation for participants, solved problems and reflected needs and priorities. The average ratings ranged from 3.76 to 4.26 (1 = none of the time; 5 = all of the time). The findings are delineated in the following chart.

Chart 7. *Average Ratings of Aspects of Planning Process*



A significant difference was found between the average responses of those indicating they were "not involved" and those "involved" in the planning process in all but one area (had clear ways for solving problems). These findings are summarized in the following chart.

Chart 8. *Average Ratings of Aspects of Planning Process by Involvement Level*



* *Note*. Indicates a significant difference, $p < .05$.

About a quarter of the respondents offered comments regarding their satisfaction with the planning process. Responses regarding areas for improvement in the planning process related to the timeline of the process, roles and responsibilities, and process clarity. Within the interviews, the most common areas of improvement for the process related to the representation of those involved and the time commitment. These two themes related in that while they viewed the process as "open," several interviewees felt that a small amount of people did most of the work and thus, the time commitment was challenging. In response to time limitation, several Chairs mentioned the value of having interns or more "administrative support" for their Workgroups. A summary of common themes are presented in the following table.

Table 6. *Areas for Improvement of Cancer Plan Process*

Theme	Comment
Process structure	"Timeline for getting feedback was not adequate." "Very confusing." "I was not impressed with the way the goals and so on were formulated at the annual meeting. I thought that was very chaotic." "I think that the administrative support of the planning process was good but there should have been more time to circulate and debate the final draft."
Roles, representation	"I was not at all sure of what my involvement was supposed to be. In other words I have no idea of what my role or expectations from this group are." "Revised/updated objectives without having evaluation results from 2000-2005 plan. Objectives largely represented established objectives of an individual program, not the Consortium." "I am concerned that possibly a few people did a lot of the work." "There should be a stronger effort to include major national level partners with similar goals and objectives, through their state and regional representatives." "It is important to get a variety of input from a broad base of constituents."
(Interviews) Roles; representation	"A few people making decisions; not as many participated." "Self-selecting…hard to get people to volunteer. [Need] less public health people [to enhance process], doesn't necessarily reflect middle-class Maine."
Time Commitment	"Deadlines too prompt. Timeline was a little aggressive." "Quite a bit of time, mostly for me [the Chair]…[I] ended up being the depository of information; a lot of secretarial work."

The most commonly mentioned strengths of the planning process included having an “open process” and inclusion of “various perspectives.” Participants specifically cited the Annual Meeting as a strength of the planning process. The findings from the interviews mirrored these sentiments. For example, one interviewee described the process as “smooth…not unilateral, a collaborative effort.” A sampling of comments from the survey and interviews is provided in the following table.

Table 7. *Summary of Strengths of Planning Process*

Comments: Related to Open, inclusive process
“Everyone had a chance to have their opinions heard, ample time was given to give feedback, giving other groups the chance to look at goals/objectives of other groups gave the opportunity for fresh perspectives.”
“A chance to hear many views of what was important in all aspects of cancer.”
“I felt like all of our opinions and ideas mattered to the planning process but that after all the 'processing' a plan would be put in place that reflected a lot of work and attention paid to those who were asked to share their thoughts.”
“Recognition given to individuals, committees for efforts, honest evaluations of year-long activities.”
“The process at the annual board meeting was very beneficial especially to those who were new to the Consortium.”
“Involvement of diverse members of the health care field”
“The strength of the process is in the individuals who participate. All the participants are respectful and sensitive to the needs and perspectives of others.”
Interviews: “”Got it done. A lot of people put a lot of work, good product. Showed a lot of input. Open process.”
“Feedback portion of Annual Meeting…strong approach to get as much input into the process.”
“I really liked how we set up the Annual Meeting to provide input into the plan.”

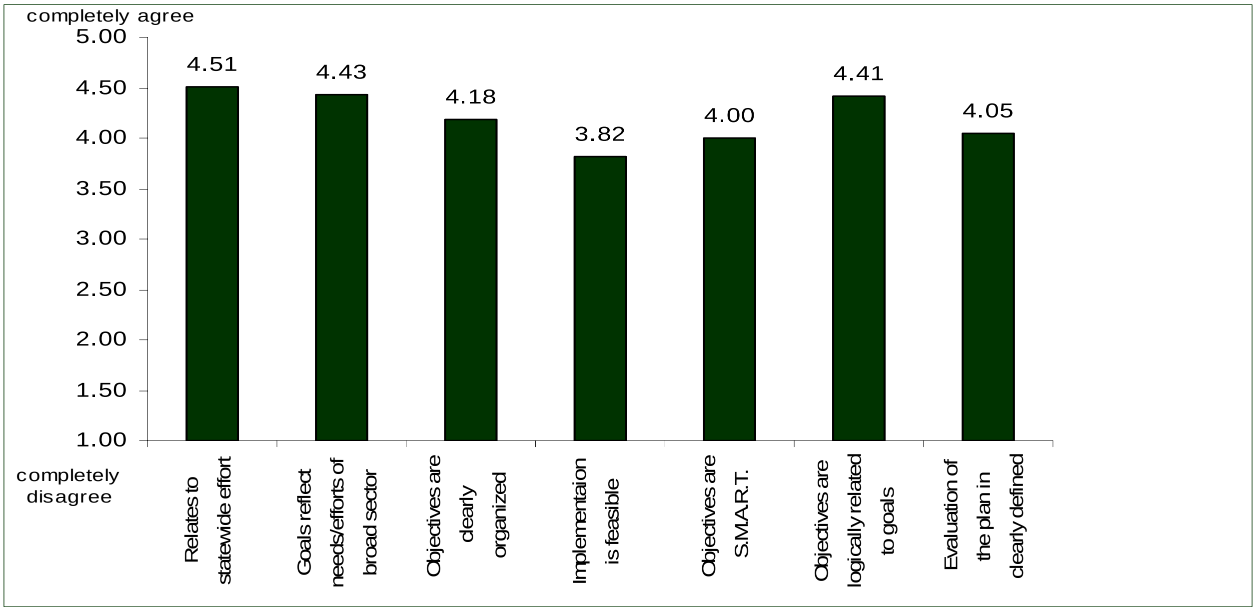
Assessment and Utilization of the Cancer Plan

An average of 51 participants responded to the questions in this final section. All but 15 respondents indicated that they had either read all of the Cancer Plan (n = 17; 32.7%) or their Workgroup section of the Cancer Plan (n = 20; 38.5%).

Respondents (*n* = 49) were asked to indicate their agreement to seven statements regarding the quality of the Cancer Plan[3]. Average responses ranged from 3.82 to 4.51 on a 5-point scale (1 = completely disagree; 5 = completely agree). Moreover, for each area the highest number of responses were in the "agree" or "completely agree" categories. Thus, respondents rated the quality of the Cancer Plan quite high. Feasibility of implementation had the lowest level of agreement.

As noted previously, these results do not reflect those respondents who indicated "don't know" or "not applicable," therefore, lowering the number of applicable responses. A summary of these findings is presented in the following charts.

Chart 9. *Average Quality Ratings of Plan*



Quality ratings differed between the "involved" (*n* = 28) versus "not involved" (*n* = 9) respondents; however, the extreme difference in sample sizes limited the ability to identify statistically significant differences. The average ratings organized by level of involvement in the planning process are presented in Chart 10.

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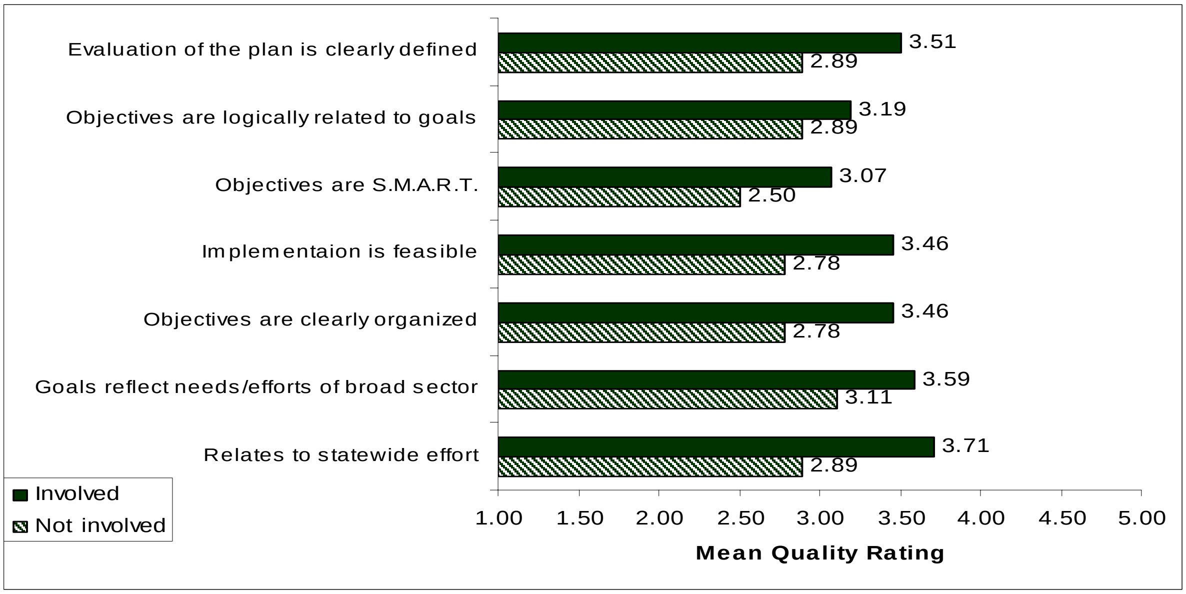
[3] Adapted from: Butterfoss FD, Dunět DO (2005). State Plan Index: A tool for assessing the quality of state public health plans. *Preventing Chronic Disease* [serial online]. Available from: URL: http://www.cdc.gov/pcd/issues/2005/apr/04_0089.htm.

Chart 10. *Average Quality Ratings of Plan by Planning Process Involvement Level*



Interviewees were also asked to describe the strengths of their Workgroup's goals, objectives, and strategies and the overall strengths of the Cancer Plan. Interviewees voiced their satisfaction with their Workgroup's section of the Plan and noted that their goals, objectives and strategies were "concise," "measurable," and that their group had "ownership" over their section. When asked about the Plan, the most common responses related to the "comprehensive" and "measurable" nature of the Plan. As one interviewee noted, the Plan is, "grounded in reality [and] doable." Finally, most interviewees mentioned the value of having "buy-in" and "input" from the Consortium membership.

Congruent with the survey findings, implementation was the most common area of concern. While neither survey respondents nor interviewees strongly questioned the feasibility of implementation, it is clear that implementation is the most challenging aspect of the Plan. Reasons given for this challenge included internal or organizational structures, such as a lack of time, resources and money. For example, one interviewee noted the difficulty in "sustaining energy." Similarly, another participant opined that "engaging new folks" will be a barrier to implementation. In addition, another felt that there is "no financial security behind objectives."

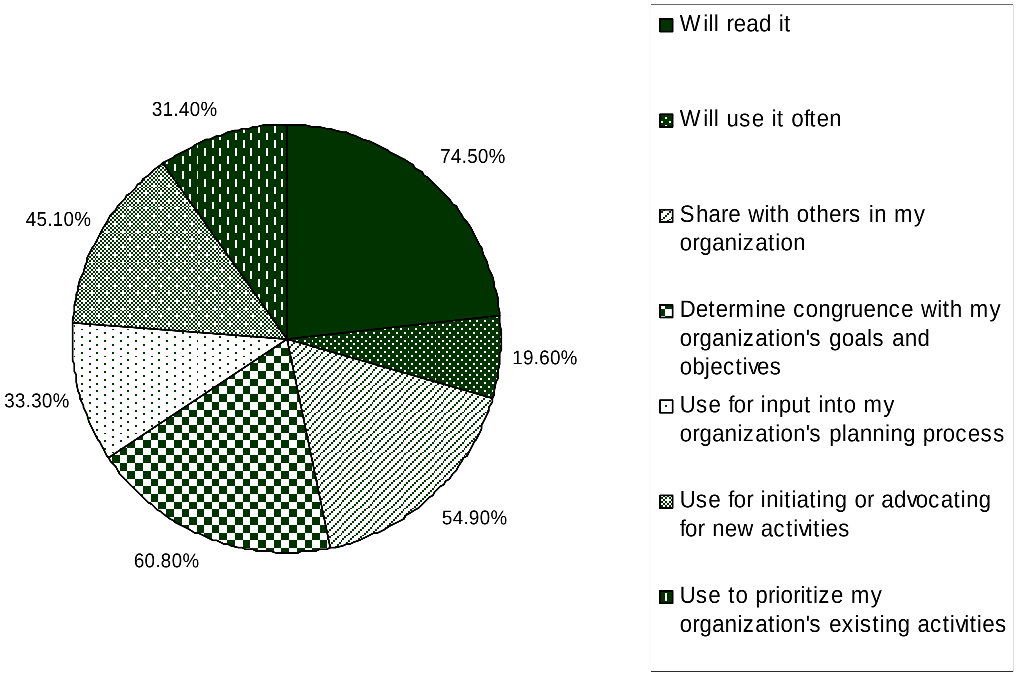
Finally, several interviewees listed potential *external* factors that may affect the implementation of the Cancer Plan. The two most common factors included governmental resources (e.g., "may need more publicly-funded program for Colon, Hospice") and system barriers or what one participant described as "the reality of the health care environment" and "reimbursement" issues.

Uses of the Cancer Plan

Finally, respondents were asked to indicate the various ways they plan on using the Cancer Plan. Approximately 75% of respondents noted they would read the Plan, 61% indicated they would review their organization's goals and objectives to determine their congruence with the

Cancer Plan, and over half (55%) noted that they would share the Plan with others in their organization. A full summary of the results is located in the following chart.

Chart 11. *Uses of the Cancer Plan*



Additional Consortium Findings

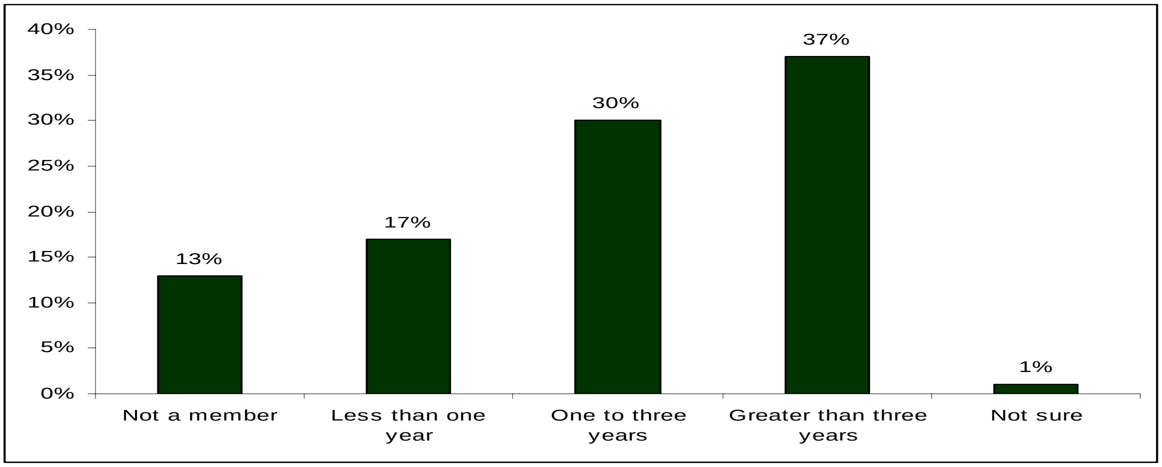
Annual Meeting Evaluation Results

The Maine Cancer Consortium held its annual meeting October 18, 2005 with the primary purpose of beginning the planning process for the new 2006 Cancer Plan. Approximately 75 people attended. Of these, 30 people returned evaluation surveys for a 40% response rate. The purpose of the survey was to capture attendees' feedback regarding the meeting goals and to find out more those people who attended the meeting. The findings are summarized below.

Participant Characteristics

A total of 30 people returned evaluation surveys. Most of the participants (84%) were members of the Consortium and many (67%) had been involved in the Consortium for more than one year. Participants' length of involvement in the Consortium is presented in the following chart.

Chart 12. *Annual Meeting Participants' Length of Involvement in Consortium*



Participants were asked to indicate if they were involved in the Board of Directors or Workgroups of the Consortium. These responses are summarized in the following table.

Table 8. *Annual Meeting Participants' Involvement in Workgroups*

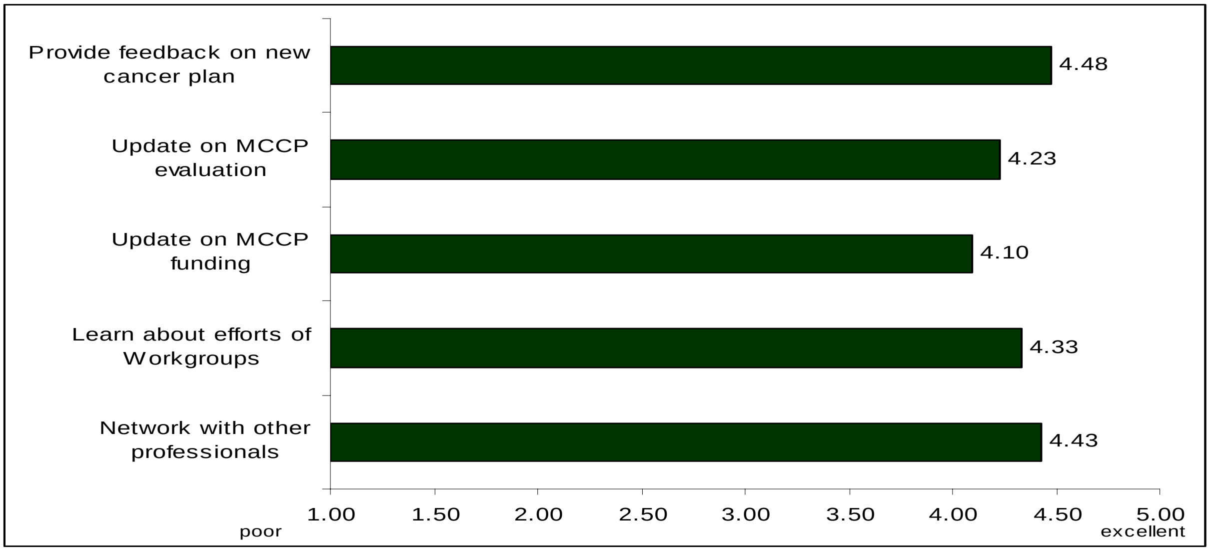
Consortium Group	Percent Involved
Board of Directors	13%
Primary Prevention Workgroup	23%
Skin Cancer Task Force	23%
Early Detection Workgroup	23%
Rehabilitation & Survivorship Workgroup	23%
Hospice & Palliation Workgroup	17%
Colon Cancer Task Force	13%
Data Workgroup	7%
Communication Workgroup	3%
No involvement in groups	23%

Finally, most respondents (63%) had participated in the planning process for the new Cancer Plan outside of the annual meeting.

Feedback on Meeting Goals

Using a 5-point scale, (1 = very poor; 5 = excellent) participants rated how well the meeting goals were achieved. All of the goals were rated relatively high with average ratings ranging from 4.10 to 4.48. As shown in the following chart, participants rated the opportunity to provide feedback on the new cancer plan the highest. This finding is congruent with the Cancer Plan Process Survey presented in a previous section.

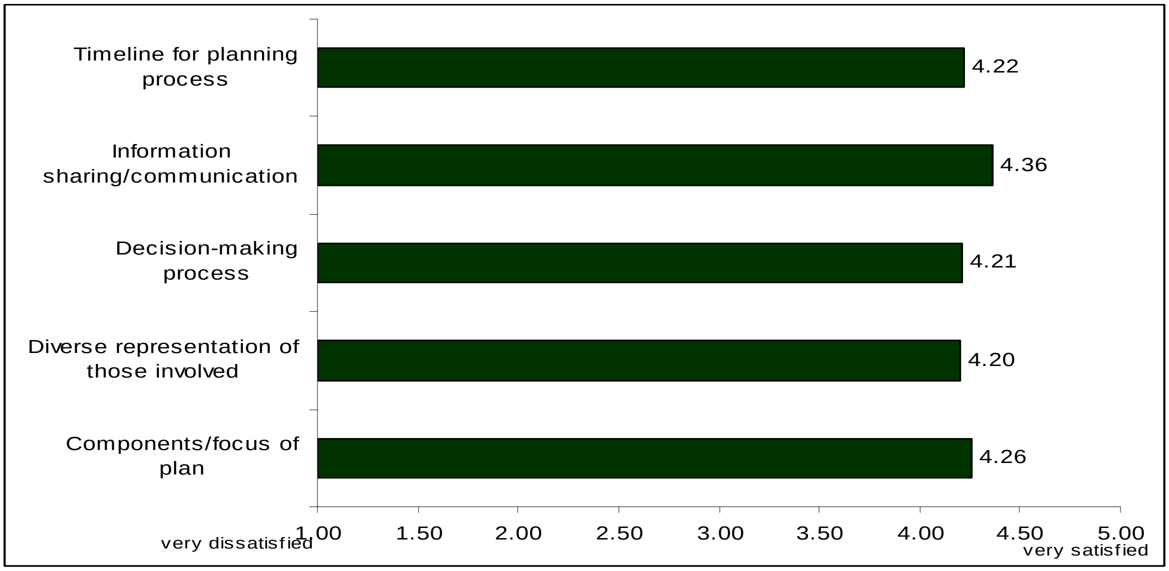
Chart 13. *Average Ratings of Annual Meeting Goals*



Satisfaction with Planning Process for New Cancer Plan

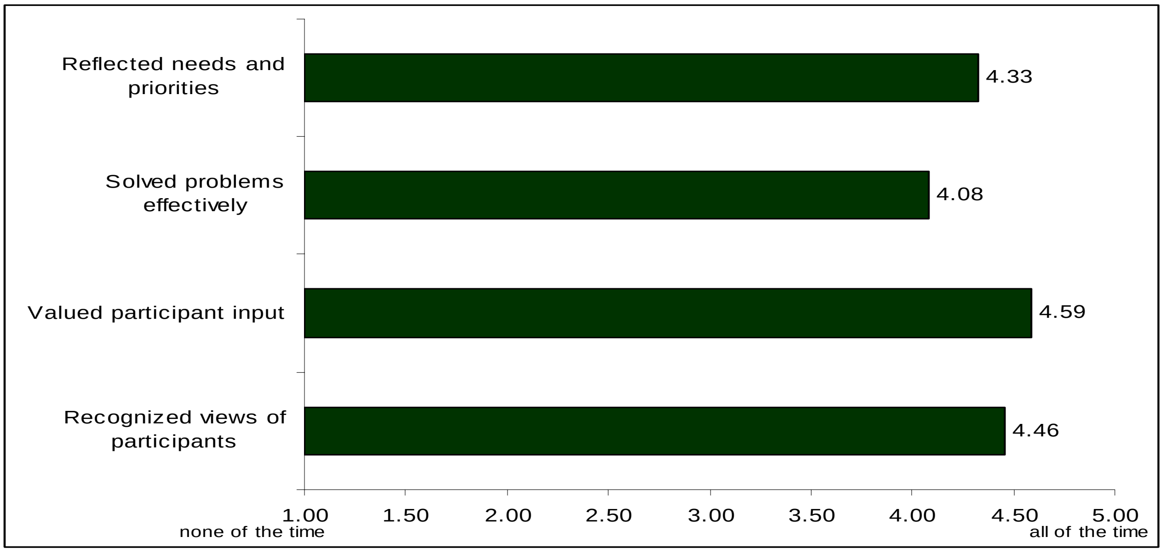
Similar to the Cancer Plan Process Survey, participants were asked to rate their level of satisfaction with five aspects of the planning process. Congruent with the findings from the process survey, participants were satisfied with the planning process that took place at the annual meeting. Based on a 5-point scale (1 = very dissatisfied; 5 = very satisfied), the average satisfaction ratings ranged from 4.20 to 4.36. Participants were most satisfied with the information sharing and communication aspect of the meeting's planning process. Chart 14 summarizes these findings. As shown in this chart, these findings are similar to those of the larger planning process survey indicating that while participants were satisfied with the planning process, areas of growth may include increasing the diversity of representation, decision-making process, and the timeline for the planning process. Moreover, a clear area of strength is the sharing of information and communication involved in the planning process.

Chart 14. *Average Satisfaction Ratings of Planning Process, Annual Meeting*



Participants were asked to rate the extent to which the planning process recognized the views of and valued input of participants, solved problems, and reflected needs and priorities. Based on the responses, there is little room for improvement as the average ratings ranged from 4.08 to 4.59 (1 = none of the time; 5 = all of the time). The findings are delineated in the following figure. Congruent with the planning process survey, participants felt strongly that the process valued input and recognized views of participants.

Chart 15. *Average Ratings of Aspects of Planning Process, Annual Meeting*



RESULTS PART II: IMPLEMENTATION

This component of the evaluation focused on the implementation of activities and strategies designed to bring about changes that are directly linked to program goals, as depicted in the logic models. As many program managers well know, the implementation phase is often challenging due to uncertainties and other contextual factors that can affect the process. This part of the evaluation provides valuable information that can be used on an ongoing basis to make programmatic improvements during implementation. In addition, it allows for more effective management of individual and group efforts.

Activity-Monitoring Tool Results

An Activity Monitoring Tool (AMT) was developed in 2004. This tool was then modified in 2005 to meet the changing needs of the Consortium. The AMT tracks progress towards achievement of the stated measure and reports feedback on accomplishments, strengths, and challenges. While the revised AMT was used to collect information on all strategies depicted in the Maine Cancer Plan, the evaluation plan and previous reports were based on criteria listed on page eight of this report.

Due to the modifications made to the tracking tool and the Consortium’s desire to track all Workgroup strategies, this report focuses on all strategies outlined in the Maine Cancer Plan, regardless of the measurability of the accompanying objective. This report also focuses solely on those strategies for which there was an active Workgroup or Task Force. Finally, it is important to note that this report does not include Maine Comprehensive Cancer Control Program-specific strategies due to their exclusion in the new tracking tool.

Considerations for the Interpretation of Tracking Information

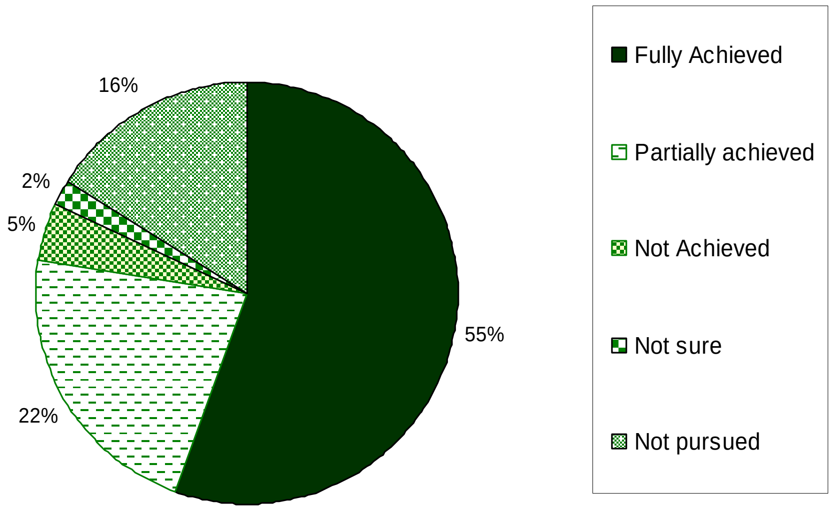
When reviewing data collected by this tracking tool, it is important to recognize the varied roles and responsibilities of the Workgroups. The Primary Prevention and Early Detection Workgroups focus primarily on coordinating and monitoring existing related efforts that are consistent with the Cancer Plan. Yet, the remaining Workgroups are more directly involved in strategy implementation. The progress results reported in the *Activity-Monitoring Tool* may reflect this difference in oversight versus participation/initiation.

It is also important to keep in mind that some strategies may be sequential and thus reliant on the completion of other strategies. Additionally, some strategies may not have been pursued for a variety of reasons, such as lack of resources and lack of clarity. Some strategies may have changed during the course of the initiative, and some may have been dropped since the initial inception and dissemination of the Maine Cancer Plan.

Chart 16 illustrates the overall combined status of all Active Workgroups. A little over 75% of strategies ($N = 200$) were partially or fully achieved, thus, showing an increase from last year (57% of the 180 strategies measured). Only 5% of strategies were not achieved.

Approximately 16% of strategies were not pursued. The lack of attention given to select strategies was often deliberate and a result of new knowledge, technology, or strategic direction. In addition, most of the strategies listed as "partially achieved" were identified as on-going and included in the new Cancer Plan.

Chart 16. *Overall Combined Strategy Status of All Active Workgroups*



As indicated in Chart 17 and Table 9, most Workgroups partially or fully achieved their section of the Cancer Plan.

Chart 17. *Fully Achieved Strategies by Active Workgroups*

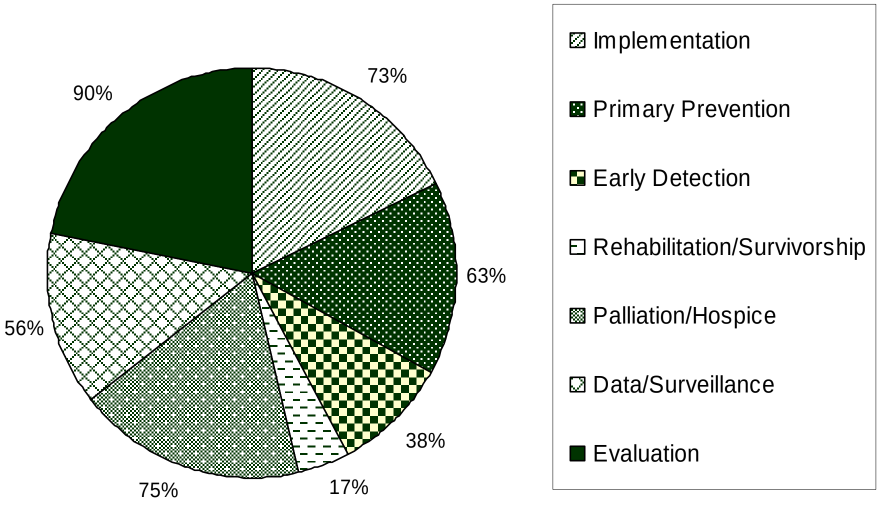


Table 9 provides a summary of the status of strategies for each active Workgroup. Due to the diversity among Workgroup functions and roles, this information should be interpreted with caution and should not be used for comparison purposes.

Table 9. *Summary of Strategy Status for All Active Workgroups*

Work Groups & Goals	**Total Strategies**	**Progress**				
		Fully Achieved	Partially Achieved	Not Achieved	Not Sure	Not Pursued
Primary Prevention	70	63%	30%	4%	1%	1%
Early Detection	45	38%	22%	2%	2%	36%
Rehabilitation & Survivorship	23	17%	22%	4%	9%	48%
Palliative and Hospice Care	28	75%	11%	11%	--	3%
Data and Surveillance	9	56%	33%	11%	--	--
Implementation	15	73%	6%	--	--	20%
Evaluation	10	90%	10%	--	--	--

Cancer Plan Implementation Strengths

As part of the AMT, Workgoups were asked to identify the strengths and challenges to implementing each strategy. A review of strengths for all strategies combined revealed several consistent themes:

- Network of partners and the existing local Healthy Maine Partnerships
- Funding to pursue strategies, objectives, and goals
- Dedicated members and program staff who continue to support Consortium efforts
- Support from other state programs (e.g., Maine Cancer Registry, Maine Breast and Cervical Health Program)

Challenges

For the strategies that have not been fully achieved or in some case, pursued, there are a variety of explanations. Many of the challenges faced by the Workgroups are specific to their unique objectives. For example, some of the technologies reported in the original Cancer Plan are no longer promoted (e.g., female condoms) or were inconsistent messages regarding most effective prevention activities (i.e., best practices). Other challenges are more general, such as limited time and funding, geographic challenges of Maine (sparsely populated), lack of available tracking data, and non-measurable objectives, all of which were commonly reported.

Program Accomplishments

Unlike other state programs, Maine's Comprehensive Cancer Control Program is relatively new and directly tied to the development of this overarching initiative. Since the Program's inception there have been a number of notable accomplishments achieved. These accomplishments, organized by program area, include, but are not limited to:

Overall Implementation

- Recognized as a state program
- Developed two state positions
    - Program manager
    - Health educator
- Received federal funding for implementation from the Centers for Disease Control and Prevention
    - Amount: Over $2,400,000 over five years
- Recognized as a model program and state throughout the country
    - Cancer Plan and Evaluation used and adapted by other states
- Coordinated the revision of the Maine Cancer Plan for the Maine Cancer Consortium
- Developed several requests for project proposals and selected qualified applicants
- Awarded $24,000 in mini-grants to the Prevention, Early Detection, Palliation and Rehabilitation and Survivorship Work Groups and Colon and Skin Cancer Task Force to assist with implementations of their work plan
- Provided significant staff support to the Maine Cancer Consortium, individual Workgroups, and the Board of Directors
- Sponsored and organized Maine Cancer Consortium annual meetings
- Served as a resource for comprehensive cancer control efforts
- Worked to integrate and link comprehensive cancer control efforts with other state programs
- Developed and managed multiple contracts
- Maintained the database of Consortium members
- Assisted the Board of Directors in organizing and facilitating annual planning meetings
- Established educational seminars for Consortium members and others interested in comprehensive cancer control
- Communicated with Consortium members via paper, email, the website, and newsletters
- Developed Institutional Review Board applications through the Maine Centers for Disease Control and Prevention when appropriate

Colorectal Cancer Prevention Activities

- Received federal funding for a colorectal cancer social marketing campaign from the Centers for Disease Control and Prevention
    - Amount: Over $670,000 for three years
- Created and distributed materials to Maine's communities
    - Fact sheets to hospitals
- Included colon cancer question on the 2006 *Behavioral Risk Factor Surveillance System* (BRFSS) in Maine

Skin Cancer Prevention Activities

- Received federal funding to support specific skin cancer efforts
    - Amount: Over $72,000 for two years
- Awarded $19,000 in mini-grants to 19 hospitals to conduct sun safety education with parents of newborn babies
- Included skin cancer questions on 2006 BRFSS and the Youth Risk Behavior Survey in Maine
- Participated in various statewide discussions and conferences regarding sun safety
- Held an annual *Protect the Skin You're In Day* on June 25th at the Portland Sea Dog's baseball game and provided over 3,500 packets of sunscreen to attendees

Evaluation

- Developed a 5-year comprehensive evaluation plan for the Program, Consortium and Cancer Plan
    - Developed Activity-Monitoring Tool to track progress on Cancer Plan goals and objectives
- Recognized as a model for evaluation
- Used evaluation results to inform program planning

Program-Sponsored Initiatives: Evaluation Results

Screen Me! Colon Cancer Social Marketing Campaign[4]

Background

In Maine, colon cancer is the second most common cause of cancer deaths in both men and women. It is estimated that colon cancer was diagnosed in 810 Mainers and caused 300 deaths in 2006. Since colon cancer primarily affects people over the age of 50, and Maine ranks fourth in the nation for the percentage of adults over the age of 65 (a rapidly increasing population), the need for colon cancer screening and detection in the State of Maine is pressing.

Campaign Description

Against this backdrop, the Maine Comprehensive Cancer Control Program (MCCCP) began working with Burgess Advertising and Associates in December 2004 to develop and implement a three-year social marketing campaign to increase awareness and screening of colon cancer prevention in Maine. While the campaign has been evaluated at several time points, the findings presented in this report represent the results from the most recent campaign (2005-2006).

In addition, upon conclusion of the last wave of telephone interviewing in Spring 2006, a small scale evaluation was initiated in order to explore the perceptions and attitudes toward the media campaign from the perspective of those individuals who actually perform colorectal screenings – Gastroenterologists (GIs). The findings from this exploration are summarized at the end of this section (p. 38).

Summary of Methods

In an effort to evaluate the effectiveness of the social marketing campaign, Burgess Advertising and Associates contracted with Digital Research Incorporated (DRI) to conduct a series of surveys with a random sample of Maine residents aged 50 and older. The findings represent results from the pre and post campaign data for 2006. The reports from the pre-wave and follow-up in 2005 can be provided upon request. Finally, all results, analysis, and recommendations have been provided by DRI.

The primary objective of the Post-Campaign data collection was to measure the level of awareness, attitudes, and behavior toward colon cancer early detection and to assess whether any shifts in these levels have occurred since the initiation of the Campaign. In addition, this research measured the effectiveness of the media campaign sponsored by the MCCCP. This is a particularly important measurement objective because at the time of the airing of the MCCCP television ads in 2005, the American Cancer Society and the Centers for Disease Control and Prevention also aired related ads. This resulted in the inability to precisely attribute colon cancer ad awareness to any one of the campaigns in the 2005 Follow-Up study. Therefore, in

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[4] This section provided by Digital Research Inc.

2006, the MCCCP television ad campaign was aired in February, prior to the advertising campaigns of the American Cancer Society and the Centers for Disease Control and Prevention in March. This timing allowed the MCCCP to evaluate its ad campaign's effect on attitudes and behavior independently of other advertising campaigns with similar subject messages.

Participant Characteristics

The results of the report are based on 398 Maine residents, aged 50 years or older, with no personal history of colon disease. The survey was conducted between February 17, 2006 and February 27, 2006.

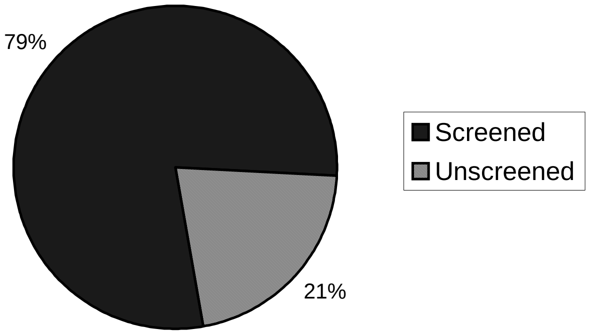
A number of questions were asked in order to create a demographic profile of the respondents. Respondents are generally younger (ages 50-65), female, and have a high level of education.

In general, a comparison between the respondents from the previous and current surveys suggest a similar demographic profile.

Screened vs. Unscreened Respondents

By February 2006, 79% of the 398 Maine adults aged 50+ surveyed have been screened for colon cancer, while 21% have not been screened.

Chart 18. *Screened versus Unscreened, Social Marketing Survey Participants*



Prior to MCCCP social marketing campaign efforts, Digital Research found that 67.6% of survey respondents were screened and 32.4% were not screened. In the 2005 Campaign survey, the percentage of screened respondents increased to 78%, while the percentage of those not screened decreased to 22%. The percentage of screened vs. unscreened remains unchanged between the current 2006 survey and 2005 survey (79% and 21%).

Respondent Health Profile

All survey respondents were aged 50 or older with no personal history of colon disease. The health profile of these respondents demonstrated that the survey population was generally comprised of Maine adults in reasonable health, with sufficient access to health care, and engaged in the health care system. In fact, over half (51%) consider themselves to be in *Excellent/Very Good* health.

A comparison of the current sample of respondents with those from the prior two studies (Pre-Campaign and Post-Campaign) indicates that the three samples are similar with regard to their general health profile. Respondents from all three samples have similar levels of access to health care coverage, similar attitudes regarding their current health status, and a similar family history of colon cancer.

Cancer Diagnosis

Fifteen percent of respondents had been previously diagnosed with cancer (excluding colon cancer). The most frequently mentioned diagnoses were skin and breast cancer.

Overall, the current sample of respondents was very similar demographically to the respondents in both the Pre-Wave and Follow-Up surveys conducted in 2005.

Summary Findings

The MCCCP Media Campaign

While the 2005 Follow-Up surveys provided some useful findings regarding the effect of colon cancer advertising on screening attitudes and behavior, it was difficult to measure the specific contribution of the MCCCP ads. In order to isolate the effect that the MCCCP ads have on the attitudes and potential behavior of Mainers in the current 2006 survey, the MCCCP ads were released in February 2006, one month prior to colon cancer month and its corresponding advertising campaigns by other organizations. In addition, respondents were surveyed during the latter half of February in order to avoid any confounds with advertisements associated with colon cancer month.

Overall, 60% of respondents recalled having seen, heard, or read a colon cancer screening commercial or an ad during the past several months.

As seen in the prior two surveys, television appears to be the most effective medium for recalling the need to screen for colon cancer as all regions of Maine had the most exposure through TV (84% cited the TV as where he/she heard or saw the advertisement).

- Interestingly, those who had not been screened are more likely than those who had been screened to recall seeing television ads (93% vs. 82%).

Of those who recalled a colon cancer advertisement, 90% of respondents could not recall the sponsor.

When asked about the main message of these advertisements, 45% recalled the message that you should *get tested if you're over 50.* While there were very few differences found across other demographic variables, men appeared to be more sensitive than women to messages such as *getting tested can find colon cancer in an early stage when it is treatable* (22% vs. 9%).

Respondents who recalled the TV advertisements were also asked if the ads changed the likelihood that they would screen for colon cancer in the future. In general, more than half of the respondents (53%) state that the ads do not change their likelihood to screen for colon cancer. However, younger respondents (ages 50-65) and/or employed respondents state they are much more likely (24% and 28%, respectively) to be screened in the future because of the ads compared to those ages 66 and older (12%) and those who are retired/not working (11%).

Concern about Cancer

Personal concern regarding being diagnosed with cancer was fairly low. One in ten were *Very* or *Extremely* concerned about any of the cancers mentioned (lung, colon, breast, skin, and prostate cancers). In addition, only 11% were *Very* or *Extremely* concerned about being diagnosed with colon cancer.

In contrast to low levels of concern regarding being personally diagnosed with cancer, more respondents believed that cancer is a widespread problem in Maine. Breast and lung cancer were perceived to be *Very* or *Extremely* widespread by four out of ten respondents, while only about one-third believed colon cancer to be *Very* or *Extremely* widespread.

While there were no notable differences in responses between the 2005 pre and post survey, there were some differences observed between the latest survey and the 2005 post-survey. In general, the perceptions regarding the prevalence of various cancers across Maine appears to be trending in the downward direction. In addition, respondents appear to be less concerned about being personally diagnosed with most forms of cancers. This finding, however, does not hold true for colon cancer. There has been no shift in the concern regarding a personal diagnosis of colon cancer since the 2005 survey.

Colon Cancer Screening

When comparing screened vs. unscreened respondents, screened respondents were more likely to report having heard of the blood stool home test kit (83% vs. 44%, respectively) and sigmoidoscopy/colonoscopy exams (75% vs. 52%).

Looking at pre and post survey data, there was a significant increase in the percentage of respondents who say they had already had a colonoscopy (44% vs. 34%).

Importantly, the majority of respondents (76%) stated that they will screen for colon cancer by home stool test kit or by sigmoidoscopy/colonoscopy either within the next 6 months or at some time in the future (but not within the next 6 months). While this represents a 9% increase since the Pre-Wave conducted in January 2005, there has been no shift in intended behavior from the Follow-Up to the Wave III study.

In addition, those who have been screened were more likely than those who have not been screened to state that they intend to be screened in the future (56% vs. 33%).

Conclusions and Recommendations

Overall, the findings from this study are encouraging. Since the initial Pre-Wave conducted and Follow-Up in 2005, the 10% increase in the number of respondents claiming to have been screened has remained unchanged. This suggests that the continued media campaign by the MCCCP and others has served to maintain this increased base rate in claimed screening behavior for colon cancer.

In addition, it appears that the MCCCP ads may be as effective as the media campaigns sponsored by other organizations. The current study was completed prior to the colon cancer advertising scheduled for colon cancer month in March. Our findings show that the level of television ad recall is no different than what was observed during the 2005 Follow-Up study in which the MCCCP ads ran concurrently with the CDC and the American Cancer Society. Thus, the MCCCP ads alone appear to be as effective as the onslaught of ads seen during colon cancer month in terms of building awareness.

However, while the ads from the MCCCP seem to produce equivalent levels of ad recall there are significantly fewer respondents in Wave III than in the Follow-Up who claim that the ads are *much more likely* to affect their intent to be screened. This finding suggests that the ability to change behavior may be more powerful in the context of colon cancer month in which multiple sources encourage early detection screening methods. In addition, the findings suggest that advertising alone may not be the complete panacea for this issue. While advertising plays an important role in increasing awareness and lessening the stigma attached to colorectal cancer testing, other factors/barriers persist that influence the intention to screen for colon cancer. These possible barriers include not being able to pay for the test due to a lack of insurance coverage, an inability to pay for the test, and/or ready access to testing facilities.

Several other positive indicators are evident from this research. Below are some of the findings that suggest that early detection advertising for colon cancer works and should be continued.

- Younger respondents are more likely to state that they are much more likely to be screened because of the advertisements;

- Since the Follow-Up study in 2005, there has been a 10% increase in the percentage of respondents who claim to have had a colonoscopy (from 34% to 44%). This positive trending has been observed since the initial Pre-Wave study; and

- While the concern that most forms of cancer are a widespread problem throughout Maine is trending downward, the concern about colon cancer remains unchanged. This finding suggests that continued advertising is likely to be maintaining this cancer in the forefront, thus keeping Maine residents in touch with the dangers of colon cancer.

While the advertising campaign has shown excellent benefits and progress, work still needs to be done. The following recommendations have been made:

1. This research shows that women are less likely to be concerned with a personal diagnosis of colon cancer. Perhaps continued advertising needs to also focus on colon cancer as "not just a cancer for men;"

2. Those who are 66 years or older also seem to be less concerned with being diagnosed with colon cancer;

3. The advertising campaign does seem to reach those who are unscreened. This research demonstrates that those who have not been screened for colon cancer are more likely than those who have been screened to recall seeing advertising for colon cancer. This suggests that unscreened respondents are sensitive to the information presented to them and thus additional efforts may influence their intent to screen in the future;

4. However, the unscreened remain less likely than the already screened to anticipate that they will be screened in the future. More needs to be done to understand and eliminate any remaining barriers to screening.

GI Telephone Survey

Methodology

The Digital Research Inc (DRI) conducted a telephone survey with the Gastroenterologists (GI) in Maine. The Chair of the Maine Cancer Consortium's Colon Cancer Task Force, a fellow gastroenterologist, proposed the project and wrote a letter to all the GIs requesting their participation. DRI's Virtual Field telephone staff interviewed GIs during the period of June 1, 2006 through July 7, 2006. All responses were entered into an Access database and analyses were conducted using Wincross, a statistical software package.

In recognizing the difficulty in securing cooperation from busy professionals, several steps were taken to increase participation.

- Using letterhead from the Colon Cancer Task Force, a letter from John Bosco, MD, Chair of the Colon Cancer Task Force, was sent to each of the GIs encouraging them to participate in the upcoming evaluation;

- The utilization of a very brief questionnaire (5 minutes or less) designed by DRI in conjunction with the MCCCP;

- In order to make contact with and elicit cooperation from the GIs, four or more phone calls were made to each physician/office to schedule an interview;

- GIs were given the option to complete the survey via telephone at a time convenient for him or her or to return the completed survey via fax; and

- Follow-up phone calls were made to GIs agreeing to participate, but had not yet returned a completed survey.

The questionnaire (see Appendix F) was designed to address the following topics:

- Are GIs aware of the colorectal screening campaign (i.e., Screen Me Campaign)?;
- Do GIs perceive an increase in the rate of colorectal screenings since the advertisements have aired?;
- Do patients make reference to the advertisements?; and
- What methods do GIs suggest to increase colorectal screening in Maine?

Response Rates

While the list of GIs provided to DRI included 51 names, 11 of the doctors listed were not reachable due to reasons such as retirement, no longer practicing, or having moved out of state. Of the remaining 40 valid contacts, 2 were unreachable because they were vacationing or out of the country for an extended period of time and one GI has been unresponsive. In all, 37 eligible gastroenterologists were reached, with 21 completing the questionnaire. This resulted in a 55% response rate.

Findings

The findings contained in this summary report are based on the responses of 21 participants and, for ease of discussion, are reported in order of the topics presented on the questionnaire itself.

While the findings are presented in a quantitative fashion, please note that due to a very small sample size, the interpretation should be regarded as qualitative in nature. We therefore recommend that these findings be considered exploratory and/or utilized to determine further areas of study.

Awareness and Perceived Campaign Influence. Respondents were first given a brief description of the *Screen Me!* Campaign. Participants were then asked to rate his/her level of agreement with the following statement on a scale of 1 to 5 with a “1” being “strongly disagree” and a “5” being “strongly agree:”

The Screen Me Campaign has had a positive influence on colorectal screening rates.

Respondents were also given the option of answering “not sure/don’t know” or “I have never heard of this campaign before.”

- The majority of GIs (nineteen of twenty-one respondents) report being aware of the *Screen Me* campaign. Only two of the twenty-one respondents interviewed indicated that he/she had never heard of the campaign;
- Approximately, a third of the GIs indicated that they *strongly agree/agree* that the campaign has had a positive influence on colorectal screening. However, the

percentage of those agreeing with the statement does not differ from those giving it a "neutral" rating;

- Only one respondent indicated that he/she *strongly disagrees* with the statement; and
- Almost one-quarter of the respondents stated that they are *not sure/don't know*.

Level of Agreement (N=21)	# of responses	%
5 – Strongly Agree	2	10
4	5	24
3	6	29
2	0	0
1 – Strongly Disagree	1	5
Not sure/Don't know	5	24
I have never heard of this campaign before	2	10

Patients' Recall of Advertisements. GIs indicating some familiarity with the *Screen Me* Campaign in the previous question (*n* = 19) were asked if their patients had made any mentions of the recently aired advertisements.

- Approximately, half of the GIs reported *no mentions* of the ads (10 responses). This is roughly equivalent to the number who experienced patients mentioning the ads (8 responses). Only one doctor indicated that he/she "does not remember."

Colorectal Screening Predominance. All GIs were asked to indicate from a list which colorectal screening test that he/she has performed most frequently in the past three months.

- A full majority (90%) indicated that they performed *colonoscopies* most frequently during the past three months.

Perception of changes in testing frequency. After indicating the test performed most frequently over the past three months, the GIs were asked to indicate whether he/she had noticed any changes in the number of these tests performed compared to last year.

- Approximately, two-thirds of the doctors indicated that there has been no change in the frequency of performing this test as compared to last year;
- About a quarter of the GIs report an increase in colonoscopies, slightly more than the 10% reporting a decline;
- Interestingly, there appears to be some evidence that the level of agreement with the statement, *"The Screen Me Campaign has had a positive influence on colorectal screening rates,"* affects perceptions of changes in frequency. For example, GIs indicating agreement that the campaign has been influential are more likely to state that they noticed a small increase in testing frequencies than those GIs who indicated less

agreement with the statement. Moreover, those who did not indicate agreement with the statement are more likely to indicate that there has been no change.

	Total	**Campaign Influence**	
		Influential	Non-influential
	(n=21)	(n=7)	(n=12)
Response to Q4	# of responses	# of responses	# of responses
I have noticed a large increase	0	0	0
I have noticed a small increase	5	3	2
I have noticed no change	14	4	9
I have noticed a small decrease	2	0	1
I have noticed a large decrease	0	0	0
Not sure/Don’t know	0	0	0

Note: For campaign influence, respondents are classified as “influential” if he/she agree or strongly agree with the statement in question 1. Respondents are classified as “non-influential” if he/she responded neutrally, disagree/strongly disagree, or don’t know in question 1.

Methods to Increase Colorectal Screening. GIs were also asked what methods should be implemented to increase the incidence of colorectal screening in Maine. The following responses are noted.

- The majority of respondents indicated that *TV Advertising* should be implemented, followed by *education*, and *celebrity endorsements*;
- GIs secondarily indicated that *literature/pamphlets in primary physician offices or clinics* and *primary physician referrals* would be helpful; and
- Fewer mentions included *free screenings for those with low incomes* and *showing colorectal screening procedures on television*.

Activities to increase Colorectal Screening Incidence	# of responses
TV Advertising	13
Education	10
Celebrity Endorsements	9
Literature/pamphlets in primary physician office and clinics	7
Primary Care Physician referrals	7
Free screenings for those with low incomes	5
Showing colorectal screening procedure being performed on TV	4
Other	8

- Other responses included the following:
  - *See all people,*
  - *More gastroenterologists working in Maine is required,*
  - *Newspapers,*
  - *Billboard ads,*
  - *Maine should have done their ads on a national screening campaign, not just statewide,*
  - *Celebrity incidences and talking about it on PBS, Robert Wood Foundation,*
  - *Educate MDs as well as the population,*

Conclusions and Recommendations

In beginning to explore the success of the *Screen Me* Campaign through the perspective of gastroenterologists, a few takeaway messages can be gleamed from this project.

Gastroenterologists are generally aware of the colorectal screening campaign efforts. The majority of the respondents indicate some level of awareness. In addition, a small degree of respondents state that the campaign has had a positive impact on colorectal screening rates. However, a larger portion, either gives a neutral rating or state that they do not yet know of its effect.

GIs seem to be gaining the belief that patients are being impacted by the TV advertisements recently aired. This evaluation suggests that patients may be somewhat influenced by the Tim Sample and/or Joan Benoit-Samuelson advertisements. Perhaps primary care physicians might see more of a "first line" impact with patients.

Despite the potential awareness of the ads, to date there is not a strong perception that colorectal screenings have increased since last year. It should be noted that perceptions or sensitivity to changes in frequency over time, as measured in this evaluation, can be difficult to assess. A more accurate measure of change would be an evaluation of patient records that quantifies the number of colorectal screenings and/or referrals for the same three month period over several years, or a measurement of scheduling wait (assuming a stable capacity to conduct the tests).

The use of TV advertisements to increase the incidence of colorectal screenings appears to be well endorsed by Gastroenterologists. The GIs interviewed indicate that TV ads should be implemented to increase the incidence of colorectal screenings in Maine. This finding, coupled with the finding that a large portion of GIs report patient mentions of the recently aired advertisements, suggests that GIs are on board with this program.

No Sun for Babies, Sun Safety Hospital Project

Project Description

In an effort to encourage sun protective behaviors early in life, the Maine Comprehensive Cancer Control Program and the Maine Skin Cancer Task Force, a committee of the Maine Cancer Consortium (MCC), developed the *No Sun for Baby Program,* a sun protection education program for parents of newborns. The goal of the program is to increase parents' awareness of sun protection methods for babies in order to decrease the incidence of skin cancer.

Piloted in 2001, the program has received positive feedback from both parents and hospital staff. Using a mini-grant process, the program has provided hospitals with funds to distribute Sun Safety Kits. The Kits include a plastic pail and shovel, a baby sun hat, educational materials about newborn sun safety, and an evaluation postcard. In addition, hospitals received information on skin cancer and sun safety for newborns for their staff.

Twenty hospitals participated in the program (69% of all hospitals in Maine with a birthing unit). It is important to note that various contextual factors have impacted the evaluation results. Specifically, the delayed launch of most of the programs (e.g., ordering and receiving materials delayed the creation of Kits) and staff turnover affected the evaluation data.

Methods

The success of the program was measured by the following indicators: 1) the number of new parents who receive information about sun safety; 2) the number of new parents who intend to follow sun safety precautions as a result of participating in the Program; 3) the number of Sun Safety Kits distributed; 4) number of hospitals with birthing units in Maine that have implemented the Program; and 5) feedback from hospital staff on the Program. Two surveys were developed to measure these indicators.

Parent Survey

The parent survey was designed to measure parents' intention to practice sun safety with their newborns (see Appendix C). The survey consisted of five yes/no questions:

1) Did you read the information on sun protection for babies;
2) Was the information helpful;
3) Do you plan on using the sun hat on your baby this summer;
4) Do you plan on dressing your baby in clothing that protects his or her body from the sun and;
5) Do you plan on keeping your baby out of direct sunlight? The postcards were included in the Sun Safety Kit provided to the parents.

Hospital Survey

A 15-item survey was administered to the hospitals in early June 2006 (see Appendix D). The survey was designed to measure the number of kits distributed and feedback from hospital staff regarding their satisfaction with the program. At the time of survey, none of the hospitals had completed their activities, thus the numbers reported in the survey reflect only those Sun Safety Kits distributed as of June 2006 and should not be considered final numbers.

Hospital Final Report

In addition to the evaluation survey, hospitals were required to submit a final report in July 2006 to the MCCCP outlining their successes, obstacles, number of parents/babies served, and a plan for sustainability. A brief summary of these reports is provided.

Key Findings

The following results represent findings as of June 2006, before the end of the program. Thus, this data is meant to provide only a snapshot of the impact of the program.

Parent Survey

To date, 62 parents returned an evaluation postcard. Hospital staff received the evaluation postcards several months after the launch of the program, thus, a response rate is unclear as it is unknown how many parents received a postcard. Of the parents who returned a survey, all indicated they read the information on sun protection, and all indicated their intention to practice at least one sun safety precaution suggested in the materials. A summary of these responses are shown in Table 10.

Table 10. *No Sun for Baby, Parents' Survey Responses*

Question	Yes	No	Maybe
Did you read the information on sun protection for babies?	100%	0	0
Was the information helpful?	97%	3%	0
Do you plan on using the sun hat on your baby this summer?	90%	6%	4%
Do you plan on dressing your baby in clothing that protects her or her body from the sun?	100%	0	0
Do you plan on keeping your baby out of direct sunlight?	98%	2%	0

The primary reason (all but one) given for not using the sun hat was that it was too big for the baby. Select comments are provided below.

> *"If it fits…it is very big for him right now."*
>
> *"Doesn't fit yet- if she grows into it. I have others."*
>
> *"When she gets bigger. She's only 2 days old."*

Parents provided additional comments regarding the program including their gratitude for the kits. Select responses are provided below:

- I've made it a point to be well educated abut the sun. This is a good program for the parents who don't take the time to educate themselves.
- Thank you! (9)
- I think this is great!
- I think you should give sun info to all parents w/infants & young children
- A good reminder
- She's too little for sun screen which I didn't know until I read it in the info
- Common sense info I already knew
- Keep telling people the importance of sun protection, especially in newborns and babies
- Information is prevention
- Wonderful and useful things

Hospital Survey

To date, 18 out of the 20 (90% response rate) hospitals have returned surveys. Of the two who did not return a survey, one had just launched their program in June. The participating hospitals are shown in Table 11. As shown here, the program included 20 hospitals in 12 of the 16 counties in Maine. Thus, the program has been implemented in most of the state reaching northern and southern parts of the state.

Table 11. *Hospitals Participating in No Sun for Baby Program*

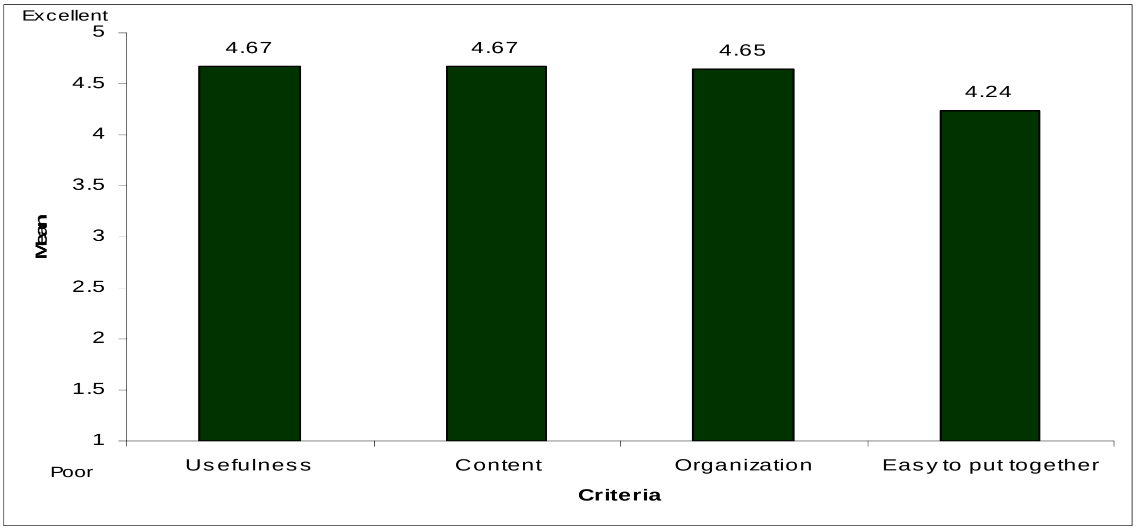
Hospitals	Town/County
Aroostook Medical Center	Presque Isle/Aroostook
Blue Hill Memorial Hospital	Blue Hill/Hancock
Cary Medical Center	Caribou/Aroostook
Central Maine Medical Center	Lewiston/Androscoggin
*Franklin Memorial Hospital	Farmington/Franklin
Houlton Regional Hospital	Houlton/Aroostook
Inland Hospital	Waterville/Kennebec
Maine General Medical Center	Waterville/Kennebec
*Maine Medical Center	Portland/Cumberland
Mayo Regional Hospital	Dover-Foxcroft/Piscataquis
Mercy Hospital	Portland/Cumberland
Mid Coast Hospital	Brunswick/Cumberland
Miles Memorial Hospital	Damariscotta/Lincoln
Northern Maine Medical Center	Fort Kent/Aroostook
Penobscot Valley Hospital	Lincoln/ Penobscot
Redington-Fairview General Hospital	Skowhegan/Somerset
St. Mary's Regional Medical Center	Lewiston/Androscoggin
Southern Maine Medical Center	Biddeford/York
Stephens Memorial	Norway/Oxford
York Hospital	York/York

**Note*. Have not completed evaluation survey as of July 31, 2006

Sun Safety Kit Use

As of June 2006, a total of 812 (*mean* = 47.8) new parents had received information about sun safety for their newborn. A total of 633 Kits have been distributed with an average of 37.3 per hospital. Using a 5-point Likert-type scale (1 = poor; 5 = excellent), respondents rated the Sun Safety Kit in terms of usefulness, content, organization, and ease of assembling. The mean rating ranged from 4.24 to 4.67, indicating the Kits were rated quite high on most criteria. While the Kit was rated the lowest on "easy to put together," all but two respondents considered the Kit to be "good" or "excellent" in this area.

Chart 19. *Average Ratings of No Sun for Baby Kits*



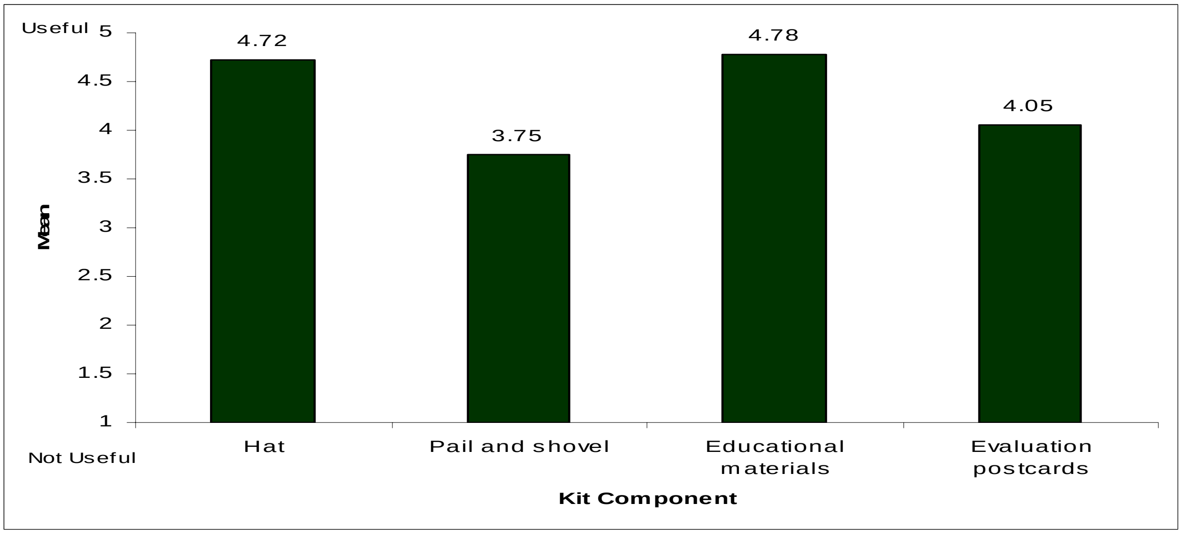
Finally, all of the respondents reported conducting sun safety activities and/or training with hospital staff. Examples of such activities included creation of an educational board, conducting an "in-service" with birthing center or obstetrics staff, and presentations or discussions at staff meetings.

Utilization and Usefulness of Kit Components

In terms of the specific components of the Kit, results indicated that all of the hospitals have used the hat and educational materials. All but two hospitals (89%) used the evaluation postcards. Only 72% of hospitals used the pail and shovel, and 22.2% had no interest in using them. The remaining 5.6% had not used them but were interested in using them. Not surprisingly, therefore, the pail and shovel were considered the least useful of the Sun Safety Kit components. The evaluation postcards were also rated lower (*Mean* = 4.05), with the primary reason given receiving them too late. The hat and educational materials were considered to be useful receiving average ratings of over 4.70.

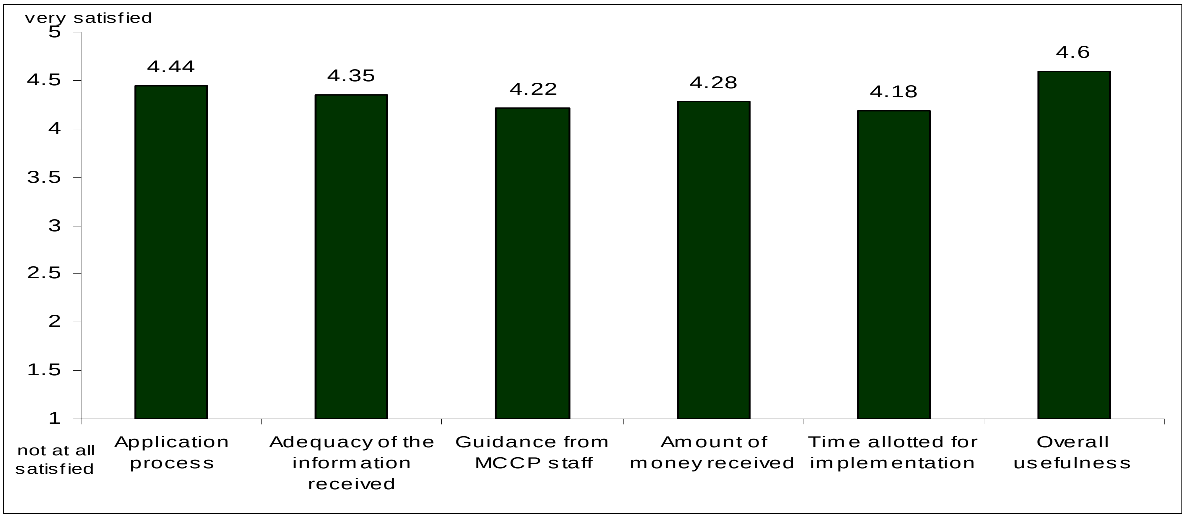
These results are delineated in the following chart.

Chart 20. *Average Ratings of Usefulness of No Sun for Baby Kit Components*



Feedback on Program
Using a 5-point Likert-type scale (1 = not at all satisfied; 5 = very satisfied), hospital respondents rated their satisfaction with various aspects of the program. As indicated in the following chart, average satisfaction ratings ranged from 4.18 to 4.60, thus indicating a high level of satisfaction with various aspects of the program. Congruent with comments provided on the survey, respondents were least satisfied with the timeline allotted for the implementation of the program.

Chart 21. *Average Satisfaction Ratings of the No Sun for Baby Program*



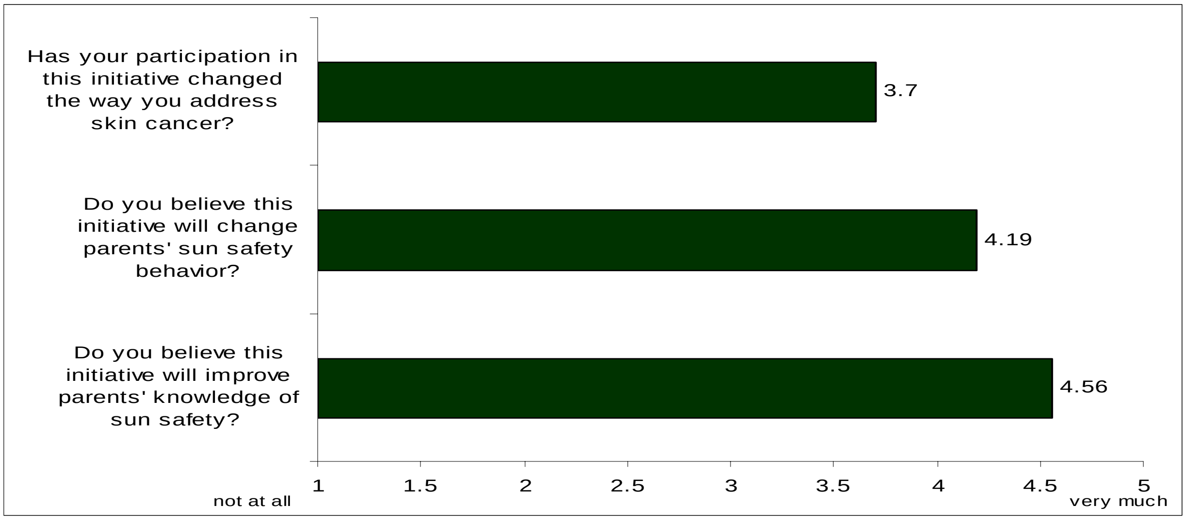
Program Success. Using a 5-point Likert-type scale (1 = no effective; 5 = very effective) respondents were asked to rate the success of the program in their hospital. The average rating was 4.44, indicating a high level of perceived effectiveness. Moreover, respondents were asked their perception of the impact of the program on parents' knowledge and behavior related to sun safety and the way in which they (the hospital) address skin cancer. Based on a 5-point scale (1 = not at all; 5 = very much) average responses ranged from 3.70 to 4.56. These findings are presented in Chart 22. As shown in this chart, while respondents felt the program will improve parents' knowledge and behavior, their responses were more neutral in terms of the impact of the program on their own behavior.

It should be noted that the wording of the question led many respondents to rate the impact of the program on their *personal* sun safety behavior as opposed to the way they address skin cancer in their professional capacity (as shown by their open-ended comments provided on the survey). For example, one respondent noted changes in his/her sunscreen use:

"It has certainly made me more aware of the dangers of excessive sun exposure. I have never been one to use sun screen routinely but I will be changing my practice."

While this might not have been the intent of the question, this unintended impact on the personal sun safety behavior of the hospital staff is something to be considered for program planning.

Chart 22. *Perceived No Sun for Baby Program Impact*



Seventy-two percent (n = 13) of hospitals stated that they would continue the program. The remaining 28% (n = 5) indicated they might continue the program. The most common reason given for not continuing the program was funding. As illuminated in the following quote, those hospitals unsure if they would continue the program noted that they would continue to provide new parents with sun safety education: "We will continue to give out the pamphlets. [We] will give out pails, shovels, and hats as long as there is a funding source."

Qualitative feedback on program. Respondents were given the opportunity to provide comments regarding the strengths and areas of improvement for the program and the resources needed for improved implementation. The common themes and selected responses are presented in Table 12.

Table 12. *Qualitative Feedback, No Sun for Baby Program*

Resources to Improve Implementation	
Theme	**Example**
Better source for materials	“A source for ready-made sun hats that are actually sized 0-6month heads. Our hats are ‘to grow into’ size.” “Where to buy the pails at a reduced rate.”
Money	“Ongoing source of funding for hats, etc.”
More materials	“Large posters to show in class or hang on our Maternity Unit outlining the program” “A short video would be great for staff meetings to introduce program/educate staff.”
Best Things about the Program	
Theme	**Example**
Education of new parents/ early prevention	“An important message for new parents.” “Providing parents with health promotion messages for kids at earliest possible age.” “It is a creative way to educate new parents” “It's done early so early intervention can be prevention”
Skin cancer awareness (staff, community)	“Heightened awareness of skin cancer & precautions for the skin.” “Involvement of our Birthing Center staff in cancer prevention”
Fun	“Fun way to introduce *No Sun for Babies*” “It was fun and informative.”
Areas of Improvement	
Theme	**Example**
More funding/increased programming	“Give additional money to current participants so we can expand the program further out into the community such as Health Fairs…” “Maintain funding for supplies. If enough funds, run TV and radio ads regarding sun safety.”
Timeline for evaluation (e.g., postcards)	“The feedback postcards could have been sent sooner and the date for the evaluation could have been pushed further out so we could have better evaluated the program.” “I don't think the evaluation should occur until August so we have time to distribute the kits during the summer months.”
More materials	“Maybe sun block samples for MDs to use in office to give at the 6 month old visit…” “One thing that we did to improve it …was to include siblings of the new babies. We purchased samples of sunscreen that the parents could use on the older children.” “Large posters to hang in physician's offices and on the nursing unit.”

Hospital Final Report

Eleven hospitals submitted a final report as of August 1, 2006. In general, the findings mirror the hospital survey results. The primary difference was the number of Kits distributed as reported was less than the number reported on the hospital survey. This differs due to the lower number of hospitals submitting a final report. Hospitals listed several successes of their program including patient and staff awareness of sun safety issues, community outreach, reaching all newborn babies in their hospital regarding sun safety, formalized and creative sun safety education, increased volunteer involvement and having well-received materials and Kits to give out to new parents.

In terms of obstacles to the program, similar to the survey securing the materials (i.e., hats) was the most common barrier to implementation. Several hospitals also noted the delay in receiving the evaluation postcards as an obstacle to implementation. Three hospitals noted no obstacles in implementation. Finally, congruent with the hospital survey, all but one hospital noted that they would continue the program. Most, however, stated that this was contingent on funding.

Conclusions and Recommendations

Overall, the *No Sun for Baby* program has been successful. The program has been implemented statewide in 70% of Maine hospitals with a birthing unit, through which it has helped to educate over 500 parents of newborns about sun safety in a matter of months. According to the results of the parent survey, the Kits have been well-received and successful in helping at least some parents protect their babies from the dangers of sun exposure. Based on the evaluation data, the program does, however, have some room for improvement.

The following recommendations have been made.

1. Clarify instructions regarding time frame for program implementation. Encourage hospital staff to order materials early to prevent program delays.
2. Ensure use of parent evaluation postcards by including in program manual. Consider providing incentives for returning postcards.
3. Follow-up with hospital staff with ideas for program sustainability.
4. Incorporate program suggestions from hospital staff to help support program adoption and sustainability.
5. Consider the use of hospital success stories to encourage more hospitals to participate in the program.

Middle-School Sun Safety Kits

Project Description

In 2005 MCCCP contracted with Burgess Advertising & Associates, Inc. to increase awareness of sun safety among 7th grade students. As part of their contract, Burgess adapted previously created High School Sun Safety Kits and created the campaign BU-B-UV Safe! targeted to 7th grade students in Maine. The purpose of the Sun Safety Kits was to help raise awareness among Maine's young people and their parents of skin cancer risks related to exposure and sunburns during childhood and adolescence.

The kits were modeled after a similar high school initiative and implemented by the Maine Department of Education in conjunction with the Maine Comprehensive Cancer Control Program. Two hundred and thirty-four Sun Safety Kits were sent to all public middle schools with a 7th grade classroom in June 2005 to the attention of the principal. The Kits included a variety of education materials, posters and UV bracelets for all of the 16,736 public school 7th graders.

Methods

Paper and pencil surveys were sent to all middle schools across the state in the spring of 2006. The survey was designed to collect information on the utilization (or intended use) of the Sun Safety Kit (Kit). In addition, information was collected to help assess specific components of the Kit and its potential impact.

Response Rate and Participant Characteristics

A total of 236 surveys were sent to middle school principals across the state. Forty-seven surveys were returned for a response rate of 20%. While the surveys were sent to principals, only 21% of respondents were principals. The following table presents an overview of the respondents' position in their school.

Table 13. *Middle School Sun Safety Kit Evaluation, Respondents' Position in School*

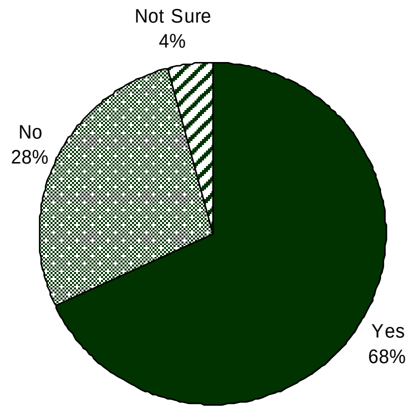
Position	Frequency
Administrative staff	5
Principal	10
School Nurse	12
Teacher	18
- Science	*5*
- Health	*7*
- Physical Education	*1*
- Not listed	*5*
Other: Guidance Counselor,	1
School Health Coordinator	1
Total	**47**

Key Findings

Sun Safety Kit Utilization

As shown in the following chart, 68% of respondents ($n = 32$) had used the *Sun Safety Kit.*

Chart 23. *Schools' Sun Safety Kit Utilization*



For those schools that did not use the Kit ($n = 13$), the most common reasons given were receiving the Kit too late in the school year or not receiving one at all. Select responses are provided below.

> *"To my knowledge, we did not get a sun safety kit."*
>
> *"The kit arrived too late in the school year. The science teacher had already covered the material in 7th grade science…"*

In an effort to address this concern, the MCCCP waited until 2006 to conduct evaluations to allow more time for use. Additionally, a letter was sent to all schools to remind them to use the kits.

Other reasons given for not using the Kit are provided below.

> *"I gave them the bracelets but didn't do the program."*
>
> *"It will be distributed in about a week."*
>
> *"Plan to share with students this week."*

Finally, several respondents listed specific barriers to using the Kit. The most common response was a lack of time, as illuminated in the following selected quotes:

> *"I don't have enough time to give all of the information."*
>
> *"I cover 2 schools with approx 800 students, I do not have the time."*
>
> *"We need to get them by Feb or March so we have time to work them into curriculum."*

Finally, one respondent stated that, "The material does not fit into our curriculum."

Used/Interest in Using the Kit. Table 14 summarizes the list of individuals who have used the Kit. The table also includes information on those who do and do not intend to use the Kit as well as those who are unsure.

The findings suggest that teachers and nurses are the most frequent users of the Kit and among the most interested in utilizing the resources with their students. Lack of familiarity with the Kit may be one explanation for the relatively high "not sure" and missing responses. "Other" users of the Kit listed included students, janitors, summer staff, and a guidance counselor.

Table 14. *Those Who Have Used and Intend to Use the Sun Safety Kit*

Who	Have Used	Not Used (Interested)	Not Used (No Interest)	Not Sure	No Response
Teacher	72%	9%	---	3%	19%
Nurse	34%	3%	---	9%	53%
Coach	9%	3%	---	19%	69%
Volunteer	---	---	3%	22%	75%
Other	25%	---	---	3%	72%

Note. Numbers only include those respondents who indicated they used the Kit.

Utilization and Intentions to Use Components of the Kit. Respondents were asked to indicate their utilization of select components of the Sun Safety Kit. In addition, the middle schools were asked to identify their intentions to use various sections and resources provided within the Kit.

Table 15. *Use and Intentions to Use Sun Safety Kit Components*

Kit Component	Have Used	Not Used (Interested)	Not Used (No Interest)	Not Sure	No Response
PowerPoint	22%	31%	3%	6%	69%
UV Bead Bracelet	91%	3%	---	3%	3%
DVD	38%	25%	3%	6%	28%
Guidelines	50%	19%	---	9%	22%
Resource List	53%	16%	---	6%	25%
Fact Sheet	91%	---	---	---	9%
Sun Safety Policy	34%	19%	3%	13%	31%
Sun Safety Lesson Plans	50%	16%	---	13%	22%
Other	13%	---	---	---	87%

Note. Numbers only include those respondents who indicated they used the Kit.

Other components listed as being used included the following:

> "*A tri-fold on sun safety was purchased with the grant money and has been placed in the library as a resource.*"
>
> "*[A] bulletin board with the information provided.*"
>
> "*[A] Frisbee.*"
>
> "*Eye on America DVD clip.*"

Use of Kit in Health Education Curriculum. Forty-four percent of respondents indicated that they have incorporated the Kit into their health education curriculum. Another 44% indicated that they have not incorporated it into their curriculum. One respondent (3%) was unsure and another 9% did not respond.

Of those who have not incorporated the Kit into their curriculum, 57% stated that they intend to. Another 29% stated that they do not intend to incorporate the Kit. The remaining respondents either did not respond or stated they did not know if they would incorporate the Kit into their health education curriculum. Reasons why the respondents are not planning on integrating the Kit into their curriculum varied. For example, some schools noted that they no longer teach health class while others explained that sun safety is covered in the science curriculum. Select comments are provided below.

> *"Don't teach [health class] anymore."*
>
> *"The kits were not used by the health teachers; they may still decide to use them in the future."*
>
> *"Sun safety is not specifically written in our curriculum but I am using the information under learning objectives for Disease Prevention."*

Uses of Sun Safety Kit, Qualitative Responses

The most commonly mentioned use of the Sun Safety Kit was during a health, science or other class. Select comments are provided below.

> *"Last year I went to the 7th graders during health class and using brochures and posters explained the effects of sun cancer."*
>
> *"Lessons taught in health classes were used to prevent specific diseases related to sun safety. Powerpoint presentation, worksheets and bracelets were used in class as well."*
>
> *"Lesson on sun safety during science class to 7th graders. We made the bracelets."*

Other common uses were the creation of a bulletin board, distribution of the bracelets, using the bracelets during an outside field trip (e.g., "Outside Adventure Day"), and using the information to write an article for the school newsletter.

Overall Kit Rating

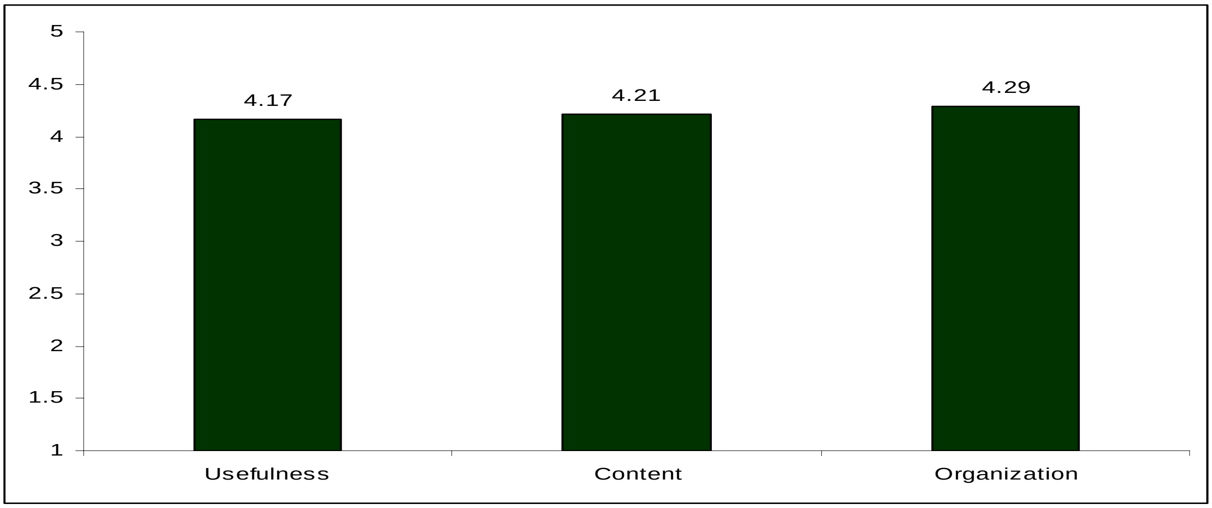
Using a 5-point scale (1 = poor, 5 = excellent), participants were asked to rate the Kit overall based on three criteria including the usefulness, content, and organization. Table 16 highlights the responses. As shown in this table, the majority of the responses were in the high ranges.

Table16. *Overall Sun Safety Kit Rating*

Kit Criteria	Poor 1	2	3	4	Excellent 5	No Response
Usefulness	0	3%	16%	38%	34%	9%
Content	0	0	19%	31%	38%	13%
Organization	0	3%	13%	28%	44%	13%

As shown in the following chart, the mean scores for usefulness, content and organization are all relatively high. This suggests that those who were familiar with the Kit rated it favorably in all of the three areas.

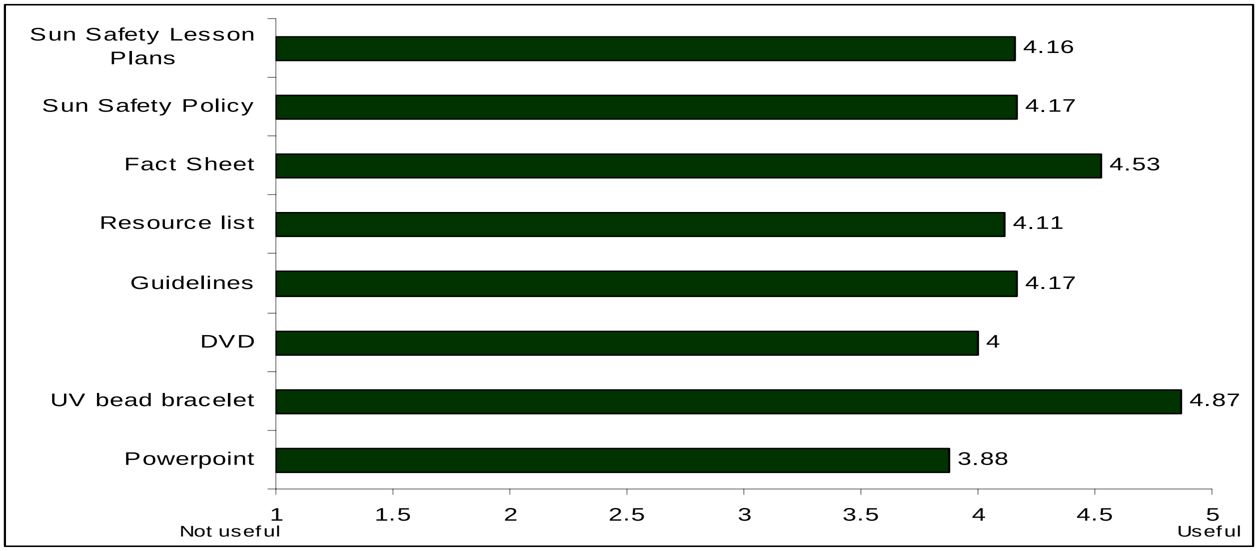
Chart 24. *Average Sun Safety Kit Ratings*



Ratings of Kit Components

A total of eight components within the Kit were assessed for usefulness. Chart 25 summarizes the findings. As shown in this table all of the components were considered to be relatively useful. Overall, the most useful component appears to be the UV bead bracelets. The fact sheet was also cited as useful. Among all of the listed components, the PowerPoint scored lowest in terms of usefulness. Approximately 45% of respondents were unsure of the usefulness of the PowerPoint presentation, thus, this may account for the lower rating.

Chart 25. *Average Ratings of Sun Safety Kit Components*



Perception of Students' Reaction to Kit Materials

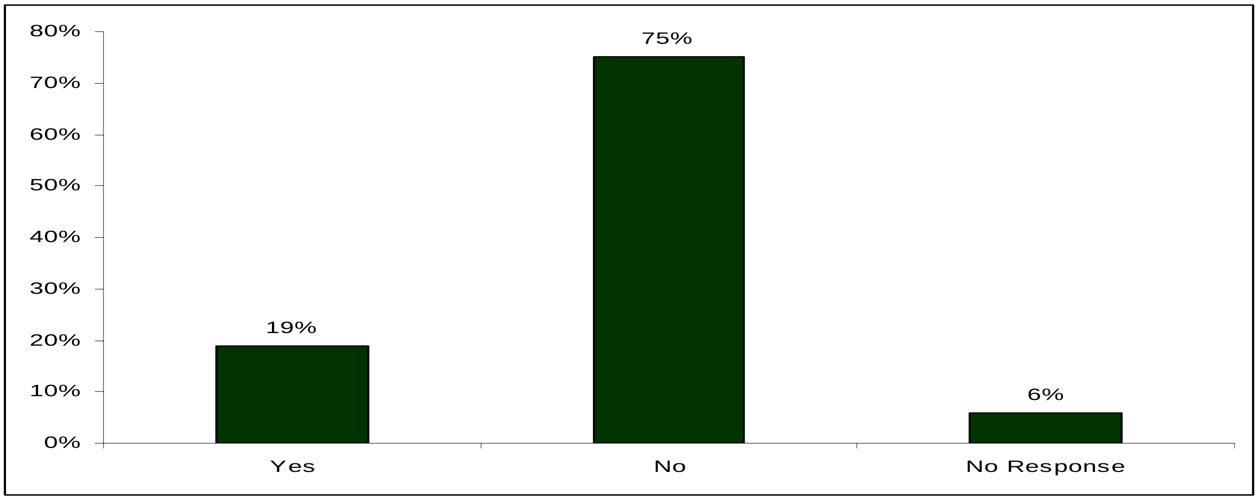
Using a 5-point scale (1= poor; 5 = excellent), respondents were asked to rate how they think the students reacted to the Kit materials and information used in their school. Of the 30 people who responded to this question, approximately half (47%) indicated that the students had an "excellent" reaction to the Kit. Another 36% felt their reactions were "good." Moreover, the average rating was 4.26, suggesting that most respondents perceived the students' reaction to be favorable.

Development of School Guidelines

A total of six schools (19%) indicated that they used the information provided in the Kit to develop school guidelines on sun safety (see Chart 26). Of those that did not use the information in the Kit for this purpose, the reasons included existence of informal policies (e.g., "sunscreen on list for field trips"), guideline in progress, lack of time and others such as:

> *"Not to that point."*
>
> *"That is a school district policy decision."*
>
> *"We have a newly formed Wellness Team and perhaps that is a good group to share this information with."*
>
> *"Not yet but on the to-do list."*

Chart 26. *Percentage Used Information in the Kit to Develop School Guidelines on Sun Safety*



Observed Changes in School

Participants were asked to identify any changes they have observed at their school as a result of using the Sun Safety Kit. The verbatim responses included:

- Not sure.
- Not at school but I think some have at home. I have them talk about using sunscreen at home.
- Students are practicing sun safety.
- We have recently ordered our own kits to use in the science curriculum.
- None (4)
- I don't believe the kit alone made changes but I do think the entire unit on sun safety has increased awareness, etc.
- I have not observed any changes at school but students have mentioned their prevention measures practiced at home.
- Prevention
- The use of sunblock during games was somewhat evident. The choices people make around sun safety would hopefully be more visible.
- I continue to point out to my students the importance of being aware of UV radiation. The bracelets also helped to make a lasting impression.
- The students are more aware of UV rays or more likely to use protection on their skin.
- It made students aware of what sun can do to you
- The students are more aware of sun safety and remember to protect themselves. Also students are more apt to bring and wear sunblock.
- More awareness.
- Seeing less after weekend sunburns.
- Conversations in the hallway related to sunscreen and protection.
- More students have sunglasses, hats and sunscreen than before.
- Student and teacher awareness
- More hats at recess; increased volume of sunscreen being used
- Staying in shaded areas and wearing sunblock

Feedback on Dissemination

Participants were asked if the method of dissemination of the Kits was effective. Seventy-eight percent responded to this question. Of these, 80% felt the distribution was effective. Comments provided regarding potential ways to improve the dissemination process included the timing and audience. For example, one respondent noted,

"There was no administrative direction. The kits went to classroom teachers (homeroom) so others did not have the opportunity to use them."

Another requested more beads: "*Would like to have had enough beads to all of the middle school…6th graders got the beads."*

Additional Comments

Participants were also asked to share any additional information about the Sun Safety Kits. The responses (verbatim) are listed below.

- Please share with me how the DVDs work
- There is a lot of good information. I wish all students could get the bracelets every year. It only went to last year's 7th grade students
- Excellent kit and grant
- We decided to order a replacement kit to use this year
- Additional training for training would be useful
- Can we receive more items? Thank you
- A kit could be sent to curriculum coordinator in all schools/districts
- Any updated information would be helpful
- Used it and explained it in one 45 minute class period. Kids were excited to find out useful info. and --- the bracelets.
- The bracelets were very popular with our students
- Kids loved bracelets
- Should have included info on where to get the beads. It came up on school nurse listserv and we were able to get more but too late. Problem area -- teachers & tanning booths. They are the daily role models. Need info targeted at adults (women in particular). Also wish this survey came out earlier as I would have better recall of my classroom experiences
- Very informative and helpful for education
- The 7th students LOVED the bracelets and students of all ages wanted them. I would like to get more of the bracelets to use in future years. When we had them just before Field Day it helped the kids be more aware of their sun levels when we were outside all day
- Loved it. Would love to use one again. We have 2 science teachers next year and would love to have enough materials for 130 students
- The beaded bracelets are wonderful - I hope they are on the resource list so I can get more. Time is the biggest problem getting these lessons out to the students. Health Ed is given low priority in terms of time (less than once a week)

Conclusions and Recommendations

Based on the evaluation results the Kits were well received; particularly the UVB bracelets. This finding differs from previous evaluation results noting that high schools found the bracelets the least useful of all the Kit components. While the current results are based on only 20% of the sample of schools, they are consistent with previous evaluation reports noting the overall positive reactions to the Sun Safety Kits. Clear barriers to the implementation and evaluation of the Sun Safety Kits include time and staff turnover. Moreover, low response rates and lack of information on students' reaction to the Kit limit the evaluation results.

The following recommendations are provided.

1. Follow-up with those schools who expressed interest and did not receive the Kit or a component of the Kit.
2. Strengthen the dissemination plan for future efforts. Consider sending Kit earlier in school year to provide more opportunities for use. Re-examine issues related to audience (e.g., teachers, coaches, etc.).
3. Provide enough materials for use in all grade levels.
4. Identify opportunities to increase utilization of the Kits in the community setting (e.g., health fairs, summer camps, recreation departments).
5. Incorporate students' reaction and behavioral intent in evaluation plan of the project. Consider including a survey/postcard with the Kit.

RESULTS PART III: OUTCOMES

Outcome evaluation is an important component of any comprehensive evaluation plan. This part of the evaluation is intended to determine short- and long-term results of a program as well as the anticipated and unanticipated changes brought about by the initiative. Outcome evaluation can play an important role and can serve many purposes throughout the program.

The information provided below is based on outcome data for select objectives. All objectives (with baseline data) that are included in this evaluation are listed below. Once again, the results should be interpreted with caution. While the program theory delineated in the original logic models suggests that the accomplishments of specific strategies will lead to achieving the objective, there are a series of additional factors that clearly can impact program replication. Until these factors are better understood, generalizations about changes in the data should be made with caution.

Intermediate Outcomes

Intermediate outcomes often focus on behavior and systems change. Tables 17-20 provide data from the Behavioral Risk Factor Surveillance System (BRFSS) in Maine[5]. These data are collected annually through a random digit dial telephone survey of Maine adults. Data pertaining to youth are collected utilizing the Youth Risk Behavior Surveillance System (YRBS). This school-based survey is administered to 9th – 12th grade students every two years. Citations are provided for data reported from additional sources.

Table 17. *Intermediate Outcomes: Tobacco Use*

Measurable Objectives	**Pre Plan**		**Plan**	**Post Plan**			
	98/99[1]	2000	2001	2002	2003	2004	2005
Tobacco Use							
• Reduce proportion of Maine adults aged 18 and older who use tobacco products to 15% by 2005[2]	22.0	23.8	NA	23.6	23.6	21.0	NA
• Increase proportion of young people who have never tried smoking to 60% (8th grade) by 2005	51.0	- -	61.9	- -	67.1	- -	75[3]
• Increase proportion of young people who have never tried smoking to 45% (12th grade) by 2005	37.8	- -	NC	- -	NC	- -	NC

Notes:

[1] Baseline data as reported in the Maine Cancer Plan. BRFSS baseline results compiled for 1998, YRBS results compiled for 1999 (not weighted)

[2] Results based on current cigarette smokers, BRFSS 2004

[3] Results based on 2005 Maine YRBS

NA = Data not available/not yet provided

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[5] Maine Department of Human Services and U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System.*

NC = Data not comparable due to discrepancies in questions
- - = Data not collected (YRBS survey administered on odd years only)

The tobacco use results suggest that the rate of current adult smokers has remained relatively stable over the past several years. However, youth smoking rates have decreased according to trend analyses conducted using the Youth Risk Behavior Survey. Although data pertaining to 12th graders who ever tried smoking was not available, results from the YRBS suggest that the percentage of high school students who smoked cigarettes during the past 30 days decreased from 24.8% in 2001 to 16.2% in 2005. In terms of cigarette use, the percent of high school students who smoked on one or more of the past 30 days also decreased from 24.8% in 2001 to 16.2% in 2005. Finally, according to the YRBS the percentage of middle-school students who smoked cigarettes in the past 30 days decreased from 9.9% in 2001 to 7.5% in 2005.

Table 18. *Intermediate Outcomes: Physical Activity and Nutrition*

Measurable Objectives	**Pre Plan**		**Plan**	**Post Plan**			
	97-99[1]	2000	2001	2002	2003	2004	2005
Physical Activity and Nutrition							
• Increase proportion of persons who eat "Five-A-Day" to 30% of adults (18+) by 2005	26.4	24.5	NA	29.3	27	- -	28.7
• Increase proportion of persons who eat "Five-A-Day" to 35% of high school students by 2005	26.7	- -	25.0	- -	22.6	- -	19
• Increase proportion of adults (18+) who engage in 30 minutes of activity daily to 30% by 2005	24.1	- -	NA	- -	53.1[3]	- -	54.1
• Increase proportion of youth who engage in 20 minutes of activity (≥ 3 days) to 75% by 2005	70.6	- -	65.9	- -	60.6	- -	67[4]
• Decrease proportion of adults (18+) who are overweight (obese/overweight combined) to 50% by 2005[2]	53.2	54.1	NA	59.0	58.2	61[6]	--

Notes:

[1] Baseline data as reported in the Maine Cancer Plan. BRFSS baseline results compiled for 1998 or 1997, YRBS results compiled for 1999

[2] Overweight based on Body Mass Index of ≥ 25

[3] BRFSS, 2003 -2005. Question wording may differ from baseline. "Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week

[4] BRFSS, 2005. Question wording may differ from baseline. Percentage represents combined totals of middle school and high school students, vigorous and moderate activity every day in the past week.

NA = Data not available/not yet provided

- - = Data not collected (YRBS survey administered on odd years only, select BRFSS questions not included annually)

The results in Table 18 suggest that adults have increased fruit and vegetable consumption over the past several years, nearly achieving the objective. However, high school students'

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[6] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey. *Healthy weight, overweight, and obesity among U.S. adults.* Available at http://www.cdc.gov/nchs/nhanes.htm

consumption of fruits and vegetables appears to be on a downward trend with less than 25% of students eating five or more servings daily, as reported in 2003 and 2005.

Reported levels of physical activity also appear to be fluctuating for youth. The findings suggest that youth were less active in 2003 when compared to 1999 and 2001. However, according to the 2005 Maine YRBS, 31% of middle school and 36% of high school students reported participating in moderate to vigorous physical activity for at least 20 to 30 minutes for every day in the past week. Trends in adult physical activity rates suggest that adult physical activity has steadily increased, however, the wording of BRFSS questions pertaining to physical activity vary slightly from the objective stated above.

According to the 2004 BRFSS, while Maine's rates of overweight and obese adults are comparable to national rates, Maine has the highest adult obesity rate in New England. Moreover, the rates of overweight and obesity (BMI $\geq$ 25) for those 18 and older suggest an upward trend. The overweight/obesity results for 2003 are relatively consistent with 2002 data, although the 2004 data reflect a slightly higher percent.

Table 19. *Intermediate Outcomes: Sun Safety*

Measurable Objectives	**Pre Plan**		**Plan**	**Post Plan**			
	98/99[1]	2000	2001	2002	2003	2004	2005
Sun Safety							
• Increase proportion of adults who "always" or "nearly always" stay in shade to 35% by 2005	29.7	- -	- -	33.3	- -	26.4	- -
• Increase proportion of adults who "always" or "nearly always" wear a hat to 45% by 2005	37.3	- -	- -	27.6	- -	- -	- -
• Increase proportion of adults who "always" or "nearly always" use sunscreen to 40% by 2005	32.2	- -	- -	33.3	- -	37.8	- -
• Reduce the proportion of adults who use artificial sun tanning to 5% by 2005	11.0	- -	- -	- -	- -	- -	- -

Notes:

[1] Baseline data as reported in the Maine Cancer Plan. BRFSS baseline results compiled for 1999

- - = Data not collected as part of Maine Survey

Questions pertaining to sun safety were not included in the BRFSS Maine survey in 2000, 2001, and 2003. However, based on the 2002 and 2004 results, the findings suggest a modest improvement in reported behavior related to wearing sunscreen.

Table 20. *Intermediate Outcomes: Screening Behavior*

Measurable Objectives	Pre Plan		Plan	Post Plan			
	98/99[1]	2000	2001	2002	2003	2004	2005
Screening Behavior							
• Increase proportion of women (40-49) who get mammogram and breast exam to 80% by 2005	70.2	NA	- -	71.3	NA	80.3	--
• Increase proportion of women (50+) who receive mammogram and breast exam to 70% by 2005	59.5	NA	- -	NA	NA	85.5	--
• Increase proportion of women (18+) who ever receive Pap test to 98% by 2005	95.3	95.4	- -	95.6	NA	96.0	--
• Increase proportion of adults (50+) who receive FOBT within past two years to 60% by 2005	35.9	- -	42.4	43.5	NA	39.8	--
• Increase proportion of adults (50+) who receive sigmoidoscopy/colonoscopy to 45% by 2005	42.4	- -	47.7	42.3	NC	59.2	--

Notes:

[1] Baseline data as reported in the Maine Cancer Plan. BRFSS baseline results compiled for 1999
NA = Data not available/not yet provided
NC = Data not comparable due to discrepancies in questions
- - = Data not collected as part of Maine Survey

Based on the results provided, screening behavior appears to have increased for mammograms and clinical breast exams. Both objectives in this category have been achieved. There also appears to have been an increase in sigmoidoscopy/colonoscopy screenings since 2001, therefore achieving this objective. This increase may be due, in part, to what has been reported in the scientific literature as the "Couric effect" following Katie Couric's (Today Show host) live colonoscopy in 2000. Nevertheless, the increase in 2004 indicates an upward trend for colon cancer screening.

Long-Term Outcomes

Long-term outcomes often focus on changes in incidence, mortality, and quality of life. Table 21 provides data from the Maine Cancer Registry on incidence and data from CDC Wonder on mortality rates for select types of cancer. A shown in this table, the latest available data is from 2002.

Table 21. *Incidence and Mortality Rates for Select Cancers*

Objectives	**Baseline**	**Pre Plan**		**Plan**	**Post Plan**			
	1996[1]	1999	2000	2001	2002	2003	2004	2005
Incidence[2]								
• Lung cancer	76.9	71.7	77.7	79.1	75.9	NA	NA	NA
Men	99.0	93.3	100.4	99.6	96.0	NA	NA	NA
Women	61.2	54.6	60.2	65.0	60.7	NA	NA	NA
• Colorectal cancer	56.5	60.6	58.1	54.2	61.2	NA	NA	NA
Men	67.9	71.1	62.6	65.2	74.3	NA	NA	NA
Women	48.4	53.0	54.4	46.8	51.8	NA	NA	NA
• Melanoma	14.6	18.0	17.1	20.0	20.7	NA	NA	NA
Men	17.8	21.5	22.9	23.5	24.1	NA	NA	NA
Women	12.0	16.2	12.2	17.1	18.6	NA	NA	NA
• Breast cancer[3]	129.2	126.0	133.5	140.9	126.1	NA	NA	NA
• Cervical cancer	11.0	7.5	6.5	9.2	7.1	NA	NA	NA
Mortality[2]								
• Lung cancer	65.3	58.0	62.2	58.7	63.3	NA	NA	NA
Men	88.9	77.1	79.8	79.5	81.6	NA	NA	NA
Women	49.5	44.9	49.0	44.7	50	NA	NA	NA
• Colorectal cancer	22.3	23.3	23	21.2	21.6	NA	NA	NA
Men	28.9	27.7	24.2	26.3	27.6	NA	NA	NA
Women	18.4	20.1	21.5	17.6	17	NA	NA	NA
• Melanoma	3.0	2.6	2.5	3.3	3.5	NA	NA	NA
Men	5.1	2.8	3.4	4.8	5.9	NA	NA	NA
Women	1.6	2.4	2.1	2.2	1.7	NA	NA	NA
• Breast cancer[3]	28.1	27.1	24.2	21.9	23.9	NA	NA	NA
• Cervical cancer	3.0	2.6	1.8	1.6	2.1	NA	NA	NA

Notes:

[1] Baseline rates included in the Maine Cancer Plan

[2] All data are calculated per 100,000 and age-adjusted to the 2000 U.S. Standard Population

[3] Females only

NA = Data are not yet available

Based on the limited amount of data available, no trends were identified based on the long-term outcome measures listed above. In order to determine the potential preliminary impact of the CCC initiative, additional years of data will be necessary.

Recommendations: MCCP and Consortium Overall

The following recommendations have been provided[7]:

1. **Enhance the Consortium's membership and participation.**
   - Identify specific opportunities for individuals to remain involved and actively participate in Consortium efforts.
   - Develop a subgroup to address membership issues, paying particular attention to diversifying the membership. Create a one-year workplan with specific tasks assigned to individual members of the subgroup. Request that a representative of the membership committee provide updates of progress at Board meetings.
   - Update the membership database annually. This may require contacting all listed members to ask about their interest in remaining involved.
   - Identify opportunities for engaging new members. Develop incentives for recruitment. Engage groups which lack representation or knowledge about the initiative (e.g., cancer service providers in Maine hospitals).
   - Formally recognize the efforts of members through multiple venues (e.g., annual meeting, quarterly newsletters, etc.).

2. **Reach consensus on the various functions of the Workgroups, Board, and Program, as well as the role of Consortium members and potential staff.**
   - Continue to develop and finalize the guiding document that details the structure, relationship and agreed upon functions for each Workgroup, the Board of Directors, and the Program for a five-year period.
   - Disseminate this document to all members through multiple channels.
   - Modify and/or review the document annually, if appropriate.
   - Ask members to sign a letter indicating their understanding of these functions and their given role. Provide clarity when necessary.

3. **Narrow the Consortium's focus to select priorities.**
   - Maintain an emphasis on a comprehensive approach, yet establish a small number of objectives and accompanying strategies to support in one year. These objectives should be based on a priority setting process. Continue establishing priority objectives to focus on for subsequent years.
   - Identify a process for determining priority objectives (e.g., priorities based on criteria established by Workgroups, priorities selected at annual meeting).
   - Develop an annual Consortium workplan with measurable objectives and task assignments for specific Workgroups and members where applicable. This workplan should be used as the basis for Workgroup activities and be congruent with the goals outlined in the Cancer Plan.
   - Monitor the workplan and provide updates at Workgroup and Board meetings.

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[7] Most carried over from the 2005 final evaluation report as many are still in the process of being addressed.

4. **Enhance Communication**
   - Develop, implement, and evaluate routine mechanisms for communicating with members. Specifically, continue to build and activate the Communications Workgroup
   - Showcase, celebrate, and publicize accomplishments among Consortium members and others.

Appendix A:

Cancer Plan Process Survey, text version

Maine Cancer Consortium
Cancer Planning Process Evaluation Survey

SECTION 1. Description

The purpose of this survey is to get Maine Cancer Consortium members' feedback on the planning process for the New Cancer Plan.

All of your answers are anonymous and confidential and the results will be used for evaluation purposes only. The survey should take approximately 15 minutes to complete. Thank you for your time!

SECTION 2. About you

This section is about you and your involvement in the Consortium. Please answer all questions to the best of your ability.

* 1. Please indicate the sector you represent:

Community Organization, Non-profit, HospitalState/Governmental Office, Voluntary Agency
Other (please specify)

2. How long have you been a member of the Consortium?

Not a member
Less than one year
One to three years
Greater than three years
Not sure

3. Are you a member of a Workgroup?

Yes
No
Used to be

4. If a member of a Workgroup, to which one do you belong? (Please check all that apply)

- Prevention
- Skin cancer task force
- Early detection
- Colon cancer task force
- Rehabilitation/survivorship
- Palliative
- Data
- Communication

5. How long have you been a member of the above Workgroup(s)?

Not a member
Less than one year
One to three years
Greater than three years
Not sure
Other (please specify)

6. How involved in the Consortium would you say you are?

Not at all involved Somewhat involved Extremely involved N/A

7. Please check all the ways you stay involved in the Consortium

- Stay informed of Consortium through email updates
- Participate in meetings once in a while
- Attended Annual Meeting
- Attend regular meeting of Workgroup
- Member of the Consortium Board
- Workgroup Chair
- Participated in current Cancer Plan planning
- Not involved
- Other (please specify)

8. How satisfied are you with your level of participation in the Consortium?

Not at all satisfied Somewhat satisfied Extremely satisfied N/A

SECTION 3. Feedback on Consortium

In this section, we'd like to know your feedback about the Maine Cancer Consortium. Please answer only those questions that apply to your experiences.

9. Please rate your satisfaction with following aspects of the Consortium

[(1-5) Not at all satisfied Somewhat satisfied Extremely satisfied Don't know Other]

- Strength and competence of Consortium leadership
- Willingness of members to take leadership roles
- Participation of influential people from key sectors
- Efforts in getting funding
- Efforts in providing funding for community efforts
- Use of the media to promote awareness
- Communication among Consortium members
- Clarity of roles

- Progress in meeting Consortium Objectives/Strategies
- Capacity of the Consortium to advocate effectively
- The Consortium's contribution to the health and well-being of Maine

SECTION 4. New Cancer Plan Process

In this section we'd like to know your feedback regarding the New Cancer Planning Process. Please answer only those questions that relate to your experiences and add any comments when possible.

* 10. Please indicate your level of involvement in the NEW Cancer Plan planning process [check all that apply]

- Developed goals, objectives and strategies for the Cancer Plan in my Workgroup(s)
- Participated in the October 18th Annual Meeting
- Provided feedback on the revised goals and objectives
- Provided feedback on the draft Cancer Plan
- Provided feedback at the Board of Directors' meetings
- Not involved in the planning process
- Other (please specify)

11. How involved would you say you were?

Not at all involved Somewhat involved Extremely involved Involvement level

12. Please rate your level of satisfaction with the planning process based on the following aspects.

[Not at all satisfied Somewhat satisfied Extremely satisfied Don't Know N/A]

- Components/focus areas of the plan
- Diverse representation of those involved in planning
- Decision-making process
- Information sharing & communication
- Timeline for the planning process

13. Please indicate the extent to which the planning process…

[None of the time Some of the time All the time Don't know N/A]

- Recognized the views of participants
- Demonstrated appreciation for participation
- Had clear ways for solving problems
- Reflected needs and priorities

14. Overall, were you satisfied with the planning process?

Yes
No
Don't Know
Other (please specify)

15. Please use this space to explain why you were or were not satisfied with the planning process.

16. Please describe the major strengths of the planning process.

17. Please describe the major weaknesses of the planning process.

SECTION 5. Assessment of Cancer Plan [8]

In this section we'd like to know your thoughts and feedback on the new Cancer Plan. Please answer all questions to the best of your ability and add any comments when possible.

* 18. Have you reviewed the New Cancer Plan?

Yes, all of it

Yes, my Workgroup section

No

19. Please indicate your agreement to the following statements regarding the quality of the Cancer Plan...

Completely disagree Somewhat agree Completely Agree Don't know N/A

- Plan relates to statewide effort, not just to selected cities, counties, or regions of state
- Goals reflect needs and efforts of broad sector of organizations, not just the state health department.
- Objectives are clearly organized
- Implementation of the plan is feasible
- Objectives are S.M.A.R.T. (Specific, Measurable, Attainable, Results-oriented, and Time-phased)
- Objectives are logically related to goals
- Evaluation of the plan is clearly defined

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[8] Question 19 adapted from State Plan Index. Butterfoss FD, Dunět DO (2005). State Plan Index: A tool for assessing the quality of state public health plans. *Preventing Chronic Disease* [serial online]. Available from: URL: http://www.cdc.gov/pcd/issues/2005/apr/04_0089.htm.

20. Please indicate how you plan to use the Maine Cancer Plan. Check all that apply.

- Will read it
- Will use it often
- Will share the Plan with others in my organization
- Will review my organization's goals and objectives to determine their congruence with the Maine Cancer Plan
- Will use the Maine Cancer Plan as input into the planning process in my organization
- Will use the Maine Cancer Plan as a basis for initiating or advocating for new activities
- Will use the Maine Cancer Plan to prioritize existing activities in my organization
- Other (please specify)

SECTION 6: Feedback on Survey

Okay, you're almost done! Please use the following space to make any additional comments.

21. Please use the space below to make additional comments about the Cancer Plan, the Consortium, or this survey.

Thank you for your time and input! Your responses will help us continue to make improvements to the Consortium and Cancer planning process. For questions or comments about this survey or to request the results, please contact the MCCP evaluator, Amy Black at ablack@mcph.org

Appendix B:

Interview Protocol, 2006

Date: _________
Role: Member ☐
Workgroup Chair ☐

Interview Protocol and Questions
Project: Comprehensive Cancer Control Evaluation
Purpose: Cancer Plan Process/Partnership Satisfaction

Prepared by: Amy N. Black/Netta Apedoe
UPDATED: March 9, 2006

This component of the evaluation involves telephone structured interviews with key individuals involved with the Comprehensive Cancer Control (CCC) Program and the Maine Cancer Consortium including: 1) the Maine Cancer Consortium Chair 2) the Workgroup Chairs or Co-chairs, and 3) other members of the Maine Cancer Consortium.

Introduction

- Greeting
- Role of MCPH
- Purpose of interview (Further understand the effectiveness of the Consortium)
- Length of interview (20-30 MINUTES)
- How information will be used (written in a final evaluation report, names will be omitted)

Section #1: About You

1. How long have you been a member of the Consortium?

____ Not a member
____ Less than one year
____ One to three years
__ Greater than three years
___ Not sure

2. Are you a member of a Workgroup? ☐ Yes (list)__________________ ☐ No

Section #2: New Cancer Plan: Planning Process [Chairs only]

1.What did you think about the Cancer Planning Process?

2. How would you say the group viewed the process?

3. How did you feel about the amount of time the Work Group put into revising the goals/objectives/strategies for the Cancer Plan?

4. Did you experience any challenges in getting the work group to work on revising the goals and objectives?

   4a. What worked well with the process and what should be changed for next time?

5. How satisfied are you with the resulting goals/objectives and strategies for your work group?

6. What are some of the strengths of this Plan? Do you think this is a plan that all the Consortium partners can embrace?

   6a. What barriers do you anticipate in implementing this plan?

Section #3: Internal and External Factors – Lessons Learned

1. The efforts, successes, and limitations of the Maine Cancer Consortium are shaped, in some way, by the broader political, economic, and social environment. They are also due, in part, to the internal dynamics, structure, and personnel involved in the initiative. In your opinion, what have been the most significant factors that have *positively* impacted the implementation of the Maine Cancer Plan during the past five years?

2. What have been the most significant factors that have *negatively* impacted the implementation of the Maine Cancer Plan during the past five years?

Section #4: Next Steps

1. What, if anything, should we do differently as we embark on the new phase for the Maine Cancer Consortium (the new Cancer Plan)?

Section #5: Summary & Wrap-Up

1. Is there anything else you want to tell me about the implementation, Workgroups, Consortium, or program?

Appendix C:

No Sun for Baby, Parent Survey

No Sun For Baby

Congratulations on the arrival of your baby! We hope the information on sun protection has been helpful to you. Please take a minute to tell us how we can serve you better.

Did you read the information on sun protection for babies?
☐ yes ☐ no, *please explain* ______________________
____

Was the information helpful? ☐ yes ☐ no, *please explain* __________
____

Do you plan on using the sun hat on your baby this summer?
☐ yes ☐ no, *please explain* ______________________
____

Do you plan on dressing your baby in clothing that protects his or her body from the sun? ☐ yes ☐ no, *please explain* __________
____

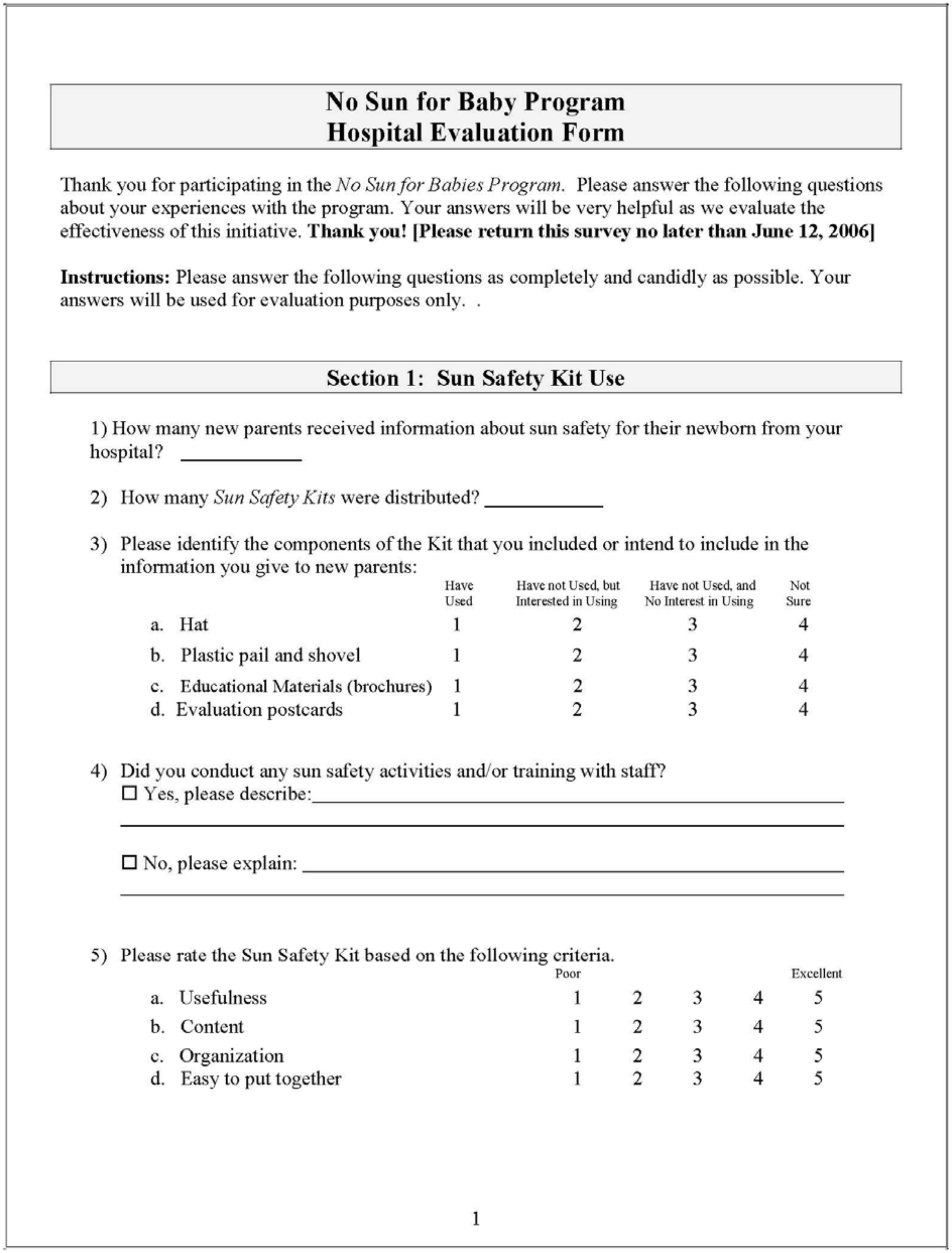
Do you plan on keeping your baby out of direct sunlight?
☐ yes ☐ no, *please explain* ______________________
____

*Comments*______________________
____
____

Thank you for your time

Appendix D:

No Sun for Baby, Hospital Survey



No Sun for Baby Program
Hospital Evaluation Form

Thank you for participating in the *No Sun for Babies Program.* Please answer the following questions about your experiences with the program. Your answers will be very helpful as we evaluate the effectiveness of this initiative. **Thank you! [Please return this survey no later than June 12, 2006]**

Instructions: Please answer the following questions as completely and candidly as possible. Your answers will be used for evaluation purposes only. .

Section 1: Sun Safety Kit Use

1) How many new parents received information about sun safety for their newborn from your hospital? ____________

2) How many *Sun Safety Kits* were distributed? ____________

3) Please identify the components of the Kit that you included or intend to include in the information you give to new parents:

	Have Used	Have not Used, but Interested in Using	Have not Used, and No Interest in Using	Not Sure
a. Hat	1	2	3	4
b. Plastic pail and shovel	1	2	3	4
c. Educational Materials (brochures)	1	2	3	4
d. Evaluation postcards	1	2	3	4

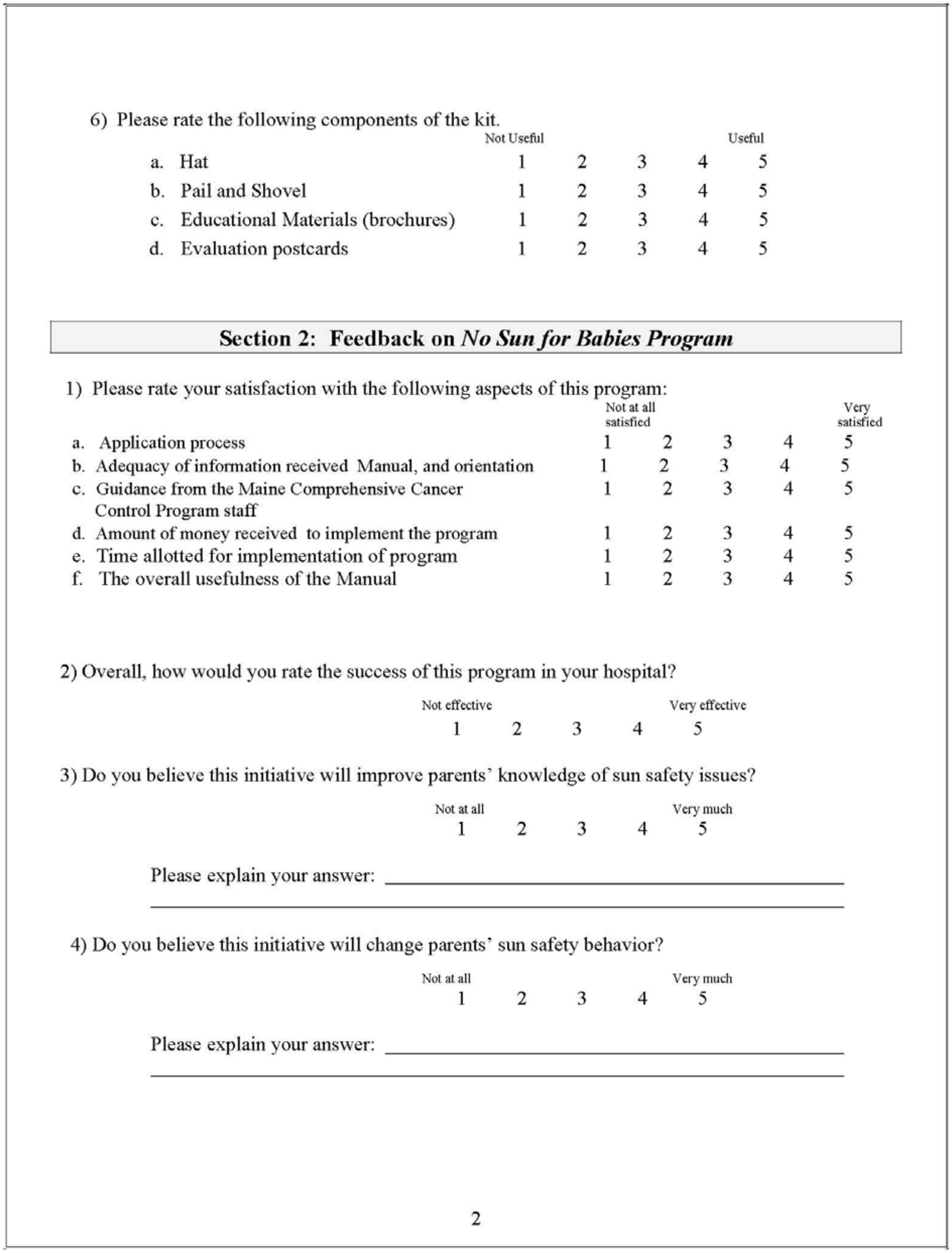
4) Did you conduct any sun safety activities and/or training with staff?

☐ Yes, please describe:____
____

☐ No, please explain: ____
____

5) Please rate the Sun Safety Kit based on the following criteria.

	Poor				Excellent
a. Usefulness	1	2	3	4	5
b. Content	1	2	3	4	5
c. Organization	1	2	3	4	5
d. Easy to put together	1	2	3	4	5



6) Please rate the following components of the kit.

	Not Useful				Useful
a. Hat	1	2	3	4	5
b. Pail and Shovel	1	2	3	4	5
c. Educational Materials (brochures)	1	2	3	4	5
d. Evaluation postcards	1	2	3	4	5

Section 2: Feedback on *No Sun for Babies Program*

1) Please rate your satisfaction with the following aspects of this program:

	Not at all satisfied				Very satisfied
a. Application process	1	2	3	4	5
b. Adequacy of information received Manual, and orientation	1	2	3	4	5
c. Guidance from the Maine Comprehensive Cancer Control Program staff	1	2	3	4	5
d. Amount of money received to implement the program	1	2	3	4	5
e. Time allotted for implementation of program	1	2	3	4	5
f. The overall usefulness of the Manual	1	2	3	4	5

2) Overall, how would you rate the success of this program in your hospital?

Not effective				Very effective
1	2	3	4	5

3) Do you believe this initiative will improve parents' knowledge of sun safety issues?

Not at all				Very much
1	2	3	4	5

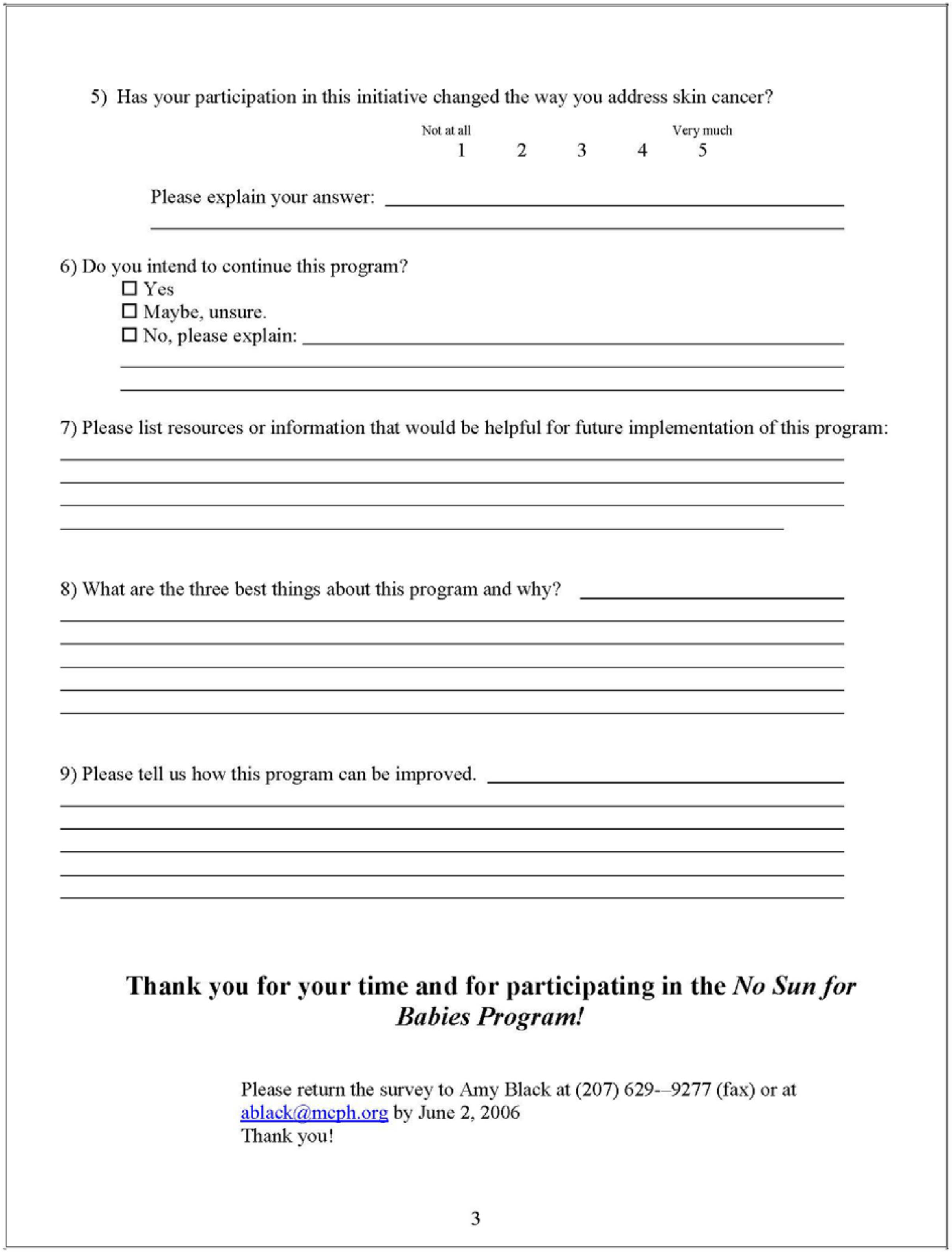
Please explain your answer: ______________________________
____

4) Do you believe this initiative will change parents' sun safety behavior?

Not at all				Very much
1	2	3	4	5

Please explain your answer: ______________________________
____

2



5) Has your participation in this initiative changed the way you address skin cancer?

Not at all				Very much
1	2	3	4	5

Please explain your answer: ______________________________
____

6) Do you intend to continue this program?

☐ Yes
☐ Maybe, unsure.
☐ No, please explain: ______________________________
____
____

7) Please list resources or information that would be helpful for future implementation of this program:
____
____
____
____

8) What are the three best things about this program and why? ______________
____
____
____
____
____

9) Please tell us how this program can be improved. ______________________
____
____
____
____
____

Thank you for your time and for participating in the *No Sun for Babies Program!*

Please return the survey to Amy Black at (207) 629-–9277 (fax) or at
ablack@mcph.org by June 2, 2006
Thank you!

Appendix E:

Middle School Sun Safety Kit,
Evaluation Survey

Code: _____

Sun Safety Kit Evaluation Form

Directions: Please answer the questions below by checking or circling the appropriate response. Your feedback is important and the information you provide will be used to help evaluate the Sun Safety Kit.

Middle-School: ______________________________ Position: ______________________________

Section #1: Use of Sun Safety Kit

1. Has your school utilized the Sun Safety Kit that was distributed by the Department of Education and the Maine Comprehensive Cancer Control Program?

☐ Yes ☐ No* ☐ Not Sure

*If no, please explain: ____
____
____

*What are the barriers to using the Kits and what would make you more willing to use it? ____
____
____

Please stop here if your school did not use the Sun Safety Kit

2. Please identify those who have used the Sun Safety Kit.

	Have Used	Have not Used, but Interested in Using	Have not Used, and No Interest in Using	Not Sure
a. Teacher	1	2	3	4
b. Nurse	1	2	3	4
c. Coach	1	2	3	4
d. Volunteer	1	2	3	4
e. Other (specify) _______________	1	2	3	4

3. Please identify any components of the Kit that you have used or intend to use in the future?

	Have Used	Have not Used, but Interested in Using	Have not Used, and No Interest in Using	Not Sure
a. PowerPoint presentation	1	2	3	4
b. UV bead band bracelet	1	2	3	4
c. Skin cancer prevention video	1	2	3	4
d. Guidelines for school programs	1	2	3	4
e. Skin cancer resource list	1	2	3	4
f. Skin cancer materials/fact sheet	1	2	3	4
g. Sun safety policy	1	2	3	4
h.. Sun Safety Lesson Plans	1	2	3	4
i. Other (specify) _______________	1	2	3	4

- Over -

4. Please describe how your school has used the Kit: ______________________________
____
____
____
____
____

5. Have you incorporated the Kit into your comprehensive health education curriculum?
☐ Yes ☐ No*

* If no, do you intend to incorporate the Kit into your curriculum?
☐ Yes ☐ No, please explain: ______________________________
____

Section #2 General Information about the Kit

6. Please rate the Sun Safety Kit (binder) based on the following criteria.

	Poor				Excellent
a. Usefulness	1	2	3	4	5
b. Content	1	2	3	4	5
c. Organization	1	2	3	4	5

7. Please rate the following components of the kit.

	Not Useful				Useful	
a. PowerPoint presentation	1	2	3	4	5	Not Sure
b. UV bead band bracelet	1	2	3	4	5	Not Sure
c. Skin cancer prevention video	1	2	3	4	5	Not Sure
d. Guidelines for school programs	1	2	3	4	5	Not Sure
e. Skin cancer resource list	1	2	3	4	5	Not Sure
f. Skin cancer materials/fact sheet	1	2	3	4	5	Not Sure
g. Sun safety policy	1	2	3	4	5	Not Sure
h. Sun Safety Lesson Plans	1	2	3	4	5	Not Sure
i. Other (specify) ____________________	1	2	3	4	5	

- Over -

8. How would you rate the students' reaction to the Kit materials and information used in your school?

Poor				Excellent	
1	2	3	4	5	Not Sure

Section #3 Outcomes

9. Did your school develop school guidelines on sun safety? ☐ Yes ☐ No*

*If no, please explain: ____________________

10. What, if any, changes in practice or behavior have you observed at your school as a result of using the Sun Safety Kit?

Did the method of distributing the Kit allow for effective use of the material?

Section #4 Additional Information

11. Please share any additional information you would like to tell us about the Sun Safety Kit.

Thank You!

Appendix F:

Screen Me! Social Marketing Campaign

MCCCP GI Telephone Survey

MCCCP GI Telephone Survey

My name is ________ from Digital Research in Kennebunk and I am following up on a letter and a request sent from Dr. Bosco, the Chairman of the Colon Cancer Task Force to ask Dr. _____________ a few brief questions about the State's colon cancer screening efforts. Could I please speak with Dr. ____________________."

If no, *then schedule a time to speak with the Doctor.*

May I please schedule 5 minutes to speak with Dr.__________________?

Attempt 1: ( ) Yes ( ) No *If no,* schedule call back date and time ____________________
Attempt 2: ( ) Yes ( ) No *If no,* schedule call back date and time ____________________
Fax a copy of this to his/her office and have them fax it back to DRI
Attempt 3: ( ) Yes ( ) No *If no,* schedule call back date and time ____________________
Attempt 4: ( ) Yes ( ) No Stop calling

If Yes, *see script below.*

Hello. I'm _____________ from Digital Research, a local Maine marketing research firm. Thank you very much for speaking with me. As you may be aware we are conducting a very brief interview about colorectal screening with Gastroenterologists like yourself from the state of Maine on behalf of the Colon Cancer Task Force. This will take less than 5 minutes of your time and please know that any information we obtain from you will remain confidential.

1. Recently, the Maine Colon Cancer Task Force has been engaged in the *Screen Me Campaign* which is intended to increase awareness of and encourage screening for colon cancer. The campaign aired two television advertisements in February which featured Tim Sample, a humorist/cartoonist from Maine and Joan Benoit-Samuelson, a marathon runner. In thinking about this campaign, how much do you agree or disagree with the following statement on a scale of 1 to 5, with 1 being "Strongly Disagree" and a 5 being "Strongly Agree."

   The Screen Me Campaign has had a positive influence on colorectal screening rates.

   ( ) 1 – Strongly Disagree
   ( ) 2
   ( ) 3
   ( ) 4
   ( ) 5 – Strongly Agree
   ( ) Not sure/ don't know
   ( ) I have never heard of this campaign before **(Skip to Q3)**

2. Have your patients made any references or mentions to you about the recent advertisements featuring Tim Sample and/or Joan Benoit-Samuelson? **(Do not read choices to respondent)**

   ( ) Yes
   ( ) No
   ( ) Not sure/ don't know/ don't remember

3. Which colorectal screening test have you performed the most in the past 3 months?

   ( ) Colonoscopies
   ( ) Flexible Sigmoidoscopies
   ( ) Fecal occult blood test (FOBT)
   ( ) Double-contrast barium enema

4. Have you noticed any change in the number of **___[test chosen in Q3**]___ that you have performed over the past three months when compared to last year? Please choose the response option that best represents your observations. (Read response options)

   ( ) I have noticed a *large increase* in the number performed over the past three months.
   ( ) I have noticed a *small increase* in the number performed over the past three months.
   ( ) I have noticed *no change* in the number performed over the past three months.
   ( ) I have noticed a *small decrease* in the number performed over the past three months.
   ( ) I have noticed a *large decrease* in the number performed over the past three months.
   ( ) [**Do not read this option**] Not sure/ Don't know

5. What methods do you believe should be implemented to increase the incidence of colorectal screening in Maine? **(Do not read the response options)**

   [ ] TV advertising
   [ ] Celebrity endorsements
   [ ] Showing colorectal screening procedures being performed on TV
   [ ] Primary Care physicians referrals
   [ ] Literature/pamphlets in the primary physician office and clinics
   [ ] Education
   [ ] Free screenings for those with low incomes
   [ ] Other [_4X50]

That is all of my questions. Thank you again for participating in this survey.

Name of Doctor: ____

Facility: __________________________