MAINE COMPREHENSIVE CANCER CONTROL PROGRAM

A REPORT ON THE EVALUATION

FY 2008-2009

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Prepared for:
Maine Comprehensive Cancer Control Program
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Acronyms

ACoS	American College of Surgeons
ACS	American Cancer Society
AMT	Activity Monitoring Tool
BRFSS	Behavioral Risk Factor Surveillance System
CCC	Comprehensive Cancer Control
CDC	Centers for Disease Control and Prevention
CME	Continuing Medical Education
HMP	Healthy Maine Partnerships
HPV	Human Papillomavirus
IRB	Institutional Review Board
MCCCP	Maine Comprehensive Cancer Control Program
MCPH	Maine Center for Public Health
MCS	Maine Cancer Society
ME-CDC	Maine Center for Disease Control and Prevention
MYRBS	Maine Youth Risk Behavior Surveillance System
PCP	Primary Care Physician
PRAMS	Pregnancy Risk Assessment System
STD	Sexually Transmitted Disease
YRBS	Youth Risk Behavior Surveillance System

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Executive Summary

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 (MCCCP)
2. Maine Cancer Consortium (Consortium)
3. 2006-2010 Maine Comprehensive Cancer Control Plan (Cancer Plan)

In relation to these areas, this report provides an overview of findings related to the fourth year of implementation of the Cancer Plan, the effectiveness of the Maine Cancer Consortium partnership, and MCCCP-related activities and accomplishments.

Moreover, the report includes evaluation data from the following initiatives implemented by the MCCCP along with the Consortium:

1. *No Sun for Baby Program*
2. *Sun Blocks Childcare Sun Safety Pilot Program*
3. *Elementary School Sun Safety Grants*
4. *Colorectal Cancer Screening: Healthy Maine Partnerships*

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 CCC 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 as one of several tools utilized to ultimately help strengthen the collective efforts of those seeking to reduce the burden of cancer in Maine.

Results: At-a-Glance

2006-2010 Maine Comprehensive Cancer Control Plan Implementation Findings

This evaluation report provides information on select goals, objectives, and strategies delineated in the Maine Cancer Plan. The *Activity-Monitoring Tool* was used to track progress to date, with regard to implementation for all strategies listed in the 2006-2010 Maine Cancer Plan. Overall, for the fourth year of implementation the results suggest that approximately 76% of the strategies have been achieved either partially or completely.

Cancer Consortium Findings

The Maine Cancer Consortium, Maine's statewide comprehensive cancer control partnership, conducted a membership survey in 2008 and this report includes a summary of the data

collected from those surveys. The report also presents findings from the Consortium's Annual Meeting held November 18, 2008. Both surveys provide insight and direction for the continued work of the Consortium.

2008-2009 MCCCP Accomplishments

Maine's Comprehensive Cancer Control Program (MCCCP) is in year two of implementing its second 5-year program implementation grant from the US Centers for Disease Control and Prevention. Since MCCCP's inception there have been a number of notable accomplishments and this report highlights some of the 2008-2009 accomplishments.

No Sun for Baby Program

The *No Sun for Baby* (NSFB) Program is a sun protection educational program for parents of newborns administered by hospitals across Maine. Through a mini-grant process administered by the Maine Cancer Consortium's Skin Cancer Workgroup, hospitals receive funds to distribute Sun Safety Kits to parents of newborns as they leave the hospital.
The evaluation findings for the third year (2008) of grant funds reflect the continued success of the program and ideas for embedding evaluation into on-going program administration.

Sun Blocks Childcare Sun Safety Pilot Program

The goal of the *Sun Blocks* Childcare Sun Safety Pilot Program evaluation was to determine if the pilot program is a practical, sustainable and effective approach to reduce overall UV exposure among children attending childcare centers in Maine. The quasi-experimental evaluation was designed as a follow-up to the baseline assessment completed last year. Findings reflect that while funding can enhance a center's ability to sustain the *Sun Blocks* program, a comprehensive program that includes educational materials and complementary training without the provision of funding, may still be effective in impacting and changing sun safety practices within the childcare setting. Also included here is an evaluation summary of the *Sun Blocks* training program that is one element of the quasi-experimental evaluation.

Elementary School Sun Safety Grants

In the current round of Elementary School Sun Safety grant funding, the MCCCP provided funds for public elementary schools to support skin cancer prevention initiatives. Based on the Centers for Disease Control and Prevention's School Recommendations for Skin Cancer Prevention, grantees were asked to focus on specific activities to educate about and encourage sun protection behaviors when outdoors. As in the past, the grant program was administered by the Maine Department of Education with the final evaluation being completed by the MCCCP independent evaluator. The findings of that evaluation are included in this report.

Colorectal Cancer Screening: Healthy Maine Partnerships

In early 2008 the MCCCP announced the availability of 3-year Colorectal Cancer Screening and Awareness Community Grants to support the Healthy Maine Partnerships (HMP) with additional resources to enhance their on-going colorectal cancer prevention and awareness activities. The evaluation results presented in this report reflect the second year grant activities in the five program areas identified during the first grant year — Public Awareness Campaign, Education Initiatives, Practice Changes, Capacity Building, and Strengthening Partnerships.

Outcome Findings

Outcome data, when available, is also included as part of this report. The findings indicate that improvements were noted in several areas. The Results Part III section of this report details those findings. Additional outcome information on all cancers is accessible through the comprehensive surveillance document and plan developed by the Maine Cancer Consortium's Data Workgroup that was published in the fall of 2009. The report is available on the Maine Cancer Consortium's website, http://www.mainecancerconsortium.org/.

Recommendations

The following recommendations identified through the evaluation process have been provided:

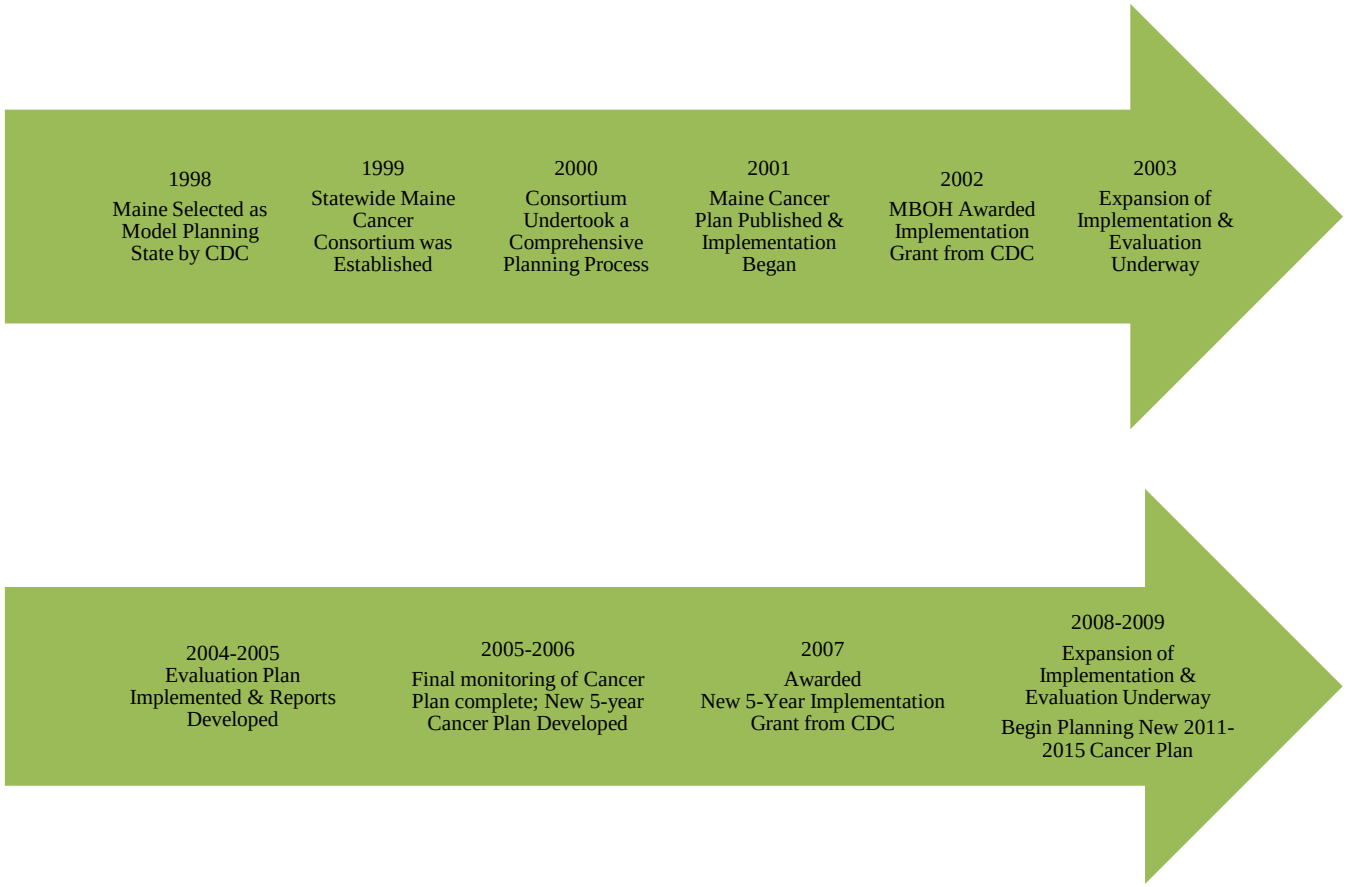
1. Utilize the 2011-2015 Cancer Plan Development Process as a forum for enhancing Consortium's membership.
2. Increase Consortium's participation in the enhancement of the Cancer Plan's Activity Monitoring evaluation process.
3. Continue to utilize evaluation results to adapt, enhance and or expand program initiatives and workgroup/taskforce activities.
4. Embed continuous program evaluation wherever appropriate and possible.

Background

The Maine Center for Disease Control and Prevention (ME-CDC) contracted with the Maine Center for Public Health (MCPH) to evaluate the statewide Comprehensive Cancer Control (CCC) Initiative. As depicted in Figure 1, the implementation of the Maine Cancer Plan has been underway since 2001. The second 5-year Cancer Plan was announced May 18, 2006 with implementation beginning in the fall of 2006 and completion of the plan scheduled for 2010. The third 5-year plan is currently being designed for a spring 2010 roll-out with a fall 2010 start date. A comprehensive evaluation plan was developed in 2007 and is designed to address the process, outcomes and contextual factors related to the CCC initiative.

This report attempts to capture activities, successes, and challenges that have occurred during the previous year (2008 – 2009) of implementation of the CCC Initiative, related to three major areas. These areas include: 1) the Maine Comprehensive Cancer Control Program housed within the ME-CDC; 2) the Maine Cancer Consortium and its related Workgroups or Task Forces; and 3) the Maine Cancer Plan. The three areas complement one another and many of the activities overlap.

Figure 1: *Maine Comprehensive Cancer Control Initiative Timeline, 1998-2008*



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 Comprehensive Cancer Control Plan (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.

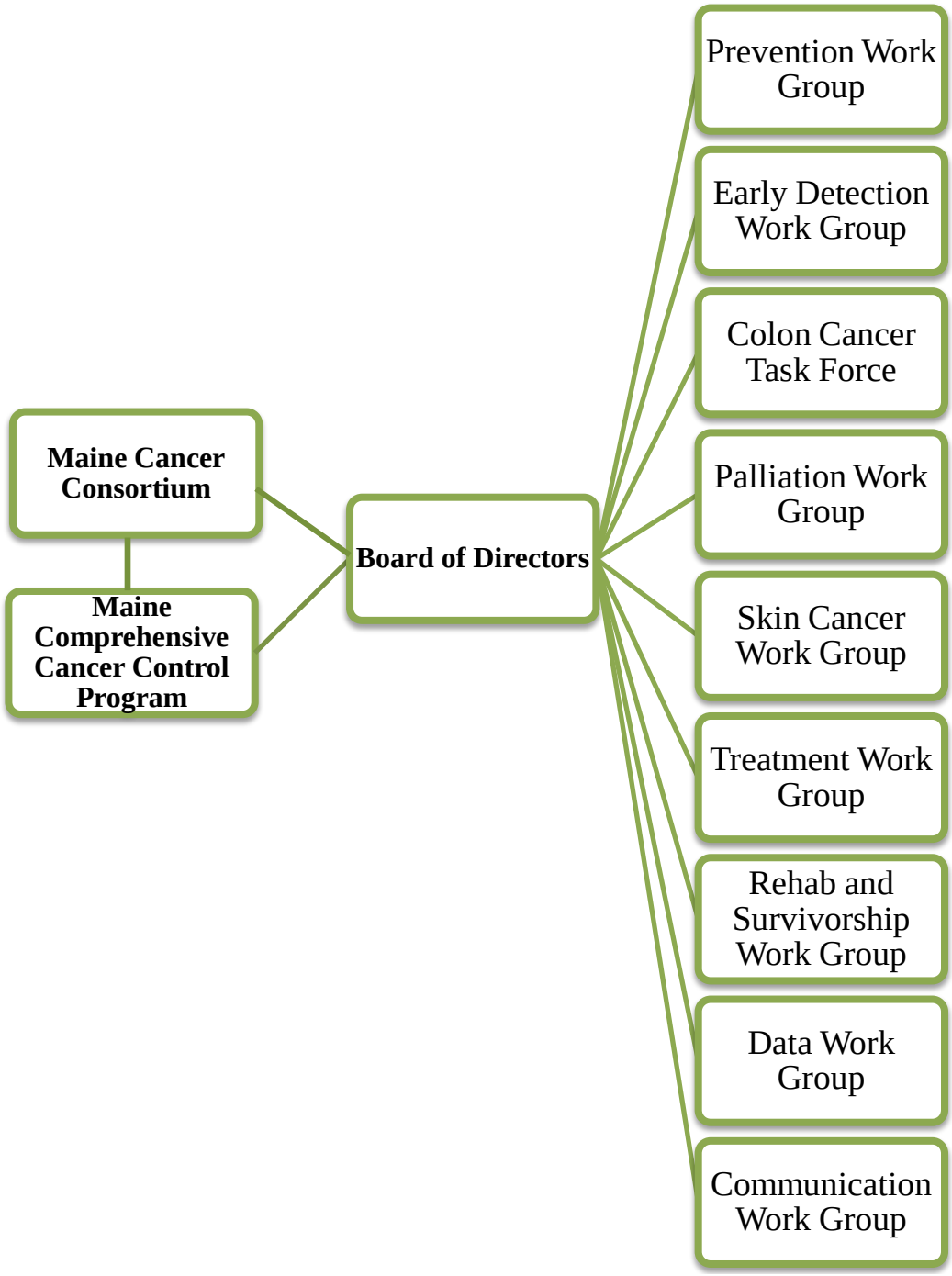
The programmatic objectives of MCCCP are:

- 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 MCCCP.

Maine Cancer Consortium

The Maine Cancer Consortium (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 in Figure 2.

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 MCCCP worked collaboratively to create the *Maine Comprehensive Cancer Control Plan*, published in 2006. 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 2010. The nine components of the Maine Cancer Plan are depicted below in Figure 3.

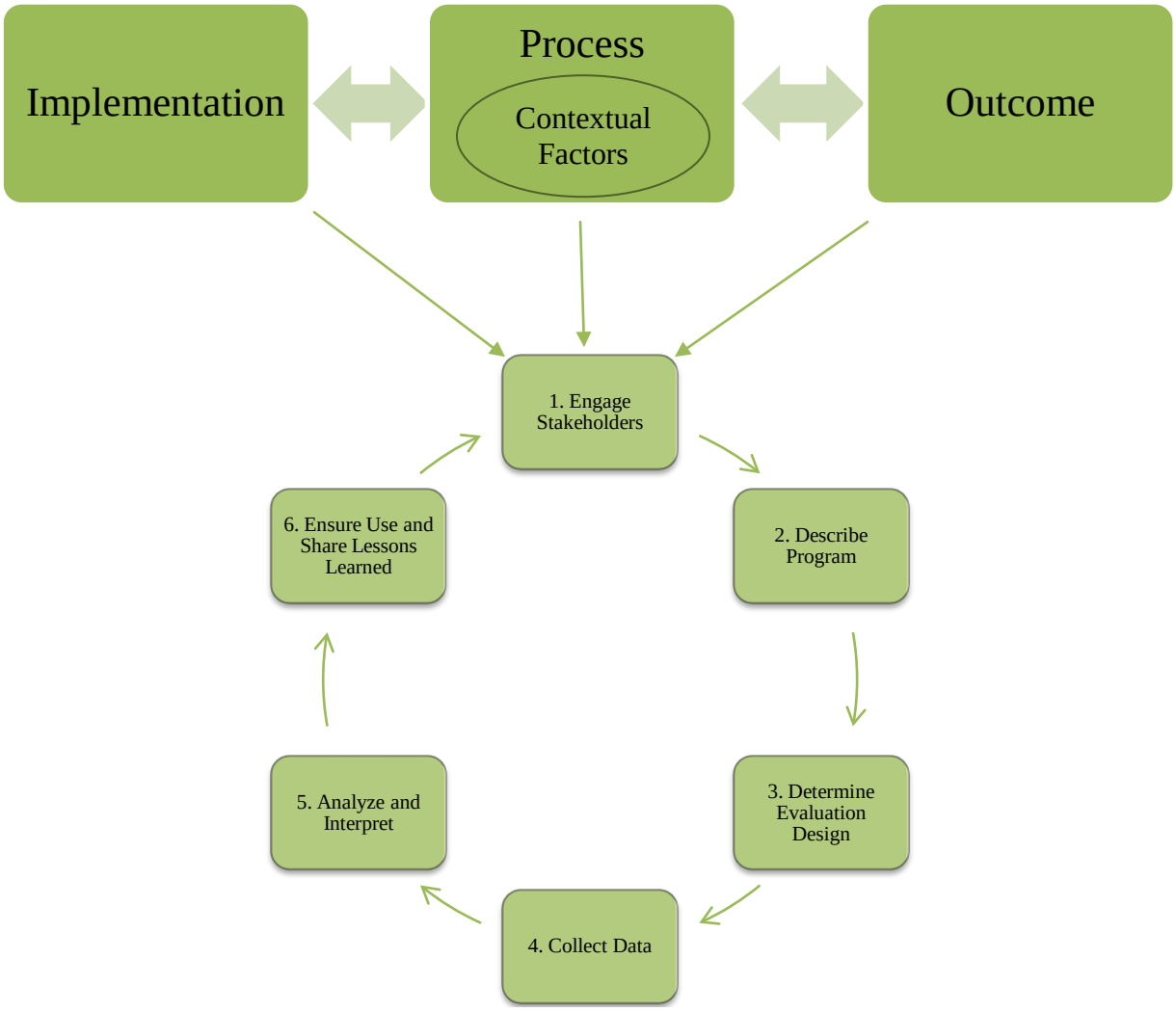
Figure 3: *Maine Cancer Plan Components, Goals, and Objectives: 2006-2010*

Evaluation Design

Evaluation Framework

As seen in Figure 4, the evaluation design includes three components that interface with the CDC's Program Evaluation Framework. The first component focuses on the implementation of initiative activities that collectively and theoretically result in improvements in health outcomes and other programmatic objectives. The second component is designed to assess the process aspects of the initiative, including the evaluation of how contextual factors affect implementation. The third component attempts to determine the outcomes or impact of the initiative. Each component is executed utilizing the overarching framework developed by the CDC for program evaluation.

Figure 4: *CCC 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 2008-2009 cycle year. All tools developed by the MCPH were done so using a collaborative process with the MCCCP.

Table 1: *Data Sources*

Evaluation Component	Source
Process Evaluation	
• **Modified Activity Monitoring Tool** - Both electronic tool and paper /pencil tracking tool used with workgroups by MCPH Evaluator	• Developed by Maine Center for Public Health
• **Interviews with Staff** - Email, program accomplishments updates	• Developed by Maine Center for Public Health and Maine Comprehensive Cancer Control Program
• **Cancer Consortium Annual Meeting Evaluation** - Paper/pencil survey administered at annual meeting	• Developed by Maine Center for Public Health
• **Cancer Consortium Membership Survey** - Electronic survey administered in Nov/Dec 2008	• Developed by Maine Center for Public Health
Program-Sponsored Initiatives: Formative Evaluation	
• **No Sun for Baby Program** - Parent paper/pencil survey - Hospital paper/pencil survey	• Developed by Maine Center for Public Health
• **Elementary School Sun Safety Mini-grant Program** - Paper/pencil Grant Report Documents - Electronic survey	• Developed by Maine Department of Education and Maine Center for Public Health
• ***Sun Blocks* Childcare Sun Safety Pilot Program** - Training paper/pencil surveys – administered in September 2008 - Pre/Post Paper and pencil mail-in survey administered in June 2009	• Developed by Maine Center for Public Health And Maine Comprehensive Cancer Control Program
• **Colorectal Cancer Screening Grants (Year Two): Healthy Maine Partnerships** - Electronic Grant Survey administered in June 2009	• Developed by Maine Center for Public Health
Outcome Evaluation	
• **Maine Cancer Registry, CDC Wonder** - Secondary data (incidence and mortality)	• Maine-CDC • CDC
• **Maine Youth Risk Behavioral Surveillance System** - Secondary data (behaviors)	• Maine-CDC • CDC
• **Behavioral Risk Factor Surveillance System** - Secondary data (behaviors)	• Maine-CDC • CDC
• **Maine Pregnancy Risk Assessment System** -Secondary data (behaviors)	• Maine CDC • CDC
• **Maine Child Health Survey**	• Maine CDC

Results Part I: Process

This component of the evaluation focuses on the implementation of activities and strategies designed to bring about changes that are directly linked to program goals and outlined in the Cancer Plan. 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.

Cancer Plan Implementation: Activity-Monitoring Tool Results

An Activity Monitoring Tool (AMT) was developed in 2004 and in 2008 an electronic version was developed for some portions of the tool. The AMT tracks progress towards achievement of the stated measures in the Cancer Plan and reports feedback on accomplishments, strengths, and challenges to meeting the plan's goals.

The AMT focuses on all objectives and related strategies as outlined in the Cancer Plan. This report encompasses those strategies for which there was a workgroup or task force with members available to complete the tool at the time of administration. Historically, administration of the tool has happened at workgroup/task force meetings. In 2008, with the electronic tool, administration took place in three different ways. For some workgroups administration was solely via the electronic tool, for others the paper tool was administered at a group meeting, and for one group both tools (paper and electronic) were an option.

The data presented here represents all active workgroups and pertinent stakeholders who were either part of a group AMT meeting or completed the electronic AMT. Also included in this year's report are the Maine Comprehensive Cancer Control Program-specific strategies in the areas of evaluation, disparities, and implementation as reported by MCCCP staff. In order to preserve the accuracy of the data, strategies that were duplicated across more than one objective are reported upon only once.

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. The remaining workgroups are more directly involved in strategy implementation. The progress results reported in the AMT may reflect this difference in oversight versus initiation.

It is also important to keep in mind that some strategies may be sequential and thus reliant on the completion of preceding strategies. Other strategies may be, by definition, on-going activities and thus "fully achieved" does not apply even though much work has been done around that strategy — for example, sun safety protection efforts may be deliberately on-going as a result of wanting to reinforce the message at every age and because new babies are born each year. Additionally, some strategies may not have been pursued for a variety of reasons,

such as lack of resources and lack of clarity, while other strategies may have been revised since the initial inception and dissemination of the Cancer Plan.

Figure 5 illustrates the overall combined status of strategies (N=143) for all workgroups and task forces completing the activity-monitoring tool: Data and Surveillance, Early Detection, Colorectal Cancer, Palliative and Hospice, Rehabilitation and Survivorship, Skin Cancer, and Treatment. The figure reflects the 143 strategies that represent 56% of the total Cancer Plan strategies (254) which were tracked through the AMT process in 2008. The other 111 (44%) strategies were tracked by individual stakeholders and partners either electronically or via a paper tool.

From the AMT collection activities with workgroups, 64% of their strategies were fully achieved and 11% were partially achieved. Thus, 75% of workgroup-tracked strategies were at least partially achieved which is five percentage points away from reaching the Consortium's implementation objective of 80% (Objective 17.1, Maine Comprehensive Cancer Control Plan 2006-10). Given this is the end of Year 4 of the plan, it can be anticipated that more strategies will move to the fully achieved category during the final year of the plan.

Figure 5: *Progress of Strategies for All Workgroups (56% of all strategies)*

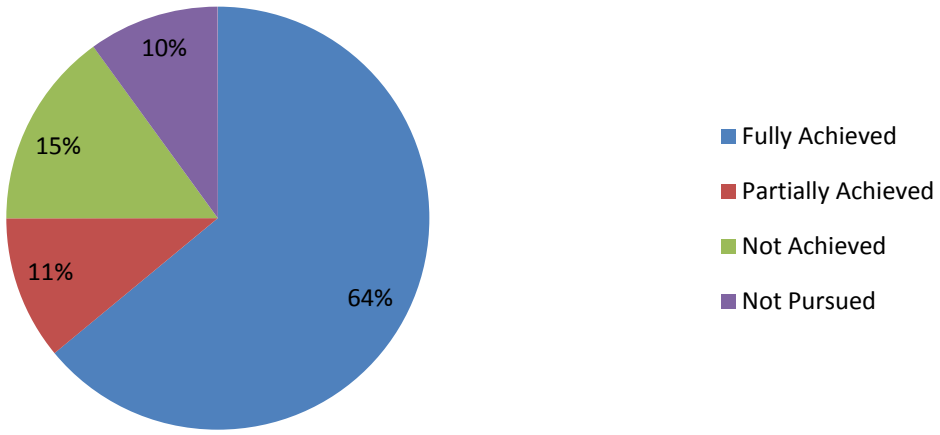


Figure 6 illustrates the overall combined status of all other strategies (N=111) that were also measured via an AMT activity. For this 44% of Cancer Plan strategies, 44% were reported as fully achieved and 32% were partially achieved. Thus, another 76% of non-workgroup-tracked strategies were at least partially achieved, and again this percentage is only four percentage points off the 2010 implementation objective. And finally, Figure 7 represents overlaying Figure 5 and Figure 6, i.e. status of all strategies tracked in 2008 (both workgroup and individual stakeholders and partners).

Figure 6: *Progress of Strategies tracked by Individual Stakeholders and Partners (44% of total strategies)*

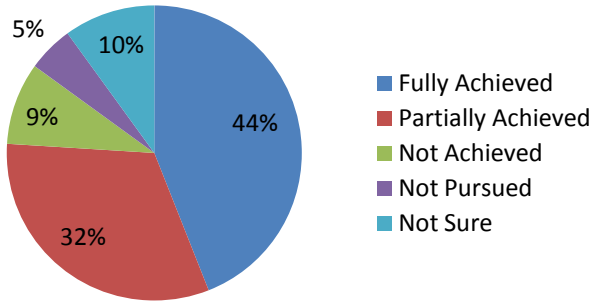
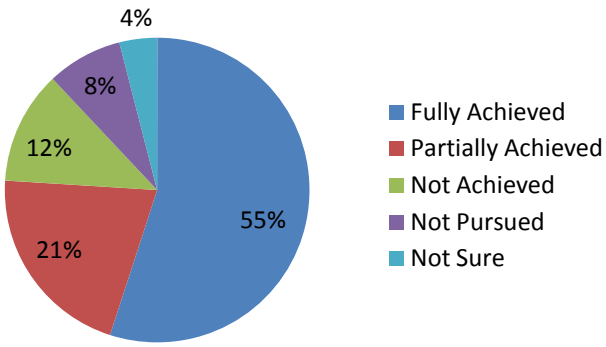


Figure 7: *Progress of Strategies Reported by ALL sources (100% of strategies)*



The overall 254 strategies tracked through the AMT efforts in 2008 are broken down by status of work on the strategies in Table 2. Although Skin Cancer and Colorectal Cancer strategies are very much prevention and early detection focused, in the AMT process they are not listed in those goal areas as they are in the Cancer Plan. Instead they are listed separately by their

workgroup or task force when recording their activities. The table below also includes an indication of what tool was used during 2008 AMT data collection.

Table 2: *Summary of Strategy Status for All Work Groups & Goal Areas*

	Unduplicated	Status				
Workgroups/Goal Areas	**Strategies**	Fully Achieved	Partially Achieved	Not Achieved	Not Pursued	Not Sure
Cancer Disparities	**17**	**3** ***(18%)***	**8** ***(47%)***	**3*(17.5%)***	**3*(17.5%)***	**0**
Primary Prevention**	**81**	**34** ***(42%)***	**28** ***(35%)***	**4** ***(5%)***	**4** ***(5%)***	**11** ***(13%)***
Tobacco Use	28	21	6	0	1	0
Overweight/PAN	15	3	10	0	2	0
Oral Health	5	1	2	1	0	1
Sexual Health	13	2	6	1	1	3
Environmental Health	20	7	4	2	0	7
Early Detection*	**25**	**15** ***(60%)***	**5** ***(20%)***	**2** ***(8%)***	**3** ***(12%)***	**0**
Breast Cancer	11	8	1	0	2	0
Cervical Cancer	7	3	2	2	0	0
Prostate Cancer	4	3	0	0	1	0
Genetics	3	1	2	0	0	0
Colorectal Cancer	**6**	**4** ***(67%)***	**0**	**0**	**2** ***(33%)***	**0**
Skin Cancer**	**24**	**21** ***(88%)***	**2** ***(8%)***	**0**	**1** ***(4%)***	**0**
Treatment*	**16**	**8** ***(50%)***	**1** ***(6%)***	**0**	**7** ***(44%)***	**0**
Rehabilitation & Survivorship***	**19**	**8** ***(42%)***	**2** ***(11%)***	**9** ***(47%)***	**0**	**0**
Palliative and Hospice Care	**34**	**23** ***(68%)***	**4** ***(12%)***	**7** ***(20%)***	**0**	**0**
Data and Surveillance	**13**	**8** ***(62%)***	**2** ***(15%)***	**3** ***(23%)***	**0**	**0**
Implementation	**12**	**11** ***(92%)***	**0**	**1** ***(8%)***	**0**	**0**
Evaluation	**7**	**5** ***(71%)***	**0**	**2** ***(29%)***	**0**	**0**
Total	**254**	**140 (55%)**	**52 (21%)**	**31 (12%)**	**20 (8%)**	**11(4%)**

Notes.

*Workgroup members met with MCPH evaluator to complete the AMT

**Workgroup members and key stakeholders completed an electronic version of the AMT

*** Workgroup members met with MCPH evaluator and also had the option to complete an electronic version of their workgroup AMT.

Changes from 2007 AMT Process

In addition to the changes this year in how Cancer Plan implementation activities were monitored, there were also significant changes in the amount of activities moving towards completion. Among the noteworthy changes are the following:

- Between 2007 and 2008 the number of "Fully Achieved" strategies rose by 19%, and the average rate of increase in the fully achieved category for each workgroup or goal area was 19.7% with a range of 6% (for Cancer Disparities strategies) to 40% (for Early Detection strategies).

- Only one set of strategies (Palliative and Hospice Care) remained unchanged over the year in terms of the achievement levels (fully, partially, and not) with 68% of strategies being fully achieved.

- Two goal areas exceeded the Cancer Plan goal (80% achievement of strategies) in 2008. Implementation increased its fully achieved category by 17% to reach a total of 92% of its strategies being fully achieved as of 2008. The Skin Cancer Workgroup reported an increase of 17% also in the fully achieved category to move that set of strategies to 88% fully achieved as of the 2008 AMT process.

- Overall 76% of the 254 strategies have been either fully or partially achieved which would suggest that at the current pace, workgroups and key stakeholders should reach the Cancer Plan goal of implementing 80% (fully or partially) of the strategies in the current cancer plan by 2010.

Cancer Plan Implementation Accomplishments, Strengths and Challenges

Accomplishments

As part of the AMT process, workgroups were asked to identify the accomplishments, strengths and challenges of implementing strategies. Commonly shared accomplishments among workgroups include:

- increased visibility of a key issue;
- partnership development;
- extensive education and training;
- public relations initiatives;
- secured funding and resources; and
- passage of legislation.

As Appendix A reflects, the workgroups and key stakeholders listed several accomplishments that occurred over the past year that contributed to the successful implementation of Cancer Plan strategies. While that list is too long to include here, the many activities and accomplishments within the various goal areas, when taken in concert with accomplishment from previous years, show a strong and steady commitment to reducing the burden of cancer in Maine.

Strengths

A review of strengths for all strategies combined revealed several consistent themes. The most commonly noted strength was the dedication and knowledge of workgroup members. Additionally, most workgroups mentioned collaborations with organizations represented on the workgroups as a significant strength, e.g., the American Cancer Society, the Maine Hospice Council, the Office of Minority Health, and the Healthy Maine Partnerships. Finally, a number of workgroups were able to secure funding to help them accomplish their work, which over the last year has grown increasingly difficult as public health budgets are consistently reduced.

Challenges

For strategies that have not been achieved or in some cases not pursued, there are a variety of challenges that have prevented completion. While some challenges faced by the workgroups are specific to their unique objectives and or the specificity of the activities in which they engage, there are some challenges that appeared repeatedly during the AMT process.

The most common challenge for all of the workgroups was the lack of time to give to the work required to realize the strategies. Due to the volunteer nature of the Cancer Consortium, the limited time members can devote to implementation of the Cancer Plan was noted as a consistent challenge. Also, available funding, specifically in terms of federal and state funds was raised as a barrier to implementation.

Other more general challenges identified include lack of available and timely data, availability of appropriate race and ethnicity data, small samples for disparity analysis, and geographical barriers in Maine. Lastly, there were some systemic issues that arose which members felt were bigger than their individual workgroup, and thus felt unable to address. For example, the Treatment Workgroup identified as an emerging challenge the lack of insurance coverage for orally (versus in intravenously) administered chemotherapy.

Conclusions

Heading into the final year of the Cancer Plan, one focus of the workgroups and key stakeholders will be on developing new goals and objectives for the 2011-2015 plan. The 76% achievement success rate of the current plan will help inform the planning process for the new plan. Building on the strengths and accomplishments of the current plan can provide direction for activities and initiatives needed over the next five years to continue the present momentum levels.

Out of the 2008 AMT process, two areas for improving the next AMT tool for the new plan were identified. First, in the “Not Pursued” strategies category are a handful of strategies that were not assigned to the most appropriate priority area. Unfortunately, these strategies were simply overlooked instead of reassigned. However, in the planning of the AMT for the 2011-2015 plan, it might be worthwhile to develop a structured process for strategies to pass from one priority area to another when appropriate.

Secondly, the need to include some rating category for strategies that are by design on-going processes was identified. Presently most of those get recorded in the Partially Achieved category even if achieving an on-going status is truly the success. Another recommendation

might be to adapt the tool to evaluate only objectives rather than all the specific plan strategies. Because individual strategies can change for a variety of reasons during the 5-year life span of the plan, designing measurable objectives to evaluate could account for the on-going nature of certain strategies and activities.

Cancer Consortium Findings: 2008 Membership Survey

The Maine Cancer Consortium Membership survey was administered via Survey Monkey in November and December of 2008. Forty-five responses were collected and provided data in all seven sections of the survey. The following is a summary of the data provided by respondents.

I. Demographics of Respondents

As the attached contact list of names (Appendix B) indicates, all forty-five of the respondents were willing to give their names and contact information. Seventeen (37.8%) of the respondents identified themselves as being in the Hospital/Health Care sector and another nine (20%) were from the Non-Profit sector. The remaining sectors were represented anywhere from 2.2% (one respondent) to 11.1% (5 respondents). In the "Other" category three respondents identified Healthy Maine Partnership as their sector, which although not technically a sector, may be a category to be added to "Community-based organization" sector in subsequent surveys. School and Insurance were the remaining two sectors identified in the "other" section. Table 3 reflects professional sector of survey respondents.

Table 3: *Membership Survey Respondents' Professional Sector*

Answer Options	Response Percent
State Program	8.9%
Professional Association	4.4%
National Society	2.2%
Non Profit	20.0%
Academic/University System	4.4%
Business/Industry	2.2%
Hospital/Health Care	37.8%
Community-based organization	8.9%
Other (please specify)	11.1%

Reflecting Maine's larger population dynamics, 97.7% (or 43 of the 44 respondents who answered question #3) identified "White/Caucasian" as the racial group to which they belong. In reference to the geographic part of the state they represent, 38.1% (16 respondents) identified District #4 (Central Maine), 26.2% (11 respondents) identified District #7 (Cumberland), and while all of the other Districts except District #3 (Downeast) had at least one respondent, District #6 (Mid Coast) was the only other district to reach a two-digit percentage — 14.3% (6 respondents). So, while an electronic survey format allows geography to have less of an impact on results, it appears that the response rate decreased the further away from Maine's capitol one gets. Table 4 reflects Public Health Districts for survey respondents.

Table 4: *Membership Survey Respondents by Public Health District*

Answer Options		Response Percent
District 1	Aroostook	9.5%
District 2	Penquis	4.8%
District 3	Downeast	0.0%
District 4	Central Maine	38.1%
District 5	Western Maine	2.4%
District 6	Mid Coast	14.3%
District 7	Cumberland	26.2%
District 8	York	4.8%

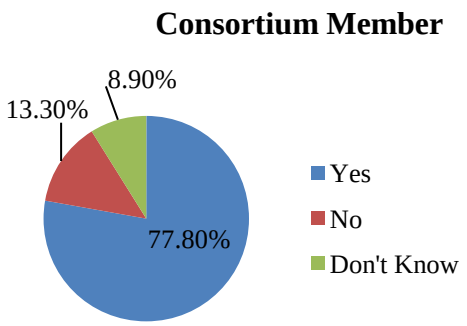
II. Consortium Membership

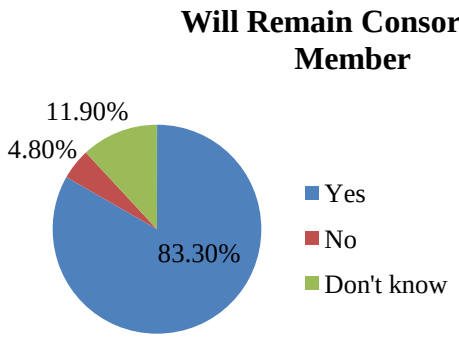
A. Membership Status

The bulk (77.8%, or 35 of 45) of the survey respondents identified themselves as a member of the Cancer Consortium. Only six respondents (13.3%) did not identify as Consortium members and the remaining four respondents (8.9%) didn't know if they were members or not. Six out of the ten non-member respondents (60%) answered question #6 concerning their interest in becoming a Consortium member and one third (2 respondents) indicated an interest in becoming a member. However, half (3 respondents) indicated that they would like to receive Consortium updates even if not a formal member of the Consortium.

Finally, in reference to remaining a Consortium member, most (83.3%) of the respondents to this question (42) answered "Yes" to this question, two (4.8%) answered "No," and five (11.9%) indicated they "Don't Know." The one reason shared for a change in membership status was, "*I have changed positions in this network.*" Figure 8 reflects the current and future membership status of survey respondents.

Figure 8: Current/*Potential Consortium Membership Status of Survey Respondents*

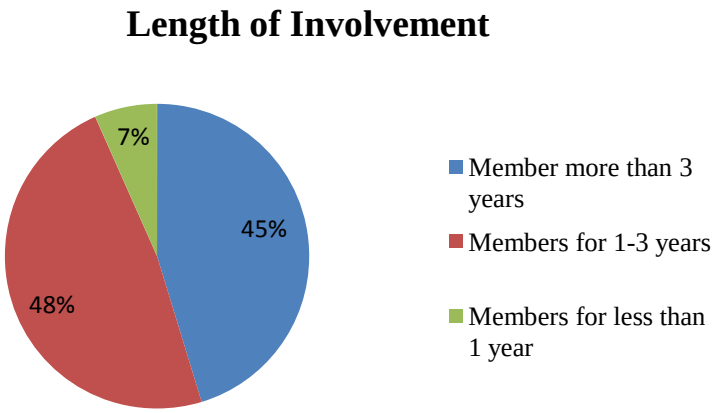




B. Dynamics of Involvement

The series of questions that addressed the details of membership involvement revealed that in terms of ***length*** of involvement, for the 35 respondents who identified as a Consortium members, close to half (45.71% or 16 respondents) have been members for more than three years. Further, another half (48.57% or 17 respondents) have been members for one to three years, and only two (6.71%) have been Consortium members for less than a year. Figure 9 reflects the length of Consortium involvement for survey respondents.

Figure 9: *Length of Involvement with Consortium for Survey Respondents*



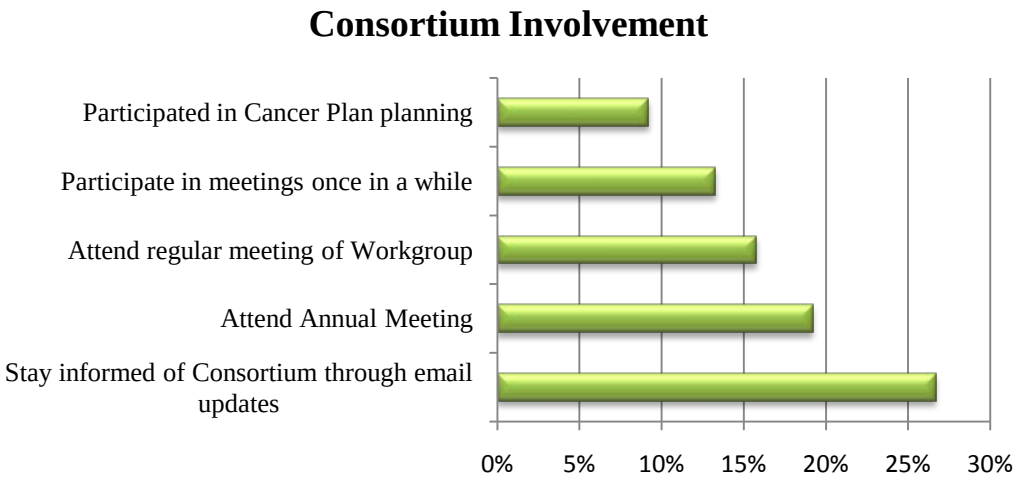
In reference to the ***type*** of involvement with the Consortium, forty-two of the forty five respondents answered this question and provided 48 responses, i.e. some respondents checked more than one category for this question. Thus, for describing one's representation in the Consortium, 50% (*n*=48) of respondents indicated involvement through their profession, 37.5% indicated they were a representative of their organization in the Consortium, 8.3% indicated individual/personal involvement, and 4.2% indicated "Other."

The last set of membership involvement questions concern the ***level*** of membership involvement. "How involved in the Consortium" on a scale from one (Not at all involved) to five (extremely involved) reveals that for the forty-two responses this question garnered, the rating average (2.86) falls just below the medium value point on the scale (3.0). Roughly a quarter of the respondents (11) identified their level of involvement at a 3 on a five point scale and another quarter (11) identified at a 2 on the scale. That said, since only 35 respondents identified themselves as members, the seven who checked "Not at all involved" are most likely not Consortium members. Thus, when we remove the non-members from the results, a more accurate average rating of 3.29 is reflected for Consortium members. This puts the average level of involvement just above the "Somewhat Involved" mid-point of the scale.

Probably of more significance are the responses to the follow-up questions to how they are involved in the Consortium, i.e. a question on how they stay involved, and a question soliciting suggestions on ways to become more involved in the Consortium. All listed options for how

one stays involved in the Consortium received at least 2 responses from the 42 respondents (3 people skipped this question). Because the questions ask respondents to check all the ways they stay involved, the 42 respondents tallied 120 responses. Figure 10 reflects the top five (84.2% of total responses) ways of keeping involved in the Consortium.

Figure 10: *Staying Involved with the Consortium*



Participation in legislative efforts got 8 responses and all other categories got 2 or 3 responses. Under the "other" category the written remarks included the following:

- ✓ *A member of my staff participates on a workgroup*
- ✓ *New to the job would like to get involved*
- ✓ *Have tried to get involved if kids could be included, otherwise this is not applicable to what I do in my work*

In terms of the second follow-up question asking for "suggestions for ways you can become more involved in the Consortium," fifteen people answered this question (30 respondents skipped this question). The key written responses include:

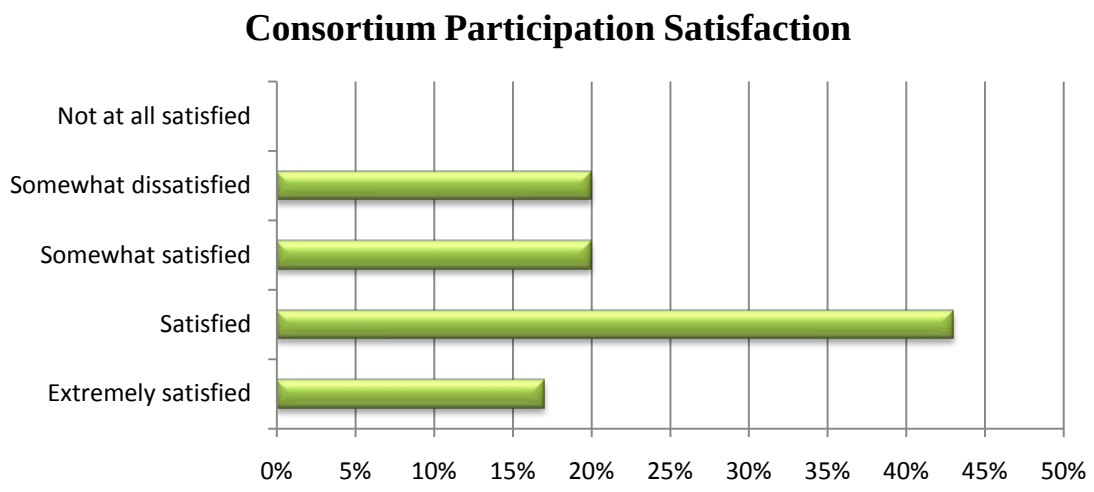
- ✓ *Get membership from the Southern Maine and Northern Maine chapters of the Oncology Nursing Society*
- ✓ *At the last Treatment group meeting we talked of looking at where Maine is today with the management of cancer pain. This would involve several focus groups - further discussion to occur at lunch at the annual meeting. The whole area of symptom management (Palliative Care) regarding the cancer patient as this occurs throughout their cancer journey from diagnosis to treatment to survivorship to end of life. It is an important component of Quality of Life for all cancer patients.*
- ✓ *Email me when news occurs, opportunities occur...direct me to the website to get info that is new etc.*
- ✓ *I was recently acquainted with the NCI Cancer Control PLANET which has a wealth of evidence-based programs that we should tap into, for prevention anyway!*

C. Satisfaction with Involvement

The survey included a question that asked members to rate their level of satisfaction with their Consortium participation, and further, to explain their answer. While 39 people responded to this question, there were only 25 written comments explaining their ratings. Once again a five point scale was utilized, with 1 being "not at all satisfied" and 5 being "extremely satisfied." As with the previous rating scale, four of the responses fell in the 1 category and are most likely the non-member responses since we have only 35 members in our cohort and this question got 39 responses (6 people skipped this question).

So once we remove the four non-member responses the average rating moves from 3.3 (when all 39 responses included) to 3.6 (for only members), which falls slightly above the 3.0 "somewhat satisfied" medium on the scale. Fifteen (43%) of the member responses registered at 4 on the scale, fourteen (40%) registered a 2 (7) or 3 (7) on the scale, and six (17%) were "extremely Satisfied" (5 on the scale). Figure 11 reflects the levels of satisfaction with Consortium participation as recorded by survey respondents.

Figure 11: *Consortium Participation Satisfaction for Survey Respondents*



In reference to the written explanation for the ratings the following remarks were included in this question:

- ✓ *I enjoy the work that I do with both workgroups that I participate in. The work that we do is extremely important.*
- ✓ *All is fine.*
- ✓ *There's so much to be done but it's challenging when you have a demanding full time job to set aside time for MCC efforts.*
- ✓ *I appreciate invitations to the meetings and the access to materials and updates.*
- ✓ *I would like to become more involved with statewide initiatives.*
- ✓ *Cancer is only one initiative under our umbrella. It takes everything we have to do the local work.*

III. Workgroup Membership

The survey contained three questions addressing Workgroup membership. For the three questions, 24 of 43 responses (55.8%) responded "Yes," 16 (37.2%) responded "NO," and 3 (7%) responded "No, but would like to be." The one comment on this question was: "*none of the workgroups relate to kids, so no.*"

The length of Workgroup membership garnered 25 responses, with two of those responses in the "Other" category with the following specifications: "*N/A*" and "*new on rehab, 3+Prevention, formerly Skin Cancer.*" Thus, for the 23 Workgroup members who responded to the four duration choices (i.e. removing the "Other" category responses), the majority (60.9% or 14) have been Workgroup members for one to three years, 30.4% (7) have participated in a Workgroup for over three years, 4.3% (1) has been involved for "less than a year", and 4.3% (1) was "not sure."

In reference to the particular Workgroups to which respondents belong, the total options garnered 31 responses for the 24 respondents who answered the question (21 respondents skipped the question as they do not belong to a workgroup), which reflects that some respondents belong to multiple workgroups. Workgroup membership was identified in the following numbers with percentages calculated on a total of 31 responses:

Rehabilitation/Survivorship	6 responses or 19.4%
Prevention	4 responses or 12.9%
Treatment	4 responses or 12.9%
Skin Cancer	4 responses or 12.9%
Early Detection	3 responses or 9.7%
Colon Cancer Task Force	3 responses or 9.7%
Palliative Care/Hospice	3 responses or 9.7%
Data/Surveillance	2 responses or 6.5%
Communication	2 responses or 6.5%

IV. Consortium Website

The survey included three questions about utilization and usefulness of the Maine Cancer Consortium website. When asked if they had visited the website 50% (22 responses) said "yes" and 50% said "no" (one respondent skipped this question, so there were 44 responses overall). In terms of how likely they are to use the website, on a scale of 1 ("not at all likely") to 4 ("extremely likely") the average rating for the 44 respondents was 2.64 with "somewhat likely" getting 20 responses and "likely" getting 17 (37 of the 44 responses). And finally, when asked how we might improve the website, only 2 respondents answered and their comments were: "*Provide regular updates of workgroup activity and links to related information;*" and "*more details on the workgroups – more links to additional resources specific to the workgroup.*"

V. Cancer Plan

The four questions relevant to the Maine Cancer Plan revealed that more than half (57.1% or 24 responses) of the 42 respondents (3 skipped this question) were not involved in developing or revising the current Cancer Plan. Seventeen (40.5%) were involved and one (2.4%) respondent checked "don't know."

The first of two questions on the utilization of the Cancer plan asked "how you use" the plan and asked respondents to check all appropriate options. While only 31 respondents answered the question (14 skipped this question), they indicated 48 ways they use the plan, and Table 5 reflects the ways in which respondents use the Cancer Plan.

Table 5: *Respondents Use of Cancer Plan*

Ways in which respondents use the Cancer Plan	**Number of Responses (*N=31*)**	**Percentage of Responses**
Use it as a basis for initiating or advocating for new activities	13	27.1%
My organization contributes to the implementation of the plan	13	27.1%
Use it as input into the planning process in my organization	8	16.7%
Use it in my work often	7	14.6%
Other	7	14.6%

The second question on utilization of the plan asked "which portion" of the plan they implement through their work or organization. Once again, it was requested that they check all options that apply to their work/organization and thus, while only 38 respondents answered this questions, they provided 150 responses. The most frequently checked options were Breast Cancer Early Detection and Prevention, which each received 17 (11.3%) responses. Early Detection and Cervical Cancer Early Detection each got 14 (9.3%) responses and Skin Cancer Prevention received 13 (8.7%) responses. The last option to register double digit responses was Colon Cancer Prevention, which got 10 (6.7%) responses. On the lower end of responses, Disparities and Hospice/Palliation each got 3 responses and the remaining options each got between 7 and 9 responses. Seven respondents identified that they do not implement the plan through their work/organization.

The final question on the Cancer Plan asked respondents if they would be willing to report on objectives and strategies (of the plan) their organization has achieved or implemented. Twenty-eight people answered this question (17 skipped this question) and of those 20 (71.4%) responded "yes" and 8 (28.6%) responded "no".

VI. Cancer Consortium

The survey attempted to determine both the level of satisfaction with the Cancer Consortium's performance and areas of growth for the Consortium. In terms of the respondents satisfaction with the various functions/responsibilities of the Consortium, a rating scale of 1 (not at all satisfied) to 5 (extremely satisfied) was provided for eleven key aspects of the Consortium's

work. The average rating for each component indicated that the 39 respondents (6 people skipped this question) were at least somewhat satisfied with all aspects and were most satisfied (4.25 on a scale of 5) with Consortium leadership (strength and competence), its contribution to the health and well-being of Maine (4.10), and its progress in meeting its objectives/strategies (4.00). The lowest average rating of 3.29 was for the clarity of roles aspect, however, that rating does fall above the mean on the scale (3.0). Table 6 Reflects levels of satisfaction with Consortium.

Table 6: *Consortium Member Satisfaction*

Consortium Function/Responsibility	**Rating (1-5 with 3.0 mean)**
Consortium leadership	4.25
Contribution to Maine's health and welfare	4.10
Meeting objectives/strategies	4.00
Effective advocacy capacity	3.84
Willingness of members to take leadership roles	3.80
Participation of key influential people	3.69
Communication among members	3.63
Efforts in providing funding for community efforts	3.48
Efforts in getting funding	3.46
Use of media to promote awareness	3.40
Clarity of roles	3.29

The two questions concerning areas of growth for the Consortium focused on how to increase and/or diversify membership of the consortium, and topic areas the Consortium might address. Ten respondents answered the question on expanding/diversifying membership (35 respondents chose not to answer this question) and most provided suggestions for areas of recruitment, including legislators, physicians, PAs, Oncology healthcare providers, and patient or family representatives.

The question concerning topic areas that the Consortium might address more often received eight responses (37 declined to answer this question), with two topics being identified more than once – Survivorship (3) and physician involvement (2). Among the comments provided was:

> "*Quality of Life issues for cancer survivors. This extends from diagnosis to treatment to survivors to end of life. Pain management, symptom management (fatigue, nausea, mucositis, sexual dysfunction, fertility problems, many more), psychosocial issues, access issues not only to treatment but also those issues which define Quality of Life. Encouraging more people/healthcare providers to specialize in Oncology."*

VII. Additional Comments

The last section of the survey provided the opportunity for respondents to give any additional comments they had about the Consortium and or the membership survey they just completed. Ten respondents chose to answer this question and their remarks ranged from "*The Consortium is an impressive group of proactive members who continue to demonstrate commitment and enthusiasm for the state initiatives,"* to *"I think there needs to be better communication between the Consortium and its members."*

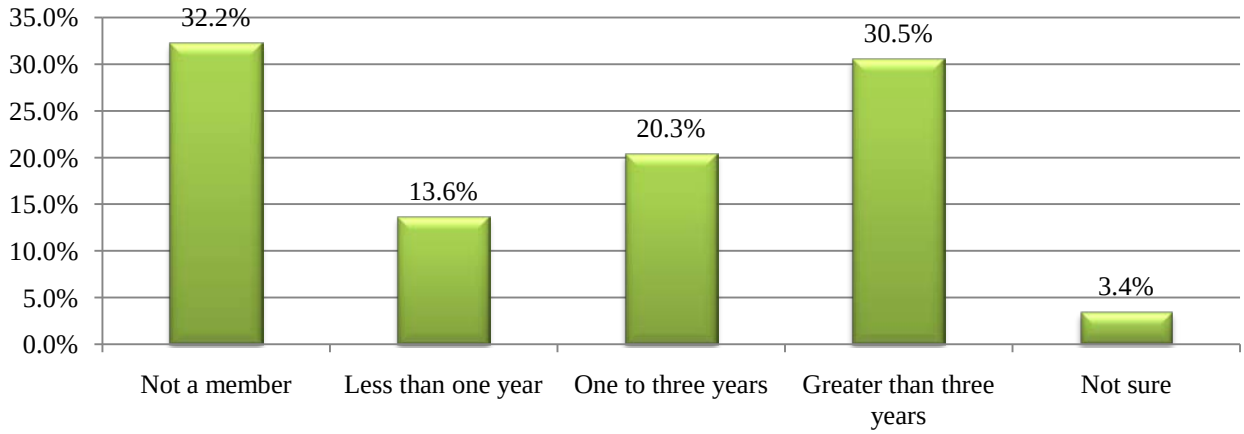
Additional Consortium Findings: Annual Meeting Results

The Maine Cancer Consortium held its annual meeting November 18, 2008 with the primary purpose of discussing the progress of and plans for the continuing implementation of the 2006-2010 Comprehensive Cancer Control Plan. Fifty-nine annual meeting attendees returned evaluation surveys distributed at the meeting. The purpose of the survey was to capture audience characteristics and attendees' feedback regarding the meeting goals and the keynote address. The findings are summarized below.

Participant Characteristics

A total of 59 attendees returned evaluation surveys. Almost two thirds of the participants (64%) were members of the Consortium and about half of those (31%) had been involved in the Consortium for three years or more. Participants' length of involvement in the Consortium is presented in Figure 12.

Figure 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/Task Forces of the Consortium. These responses of Consortium members only (*n* = 38) are summarized below in Table 3. It should be noted that some members belong to more than one group resulting in more than 100% total in Table 7.

Table 7: *Annual Meeting Consortium Members' Type of Involvement*

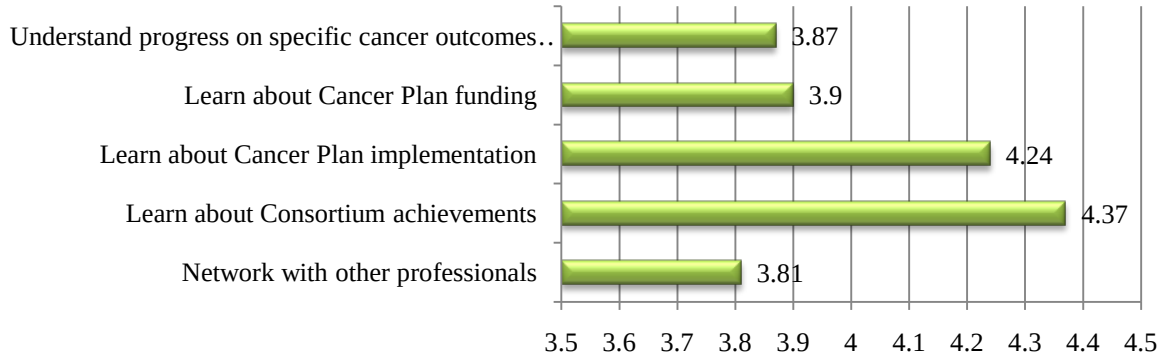
Consortium Group	Percent Involved
Skin Cancer Task Force	21.05%
Colon Cancer Task Force	18.42%
Rehabilitation & Survivorship Workgroup	18.42%
Board of Directors	15.79%
Early Detection Workgroup	15.79%
Data/Surveillance Workgroup	10.53%
Treatment Workgroup	7.89%
Hospice & Palliation Workgroup	5.26%
Primary Prevention Workgroup	5.26%
Communication Workgroup	2.63%
No involvement in groups	7.89%

Feedback on Meeting Organization and Goals

Using a 5-point scale, (1 = very poor; 5 = excellent) participants rated how well the meeting was organized. The average ratings for the organization, registration, facilities and value of meeting ranged from 4.25 to 4.63.

Participants also rated how well the meeting goals were achieved. All of the goals were rated high with an average rating of 4.04. As shown in Figure 8, participants rated the opportunity to learn about the Consortium's achievements and Cancer Plan implementation the highest. Issues related to networking with other professionals, and the funding of the Cancer Plan, were rated slightly lower. These findings suggest only minor improvements could be made in order to reach the meeting goals. The average participant ratings of the meeting goals are summarized in Figure 13.

Figure 13: *Average Ratings of Annual Meeting Goals*



Additional Feedback

Using a 5-point scale (1 = not at all relevant; 5 = very relevant) with "NA" option, participants were asked to rate the meeting's relevance to their work. The average relevance rating was 4.06, which does not include the ten" NA" responses, indicating the meeting was relevant to participants' work. When asked to explain, respondents described how the information could be applied to their work. For example, participants noted:

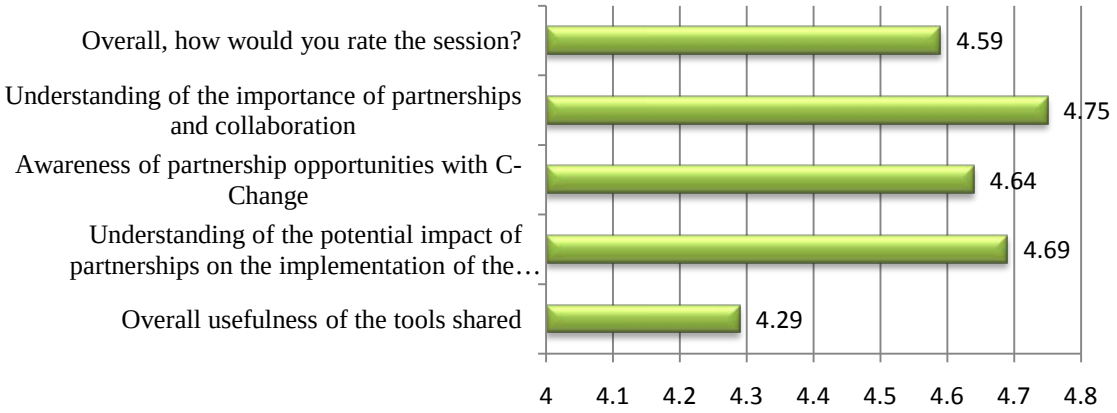
- "*Multidiscipline cooperation is hugely important for me – I can't get any work done without encouraging this. The Maine Cancer Consortium seems to be a driving force behind this cooperation.*"

- *"Even though I work in a field specific to 2 types of cancer it was useful and helpful to hear about other cancer efforts in the state. As the keynote said - we need to be one voice."*

Keynote Speaker

The keynote address was given by Tom Kean of C-Change. Using a 5-point scale (1 = poor; 5 = excellent) respondents rated the presentation in terms of its learning objective to increase participants' knowledge of partnership and collaboration, partnership opportunities with C-Change, and the role of partnerships in the implementation of the Cancer Plan. All of the objectives were given an average rating of 4 or over with an average of 4.59 for the five questions, indicating the session did well in achieving its objectives. Figure 14 summarizes these findings.

Figure 14: *Average Ratings of Annual Meeting Keynote Speaker*



As the previously presented survey results indicate, the 2008 Annual Cancer Consortium meeting not only met its objectives, it was an engaging and useful day for the attendees. The keynote speakers theme of collaboration and partnerships resonated with participants and survey comments indicate that his message was timely. Overall, attendees value the annual meeting as an opportunity to learn about the various cancer activities taking place across the state and to use that information to further their own work.

Results Part II: Implementation

2008-2009 Program Accomplishments

Maine's Comprehensive Cancer Control Program (MCCCP) is in its second phase of implementation. In 2002 and then again in 2007, the Program was successful in obtaining a 5-year implementation grant from the United States Centers for Disease Control and Prevention. MCCCP was and remains successful in achieving the objectives of the grant and in implementing the 5-year Cancer Plan. As noted in previous reports, since the Program's inception there have been a number of notable accomplishments. These accomplishments, organized by program area, include, but are not limited to:

Overall Implementation

- Recognized by legislature as a state program.
- Received 5-year federal funding in the amount of $1,275,000 for Program Implementation from the Centers for Disease Control and Prevention for 2007-2012.
- Received 5-year federal funding for both Colorectal Cancer ($180,000 per year) and Skin Cancer ($55,000 per year) prevention projects.
- Successful in competing for five year CDC Colorectal Cancer Control Program Grant ($4,250,000).
- Leveraged $62,366 in in-kind contributions from Maine Cancer Consortium members and staff during 2008-2009 fiscal year.
- Leveraged $20,000 in direct contribution to implementing the Maine Cancer Plan from partners during 2008-2009 fiscal year.
- Provided significant staff support to the Maine Cancer Consortium, individual workgroups, and the Board of Directors.
- Sponsored and organized Maine Cancer Consortium Annual Meeting.
- Sponsored and organized Maine Cancer Consortium Board Retreat.
- Awarded mini-grants totaling over $160,000 to advance colorectal cancer screening awareness efforts to the Healthy Maine Partnerships.
- Provided mini-grants of $2000 to four Native American Tribes to address skin and colon cancer in their respective communities.
- Provided technical assistance to Care Model efforts by the Healthy Maine Partnerships.
- Awarded $21,000 in mini-grants to the Consortium Workgroups to assist with implementations of their work plans.
- Presented Skin Cancer and Colorectal Cancer abstracts at the 2009 National Comprehensive Cancer Control Program Business Meeting in Atlanta in April 2009.
- MCCCP also participated on a panel discussion of CDC Optional Funds at the 2009 National Comprehensive Cancer Control Program Business Meeting in Atlanta in April 2009.

Colorectal Cancer Prevention Activities

- Provided 15 mini-grants to Healthy Maine Partnerships to implement projects addressing barriers to colorectal cancer screening.
- Distributed materials (Fact sheets, Posters, Bookmarks and Community Action Kit) to Maine's communities.
- Updated and distributed Community Resource Guide to 50 Healthy Community Coalitions statewide.
- Included colon cancer question on the 2009 *Behavioral Risk Factor Surveillance System* (BRFSS) in Maine.
- Created and distributed postcard announcing new legislation mandating insurance to cover colorectal cancer screening.
- Distributed the following materials to hospitals, Native American Tribes, community organizations and individuals:

    - 5,850 Fact Sheets
    - 1,900 Bookmarks
    - 162 Posters
    - 1050 Postcards

Skin Cancer Prevention Activities

- MCCCP awarded twenty-four $1,000 mini-grants to facility-based childcare centers across Maine to support skin cancer prevention and sun safety activities.
- Training was provided to 43 childcare centers and 75 centers received *Sun Blocks* Sun Safety Program materials.
- Successfully implemented *Sun Blocks* program in its pilot phase.
- Included skin cancer questions on the Maine Child Health Survey (in which includes Youth Risk Behavior Survey).
- Released winter sun safety awareness press release in February 2009.
- Held an annual 2009 "*Protect the Skin You're In Day"* in the summer at the Portland Sea Dog's baseball game. Provided packets of sunscreen to people attending the baseball game.
- Distributed 125 Sun Safety Kits to Maine Parks and Recreation Departments.

Program-Sponsored Initiatives: Evaluation Results

Skin Cancer Initiatives

Skin cancer is the most common form of cancer, but it is also one of the most preventable. Most skin cancers are caused by too much exposure to the sun's harmful ultraviolet (UV) rays, especially during childhood and adolescence. Teaching young children how to protect their skin from the sun, and creating environments to support these positive behaviors, can immediately result in reduced exposure to harmful UV rays, as well as the future development of healthy, life-long skin protection habits. The MCCCP and the Consortium's Skin Cancer Workgroup provided direction and support for three key childhood skin cancer prevention programs in 2008-2009. Because repetition is the key to learning, this partnership believes that skin cancer prevention efforts must cover the gamut of ages. Starting from birth, it is useful to continually reinforce the sun protection messages that these three programs expound. The next three sections of the program evaluation results reflect these age-specific and successive sun safety programs.

No Sun for Baby Program

Background

The *No Sun for Baby Program* (NSFB) is a sun protection educational program for parents of newborns administered by hospitals across the state of Maine. Through a mini-grant process administered by the Maine Cancer Consortium's Skin Cancer Workgroup, and in close partnership with the Melanoma Foundation of New England (MFNE), hospitals receive funds to distribute Sun Safety Kits to parents of newborns as they leave the hospital. The kits include sun safety educational materials and sun protection items such as baby sun hats. The goal of the program is to increase parents' awareness of sun protection methods for babies in order to decrease the rise of skin cancer later in life. The program also gives hospitals the opportunity to provide education to their staff concerning skin cancer and sun safety for newborns.

This Final Evaluation Report reflects the third year (2008) of grant funds awarded by the Melanoma Foundation of New England to twelve hospitals with a birthing unit. Since being piloted in 2002-2003, the NSFB program has been implemented in twenty such hospitals across Maine, and the past evaluations of those programs have been positive and supported the continuation of the program. In past years the success of the NSFB program has been measured by the following indicators, which will again serve as the framework for the 2008 evaluation:

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. The number of hospitals with birthing units in Maine that have implemented the Program; and
5. Feedback from hospital staff on the Program.

Design & Methodology

In 2008, as in earlier years, four tools were utilized to measure whether these indicators of success were achieved. Those tools included:

- ✓ Hospital pre-survey forwarded to the Maine Center for Public Health (MCPH) evaluator at the time of grant award;
- ✓ Hospital post-survey forwarded to the MCPH evaluator at the completion of grant activities;
- ✓ Parent survey, included in the Sun Safety Kit or given to parents as they left the hospital;
- ✓ Hospital final grant report submitted to the Skin Cancer Workgroup upon completion of the grant activities and funds

In the spring of 2008, all data was collected by MCPH evaluators. Thus, by April the MCPH evaluators had the following data sets to draw on for analysis of the 2008 program in order to determine how well this year's grant program met the above indicators:

- ✓ 73 parent surveys (Appendix C)
- ✓ Eleven hospital pre-surveys (Appendix D)
- ✓ Nine hospital post-surveys (Appendix E)

Evaluation Results

Indicator #1: The number of new parents who receive information about sun safety is tracked through both the number of parent surveys that get completed and return to MCPH, and question #1 on the hospital survey ("How many new parents received information about sun safety for their newborn from your hospital?").

- ✓ Parent data source: 73 parents received information
- ✓ Hospital data source: 3,319 for the six hospitals who answered this question numerically, the other 3 answered "*everyone delivering,*" "*not certain,*" and "*we did hand out pamphlets in June and July in our classes.*"

Indicator #2: The number of new parents who intend to follow sun safety precautions as a result of participating in the Program is tracked through questions 3, 4 and 5 on the parent survey. Responses to the three questions indicate that 97% of parents answering those questions (response rate for question 3 was 71, for 4 was 72, and for 5 was 73) will likely or very likely use a sun hat, use sun protective clothes, and keep their child out of the sun. The other 3% indicated that they are somewhat likely to engage in these behaviors, and no parents indicated that they were not at all likely to engage in these sun protection activities.

Indicator #3: The number of Sun Safety Kits distributed is tracked through question 2 on the hospital survey ("How many Sun Safety Kits were distributed?"). For the nine hospital surveys a total of 2,158 kits were distributed.

Indicator #4: The number of hospitals with birthing units in Maine that have implemented the Program is tracked through the number of grants provided in 2008. The data indicates that the number of hospitals implementing the program is eleven, although without the two missing post-survey we can't accurately determine if or how those two hospitals implemented the program. However, since all hospitals who participated in the program in 2008 had previously received grant funds for this program one could conjecture that the missing surveys were the result of an oversight rather than non-implementation of the program. As noted previously, twenty of Maine's hospitals that have birthing centers have participated in the program during the multiple funding cycles of the NSFB program

Indicator #5: The final indicator tracks feedback from hospital staff about the program, its implementation, its usefulness, and ways to improve it. Section 3 of the hospital post-survey includes questions to provide this staff feedback, and includes the following:

- Success of program in your hospital was rated at an average of **4.0** [scale of 1(not effective) to 5 (very effective) use] for the nine hospitals who responded.

- Initiative improves parent's knowledge of sun safety issues was rated **4.11** [1 was not at all and 5 was very much], and representative of the staff comments is: "*The kit is eye-catching with the sun bonnet included in the beach pail along with the literature. The brochures are to the point with facts."*

- Initiative will change parent's sun safety behavior was rated **3.00** [1 (not at all) to 5 (very much) scale], and a representative of the staff comments is: *"By providing materials to the patients and infants along with education; people will be inclined to use the tools like hats and sun block."*

- In regards to whether participation in the initiative changes the way staff address skin cancer the average rating was a **3.22** [1(not at all) to 5 (very much) scale], and comments included: *" Incorporating the sun safety slide in our PowerPoint discharge teaching class is sustainable, regardless of the season."*

- In reference to whether or not hospitals have incorporated sun safety issues into their hospital's childbirth curriculum, grantees were presented with a tri-choice question (choice of "Yes," "No, but I intend to," or "No, and I do not intend to"). Eight of nine (88.9%) of respondents answered "yes" and the remaining one (11.1%) answered "No, but intend to." The inclusion of NSFB program messages about infant sun safety into existing hospital messages and resources is a critical piece of institutionalizing the benefits of the NSFB program and sustaining program gains.

- When asked "yes," "no" or "maybe" about continuing the program, seven of eight hospitals (77.8%) answered "yes" and two (22.2%) answered "maybe/unsure."

- The following resources were identified as helpful for future implementation of the program:

  - *Large posters to hang about the hospital and birthing areas in spring and summer.*
  - *Resources for baby sun hats.*
  - *Where to get best prices on materials (hats, pails, etc.), maybe people could share their contacts or work together to obtain volume discounts.*
  - *More money for hats, pails, sunglasses, etc!*
  - *The small grant funding allows us to purchase the sun block and the hats for the babies. This cost is prohibitive for us to include in the bag. Current cuts to critical access hospitals endanger program materials such as NSFB.*

- Among the many comments identifying the top three things about the program were:
  - *Creates a good opportunity to discuss sun safety while re-enforcing it with a gift!*
  - *Hats, brochures, pails. It is something that parents can see and it also helps them realize how important it is to protect their baby now, not later.*
  - *1. The interaction between staff and the new parents about the dangers of the sun. 2. The materials for new baby bags are a huge help to support the education. 3. The case of grant funding has been a huge help. The instructions are simple and reporting is easy.*
  - *1. Ease of application. 2. Kit makes it easier for staff to educate since all materials are together, attracts attention. 3. Great cause!*

- Suggestions for program improvement included:
  - *More grant money to allow us to purchase sun bonnets. Our volunteers burn out quickly making the hats, even though we provide the fabric. There is not enough funding for both the purchase of beach pails and ready-made hats for 400. We cannot appropriate any funds from our tight budget and rely solely on the grant money.*
  - *It's great the way it is!*
  - *We could have used more monetary resources so that we could purchase the Sun proofing Your Baby brochure from the Skin Cancer Foundation. I thought this brochure was the most appropriate for this population, although it could be updated! I just went online (1/20/09) to try to locate this brochure and could not find it. I would love to see something like this available next year.*
  - *I think this is one of the best programs running for education out there. Other funding for small pools of money is so complex, this program allows the nurses and educators to do the work they need to do without constant reporting. Thank you for the opportunity to participate.*
  - *I feel that the program itself is very complete but would ask for this year to receive the survey and report earlier and clear report form with instruction that are clear for completion??*

And finally, while Indicator #5 is specific to hospital staff, it is worthwhile here to identify the parent responses in terms of helpfulness of the program to them. Sixty-nine parents (or 94.5% of the 73 respondents) chose to respond to the question: "How helpful was the sun safety information you received?" Of those respondents, 70% (48) found it "helpful", 24% (17) found it "very helpful", and 6% (4) found it only "somewhat helpful" – no parents found the information "not at all helpful."

This 2008 parent data aligns with parent data collected from 2006 via the parent postcards mailed back to the program. For the seventy-one postcards that were received independently of this evaluation, and thus recorded separately, 100% of parents found the NSFB educational information helpful. Additionally, 100% plan to use protective clothing and keep their babies out of direct sunlight, and the two responses that indicated they would not use the sun hat said it was because it was too large.

When one reviews all three years of parent responses there is a strong indication that the Sun Safety Kits have a direct impact on sun exposure for infants. Further, from both the parent and hospital data currently collected, one can conclude that the program is helpful/useful, that the information it provides is being acted upon, and that the hospitals find implementation easy.

Conclusions & Recommendations

The 2008 NSFB program evaluation substantiates previous evaluations which reflect that the program is successful and very well received by both parents and hospitals. The Sun Safety Kits repeatedly receive high marks and are effective at influencing how parents protect their infants from sun exposure right from birth. The inclusion of sun safety educational messages in existing hospital childbirth curriculums and materials indicates strong institutional support for the program and the need to reinforce its critical message.

As part of the final NSFB program evaluation, it is important to reflect on the role of the hospitals over the years to ensure continued support for grant applications in these difficult economic times. While there has not been any actual cash support for the program from any of the sponsoring hospitals, there has been strong institutional support for staff time and effort to coordinate the program. In many of the participating hospitals, NSFB could not be successful were it not for the strong volunteer base and their energy and involvement in producing program materials, such as making sun bonnets for the Sun Safety Kits. Both the non-cash and volunteer resources provided by the participating hospitals should be recognized and encouraged as part of the cultural change around sun protection that NSFB is attempting to establish through its program grants.

As the program continues to provide grants to hospitals it will be important to embed continuous evaluation into the program. Because the body of evaluation data thus far indicates strong program support and positive sun safety behavior, continuing financial commitment to the program is appropriate and should require continued program evaluation integrated into program administration. Electronic tools are critical to this effort to embed program evaluation, and thus, putting both the parent survey and the hospital evaluations online would be much warranted as the new grants gets distributed.

Email-based hospital surveys could provide the funder with information on implementation of the program, successes and barriers for the program, and feedback on impact of the program. Online parent surveys could allow the flexibility of completion of the survey either before leaving the hospital or at one's leisure at home. A follow-up message from the hospital about filling out the survey could serve not only to increase survey response rates, but also could provide the opportunity to reinforce the sun safety message and or answer questions that may have arisen for the new parents since leaving the hospital.

And finally, continued support for hospitals efforts at sustainability should be encouraged at all junctures. There is a good base of support for the NSFB program that can be built upon. Using and enhancing that base would encourage not only continuation, but also expansion, of the program. Both programmatic and financial support for participating hospitals could encourage longer or full year implementation of the program. Fiscal resources and peer support could encourage new hospitals to apply for grants. Potentially developing a mentor-type program that pairs past/current participating hospitals with new hospitals could expand the program with minimal efforts by building on "what works" in the current programs.

Sun Blocks: Childcare Sun Safety Pilot Program

Background

Skin cancer is the most common form of cancer, but it is also one of the most preventable. Most skin cancers are caused by too much exposure to the sun's harmful ultraviolet (UV) rays, especially during childhood and adolescence. Even one sunburn early in life can increase an individual's risk for developing skin cancer as an adult. Teaching young children how to protect their skin from the sun, and creating environments to support these positive behaviors, can immediately result in reduced exposure to harmful UV rays, as well as the future development of healthy, life-long skin protection habits. Since most young children in Maine are under the care of a childcare provider during peak sun hours, childcare centers have a unique opportunity to make a difference in the health of children for whom they care.

In 2008-2009, there were two aspects of the *Sun Blocks* program that were evaluated - the *Sun Blocks* training and the *Sun Blocks* pilot program. The training evaluation survey was administered at the training event November 21, 2008 and compiled shortly thereafter. The pilot program was completed in June of 2009. The following two sections include summaries of both evaluations.

A. *Sun Blocks* Training Evaluation

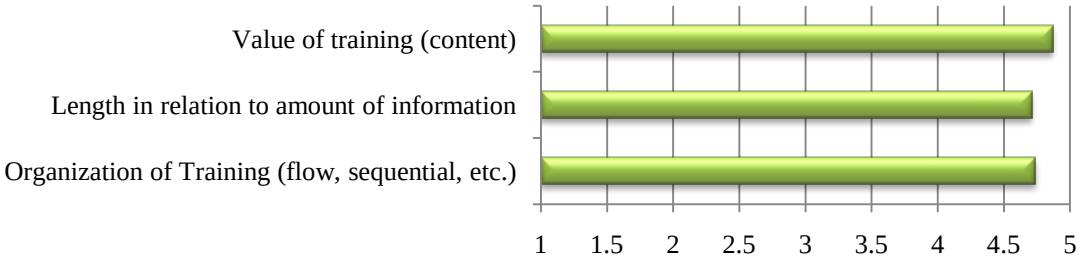
In the fall of 2008, MCCCP provided the *Sun Blocks* training statewide to all childcare centers who chose to participate. In the overall program, an evaluation survey was distributed to attendees at the end of the training. The surveys were anonymous and participants placed them in an envelope that was directly returned to the MCPH evaluator for compilation and analysis.

Thirty-one surveys were completed at the training event and overwhelmingly, the participants were clearly very pleased with the training and found it relevant, useful, and well presented. The training curriculum evaluation survey tool (Appendix F) was divided into four sections: (1) Organization of the Training; (2) Training Objectives; (3) Presentation of the Training; and (4) Overall/Other. Sections 1-3 included 13 scaled questions and Section 4 included seven

open-ended questions. For questions on a scale of 1-5, a rating of 5 was either *excellent* or *agree*, versus a rating of 1 being *very poor* or *disagree.* In Sections 1-3, there were no ratings below 3 (*average*) on the scale for any of the surveys and only nine 3s (for all 13 questions) recorded amongst all thirty-one surveys (i.e. 9 of 403 responses were a 3, with the remaining 394 responses being above a 3).

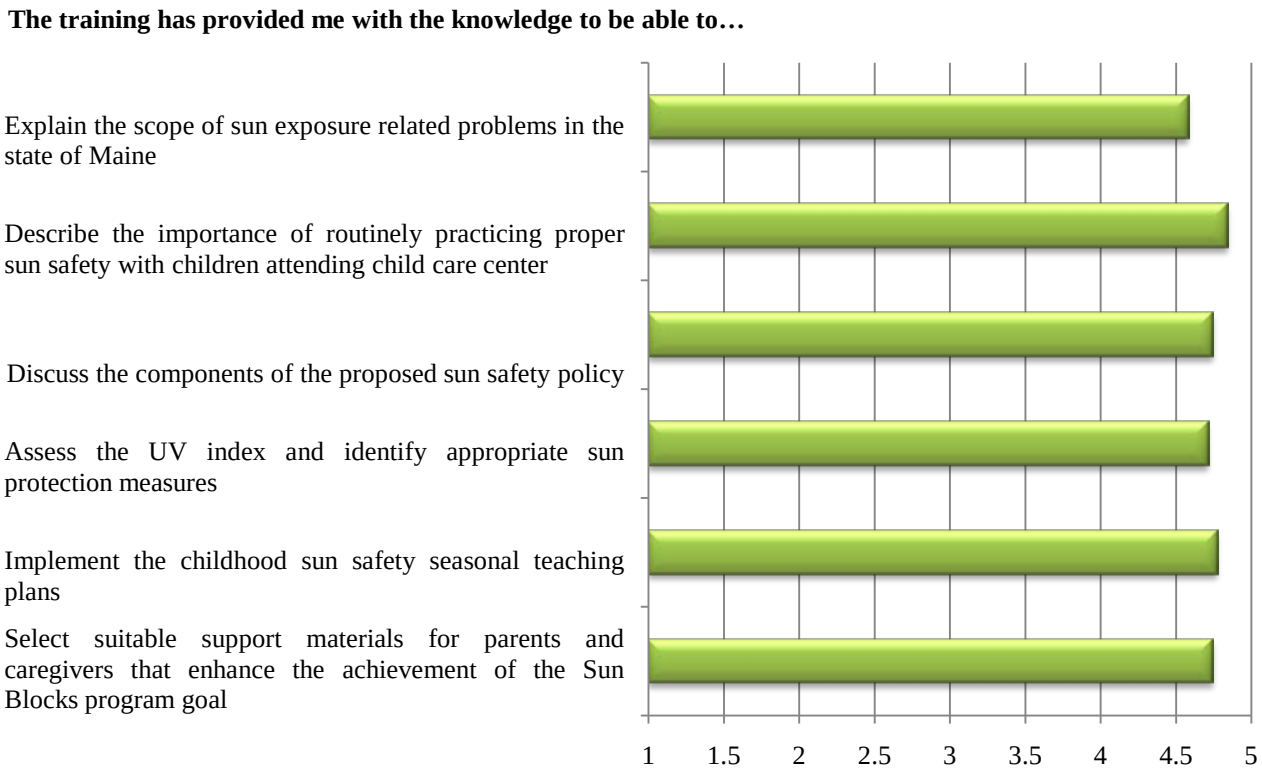
Within the specific training components that were evaluated, Section 1 on the Organization of the Training received an average response rating of 4.77 (out of a possible 5) for the three questions addressing flow of training topics, length of training, and value of training content. Figure 15 reflects the compiled responses for Section 1 of the training survey.

Figure 15: *Sun Blocks Training: Organization of Training*



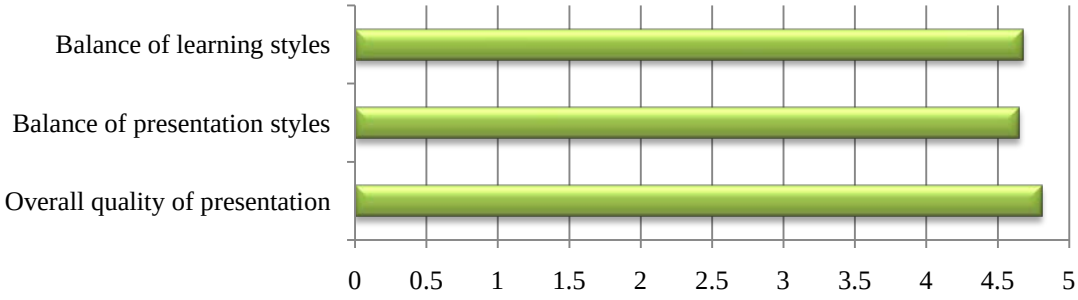
Section 2 of the survey evaluated whether the training was successful at meeting the objectives it had set out to accomplish. All seven questions in this section received a rating of either 4 or 5 on the scale. The first question sought to determine whether the training objectives were clear to participants by asking trainees to rate their knowledge of the objectives. The average response rating was 4.42 (1 being *very poor* and 5 being *excellent*), suggesting that the objectives were clearly set out at the start of the training session. For the set of six questions addressing whether individual objectives were realized, the average response rating of 4.73 (1 being *disagree* and 5 being *agree)* indicated that trainees felt the training objectives were successfully reached. Individual question averages ranged from 4.58 to 4.84, and are reflected in Figure 16.

Figure 16: *Sun Blocks Training: Success in Meeting Training Objectives*



The presentation of the training (Section 3 of the survey) also received strong positive responses, with an average response rating of 4.71 for the three questions posed, as a 4.81 average response to the question on overall quality of presentation. Figure 17 reflects the average scores of respondents on the training presentation section of the survey.

Figure 17: *Sun Blocks Training: Presentation of the Training*



As the above graphs indicate, the *Sun Blocks* training was very successful from the participants' perspectives. Additionally, Section 4 of the evaluation survey provided the opportunity for participants to add written comments in response to seven general questions. The questions and a few representative comments that reflect the compiled comments from all 31 surveys are listed below.

Q: Did you receive training materials and are they in a format that is useful to you (for example, the USB flash drives)?

- *Absolutely! This is awesome – and instantly productive. Well done!*
- *Yes, The materials are excellent and I will enjoy providing the activities to the children and resources to families.*
- *Yes – very impressed with materials provided. You could tell a lot of thought went into it.*

Q: What was the most useful part of today's training for you?

- *Interactiveness, love the crickets!*
- *Discussion and hands on activities in groups*
- *The take home resources for the classroom*

Q: What was the least useful part of today's training for you?

- *All was very good – no "fluff"*
- *More info to get teachers to buy in*
- *Taking time to actually "create" activities*

Q: What, if any, additional information or skills do you need to feel confident to implement the childhood sun safety teaching plans?

- *Resources to purchase shading tools to use in our center.*
- *Policy – and educational materials*
- *Someone to volunteer to come and teach staff.*

Q: What, if any, additional information or skills do you need to establish a sun safety policy at your center?

- *Don't know yet!*
- *This is a good start and I'll know what else we need as we go along.*

Q: Is there anything you would suggest that we change or do differently in a future training?

- *Hold more trainings. Encourage childcare licensing to indicate sun policies in requirements.*
- *Possibly a bit more moving around.*

Q: Any additional comments?

- *Very helpful! Thanks!*
- *Superb job, great program*
- *This was a very informative training. You made it interesting and I really liked how we could interact with the others.*
- *Excellent and useful training and resources*
- *Thank you for the time and thought put into this meeting. Very creative!*

The combined responses of all survey questions indicate that the training was excellent and extremely relevant to participants. From the *Sun Blocks* training evaluation, it is clear that the training provided a solid knowledge base for trainees to return to their childcare centers and implement the strategies, activities, and policies that were discussed during the training. As the

next report section on the evaluation of the childcare *Sun Blocks* pilot program implementation suggests, the *Sun Blocks* training may be a critical component to changing sun safety behaviors.

B. *Sun Blocks* Childcare Pilot Program Evaluation

The goal of the overall evaluation of the pilot program was to determine if the *Sun Blocks* program was a practical, sustainable and effective approach to reduce overall UV exposure among children attending childcare centers in Maine, based on comparison of baseline and follow-up evaluation data. The specific evaluation questions were:

1. Is the *Sun Blocks* program effective?
    - Are educational materials alone enough to impact behaviors and programmatic changes related to sun safety?
    - Is complementary training necessary to impact behaviors and programmatic changes related to sun safety?

2. Is the *Sun Blocks* program sustainable?
    - Is supplementary funding necessary to impact behaviors and programmatic changes related to sun safety?
    - Are there specific barriers to implementation of a sun safety program within the childcare setting?

Design & Methodology

The evaluation survey was designed as a follow-up to the baseline assessment, "Maine Daycare Sun Protection Questionnaire," administered in February 2008.[1] Formative evaluation research was conducted at that time to determine the number of childcare centers in Maine that currently had a formal sun safety policy, adhered to sun protection guidelines, and routinely practiced sun safety behaviors. The assessment was conducted in an effort to provide baseline data for the Maine Comprehensive Cancer Control Program's (MCCCP) sun safety objectives, and to inform future efforts related to sun safety programs in childcare centers across Maine.

For the follow-up evaluation design, four groups were to be randomly selected, from the larger representative sample of 196 baseline survey respondents (Table 1). Group A respondents were selected to receive program materials, training, and mini-grants of $1,000, following an application process open to any state-licensed, facility-based childcare center in Maine, regardless of the level of skin cancer prevention and sun safety activities at the time of application. Group B respondents were selected to receive program materials and training, which included (i) an introduction to skin cancer and importance of sun protection for young children, (ii) primary and secondary sun safety behaviors, and (iii) the "how to" of policy development, implementation of the early childhood teaching plans, and gaining parental support. Group C received program materials only, which included early childhood sun safety teaching plans, adaptable support materials for parents, adaptable sun safety policy, and staff

[1] Fletcher, A.G. (2008). *Sun Blocks: Building a Foundation for Healthy Skin. A Strategic Program for Improving Childhood Sun Protection Within State-Licensed, Facility-Based Childcare Centers in Maine.* Boston, MA: Tufts University School of Medicine, Department of Public Health and Family Medicine; Maine Comprehensive Cancer Control Program, Maine Center for Disease Control and Prevention, Department of Health and Human Services; and, Maine Cancer Consortium, Skin Cancer Workgroup.

training materials. Group D served as the control group in this design, and received no level of intervention. Table 8 portrays the proposed design for follow-up evaluation.

Table 8: *Proposed design for the follow-up evaluation*

	Mini-Grant Funds	Training	Program Materials
Group A (N_A=25)	X	X	X
Group B (N_B=25)		X	X
Group C (N_C=25)			X
Group D (N_D=25)			

Baseline and follow-up evaluation survey instruments were designed by MCCCP staff working in collaboration with an Evaluation Consultant from the Maine Center for Public Health (Appendices G, H & I). The follow-up evaluation survey comprised of sections on sun protection practices (8 questions), sun protection policy and programming (4 questions), *Sun Blocks* program activities (10 questions), and skin cancer prevention mini-grant activities (7 questions). There were two versions of the survey: Version 1 with 29 questions in five sections for Group A respondents, who were the recipients of mini-grants, and Version 2 with 22 questions in four sections for respondents from Groups B-D. In order to administer the follow-up evaluation survey, a packet containing the survey along with a letter explaining the evaluation was mailed to childcare center Directors in Groups A-D on June 12, 2009. Surveys were color-coded: blue (Group A), and green (Groups B-D). In addition, surveys in Group A had an alphanumeric code on the top-right corner of the first page, which matched the process used to code baseline surveys, following baseline data collection.

Survey data were entered, and managed in Microsoft Office Excel 2003. Descriptive results were obtained using Microsoft Office Excel 2003, and statistical tests were performed using SPSS software program v14.0.

In order to assess to what extent overall this program needs to be supported to have an impact on the sun safety practices of childcare centers in Maine, the following hypotheses were tested:

- There is a relationship between receiving educational materials and attention to sun safety in the childcare setting – A, B, C versus D. (Q: Are educational materials alone enough to impact behaviors and programmatic changes related to sun safety?)
- There is a relationship between receiving complementary training and attention to sun safety in the childcare setting – A, B versus C, D. (Q: Is complementary training necessary to impact behaviors and programmatic changes related to sun safety?)
- There is a relationship between receiving supplementary funding and attention to sun safety in the childcare setting – A versus B, C, D. (Q: Is supplementary funding necessary to impact behaviors and programmatic changes related to sun safety?)

Results

This section provides a summary of response rates and demographic information for both baseline and follow-up evaluation surveys, followed by a results summary for all follow-up evaluation survey questions. The last portion is a comparison of results for ten questions common to the baseline and follow-up evaluation surveys.

Response Rates

From the final baseline sample of 196, a sample of 99 surveys was selected retrospectively in order to select and match to data collected at follow-up. Baseline data were not available for one center in Group B, and one center in Group C of this pilot program. Retrospective data entry and analysis were performed in July 2009. The breakdown for analysis was 25 in Group A, 24 in Group B, 25 in Group C, and 25 in Group D, as shown in Table 9.

Table 9: *Denominator data for baseline survey*

Group A		Group B		Group C		Group D	
Mailed n	Received n	Mailed n	Received n	Mailed n	Received n	Mailed n	Received n
25	25	25	24	26	25	25	25

Follow-up evaluation surveys were mailed to the Directors at childcare centers in Maine, and 65 were returned by the deadline in July 2009 (Table 10). Some surveys (n=2) were returned after the deadline, and were not included in this analysis. Active follow-up was conducted for childcare centers in Group A. Please note that mailing addresses were not available for two childcare centers in Group D and attempts to contact these centers via e-mail were futile. In addition, one survey was returned unanswered from Group A due to return of mini-grant funds, bringing the final count for this follow-up assessment to 97 (24 in Group A, 25 in Group B, 25 in Group C, and 23 in Group D). The overall response rate was 67.0% (n=65) at follow-up. By group, the response rates were 100.0% for Group A (n=24), 40.0% for Group B (n=10), 56.0% for Group C (n=14), and 73.9% for Group D (n=17).

Table 10: *Denominator data for the follow-up evaluation survey*

Group A		Group B		Group C		Group D	
Mailed n	Received n	Mailed n	Received n	Mailed N	Received n	Mailed n	Received n
25	24	25	10	25	14	23	17

Table 11 highlights the loss to follow-up [Group A (-4.0%), Group B (-58.3%), Group C (-44.0%), and Group D (-32.0%).

Table 11: *Comparison of baseline and follow-up denominator data used for the analysis*

Group A		Group B		Group C		Group D	
Baseline n	F/U n	Baseline n	F/U n	Baseline N	F/U n	Baseline n	F/U n
25	24	24	10	25	14	25	17

Demographic Information

A. Baseline Survey ($N_{baseline}$=99)

Over eighty percent (80.8% or n=80) of respondents identified their facility as a childcare center, 12.1% (n=12) as a nursery school or pre=school, 4.0% (n=4) as a family childcare home, 10.1% (n=10) as a Head Start or Early Head Start, and 10.1% (n=10) as "other." The "other" category included before- and after-school childcare for K-Grade 5, summer day camps, developmental therapy, and Montessori for the age group 8 weeks-6 years. Over

thirteen percent (13.1% or n=13) of respondents identified their facilities as offering more than one type of early childcare.

B. F/U Evaluation Survey ($N_{f/u}$=65)
   - Survey responses were obtained from childcare centers in 15 of the 16 counties in Maine, excluding Piscataquis County where childcare centers did not participate in the baseline survey. One-hundred percent response rates were achieved for childcare centers in Franklin County, Lincoln County, Somerset County, and Waldo County. Counties with response rates below 50.0% were Aroostook County, Hancock County, Oxford County, Sagadahoc County, and York County.
   - The number of children licensed for by childcare centers in the sample was in the 20-500 range, with a mean of 94 children, and a median of 54 children. Some of the childcare centers included a central facility with satellite locations, which accounts for the upper limit.
   - The age range of children attending the childcare centers in the sample was 6 weeks-17 years.
   - Over forty-one percent (41.5% or n=27) of childcare centers provided both full-day and part-day care, depending on the season, and school year schedule. In addition, 47.7% (n=31) of childcare centers provided only full-day care, and 9.2% (n=6) provided only part-day care.
   - The majority (92.3% or n=60) of childcare centers reported they were open year-round.
   - Over eighty-one percent (81.5% or n=53) of childcare centers reported having more than one current funding source. These included parent fees (96.9% or n=63), state grants (29.2% or n=19), subsidies (56.9% or n=37), donations (21.5% or n=14), and "other" (24.6% or n=16). The "other" category included federal grants, MaineCare, United Way Grants, Head Start, Aspire, tuition assistance programs, town support, and personal finances.

Findings from the F/U Evaluation Survey

This section includes results of the follow-up evaluation survey completed in June 2009, compared across Groups A-D.

Sun Protection Practices

Respondents answered a series of eight statements related to sun protection practices in order to assess the frequency with which childcare center Directors and staff engage in sun protection practices at their center(s). The response scale was a Likert-type, five-point scale (Never-Rarely-Sometimes-Often-Always). On this scale, higher scores indicated more engagement in sun protection practices at childcare centers.

- Over eighty-seven percent (87.5% or n=21) of childcare centers in Group A reported encouraging children to wear hats when participating in outdoor activities "often" or "always," compared to 90.0% (n=9) in Group B, 78.6% (n=11) in Group C, and 82.4% (n=14) in Group D. Some childcare centers commented that they were more likely to encourage children to wear hats only if their parents provided them with hats.
- Over fifty-four percent (54.2% or n=13) of childcare centers in Group A reported encouraging children to wear sunglasses when participating in outdoor activities "often"

or "always," compared to 40.0% (n=4) in Group B, 57.1% (n=8) in Group C, and 35.3% (n=6) in Group D.

- Over eighty-three percent (83.3% or n=20) of childcare centers in Group A reported encouraging children to wear protective clothing when participating in outdoor activities "often" or "always," compared to 60.0% (n=6) in Group B, 64.3% (n=9) in Group C, and 47.1% (n=8) in Group D.
- One-hundred percent (n=24) of childcare centers in Group A reported encouraging children to play in shaded areas "often" or "always," compared to 100.0% (n=10) in Group B, 100.0% (n=14) in Group C, and 64.7% (n=11) in Group D.
- Over ninety-five percent (95.8% or n=23) of childcare centers in Group A reported applying sunscreen to children before they participate in outdoor activities "often" or "always," compared to 90.0% (n=9) in Group B, 85.7% (n=12) in Group C, and 100.0% (n=17) in Group D.
- Over ninety-one percent (91.7% or n=22) of childcare centers in Group A reported re-applying sunscreen when children participated in outdoor activities for extended periods of time "often" or "always," compared to 90.0% (n=9) in Group B, 85.7% (n=12) in Group C, and 100.0% (n=17) in Group D.
- Only forty-five percent (45.8% or n=11) of childcare centers in Group A reported applying sunscreen before outdoor activities in both summer and winter months "often" or "always," compared to 10.0% (n=1) in Group B, 35.7% (n=5) in Group C, and 11.8% (n=2) in Group D. Across the four groups, many respondents noted that they apply sunscreen on children before outdoor activities in summer months, but not as often in winter months.
- Fifty percent (50.0% or n=12) of childcare centers in Group A reported scheduling outdoor activities and events for children between 10:00 a.m. and 4:00 p.m. "often" or "always," compared to 60.0% (n=6) in Group B, 50.0% (n=7) in Group C, and 64.7% (n=11) in Group D.

Sun Protection Policy and Programming

Respondents also answered a series of four questions on sun protection policy and programming at their childcare center.

- Almost all childcare centers that returned follow-up surveys had a formal or informal Sun Protection Policy, with 100.0% (n=24) in Group A, 100.0% (n=10) in Group B, 92.9% (n=13) in Group C, and 88.2% (n=15) in Group D. Seven percent (n=1) of childcare centers in Group C, and 11.8% (n=2) of childcare centers in Group D had no Sun Protection Policy.
- Over ninety-one percent (91.7% or n=22) of childcare centers in Group A trained their staff on sun protection practices and policies, compared to 70.0% (n=7) in Group B, 71.4% (n=10) in Group C, and 58.8% (n=10) in Group D.
- Over eighty-seven percent (87.5% or n=21) of childcare centers in Group A distributed sun protection information to parents, compared to 80.0% (n=8) in Group B, 71.4% (n=10) in Group C, and 35.3% (n=6) in Group D.
- Over ninety-one percent (91.7% or n=22) of childcare centers in Group A provided sun protection activities or lessons for children, compared to 60.0% (n=6) in Group B, 57.1% (n=8) in Group C, and 23.5% (n=4) in Group D.

Sun Block Program Activities

In order to assess activities implemented as part of the *Sun Blocks* pilot program, respondents answered a series of ten questions.

- Groups A-C utilized *Sun Blocks* program materials for staff development and training, formal sun protection policy development, classroom curriculum and activities, parent education and resource information in the form of handouts and newsletters addressing sun safety and protection.
  "We passed out all the parent materials, used some teaching plans for our weekly lesson plans, and have a copy in the staff lounge for staff to read and educate themselves."
- Over thirty-three percent (33.3% or n=8) of childcare centers in Group A that attended the Sun Blocks program training indicated that their attendance "almost" or "entirely" depended on receiving the $100 stipend, compared to 50.0% (n=5) of childcare centers in Group B. One childcare center in Group A noted that although their attendance at the training entirely depended on the stipend, they had not yet received the stipend.

Please note that only respondents in Groups A-B answered questions 15-22, and response summaries are provided below:

- Program elements implemented by childcare centers included staff training (91.7% or n=22), early childhood teaching plans (83.3% or n=20), policy development (91.7% or n=22), and materials for parents (91.7% or n=22) in Group A, compared to staff training (80.0% or n=8), early childhood teaching plans (70.0% or n=7), policy development (70.0% or n=7), and materials for parents (90.0% or n=9) in Group B.
- For childcare centers that implemented staff training, 86.4% (n=19) in Group A "agreed" or "strongly agreed" that it was feasible to implement staff training, compared to 100.0% (n=8) in Group B.
- For childcare centers that implemented early childhood teaching plans, 85.0% (n=17) in Group A "agreed" or "strongly agreed" that it was feasible to integrate sun safety lessons into the current curriculum, compared to 71.4% (n=5) in Group B.
- For childcare centers that implemented policy development, 90.9% (n=20) in Group A "agreed" or "strongly agreed" that it was feasible to develop a sun protection policy, compared to 85.7% (n=6) in Group B.
- For childcare centers that implemented parent education activities, 90.9% (n=20) in Group A "agreed" or "strongly agreed" that it was feasible to distribute *Sun Blocks* program materials to parents, compared to 77.8% (n=7) in Group B.
- Over ninety-one percent (91.7% or n=22) of childcare centers in Group A reported staff members being "receptive" or "very receptive" to the *Sun Blocks* program training, compared to 80.0% (n=8) in Group B.
- Over ninety-five percent (95.8% or n=23) of childcare centers in Group A reported being "confident" or "very confident" in their center's ability to sustain the *Sun Blocks* program over time, compared to 80.0% (n=8) in Group B.
- Over sixty-six percent (66.7% or n=16) of childcare centers in Group A reported that their center's physical environment had changed over the past year in order to provide more sun protection for children and staff, compared to 30.0% (n=3) in Group B. For childcare centers that answered "no," barriers included funding, restrictions on altering the current physical location, and a lengthy approval process in one case.

Skin Cancer Prevention Mini-Grant Activities

This section of the follow-up survey, comprising of seven quantitative and qualitative questions, was only sent to childcare centers that received individual mini-grants of $1,000, i.e. only Group A respondents.

- Over thirty-seven percent (37.5% or n=9) of Group A childcare centers had completed their mini-grant-related activities at the time of follow-up survey administration in June 2009, and 58.3% (n=14) planned to complete their mini-grant-related activities by August 2009.

- Skin cancer prevention training, education and/or materials were provided to staff (range: 3-117; mean=19; median=9), parents (range: 15-500; mean=76; median=41), and children (range: 15-352; mean=79; median=50).

- Mini-grant funding was used to: (a) Build shade structures such as canopies, gazebos, and playhouses (83.3%), (b) Purchase hats, sunglasses, UV bracelets, trees, and other supplies (41.7%), and (c) Provide materials for staff, parents and children (33.3%).

  "We purchased a playhouse and climbing equipment - I got a great deal on 2 packages so I paid the difference. By having this equipment, it provides shade yearly and the climbing equipment encourages play in the shade. The parents and kids love the new additions as do we!"

  "We purchased "bucket" hats for each child and staff member for extra sun protection. We also purchased a pop-up tent for a shade structure to use on our beach and lake trips. Finally we purchased the supplies for each child to make a sun protector bracelet - UV detecting beads and rope."

  "Build structures over swings and sandboxes to provide shade in these popular play areas."

Some groups used grant money to plant shade trees at their day care center.

- Over forty-five percent (45.8% or n=11) of Group A childcare centers received some type of in-kind contributions or additional funds/resources to support their efforts. These included support from maintenance staff and volunteers, and discounts on labor costs and project materials such as benches, lumber, and trees.

- Over eighty-three percent (83.3% or n=20) of Group A childcare centers had developed or improved their sun protection guidelines as a result of mini-grants received.

- Barriers encountered with the mini-grants included time delay in receipt of funds, parents lack of interest and involvement, public school politics, and unpredictable weather.

  "Timing: the funds were late in coming and the cost of the sunshade went up. Also it caused delay in setting up the structure."

  "Our original plan was changed as to how we would spend the money. Due to lack of time, weather, we decided to create shade with a gazebo instead of planting trees."

  "Our only barrier was getting all parents to bring in hats, sunglasses, appropriate clothing and sunscreen for their children."

- Additional feedback on the mini-grants and *Sun Blocks* program was overwhelmingly positive, and included a request for additional training, a request to include sunscreen products as part of the grant, and a request for program materials in Spanish to serve the client population.

  "Great program, really spurred us to do more in this area, materials very helpful."

  "This was a great opportunity. Parents and staff have cooperated wonderfully."

  "Staff training on Sun Safety went well… We had a Sun Safety Awareness Week. Featured "Sun Safety" in our newsletter in May."

Comparison of Baseline and F/U Evaluation Findings

Table 12 and Figures 18-23 provide a comparison of baseline and follow-up evaluation survey data, by group, for ten common questions.

Table 12: *Comparison of baseline and follow-up evaluation survey data for Groups A-D*

	Group A		Group B		Group C		Group D	
	Baseline n (%)	**F/U n (%)**	**Baseline n (%)**	**F/U n (%)**	**Baseline n (%)**	**F/U n (%)**	**Baseline n (%)**	**F/U n (%)**
Engage in the following sun protection practices "often" or always"								
Apply sunscreen to children before outdoor activities	23 (92.0%)	23 (95.8%)	19 (79.2%)	9 (90.0%)	19 (76.0%)	12 (85.7%)	21 (84.0%)	17(100.0%)
Encourage children to wear hats for outdoor activities	19 (76.0%)	21 (87.5%)	18 (75.0%)	9 (90.0%)	22 (88.0%)	11 (78.6%)	18 (72.0%)	14 (82.4%)
Encourage children to wear sunglasses for outdoor activities	9 (36.0%)	13 (54.2%)	8 (33.3%)	4 (40.0%)	5 (20.0%)	8 (57.1%)	10 (40.0%)	6 (35.3%)
Encourage children to wear sun-protective clothing for outdoor activities	8 (32.0%)	20 (83.3%)	11 (45.8%)	6 (60.0%)	9 (36.0%)	9 (64.3%)	14 (56.0%)	8 (47.1%)
Encourage children to play in shaded areas	23 (92.0%)	24(100.0%)	19 (79.2%)	10(100.0%)	17 (68.0%)	14(100.0%)	17 (68.0%)	11 (64.7%)
Schedule outdoor activities and events during peak sun hours (10:00 a.m. - 4:00 p.m.)	17 (68.0%)	12 (50.0%)	14 (58.3%)	6 (60.0%)	15 (60.0%)	7 (50.0%)	14 (56.0%)	11 (64.7%)
Sun protection policy and programming								
Have formal or informal sun protection policy	22(88.0%)	24(100.0%)	18(75.0%)	10(100.0%)	17(68.0%)	13 (92.9%)	18(72.0%)	15(88.2%)
Provide sun protection training to teachers and staff	8 (32.0%)	22 (91.7%)	6 (25.0%)	7 (70.0%)	8 (32.0%)	10 (71.4%)	8 (32.0%)	10 (58.8%)
Provide parents with information on sun protection	17 (68.0%)	21(87.5%)	10 (41.7%)	8(80.0%)	15 (60.0%)	10 (71.4%)	10 (40.0%)	6(35.3%)
Integrate sun protection activities and lessons into curriculum	9 (36.0%)	22(91.7%)	8 (33.3%)	6(60.0%)	12 (48.0%)	8 (57.1%)	9 (36.0%)	4(23.5%)

Note 1: Group A: Mini-Grant Funds, Training, Program Materials; Group B: Training, Program Materials; Group C: Program Materials; Group D: Control.
Note 2: For denominator data, please refer to Table 4.

Figure 18: *Percentage of childcare centers that apply sunscreen to children before outdoor activities*

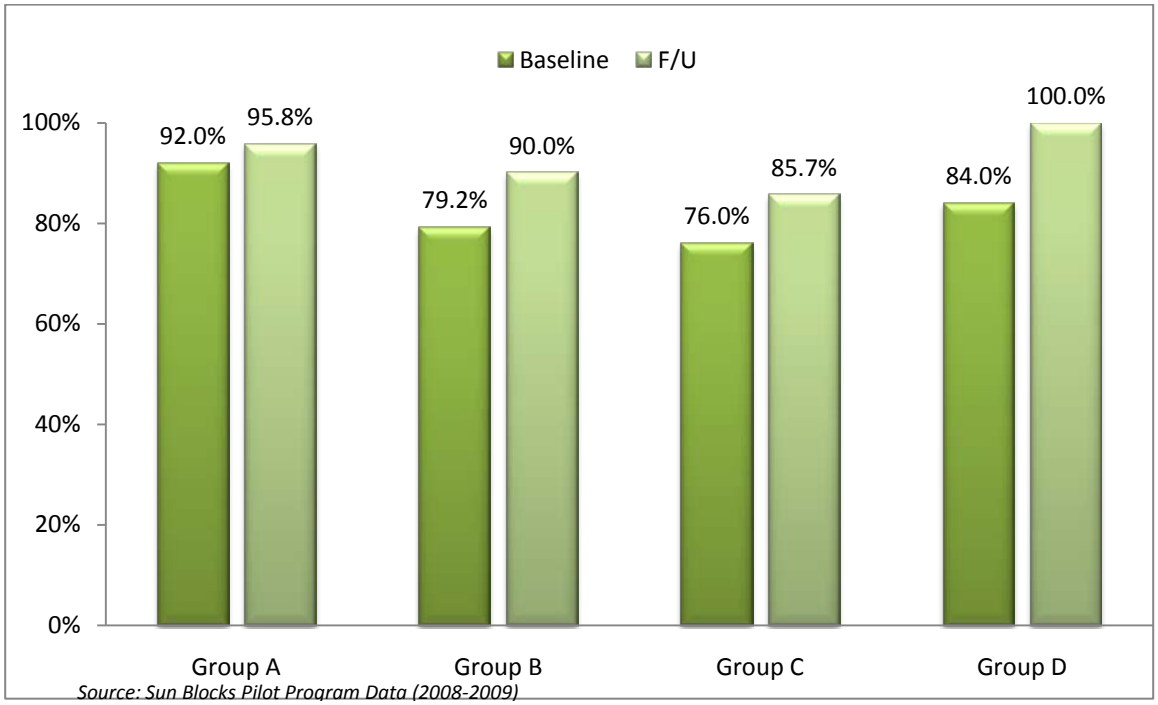
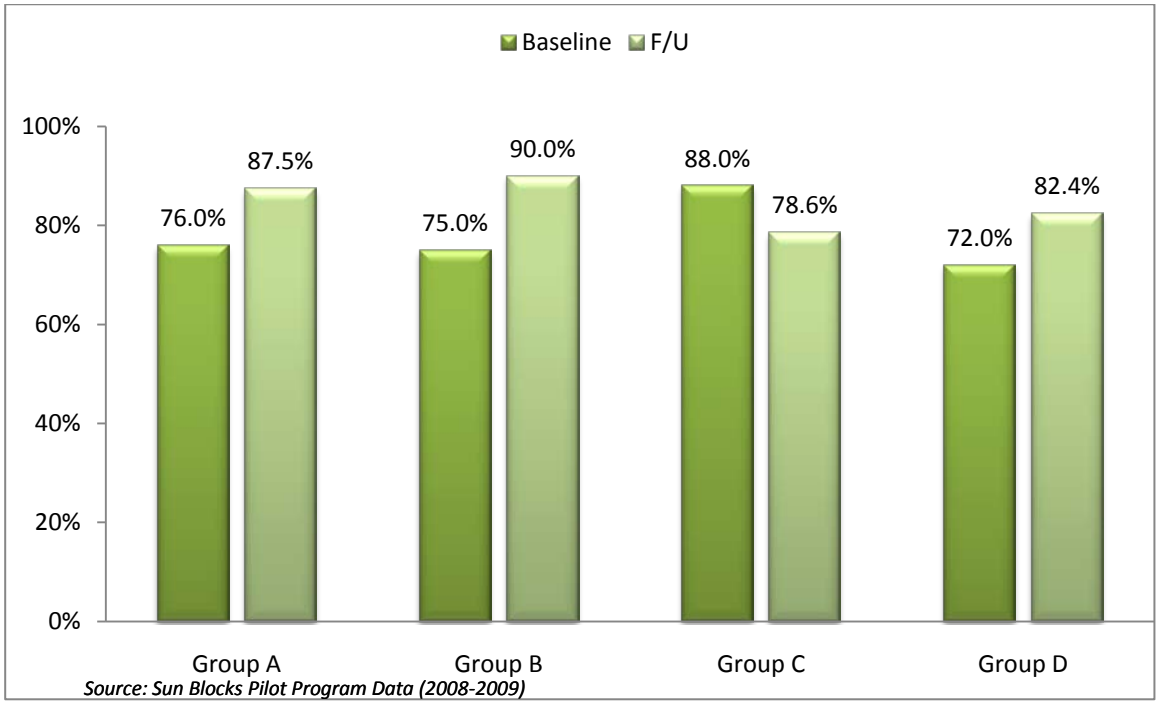


Figure 19: *Percentage of childcare centers that encourage children to wear hats for outdoor activities*



Note: Group A: Mini-Grant Funds, Training, Program Materials; Group B: Training, Program Materials; Group C: Program Materials; Group D: Control.

Figure 20: *Percentage of childcare centers that encourage children to wear sunglasses for outdoor activities*

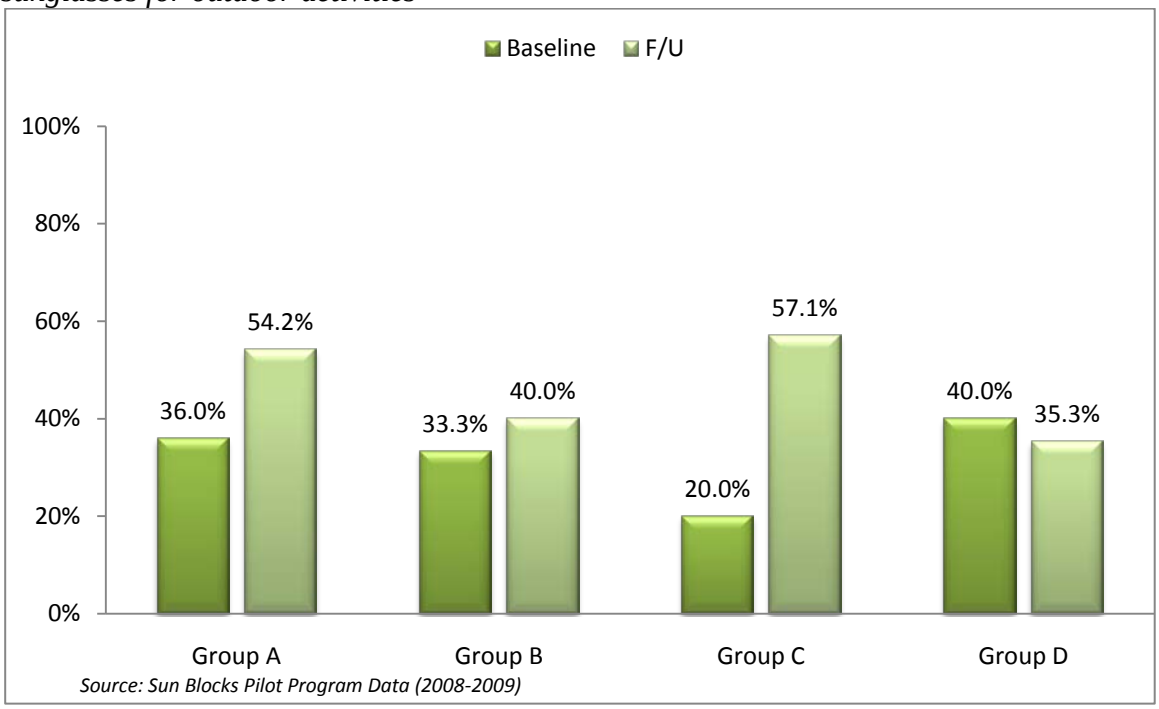
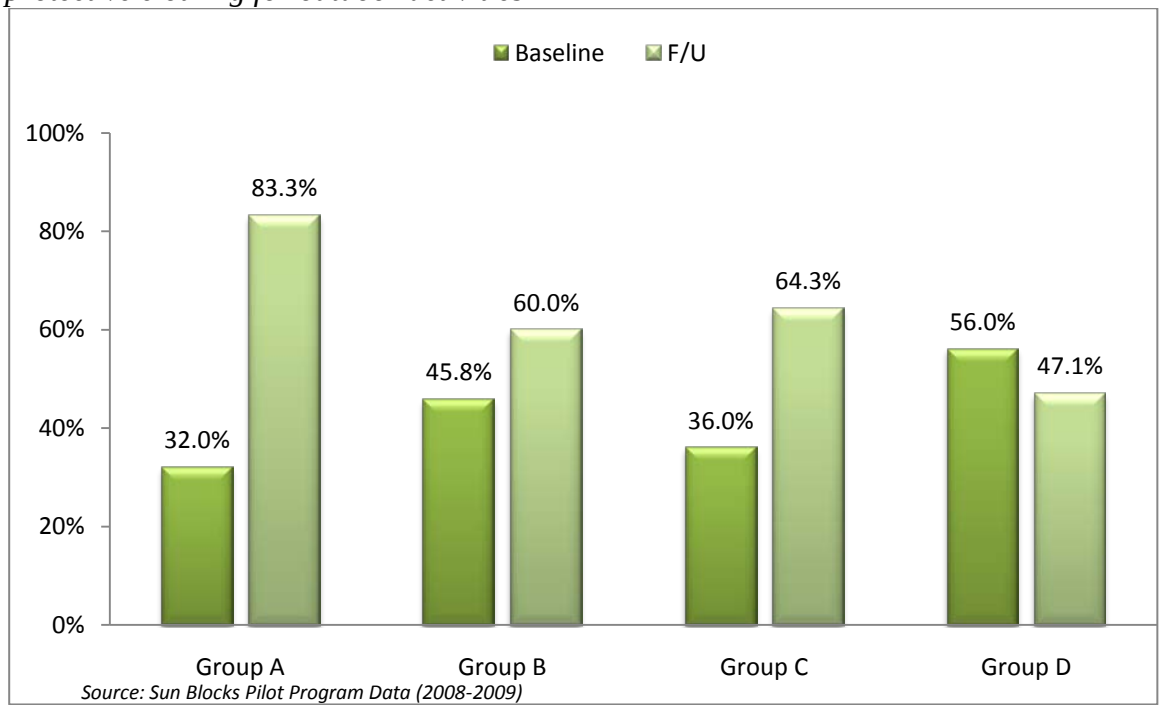


Figure 21: *Percentage of childcare centers that encourage children to wear sun-protective clothing for outdoor activities*



Note: Group A: Mini-Grant Funds, Training, Program Materials; Group B: Training, Program Materials; Group C: Program Materials; Group D: Control.

Figure 22: *Percentage of childcare centers that encourage children to play in shaded areas*

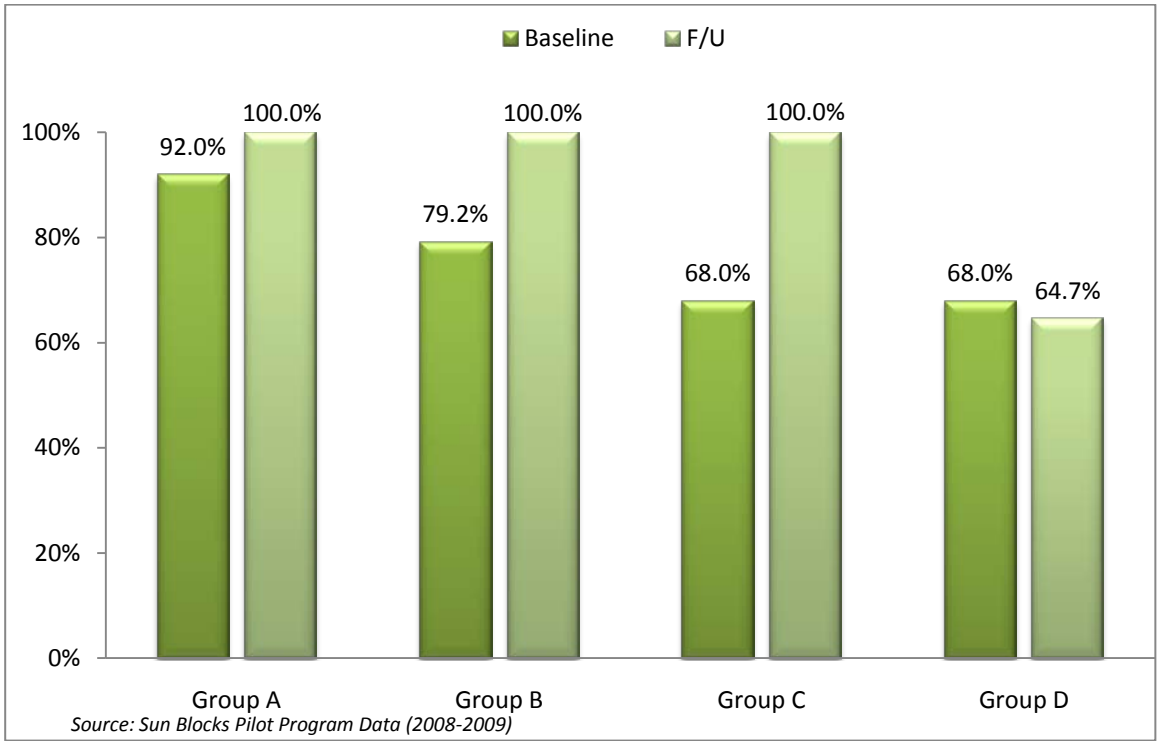
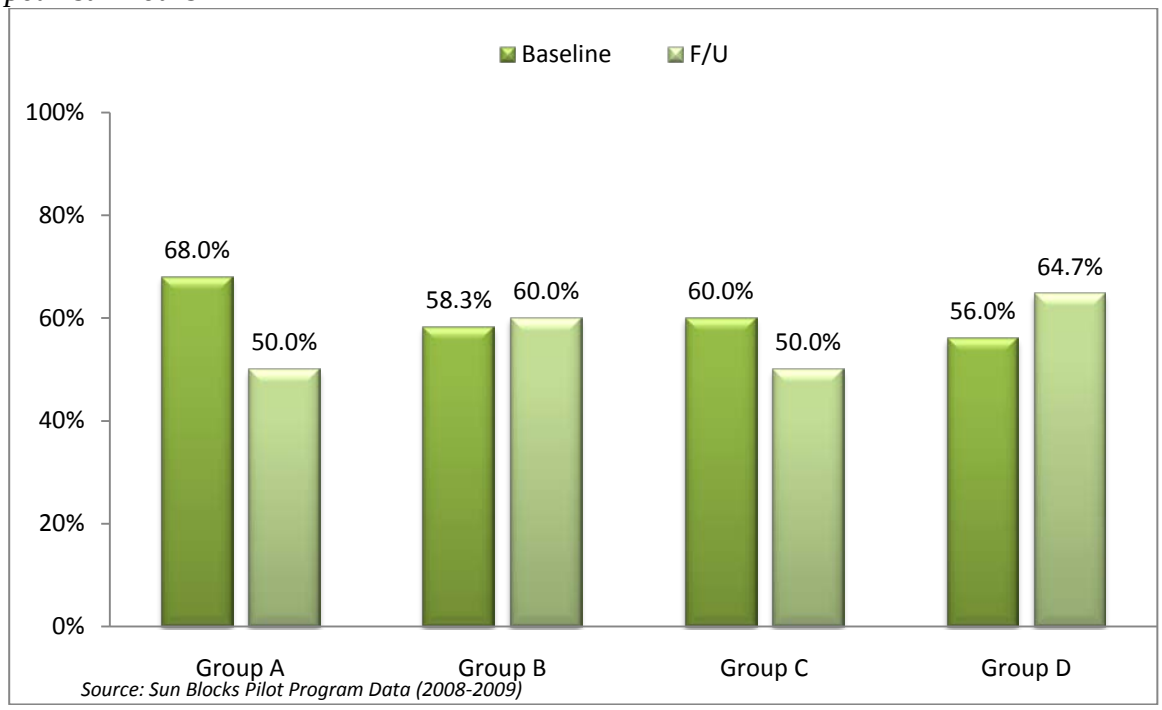


Figure 23: *Percentage of childcare centers that schedule outdoor activities during peak sun hours*



Note: Group A: Mini-Grant Funds, Training, Program Materials; Group B: Training, Program Materials; Group C: Program Materials; Group D: Control.

Limitations

The original plan, as outlined under "Design and Methodology," was to assess differences and relationships among the four groups by utilizing baseline and follow-up evaluation survey data. Independent samples t-tests would be performed to detect significant differences in mean scores between Groups A-D for ten questions common to the baseline and follow-up evaluation surveys, and paired t-tests would performed to detect significant differences in mean scores within each group at baseline and follow-up. In addition, ANOVA would also be performed. However, attrition rates at follow-up proved to be problematic, with 4.0% in Group A, 58.3% in Group B, 44.0% in Group C, and 32.0% in Group D. Such loss to follow-up would most likely bias results and the ability to reach definitive conclusions, given the differences in attrition rates among groups and if loss to follow-up occurred non-randomly. Since the effect of loss to follow-up could not be minimized by removing baseline childcare centers that did not complete follow-up surveys, the planned statistical analyses could not be performed; therefore, conclusions drawn, based on descriptive findings, are limited. Future evaluation designs involving comparison of baseline and follow-up data should attempt to minimize loss to follow-up as much as possible, and if it does occur above an acceptable threshold, careful tracking of baseline and follow-up participants should be in place in order to minimize the effect, and ultimately, be able to provide conclusive answers to the evaluation questions.

An additional limitation was the possibility of response bias related to social desirability for childcare centers in Group A, which received mini-grant funds, training, and program materials. Since they were aware of the expectations and requirements of being in the comprehensive intervention group and the lack of anonymity, their responses may have been more agreeable as a reflection of this bias.

Discussion and Recommendations

Even in the absence of statistical testing, the comparison of baseline and follow-evaluation survey data provided some insight on evaluation questions related to the effectiveness and sustainability of the *Sun Blocks* pilot program implemented at childcare centers across 15 counties in Maine. These highlights are included below.

For the question "Are educational materials alone enough to impact behaviors and programmatic changes related to sun safety?," childcare centers in Group C fared better than those in Group D, the control group, for four out of six sun protection practices, and were comparable to Groups A-B, which received education materials in combination with some other intervention, for all six practices. For policy and programming, childcare centers in Group C fared better than those in Group D, but not comparable to those in Groups A-B. The descriptive findings suggest that educational materials may impact behavior to some degree, but are not sufficient to affect programmatic change needed for sustainability.

For the question "Is complementary training necessary to impact behaviors and programmatic changes related to sun safety?," there were differences in frequency results related to sun protection practices for childcare centers in Groups A-B versus Groups C-D, with childcare centers in Groups A-B more likely to promote sun protection practices "often" or "always." For policy and programming, childcare centers in Groups A-B were more likely to provide sun protection training to staff, sun protection information to parents, and integrate sun protection activities and lessons into the curriculum, compared to childcare centers in Groups C-D. The

descriptive findings suggest that complementary training positively impacts sun safety behaviors, and provides a means of initiating programmatic change needed for sustainability.

For the question "Is supplementary funding necessary to impact behaviors and programmatic changes related to sun safety?," there did not appear to be large differences in the frequency results related to sun protection practices for respondents in Group A versus Groups B-D. In fact, Group D, the control group, had frequency results comparable to Group A for practices such as application of sunscreen, and encouraging children to wear hats during outdoor activities. For policy and programming, childcare centers in Group A were more likely to provide sun protection training to staff, sun protection information to parents, and integrate sun protection activities and lessons into the curriculum, compared to childcare centers in Groups B-D. The descriptive findings suggest that while supplementary funding may create more of an incentive to initiate programmatic change, it may not be necessary to impact behaviors. However, finding that 66.7% (n=16) of childcare centers in Group A reported that their center's physical environment had changed over the past year, compared to 30.0% (n=3) in Group B, coupled with the fact that 83.3% of those in Group A used their funds to build shade structures and improve the shade in play areas, suggests that supplemental funding, while perhaps not necessary for behavior change, may be necessary for changing the physical environment—a key element in sustainability.

Specific barriers identified by respondents in Groups A-B in implementation of a sun safety program within the childcare setting included funding, restrictions on altering the current physical location, and a lengthy approval process in one case. Other barriers used to qualify quantitative responses included insufficient parental involvement in supplying hats or sun glasses for their children, and variation in the frequency of sunscreen application in summer versus winter months.

Overall, the findings from the *Sun Blocks* pilot program provide an evaluation of various interventions implemented in order to impact practices, policies, and programming at childcare centers in Maine. Based on descriptive findings from the follow-up evaluation survey, it would appear that childcare centers in Group D, the control group, would need programmatic support in a comprehensive package, which includes training and program materials, in order to positively impact their sun protection practices, policies, and programming. While funding could enhance a center's ability to sustain such a program by providing a means of changing the physical environment, a comprehensive program that includes educational materials and complementary training without the provision of funding, may still be effective in impacting and changing sun safety practices within the childcare setting.

Elementary School Sun Safety Mini-Grants Program

Background

In the current round of Elementary School Sun Safety grant funding, the MCCCP provided funds to the Maine Department of Education (DOE) for public elementary schools to apply for the amount of $500 to support skin cancer prevention. Based on the Centers for Disease Control and Prevention's School Recommendations for Skin Cancer Prevention, grantees were asked to focus on educating students, faculty, and staff on sun protection behavior, including wearing protective clothing (pants, long-sleeve shirts, hats, sunglasses), applying sunscreen with an SPF of 15 or higher, and seeking shade when outdoors. As in the past, the grant program was administered by the DOE with the final evaluation being completed by the MCCCP independent evaluator.

Grant Implementation

"Shade shelter" built using mini-grant funds at Dresden Elementary School.

During this round of funding thirty-six elementary schools across Maine applied for, and were awarded, sun safety mini-grants. Grant funded activities could include special event days, incorporating skin cancer prevention education into comprehensive school health education, developing educational materials, purchasing and building shade structures (trees, awnings, etc) to the school campus, and/or providing faculty and staff training. Additionally, grantees were expected to develop school-wide sun protection guidelines, based on the CDC's Recommendations.

The goal of the mini-grants was to increase awareness, and use, of sun protection methods by Maine children in order to prevent skin cancer. The grant objectives included:

Objective 1: To increase the number of Maine elementary school students, faculty, and staff who have received skin cancer prevention education.

Objective 2: To increase the number of elementary schools in Maine that have developed school-wide sun protection guidelines.

Evaluation Methods

Mini-grant recipients were asked to complete a narrative final report detailing the following:

- Their sun safety activities;
- Barriers to grant implementation;
- Grant accomplishments;
- Additional support received for grant activities;
- Sustainability plans for grant initiatives;
- Numbers of students and staff reached through the grant; and
- Information about the sun protection guidelines they developed.

Grant recipients were provided a final report document that asked seven questions concerning grant implementation (Appendix J). Additionally, those schools who failed to submit their final report were sent an electronic evaluation survey (Appendix K) by the independent

evaluator. As the Appendices documents indicate, the evaluation survey tool incorporated all of the questions in the final report document so it is the seven questions on the final report form that will be addressed in this evaluation.

Combining the two report formats, this evaluation reflects data from the 29 schools that returned either their final report or the evaluation survey. Since 36 schools received grant funds but only 29 completed reports, the response rate for this evaluation is 81% (*n*=29) for the schools that were funded to complete sun safety activities in this grant cycle. The following summary findings are based on the 29 schools who returned reports/surveys unless otherwise noted.

Key Findings

I. Grant Activities Completed

Mini-grant recipients were asked to describe the activities completed for this grant. The majority of schools completed a variety of activities, most of which could be categorized as an educational activity or program, development of educational and or outreach materials, special event days, development of a sun structure, and development of sun safety guidelines as specified in the grant.

A. Educational and Environmental activities/program for students, faculty, staff

Table 13 provides a summary of the responses, frequency of responses, and examples for the specific categories of educational/environmental activities undertaken by schools which are listed below.

- Distribution and demonstration of sun safety products
  - Sun safety water bottles
  - UV beads and bracelets
  - Bucket hats and ball caps
  - Sun safety frisbees and pencils
  - UV meter

Poster created by a student at Dresden Elementary school as part of their Sun Safety Poster Contest.

- Classroom education
  - Sun safety curriculum – within the health curriculum and otherwise
  - Making UV bead bracelets & decorating sun hats
  - Weekly tips shared and posted
  - Class discussions
  - Creating library catalogues of sun safety lessons and activities

- Development or use of educational/outreach materials
  - Parent education (pamphlets and student handbooks)
  - Bulletin/display boards and posters
  - Newsletters
  - Brochures
  - Sun safety kits
  - Videos and Powerpoint presentations

- School-wide special events
    - Health or wellness fairs, sun safety booths, etc.
    - Guest speakers
    - Sun safety event for whole school, such as sun safety field day
    - Poster contest
    - Sun safety concert

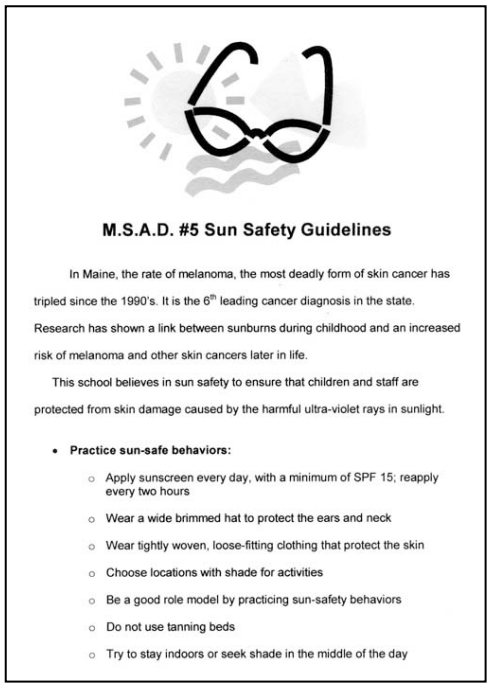
- Construction of Sun Structures
    - Shade trees
    - Sun shelters (e.g., gazebo, playground shade shelter, etc.)
    - Including area to play and/or eat (e.g., picnic tables with umbrellas, collapsible sun shade, etc.)
    - Hoophouse/greenhouse with backyard habitat that has shade trees

Table 13: *Grant Activities Reported by Schools*

ACTIVITY	FREQUENCY	EXAMPLE
Distribution and demonstration of sun safety products	100%	*"On field day each student decorated a hat to wear…which are now kept in classroom for regular use during recess and PE."* *"Children and adults who attended the fair…could decorate a baseball cap with sun safety images and wording and make a UV sun sensitive bracelet to take with them."*
Development or use of educational/outreach materials	83%	*"A group of gifted and talented students created a tri-fold with information, including websites about sun safety. Their brochures were distributed to all students…"* *"Educational materials were made available to all families (over 600) through newsletters to all parents focused on Sun Safety education to coincide with Sun Safety Week."*
Classroom education	62%	*"All fifth grade students participated in a 45-60 minute health lesson…"* *"PE teacher taught basic sun safety to all students…"*

ACTIVITY	FREQUENCY	EXAMPLE
Construction of Sun Structures	59%	*"Students planted shade trees and worked in the hoophouse…[it] provided an opportunity for students to plant, weed, water and harvest produce in a sun free area."* *"two trees were planted and a school-wide ceremony was held."* *"The school's maintenance department constructed our shade shelter…while it exceeded the amount we received…the maintenance department agreed to help us with the cost difference…the shelter has two picnic tables under it…"*
School-wide special events	52%	*"We had a hugely successful concert which included activities to promote sun safety awareness and attracted a broad audience."* *"There were two guest speakers…a dermatologist…a meteorologist…and town arborist came to help us plant a red maple…"*

B. Sun Protection Policy Development



M.S.A.D. #5 Sun Safety Guidelines

In Maine, the rate of melanoma, the most deadly form of skin cancer has tripled since the 1990's. It is the 6th leading cancer diagnosis in the state. Research has shown a link between sunburns during childhood and an increased risk of melanoma and other skin cancers later in life.

This school believes in sun safety to ensure that children and staff are protected from skin damage caused by the harmful ultra-violet rays in sunlight.

- **Practice sun-safe behaviors:**
  - Apply sunscreen every day, with a minimum of SPF 15; reapply every two hours
  - Wear a wide brimmed hat to protect the ears and neck
  - Wear tightly woven, loose-fitting clothing that protect the skin
  - Choose locations with shade for activities
  - Be a good role model by practicing sun-safety behaviors
  - Do not use tanning beds
  - Try to stay indoors or seek shade in the middle of the day

Respondents were asked if their school currently had or were developing sun protection guidelines. Twenty-seven schools (93%) responded to the question about developing guidelines. For those 27 schools, 19 (70%) reported having sun protection guidelines completed, and another five (19%) reported guideline development as in progress. In progress ranged from formation of a committee to draft guidelines to having draft guidelines that are awaiting school board approval. Ultimately there were only three schools (11%) that indicated they don't have guidelines nor a process for developing them, and those can be characterized by the following comment by a first year school nurse charged with implementing the program:

"I do not believe there are actual sun protection guidelines, however each teacher includes sun safety and protection into their daily lessons just as they would proper hand washing for example. Teachers also are very proactive about providing sun screen which they tend to purchase out of their own money. I would say that guidelines need to be implemented and that perhaps now…with a year under our belts, we'd be ready to come up with something formal."

Most of the schools listed sun protection guideline development as a grant activity which suggests that the mini-grants did help to achieve the grant's objective to increase the number of schools with sun safety guidelines. Many schools laminated and posted the school sun protection polices at the school entrance and in each classroom.

II. Barriers to Grant Implementation

Respondents were asked to identify any barriers they encountered while implementing this grant. Twenty-three schools (79%) responded to this question and for those schools 35% indicated they ran into "none." Among those responses were statements such as , *"We did not encounter any obstacles. Faculty and staff were receptive to sun safety education,"* And *"Our project went very smoothly without any obstacles. We had school board approval and permits…,"* and *"None – this was an easy program to develop."*

In terms of barriers, 35% indicated that time and scheduling presented the greatest barrier. And another 30% indicated that financial aspects of the mini-grant, such as timing of the release of funds, check getting sent to the wrong place, and expense of materials, was a substantial barrier. A summary of these findings is located below in Table 14.

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Table 14: *Barriers To Implementation Of Sun Safety Grants*

Barrier	Frequency	Example
Time constraints including: • Timing in school year • Scheduling of time • Teacher's time	35%	*"Our biggest obstacle was time as the funding arrived near end of school year…second obstacle was organization and scheduling so that we minimized interference with classroom instruction…"* *"The greatest obstacle was time. I would have liked to have spent time…with in-depth sun protection education… I should have asked the teachers to be more involved..."* *"The obstacle that is the biggest deterrent to any additional activities is time. Staff have essential curriculum that consumes most of the short school day. Adding any 'other' activities is difficult…"* *"Obstacles experienced related to teachers feeling put upon to incorporate more into their curriculums than they have time for…"*

Barrier	Frequency	Example
Financial issues including: • Receiving funds • Expense of materials & structures	30%	*"The only obstacle I encountered was not enough monies for everything I wanted to do."* *"…we have experienced difficulty in finding an affordable solution for the physical shading we hope to provide on our playground…"* *"Obtaining the check…went to district office…we did not get the money until late this fall…could not proceed with phase two…"*
Other barriers	30%	*"An obstacle…is knowing that 100% of our K-5 teachers actually taught the entire sun safety lesson…however, from the reports I got…we did fairly well in the implementation."* *"Wellness team submitted proposal to administration to consider alternative "mini-recess time" to prevent prolonged exposure…proposal was rejected."* *"The weather!!..."*

II. Grant Successes

Schools were asked to describe the major skin cancer prevention successes they accomplished as a result of the mini-grant. Twenty-five respondents (86%) answered this question. Most schools noted the increase in awareness and or expanded knowledge of sun safety issues among students, faculty, staff and parents as a major success. This would suggest that the mini-grant achieved its first objective of educating students, faculty and staff.

Specifically, successes were identified in four broad categories: (1) awareness/expanded knowledge, (2) reach of grant, (3) policy development and implementation, and (4) creation of shaded space for student activities. For a number of grantees, multiple successes were identified and a sampling of report comments is provided below.

a. Awareness and or expanded knowledge of sun protection issues included comments about promoting and increasing awareness of sun safety issues among students, faculty, staff, parents and the community (people "talking about" sun safety) was identified as a success by almost a third of the schools (32%). The following comment represents the sentiment of these comments:

"I believe the major success…is awareness. To educate individual classes as well as reinforcement with the health fair…bulletin board on sun safe practices…they all continue to help remind the students of sun safe practices and skin cancer prevention…"

b. The grant providing an ability to have greater reach both in the school and within the community was identified as a success by 24% of respondents. Among the comments about reach were the following:

"The major success of this program was my ability to reach all students and staff with the message to practice sun safety."

"The sun safety portion of the Wellness Fair was effective in informing the public…"

"One of the major successes was that I was able to purchase just enough with the grant money so that EVERY grade level received something relating to sun safety."

c. The development and implementation of Sun Protection/Safety Policies as a catalyst for grant success was identified by 12 % of respondents. A sample of these comments is:

"This process caused us to reevaluate our policies related to the amount of time children are outside in the sun…the major success is that we are looking at these areas in a new view."

d. The creation of a shade structure as positive environmental change was identified as a major success for 12% of respondents. A sample of these comments is:

"Now that we have this shaded space on our playground, students will be able to go outside on warm days to do their class work…to use the space during recess…special performances…reading aloud times."

Additionally there were a number of schools that identified their success as the impact of the multiple sun safety activities they undertook with the grant funds, i.e. the impact of all grant activities on the overall success of the program. A few examples of how some schools identified their major successes in this intersecting fashion include:

"The major activities were the lessons in all classrooms, the trees being plants, and the parents getting the Sun Safety Guide. Another unintended consequence was developing a relationship with our local chapter of the ACS…"

"We got staff and students thinking about skin cancer prevention while we also obtained some significant shade on our playground."

"Having the opportunity to start this kind of education with students and community was easy to implement and blend with the regular curriculum"

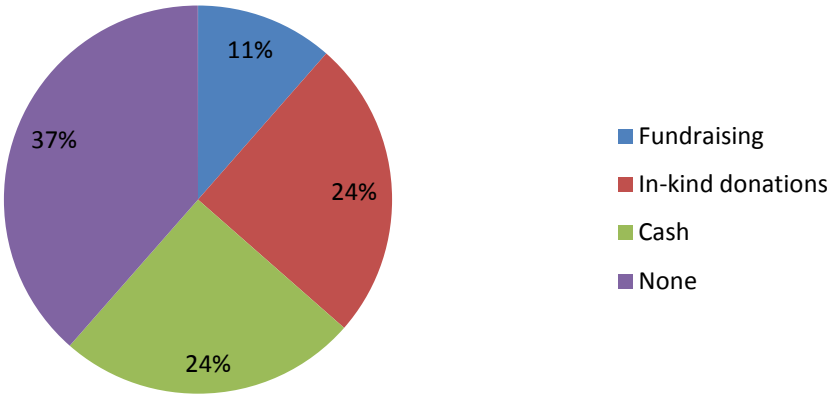
III. Additional Support

Grantees were asked to reflect on additional resources they may have generated to support grant activities. Twenty-three grantees (79%) responded to this question with many citing multiple kinds of external or community support for their sun safety grant efforts. In many cases the additional support was required in order to create some sort of sun protection

structure as the $500 Sun Safety Mini-Grant was not by itself enough to cover the costs of many of the structures erected.

From the reports submitted, external support generated (or not) to enhance the work of the Sun Safety grants falls into four categories: (1) None, (2) Cash, (3) In-kind donations, and (4) fundraising activities. As Figure 24 indicates, just over a third of the schools (37%) did not supplement the grants with additional external support. In-kind and cash support each represent just over a quarter (26%) of the external support generated. And fundraising makes up the remaining 11% of additional funds raised to supplement the Sun Safety Mini-Grants.

Figure 24: *Supplemental Funds Generated for Grant Activities (N=27)*



Note: Number of responses includes multiple responses from single source

Of particular interest is the amount of actual cash that was raised (and reported as some fundraising did not include a monetary amount) by six schools, $12,367, with individual school amounts ranging from $100 to $10,000. Over $11,000 of those funds were used to construct shade structures. Other cash funds went for materials and supplies for specific activities. In-kind donations were also predominantly associated with creating shade structures with things like trees, equipment, architectural services, concrete, and volunteer labor all being donated to complete the creation of shade on school playgrounds.

IV. Sustainability

Lastly, grantees were asked to share their sustainability plan for continuing sun safety activities begun under this grant. Only twenty schools (69%) answered this question, however, some of those schools listed multiple items to address sustainability. Thus, there were 29 sustainability activities identified under this report question and as reflected in Table 15, they include embedding lessons in curriculum, shade space created by structures, implementation of sun protection policies, annual school-wide events, and other activities.

Table 15: *Sustainability Activities Identified*

Type of Sustainability Activity	Frequency	Example
Sun Safety lessons embedded in regular curriculum	28%	*"Protecting and educating students about skin cancer and sun concerns is a regular part of our health curriculum"*
Shaded space/structure as sustainability	21%	*"The gazebo will provide us with years of safe outdoor shade."*
Implementation of Sun Protection Policies	21%	*"The health committee will continue to monitor sun safety needs during our regular meetings, as mandated by the sun safety policy."* *"Each year the school nurse and principal will review our guidelines for the school handbook."*
Annual School-wide events	17%	*"The school will include skin cancer information table at the Annual Wellness Fair and continue to inform parents & students of the importance of clothing coverage in the student handbook."* *"..run a school-wide poster contest activity prior to our field day activities next year"*
Other activities	13%	*"…putting together "info-mercial" to be recorded and televised…to be shown on public access TV and at school…post article in newsletter annually…"* *"…we were able to order extra sun safety bracelets to be utilized next spring in another sun safety lesson…"*

V. Outcomes Achieved

As stated in the grant application the two major outcomes expected for the Elementary School Sun Safety Mini-Grant program to promote skin cancer prevention are:

1. The development and implementation of sun protection guidelines.
2. The number of students and staff who have received skin cancer prevention education and materials.

As noted earlier in this report, the current year of grant funding has been successful in reaching the first outcome identified above, whereas 89% of schools either have guidelines completed or in progress. As previous narrative also indicates, the grantees have been successful in reaching the second outcome as well. The specific numbers for the second outcome are as follows:

- Twenty-five respondents (86%) answered the question concerning how many students and or staff their skin cancer prevention activities had reached.

- Two of those 25 provided answers which cannot be included in the statistical calculation but clearly reflect that a large additional number of students and staff were reached – one reported *"all students and staff,"* and the second reported a single combined number for students and staff of *450.*

- Thus, for the other 23 numerical responses reported, the combined reach of the grant activities is:

    - 6,031 students
    - 484 staff
    - 58 others, including 12 high schools students who helped with activities, 20 parent volunteers, and 26 community volunteers

Conclusions and Recommendations

The key findings reflected above suggest the following grant objectives were reached:

Objective 1: To increase the number of Maine elementary school students, faculty, and staff who have received skin cancer prevention education.

Objective 2: To increase the number of elementary schools in Maine that have developed school-wide sun protection guidelines.

Additionally, as the above narrative indicates, schools went above and beyond the parameters of the grant application, for example in raising supplemental funds for expansive shade structures. The obstacles to grant implementation identified did not hold back most of the grantees. A number of grantees indicated that they would welcome the opportunity to apply for another round of funding. And, many noted in their reports how appreciative they were of the fund and how those funds had served as a catalyst to expand the reach of their sun safety activities. The following two examples of the general comments capture the overall tenor of the many general comments:

"Thank you for the grant monies…I strongly believe this education is vital to all students at these age levels."

"I would like to thank you for giving me the opportunity to arrange school wide activities and health lessons that focused on sun protection. Students and staff were motivated to discuss the importance of sun safety and I was pleased to learn how aware that many students are about the dangers of too much sun exposure. Discussions with students proved that they are anxious to make good decisions and that they want to make healthy choices. Thanks you so much for awarding us the grants."

While the program continues to be very successful in reaching its objectives, there are a few logistical recommendations that can be made to improve the administration of the mini-grant program. They are as follows:

- In order to increase the schools' ability to complete all activities, consider revising the grant timeline and fund distribution.
- Many schools noted the unanticipated expense of a sun shade structure. Provide resources for sun shade development to help inform schools' planning for use of funds in this way. Also encourage peer to peer support around fundraising for additional funds – a number of schools this year were successful in raising additional money for structures and might be able to "mentor" other schools who need additional funds for playground structures.
- Create an online reporting form to increase the return rate, ease the burden of school representatives and enhance data analysis.

Colorectal Cancer Screening: Healthy Maine Partnerships

Background

Approximately 880 Mainers develop colorectal cancer every year, and over 300 die from the disease annually. It is the second leading cancer killer of both men and women in Maine. Many deaths from colorectal cancer are preventable through early detection. Screening can also prevent colorectal cancer from developing, since polyps that might later become cancerous can be removed during a colonoscopy. However, fewer than half of Mainers over age 50 who are of average risk get screened for colorectal cancer, despite the availability of effective screening tests.

In early 2008 The Maine Comprehensive Cancer Control Program (MCCCP) announced the availability of funds to support the Healthy Maine Partnerships (HMP) with additional resources to enhance their on-going colorectal cancer prevention and awareness activities. The purpose of the Colorectal Cancer Screening and Awareness Community Grants is to develop community-based projects to increase awareness of the importance of screening for colorectal cancer, especially among adults over the age of fifty.

During the first year of these 3-year grants, HMP across the eight public health districts were encouraged to apply for new funds to: (1) conduct in-depth analysis of barriers to colorectal cancer screening, (2) inventory current community-based colorectal cancer programs and activities; (3) develop partnerships to address colorectal cancer; and (4) develop a plan for addressing colorectal cancer and its screening barriers over the next two years. Assessing

capacity in year one set the foundation for implementing the priorities in the approved district-wide colorectal cancer plans in years two and three.

Design & Methodology

Community assessment and identification of barriers lead quite naturally to recommendations and actions for elimination of those barriers. As part of the first year of funding, each of the districts was asked to develop a district-wide colorectal cancer plan for addressing the barriers identified in their community assessments. Funding in years two and three is allowing coalitions to focus on implementing the priorities of those district-wide plans. As may have been anticipated, community recommendations and or action steps for addressing barriers are similar across the districts with some specificity for the individual characteristics of each community coalition.

After completing the year-one assessments, recommendations for addressing the barriers identified fell into five broad categories: (1) Public Awareness Campaign; (2) Education Initiatives; (3) Practice Changes; (4) Capacity Building; and (5) Strengthening Partnerships. This evaluation report highlights the activities and efforts undertaken within those five programmatic areas during grant year two. The independent program evaluator specifically reviewed HMP efforts within the five categories, as well as barriers and enhancers to plan implementation. Additionally this evaluation reviews partnerships formed, populations reached, and plan objectives achieved.

All eight public health districts undertook public awareness, educational, partnership, practice change and or capacity building activities at various levels utilizing their colorectal cancer grant funds in year two of the three year funding cycle. As with much of the work done by the HMP, where each community coalition is an individual entity, each community (or partnership of communities) within a district developed a unique plan for addressing colorectal cancer barriers in their region. In some districts a number of coalitions worked together on a unified plan that allowed flexibility to address individual community dynamics.

That said, across all the districts almost a third of the grantees, four of fourteen (or 29%), engaged in all five grant activity areas. All grantees (100%) directed a portion of their efforts in the area of public awareness. Close to all (93%) identified strengthening partnerships as an area of focus for grant activities. Sixty-four percent (64%) of the grantees engaged in education initiatives and or capacity building activities during the year. Affecting practice change was taken on by only about a third of the grantees (36%) and for most of those the percentage of grant time directed to practice change activities was not significant.

Table 16 below captures the responses of the grantees to a question asking grantees to estimate the percentage of their year two grant time allocated in each of the five programmatic areas. As the chart reflects, over half of grant time (58%) for all grantees was devoted to activities in the areas of public awareness campaigns and building/strengthening partnerships. Within that 58% of grant time expended, an average of 43% of time was spent on public awareness activities and an average of 15% of time was spent on partnership activities. While education initiatives garnered an average of 34% of time, they did so for only 9 grantees versus the 14 and 13, respectively, which engaged in public awareness and partnership activities.

Table 16: *Percentage of Time Spent on Program Areas*

GRANT ACTIVITY	Percentage of Grantees who engaged in this activity	Average percentage of time engaged grantees spent on this activity	Range of percentages of grant time devoted to this activity	Types of activities undertaken
Public Awareness Campaign	100%	43%	5% to 95%	What You Do Matters website, radio PSAs and newspaper/newsletter & grocery inserts
Strengthening Partnerships	93%	15%	5% to 30%	Partnered with Chambers of Commerce, Health Care/Hospital Networks, & Bangor Hydro
Education Initiatives	64%	34%	10% to 75%	Worksite, civic & church group presentations, and professional presentations by physicians/nurses
Capacity Building	64%	19%	5% to 40%	Surveying surgeons for screening capacity & working w/primary care providers to build capacity
Practice Changes	36%	21%	10% to 30%	Provide resources to primary care providers to create registry/tracking system for patients over 50

Evaluation Results

A. Workplan Implementation

Fourteen out of 14 grantees returned the evaluation survey (Appendix L) that was sent out electronically to HMP in early June of 2009. It is clear from those surveys that all districts have begun the 2-year process of implementing the plans they developed last year. Grantees were asked how their workplan had changed since its development in year one and almost half (43%) indicated they had made changes.

For a number of HMP the changes to their original plans were necessary and they have therefore adjusted or adapted the plans created a year ago. There appear to be two aspects to the changes, one being changes to plans based on environmental circumstances, and the second being that it is year one in a 2-year implementation process.

The reason for making changes included:

- Too ambitious given the resources actual available;
- Desire to attend to partner/community needs to better enhance relationships and to access certain locations, for example, worksites;
- The work with specific populations (for example, employers) was different than anticipated leading to changes in program activities and directions;
- Elimination of unrealistic objectives.

Similarly, when asked if they had completed the activities identified in their plans, only 29% felt they had completed the activities, while 64% responded that they had not. A number identified that they have spent this year developing materials and relationships that can be utilized in the upcoming year. So while it is not unusual that all activities would not be complete, given it is the first year of a 2-year plan, there were some issues raised that may warrant concern as HMP move forward. Issues around not being able to access data or medical providers declining to participate in educational seminars are grounded concerns that may impact year three implementation of workplans.

B. Community/External Supports to Grant Work

Grantees were asked to identify enhancers to implementing their grant activities and there were a large range of community and external supports identified. Thirteen of the fourteen respondents identified at least one community support that made their work easier and or extended the reach of their work. Building on existing relationships/partnerships and or services/activities was repeatedly raised as "helping" with plan implementation. Integration of programs and materials, as well as being able to utilize existing materials, were also seen as enhancing their work by allowing for boarder outreach.

C. Barriers to Grant Work

Grantees were also asked to identify any barriers to implementing their workplans and all 14 respondents identified at least one barrier. The most common barriers were time, money/funding, and resistance from specific groups they had targeted in their plans, such as employees at worksites. A sampling of comments concerning barriers follows:

- "*We haven't made as much progress as we'd like with worksites…haven't been as successful with the worksite based strategies.*"
- "*Lack of time and hours allotted to work on projects is the only significant barrier.*"
- "*Physicians who perform procedure are at capacity…we need to increase the capacity of providing the service in a timely manner.*"
- "*The reluctance to talk about the subject of colon cancer.*"
- "*Not able to do professional training as providers not interested.*"

D. Partnerships Developed

The survey included two questions pertaining to the partnerships that have resulted from the grant work. The first asked what partnerships have been formed, and the second asked for examples of joint activities accomplished with those partners. Reflecting the grant application priorities, the most frequently cited partners were in the health system, including physicians, hospitals, and health care providers. The next most frequent partnerships were forged with local and district-wide businesses. Table 17 captures a sampling of the range and type of partnerships that were developed with some of the many activities these partnerships undertook.

Table 17: *Range and Type of Partnerships Developed Through Grant Activities*

Partnerships Developed	Types of Activities Accomplished
Primary Care Providers and Health Care Providers	Provider tool kits and outreach tools; Provider trainings
Physicians	Provide screenings
Hospitals **Hospital PR staff**	Hospital provided doctors and nurses for professional trainings and presentations; Joint article on screening
Local businesses	Presentations and educational materials
Grocery stores	Awareness insert distribution
Bangor Hydro and CMP	Awareness insert distribution
Banks	Work with wellness programs
Co-operative Extension	Flyer in newsletter
Food pantries	Educational materials
Media	PSA development and distribution
Local Health Department	Joint website message development

E. Priority Populations Reached

The colorectal screening grant application identified three priority populations it hopes the HMP will reach as they complete their workplans — community members over 50 years of age, local employees and employers, and healthcare providers. Additionally, each HMP has priority populations it hopes to reach beyond those identified in the grant application. While priority populations were often the same, ten grantees (71%) identified specific populations in

addition to the grant priorities. Thirteen of 14 HMP (93%) worked with healthcare providers and with community members over 50, and ten (71%) worked with employers and employees. Table 18 depicts the populations HMP worked with and some of the places where they did that work.

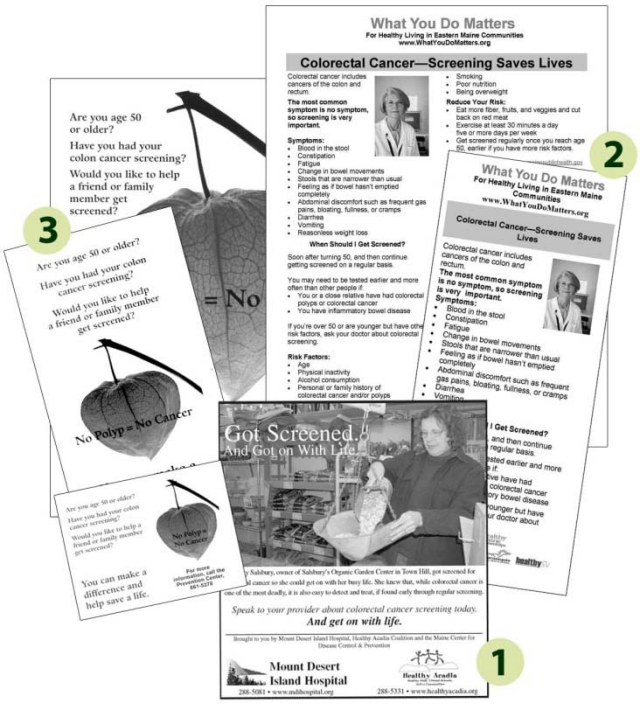
Table 18: *Populations impacted by HMP outreach*

Population: Community members 50 years and over 93% of HMP targeted some of their activities to this group
Venues: Community events; newsletters; website colorectal screening page; restaurants; newspapers; flyers/inserts; pamphlets; health classes; town offices; business worksites; hospitals; department stores; radio spots & PSAs; wellness fairs; dance & martial arts classes; medical practices; banks; health care provider offices.
Population: Healthcare providers 93% of HMP targeted some of their activities to this group
Venues: Health newsletters; Healthy living prescription pad; physician practices; health clinics/centers; hospitals; public health departments; websites;
Population: Local employers and employees 71% of HMP targeted some of their activities to this group
Venues: Employee newsletters; worksite wellness programs; employee worksites; chamber of commerce; Business Community Wellness committee; school employee wellness fairs; "Healthy Maine Works" business members; banks; Me Tourist Bureau; ME Indian Education; educational seminars and information at business worksites.
Population: Other priority populations 71% of HMP targeted some of their activities to groups such as Rotary and Kiwanis members, food pantry clients, ME tourism Bureau, ME Indian Education, and more
Venues: Food pantries; Rotary Club; Kiwanis Club; Senior church group; quilting group; restaurants; health source corners; peer to peer outreach.

F. Materials and Resources Developed

These being colorectal cancer screening awareness grants, it is evident that HMP have devoted a portion of their grant funds to producing quality materials and resources for getting the message out successfully. Resources developed incorporate a range of formats from print (educational and media) to electronic/websites to PSAs and radio scripts. Among the materials and resources developed are the following:

- Colorectal Cancer Screening radio script
- Newspaper and newsletter articles, inserts and ads (1)
- 'What You Do Matters' website
- Supermarket insert (2)
- Informational flyers and brochures (3)
- Healthy living prescription pad
- Bookmarks
- Payroll stuffer
- Electric bill mailer
- Website quiz
- Displays
- Radio PSA



G. Conclusions

From an evaluation perspective the Colorectal Cancer Screening Awareness Grant program is on mark to meet its goals by the end of year three. The 14 HMP grantees are working hard to complete their workplans and if they continue as they have in year two, it would appear they will be successful. Across the board the grantees feel the grant program and its staff are supportive of the work they are doing. Many grantees commented that the MCCCP provides not only financial support but also knowledge, expertise, and direction when asked.

Grantees see the opportunity this grant program provides to increase awareness in their communities and to build local capacity. The partnerships being formed and the doors that are opening are acknowledged, appreciated and expanded wherever possible. The energy and commitment around these grants is best captured by on grantee who wrote this comment on the survey: *"Very positive experience because of the quality of the program and the responses from the press and public"*

Moving into the third year of the grant there appears to be little that needs changing. While there were some issues around getting grant funds distributed, it appears those have been resolved. Also, as noted earlier, there are some district-specific issues (such as some non-receptive providers) and statewide issues (such as accessing needed data) that may warrant watching in year three. However, at the end of year two, the overall implementation of the grant program seems solid, and there are no recommendations regarding changes to the program at this time.

Results Part III: Outcomes

Outcome evaluation is an important component of any comprehensive evaluation plan. In the previous two Results sections of the report, the process evaluations focused on program evaluation of activities and strategies designed to bring about the change, and specifically the extent to which implementation took place. In this evaluation, data will help determine the effectiveness of activities and strategies, i.e., the results of program implementation. Additionally, outcome data can highlight the anticipated and unanticipated changes brought about by the Cancer Plan. 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 as they are linked to specific goals outlined in the 2006–2010 Maine Comprehensive Cancer Control Cancer Plan. All objectives (with baseline data) that are included in this evaluation are listed below. Outcome data is also provided for CDC core indicators. Once again, the results should be interpreted with caution. While the program theory original set forth suggests that the accomplishments of specific strategies will lead to achieving objectives and ultimately, goals, there are a series of additional factors that clearly can impact program replication (*e.g.*, funding of initiatives). Until these factors are better understood, generalizations about changes in the data should be made with caution.

Additional outcome information on all cancers is accessible through *The Maine Cancer Surveillance Report 2009*, a comprehensive surveillance document and plan developed by the Maine Cancer Consortium Data Workgroup. Published in the fall of 2009, the document has been distributed widely and is available on the Maine Cancer Consortium's website, http://www.mainecancerconsortium.org/.

Intermediate Outcomes

As noted earlier in the AMT process evaluation, some of the goals and objectives of the Cancer Plan are not tracked by the workgroups or task forces. For example, some tobacco prevention activities are implemented and tracked through the Partnerships for Tobacco-Free Maine, while ALA tracks others. Outcome data for this report delineated as intermediate or long-term.

Intermediate outcomes focus on behavior and systems change. The Cancer Plan's intermediate outcomes can be categorized into risk factors and screening behaviors. Tables 19–10 provide data from the *Behavioral Risk Factor Surveillance System* (BRFSS) in Maine[2]. These data are collected annually through a random digit dial telephone survey of Maine adults. Data pertaining to youth are collected utilizing the Maine Youth Risk Behavior Surveillance System (MYRBS). This school-based survey is administered to 7th–12th grade students every two years. Citations are provided for data reported from additional sources.

[2] 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.*

Several caveats to the reported outcomes are warranted. First, some of the objectives as written are related to more than one data source. In these cases, several BRFSS or MYRBS questions are provided to elucidate the objectives. Second, the wording of some objectives is inconsistent with BRFSS wording, thus preventing or limiting multi-year comparisons. Moreover, in some cases (*i.e.*, tobacco) the baseline data source differs from the State's recommended data source. These instances are noted. In most cases the limited availability of data since baseline prevents the identification of trends in behavior and hampers the ability to measure the long-term impact of the Comprehensive Cancer Control efforts. Moreover, changes in data have not been tested for statistical differences; therefore behavior changes cannot be confirmed. Finally, not all of the Cancer Plan objectives are considered measurable and thus are not included in the following tables.

Goal: To reduce the initiation of tobacco use, to increase the number of people who successfully quit using tobacco, and to reduce exposure to secondhand smoke.

Table 19: *Intermediate Outcomes: Tobacco Use*

Measurable Objectives	Previous Plan [1]				New Plan		
	2002	2003	2004	2005	2006	2007	2008
Tobacco Use: Adults and Youth							
• Reduce proportion of Maine adults aged 18 and older who use tobacco products to 18% by 2010[2]	23.6%	23.6%	*21%	20.8%	20.9%	20.2%	18.25
• Reduce cigarette smoking among pregnant and postpartum women to 15% by 2010[3] o Pregnant women who smoked during last 3 months of pregnancy	16%	*16%	20%	17.5%	17.1%	19.9	NA
o Postpartum women who smoked after pregnancy	NA	*21%	24.5%	23.4%	20.9%	23.5%	NA
• Reduce tobacco use of 9-12th graders to 15% by 2010[4]	--	20.5%	--	*16.2%	--	14%	--
• Reduce tobacco use of 6 -8th graders to 5.5% by 2010[4]	--	8.7%	--	*7.5%	--	5.5%	--
• To increase the proportion of adults who receive advice to quit smoking from a health care professional by 2010	78.1%[5]	--	74.9%[6]	--	NA	58.0%[7]	--
• Reduce involuntary exposure to secondhand smoke for all Maine residents[6] o Proportion of Maine adults who report no exposure to secondhand smoke at their workplace	--	--	75.4%	NA	NA	65.4%[7]	NA

Measurable Objectives	Previous Plan [1]				New Plan		
	2002	2003	2004	2005	2006	2007	2008
Tobacco Use: Adults and Youth (cont'd)							
o Proportion Maine workplaces that do not allow smoking in any work areas	87.5%[5]		89.4%	NA	NA	86.7%[7]	NA
o Proportion of Maine adults who do not allow smoking in their homes	63.3%[5]	--	71.6%	NA	NA	79.8%[7]	NA

Notes:

[1] Plan objectives have changed since the previous 2001-2005 Cancer Plan, thus the purpose of these numbers is to provide a 5-year snapshot of the current objective.

[2] Results based on current cigarette smokers [have smoked 100 cigarettes in their lifetime and smoke now]

[3] Maine Pregnancy Risk Assessment System (PRAMS)

[4] Results based on current cigarette smokers, MYRBS [smoked in the last 30 days]

[5] Results based on 2000 Adult Tobacco Survey, 2002 data not collected. Baseline reported in the Cancer Plan from BRFSS and is not comparable to current data, thus it is not reported in this report.

[6] 2004 results based on Maine Adult Tobacco Survey, questions may vary in sampling and wording from BRFSS 2000, 2002 baseline listed in Cancer Plan.

[7] BRFSS 2007 data not comparable to previous years from Maine Tobacco survey

* = Baseline as listed in 2006-2010 Cancer Plan

- - = Data not collected (MYRBS survey administered on odd years only)

The tobacco use results suggest that the rate of current adult smokers has declined since 2002. Youth smoking rates have also decreased, according to trend analyses conducted using the Maine Youth Risk Behavior Survey. Results from the MYRBS indicate that the percentage of high school students who smoked cigarettes during the past 30 days decreased from 20.5% in 2003 to 14% in 2007. Moreover, according to the MYRBS, the percentage of middle-school students who smoked cigarettes in the past 30 days decreased from 8.7% in 2001 to 5.5% in 2007. It remains to be seen if the youth smoking rates continue to decline as more recent numbers become available. Thus, any change in this objective since baseline is unknown. Finally, the data suggest that since 2000 progress has been made in terms of exposure to secondhand smoke, with approximately 80% of adults banning smoking in their homes, up from 63% in 2000. Although the data source has shifted from the Adult Tobacco Survey to BRFSS, the survey question is similar enough to suggest the change is valid. Data being collected for 2008/09 will help elucidate further changes in tobacco-related behavior.

Goal: To reduce and prevent adult risk of colorectal and other cancers through healthful eating habits and physical activity.

Goal: To reduce risk of colorectal and other cancers through healthful eating habits and physical activity beginning as a child.

Table 20: *Intermediate Outcomes: Physical Activity and Nutrition, Overweight/Obesity*

Measurable Objectives	Previous Plan[1]				New Plan		
	2002	2003	2004	2005	2006	2007	2008
Physical Activity and Nutrition, Overweight/Obesity: Adults							
• Increase to 30% the proportion of adults who consume five or more servings of fruits and vegetables every day by 2010	29.4%	*27%	- -	28.7%	NA	29%	NA
• Reduce the proportion of adults that are overweight[2] to 35% by 2010	38%	38.3%	*37.6%	36.9%	36.6%	38%	36%
• Reduce the proportion of adults that are obese to 20% by 2010[3]	20.7%	19.9%	*23.4%	22.7%	23.1%	25%	25.9%
• Increase to 80% the proportion of adults who participate in any physical activities in the past month[4]	74.2%	79.4%	*78.5%	77.7%	79.1%	77.5%	77.2%
• Increase to 55% the proportion of adults who participate in 30 minutes of moderate physical activity five or more days per week OR vigorous physical activity 20+ minutes for three or more days per week	--	*53.1%	--	54.1%	NA	56%	NA

Notes:

[1] Plan objectives have changed since the previous 2001-2005 Cancer Plan, thus the purpose of these numbers is to provide a 5-year snapshot of the current objective.

[2] Overweight based on Body Mass Index of 25 – 29.9

[3] Obese based on Body Mass Index of $\geq$ 30

[4] BRFSS, 2003-2005. Question wording may differ from previous versions. "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"

[5] High School students, MYRBS

[6] Maine Child Health Survey 2009 data will be available in Dec. 2009 or Jan.2010.

* = Baseline as listed in 2006-2010 Cancer Plan

NA = Data not available/not yet provided

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

Measurable Objectives	Previous Plan[1]				New Plan		
	2002	2003	2004	2005	2006	2007	2008
Physical Activity and Nutrition, Overweight/Obesity: Youth							
• Increase to 35% the proportion of youth who consume five or more servings of fruits and vegetables per day by 2010[5].	--	*22.6%	--	18.9%	--	20%	--
• Reduce the proportion of youth who are overweight to 5% or at risk for being overweight to 10% by 2010							
o High School overweight	--	*13%	--	10.9%	--	13%	--
o High School at risk	--	*15%	--	14.4%	--	13%	--
o Middle School overweight	--	*13%	--	12.2%	--	NA	--
o Middle School at risk	--	*18%	--	15%	--	NA	--
• Reduce the proportion of kindergarten students who are overweight to 5% or at risk for being overweight to 10% by 2010[6]							
o Overweight	15.2%		*15%	NA	--	NA	--
o At risk	21.3%		*18%	NA	--	NA	--
• Increase to 80% the proportion of youth who engage in vigorous physical activity three or more days per week for 20 minutes or more each time by 2010							
o High School	--	*61%	--	62.3%	--	59.7	--
o Middle School	--	*72%	--	74.7%	--	72.7	--

Notes:

[1] Plan objectives have changed since the previous 2001-2005 Cancer Plan, thus the purpose of these numbers is to provide a 5-year snapshot of the current objective.

[2] Overweight based on Body Mass Index of 25 – 29.9

[3] Obese based on Body Mass Index of $\geq$ 30

[4] BRFSS, 2003-2005. Question wording may differ from previous versions. "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"

[5] High School students, MYRBS

[6] Maine Child Health Survey 2009 data will be available in Dec. 2009 or Jan.2010.

* = Baseline as listed in 2006-2010 Cancer Plan

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 20 suggest that adults have continued to increase fruit and vegetable consumption over the past several years, nearly achieving the objective. However, since 2001, where the percentage was 25% (*not shown)*, high school students' 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, 2005 and 2007.

Reported levels of physical activity among youth have changed little since baseline. While the numbers fluctuated between 2002 and 2008, BRFSS data for adult physical activity show slight increases since baseline.

Finally, according to the 2008 BRFSS, while Maine's rates of overweight and obese adults (62%) are comparable to national rates (63%), Maine has the highest adult obesity rate in New England. While the data suggest the rate of Maine adults who are overweight has stayed static, the rate of obesity for those 18 and older has increased slightly since the 2004 baseline.

Goal: To reduce the risk of skin cancer in Maine.

Table 21: *Intermediate Outcomes: Sun Safety*

Measurable Objectives	Previous Plan				New Plan	
	2002	2003	2004	2005	2006	2007
Sun Safety						
• Increase to 15% the proportion of Maine youth who use a sunscreen with an SPF of 15 or higher when outside for more than one hour.	--	--	--	*12.4%	NA	14.1%[3]

Notes:

* Baseline data as reported in the Maine Cancer Plan.

[3] Maine YRBS 2007

Questions pertaining to sun safety have been included in the MYRBS just since 2005. Preliminary data from 2005 and 2007 reflect an increase in the use of sunscreen among Maine youth, though it is too soon to call this a trend.

Goal: To reduce the risk of cervical and other cancers associated with sexually transmitted disease in Maine

Table 22: *Intermediate Outcomes: Sexual Health Behaviors, Youth*

Measurable Objectives	Previous Plan				New Plan	
	2002	2003	2004	2005	2006	2007
Sexual Health Behaviors, Youth						
• Increase abstinence to 60% among sexually active 9-12th graders by 2010.	--	57.2%	--	*55%	--	NA
• Increase condom use at last intercourse to 63% among sexually active 9-12th graders by 2010.	--	58%	--	*59%	--	58.9%[3]

Notes:

* Baseline data as reported in the Maine Cancer Plan.

[3] Maine YRBS 2007

Condom use at last intercourse among sexually active high school students remained relatively stable between 2003 and 2007.

Goal: To promote, increase and optimize the utilization of high quality breast cancer screening and follow-up services.

Goal: To reduce by 30% the rate of cervical cancer deaths by 2010.

Goal: To promote, increase and optimize the utilization of high quality colorectal cancer screening and follow-up services.

Table 23: *Intermediate Outcomes: Screening Behavior*

Measurable Objectives	Previous Plan				New Plan		
	2002	2003	2004	2005	2006	2007	2008
Screening Behavior: Breast Cancer[1] (continued)							
• Increase the proportion of Maine women aged 40-49 who have received both a mammogram and a clinical breast exam within the past two years to 80% by 2010.	72.4%	--	*72.7%	76.0%[2]	72.0%	--	76.0%[3]
• *Alternate indicator:* Mammogram only within last 2 years for women 40-49.[3]							78.6%[4]
• Increase the proportion of Maine women aged 50 and older who have received both a mammogram and a clinical breast exam within the preceding year to 70% by 2010.	62.6%	--	*61.6%	60.1%[2]	61.5%	--	62.5%[3]
• *Alternate indicator:* Mammogram only within last 2years for women over 50.[3]							85.1%[4]
Screening Behavior: Cervical Cancer[1]							
• Increase the proportion of Maine women with a uterine cervix who have ever received a Pap test to 98% by 2010.	97.0%	--	*97.0%	95.2%[2]	97.0%	--	95.6%
• Increase the proportion of Maine women aged 18 and older with a uterine cervix that received a Pap test within the preceding 1 to 3 years to 92% by 2010	92.1%	--	*88.7%	87.9%[2]	89.1%	--	86.3%
Screening Behavior: Colorectal Cancer							
• Increase the proportion of people aged 50 and older who have ever received a screening colonoscopy or sigmoidoscopy to 75% by 2010.	47.3%	53.9%	*59.1%	61.9%	64.2%	--	72.6%

Notes:

[1] Data Source: University of Southern Maine reports generated from Maine BRFSS data and collected by Maine Breast and Cervical Health Program

[2] This data was collected by Maine BRFSS by special request of MBHCP even though Women's Health Module not included in Core Survey. National data is not available for this year.

[3] The Maine Cancer Consortium has changed the breast cancer screening indicators, so that only mammogram data will be used from 2008 onward.

[4] Data from Maine BRFSS

* Baseline data as reported in the Maine Cancer Plan.

NA = Data not available/not yet provided

-- = Data not collected as part of Maine BRFSS. Women's Health Module only asked in even years since 2000.

Based on the results provided, breast and cervical cancer screening behavior appears to have remained unchanged since the 2004 baseline with slight changes occurring in 2005 only.

Screening rates for colorectal cancer appear to be on the rise. There was a 25.3% increase in sigmoidoscopy/colonoscopy screenings between 2002 and 2007. The larger increase (8.4%) between 2005 and 2007 may reflect the attention, both nationally and at the state level, that colorectal cancer screening has received over the past few years. We can surmise that at the state level, the assessment surveys generated through the colorectal cancer awareness grants will, in and of themselves, have raised some level of awareness, and that the next year of grants may well do the same. Additionally, the new Colorectal Cancer Control Program, which will take effect in early 2010, will likely impact the colorectal screening rates statewide in subsequent years.

Long-Term Outcomes

Cancer is the leading cause of death in Maine with one in four deaths due to cancer. The overall cancer death rate, however, is declining due to improvements in prevention, detection and treatment of many types of cancer.[4] Despite the declines, Maine continues to have overall cancer incidence and mortality rates higher than the national rates. Moreover, Maine has the highest cancer mortality rate in New England. Within this context, the MCCCP's long-term outcomes refer to reducing both incidence and mortality for all types of cancer.

Table 24 provides data on cancer incidence and mortality, from the Maine Cancer Registry and CDC Wonder, specifically for those cancers addressed in the Maine Comprehensive Cancer Control Plan. As shown in this table, the latest available data are from 2006.[6] The baseline as noted in the Cancer Plan is from 2002.

Based on the limited data available, trends are difficult to determine. Nevertheless, trend data provided by the Maine Cancer Registry suggest that the incidence and mortality rates of colorectal cancer have been declining since 1990. However, colorectal cancer continues to be the second leading cause of cancer deaths in Maine. Lung, breast, and prostate cancers also continue to be leading causes of cancer deaths in Maine although prostate cancer has declined. Prostate cancer incidence; however, has risen likely due to improved screening. Lung cancer continues to be the leading cause of cancer death in women, while the mortality and incidence rate for men have begun to level off. Female breast cancer deaths have decreased slightly as well. Finally, while incidence rates for melanoma have been on the rise, this increase may be explained by improved reporting by physician.

[4] Maine Comprehensive Cancer Control Plan, 2006-2010

[6] Maine Annual Cancer Report: 2006 Cancer Incidence, 2005 Cancer Mortality; Published May 2009, by the Maine Cancer Registry, Maine Center for Disease Control and Prevention.

Table 24: *Incidence and Mortality Rates for Select Cancers*

Objectives	Baseline[1] 2002	2003	2004	2005	2006
Incidence[2]					
• All cancers	500.8	490.7	504.5	517.7	536.1
Men	589.9	571.0	587.6	593.2	620.6
Women	439.2	433.7	441.6	464.9	475.7
• Lung cancer	75.9	75.9	77.2	78.0	80.2
Men	96.0	96.2	96.7	95.1	98.3
Women	60.7	60.7	63.0	65.3	67.5
• Colorectal cancer	61.2	55.3	55.2	54.4	50.3
Men	74.3	67.3	61.6	63.1	57
Women	51.8	46.4	49.0	47.0	45.2
• Melanoma	20.7	21.8	22.0	23.1	21.3
Men	24.1	27.6	27.0	27.3	24.9
Women	18.6	17.4	18.4	20.2	18.5
• Breast cancer[3]	126.3	126.3	122.1	130	69.9
• Cervical cancer	7.1	8.0	8.9	6.3	NA
• Prostate cancer	162.2	156.7	165.4	151.1	NA
• Oropharyngeal cancer	12.4	12.1	12.1	10.1	12.3
Men	19.5	17.7	19.6	15.4	19.8
Women	6.5	7.0	5.6	5.7	5.8
• Bladder cancer	27.1	30.5	27.7	26.6	30.3
Men	46.7	54.7	46.5	43.7	51.3
Women	12.2	12.4	13.0	14.0	14.3

Data Source: Maine Annual Cancer Report: 2006 Cancer Incidence, 2005 Cancer Mortality. Published May 2009, by the Maine Cancer Registry, Maine Center for Disease Control and Prevention.

Objectives	Baseline[1] 2002	2003	2004	2005	2006
Mortality[2]					
• All cancers	213.9	204.1	205.8	204.7	194.2
Men	267.9	243.8	252.0	253.7	240.0
Women	177.3	178.1	173.7	171.2	163.1
• Lung cancer	63.2	62.3	61.1	60.2	61.2
Men	81.4	79.5	78.2	77.5	77.4
Women	49.8	49.9	48.9	47.6	49.5
• Colorectal cancer	21.7	19.2	17.6	17.6	16.9
Men	27.6	21.7	17.6	21.0	20.5
Women	17	17.2	17.5	15.1	14.2

Objectives	Baseline[1] 2002	2003	2004	2005	2006
Mortality[2] (cont'd)					
• Melanoma	3.5	2.5	2.9	2.6	3.3
Men	5.9	3.6	4.1	3.6	4.7
Women	1.7	1.7	1.8	1.9	2.3
• Breast cancer[3]	23.9	27.3	21.3	22.4	21.6
• Cervical cancer	2.1	1.8	2.0	1.9	1.7
• Prostate cancer	26.4	27.6	26.9	25.9	23.9
• Oropharyngeal cancer	2.8	2.7	3.3	2.4	2.4
Men	4.2	4.0	5.0	4.3	2.9
Women	1.6	1.5	1.8	0.9	2.0
• Bladder cancer	5.1	5.0	6.0	5.4	6.2
Men	8.4	7.4	11.7	9.9	9.5
Women	2.7	3.2	3.0	2.2	3.9

Source of Data: Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2006. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2006 Series 20 No. 2L, 2009. Accessed at http://wonder.cdc.gov/cmf-icd10.html on Sep 30, 2009 10:48:21 AM

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

Any differences in cancer incidence and mortality rates have not been tested for statistical significance, thus they should only be used as a general indication of change. Additionally, in order to determine the potential preliminary impact of the MCCCP initiative and the current Cancer Plan, additional years of data will be necessary.

Finally, as noted at the beginning of this section, additional information on all cancers is available in *The Maine Cancer Surveillance Report 2009* document that has just been released. This cancer surveillance document provides the most current statistical data and analysis for both Cancer Plan objectives and cancer incidence and trends, and as such, serves as an excellent compliment to this evaluation report.

Overall Recommendations: MCCCP, Cancer Plan and Consortium

1. **Utilize the 2011-2015 Cancer Plan Development Process as a Forum for Enhancing Consortium's Membership.**
   - Revitalize workgroups and taskforces around setting new 5-year goals and strategies for the upcoming Cancer Plan, i.e., use planning meetings as a vehicle to reengage or reinvigorate current Consortium members.
   - Identify additional members needed to address the new/enhanced goals of the 2011-2015 Cancer Plan. For example, if a focus on childhood cancers is added to the new plan there may be some key people who will need to be recruited to join the Consortium or its workgroups.

2. **Increase Consortium's Participation in the Enhancement of the Cancer Plan's Activity Monitoring Evaluation process.**
   - Engage Consortium and workgroup members in discussions concerning adapting or redesigning the evaluation of, and data collection process for, the goals, objectives, and strategies identified in the new Cancer Plan.
   - Adapt activity-monitoring tool. Suggestions include:
     - Work with Consortium and work group members to develop a database for tracking activities that can be reviewed, adjusted as necessary, and expanded upon annually. Also, consider making available on-line or accessible throughout the contract year to be updated as activities are worked on or completed.
     - Activities should continue to be linked to objectives and strategies. Add tracking categories for some types of strategies/activities, for example a category to capture the work completed for activities that are "on-going".
     - Enhance monitoring of Workgroup activities through the development of annual work plans for each Workgroup. Have members track activities on an on-going basis.
     - Pilot and or solicit feedback on any new monitoring tool from workgroups or task forces before using system wide.

3. **Continue to utilize evaluation results to adapt, enhance and or expand program initiatives and workgroup/task force activities.**
   - Develop outcome evaluation of select workgroup/taskforce activities each year. Work with evaluator to identify appropriate intervention and design evaluation.
   - Engage Consortium in designing evaluation plan to systemically track legislation or policies related to cancer control (*e.g.*, legislative mandate for insurance coverage of colorectal cancer screening) and work with evaluator and epidemiologist to measure impact of those changes.
   - Continue to align evaluation with surveillance activities, specifically in the tracking of outcomes.

4. **Embed Continuous Program Evaluation wherever appropriate and possible.**
   - Using the tools and results from current evaluation efforts, build continuous evaluation into on-going program initiatives, for example, the development of electronic tools for the No Sun for Baby initiative.
   - Continue to build upon current program evaluation successes, for example the use of standardized electronic reporting such as with the HMP colorectal cancer grants program in its second year.
   - When feasible, attach reporting requirements to funding so that the funding cycles, timeline, and distribution of funds better meets the needs of the programs/initiatives being sponsored.

Report Appendices List

A. Program Accomplishments from AMT Activities

B. Maine Cancer Consortium Partnership Organizations

C. *No Sun for Baby* Parent Survey

D. *No Sun for Baby* Hospital Pre-Survey

E. *No Sun for Baby* Hospital Post-Survey

F. *Sun Blocks* Training Curriculum Evaluation Survey

G. *Sun Blocks* Baseline Survey

H. *Sun Blocks* Grantee Evaluation Survey

I. *Sun Blocks* Non-grantee Evaluation Survey

J. Elementary School Mini-Grant Final Report

K. Elementary School Mini-Grant Evaluation Survey

L. Healthy Maine Partnerships Colorectal Cancer Grant Survey

Appendix A:

Program Accomplishments from AMT Activities

Cancer Consortium Workgroups & Task Forces

ACTIVITIES and ACCOMPLISHMENTS

This list is not meant to be exhaustive but rather it is meant to be representative. The list provides a sampling of the types of activities, achievements, and strengths the workgroups and task forces raised during their AMT meetings over the past two years. It is important to remember that there is much work happening across the state of Maine under the MCCC Initiative's umbrella that is not captured here. On the other hand, it is also important to celebrate the accomplishments identified through the evaluation process, and it is in that spirit that the following list of achievements was compiled.

Issue Visibility

- Radon testing and mitigation is becoming more commonplace.
- Sexually Transmitted Diseases (STDs) have been more in the eye of the public than in previous years, with info about the Human Papillomavirus (HPV) vaccine, and recently at the National STD Conference, much information was disseminated that has created a great opportunity to increase awareness.
- Increased number of HPV vaccine sites.
- Support for family planning services has continued.
- Workgroup members were invited to speak at several conferences.
- Launched new Consortium web-site.
- The Office of Minority health has taken leadership in bringing awareness to the issue of disparities around cancer and the need for more resources and collective action.
- Meetings convened with minority populations to identify disparities around end of life services and breast cancer; needs assessment to identify barriers to colorectal cancer screening.
- Published the 2009 Maine Cancer Surveillance Report.
- Development and distribution of a quarterly Consortium newsletter.
- Development of linguistically and culturally appropriate cancer resources for disparate populations.
- Promotion of *Pale Prom* and *Your Skin is In* initiatives.
- Sponsored a Sea Dogs Sun Safety day.
- Sponsored Chlamydia campaign to promote safer sex.
- Sponsored Hepatitis Campaign to increase hepatitis awareness.
- Ovarian Cancer Awareness campaign launched in Bangor media and prints networks.
- Created an updated electronic Resources Card that is on the MCC, ACS, LRC and CCC websites.
- Maintained an active Speakers Bureau

Legislation

- Proposed cuts were successfully avoided in this legislative session. The system has been including sexuality counseling and education in their quality improvement activities.
- Smoke-free schools 24/7.
- Legislative mandate (LD-2109) for colon cancer screening (insurance coverage).
- Funding for the Cancer Plan (passed but not funded).
- Proposed and advocated for passage of tanning legislation for minors (LD 395).
- Consortium sponsored Legislative Ask Day in 2008 and Cancer Awareness Day in April 2009 at Maine's legislature.

Resources and Funding

- Outcomes in terms of health curriculum completeness and quality are now being measured in some school district, providing some baselines for future progress.
- Melanoma foundation awarded group $20,000 for No Sun for Baby Project, as well as other funds for printing brochures as well as to fund mini-grants to Parks and Recs.
- Maintain funding for screening services for women in the Maine Breast & Cervical Health Program and community-based programs.
- The Maine Breast and Cervical Health Program has been successful at competing for Federal funds and has been awarded funds for the next five years.
- Skin Cancer Workgroup has leveraged funds and collaborated on projects such as the *No Sun for Baby* Manual.
- The Rehabilitation and Survivorship workgroup has secured additional funding through a mini-grant and has identified new potential sources (i.e., CDC).
- ASCO grant funded.
- Developed and promoted Survivor Care Plan.
- Maintained Patient Navigator funds in the budget.
- Surveyed to determine availability and utilization of transportation and lodging resources in Washington & Hancock counties and created ACS Transportation Services Mapping project.

Partnerships

- HMP Minimum Common Program Objectives address several Cancer Plan strategies.
- Tobacco-free recreation and entertainment sites established as a strategy choice in the new Minimum Common Program objectives for Public Health Districts and HMPs.
- HMPS doing some work with physical activity and nutrition strategies and colorectal cancer awareness.
- Translating and creating resources for minority populations.
- Dialogue with Office of Minority Health (OMH); emphasis on disparities.
- Collaborate with the Maine Hospital Association and OMH to improve valid recording of race and ethnicity on hospital admission records.

- Worked with ME School Nurse Association on sun safety issues.
- MFNE conducted "Teens & Tanning Forum" at Fenway Park with Maine students
- Office of Minority Health at Me CDC – OMH is taking lead on raising awareness of cancer disparities.
- Working with Maine Native American Tribes to develop a Chronic Disease Plan for Maine's five tribes.

Education & Advocacy

- Co-sponsored a CTC Symposium for Cancer Registrars of Maine.
- Developed and released new radon outreach & educational materials, including provision of education to over 100 individuals who provide radon education to others.
- Advocated for increasing the number of nursing schools with ELNEC-trained faculty.
- Advocated for the inclusion of palliative care indicators in QIP within health care institutions/agencies.
- Provision of education on state tanning regulations.
- Monitor national studies on prostate cancer screening.
- UMA has certificate program in hospice/palliative care.
- Created and distributed a sun safety packet for Maine Parks and Recreation Departments, including distribution of 120 at annual Parks & Recreation conference.
- Sponsored ME Hospice Education Day.
- Annual Mammogram Tech Conference attracted 125 registrants.
- Presentation of recent national study findings to Maine audiences, for example, the 2007/08 Epithelial Ovarian Malignancies study and the melanoma study.
- Updated Breast Cancer study with focus on reconstruction.

Appendix B:

Maine Cancer Consortium Partnership Organizations

2-1-1 Maine
ACCESS Health
American Cancer Society
Androscoggin Home Care and Hospice
Anthem BCBS
AstraZeneca
Bennett Breast Care Center
Beth C. Wright Cancer Resource Center
Blue Hill Memorial Hospital
BRFSS Program
Burgess Advertising
Calais Hospital
Cancer Care Center
Cancer Community Center
CancerCare of Maine
Center for Tobacco Independence, Maine Medical Center
Central Maine Medical Center
Children with Special Health Needs
Choose To Be Healthy
City of Portland, Public Health Division
CLEAN: Maine
Coalition Against Tobacco, Sanford Schools
Communities Promoting Health
Coordinated Care Services
Dermatology Associates
DHHS, Public Health Nursing
Division of Health Engineering
Eastern Maine Healthcare
Eastern Maine Medical Center
Environmental Health Strategy Center
Family Planning Association of Maine
Franklin Memorial Hospital
Genetech BioOncology
Getting Healthy
Goodall Hospital
Harold Alfond Center for Cancer Care
Health Reach Hospice
Health Reach Network
Healthy Acadia
Healthy Lincoln County
Healthy Living Project
Healthy Maine Partnerships
Healthy Peninsula Project
Healthy Waldo County
Heathy Aroostook
Hospice of Southern Maine
Indian Township Health Center
Kennebec Pharmacy & Home Care
Lung Cancer Alliance
Maine Academy of Family Physicians
Maine Association of Mental Health Services
Maine Asthma Program-Maine CDC
Maine Breast & Cervical Health Program
Maine Cancer Foundation
Maine Cancer Registry
Maine CDC
Maine Center for Cancer Care
Maine Center for Cancer Medicine
Maine Center for Public Health
Maine Coalition to Fight Prostate Cancer
Maine Comprehensive Cancer Control Program
Maine Dartmouth Family Practice
Maine Dept of Education
Maine General Medical Center
Maine Health
Maine Health Access Foundation
Maine Hospice Council
Maine Hospital Association
Maine Medical Center
Maine Municipal Association
Maine Primary Care Association
Maine Youth Camping Foundation
MaineGeneral Medical Center
MaineHealth Learning Resource Center
Martha B. Webber Breast Center
Mayo Regional Hospital
Medical Care Development
Melanoma Foundation NE
Mercy Hospital
Mid Coast Hospital
Mid Coast Medical Group -- Surgical Care
Millinocket Regional Hospital
Molly Ockett Middle School
MSAD #43, Superintendent's Office
Muskie School of Public Service
NCI
New England Rehab Hospital
Northeast Health Care Quality Foundation
Northern Maine Community College
Novartis
Office of Minority Health
Parkview Oncology/CMMC
Partners for Healthier Communities
Partnership for a Healthy Community
Partnership for a Healthy Penobscot
Partnership for a Tobacco-Free Maine
Patrick Dempsey Center for Cancer Care
Penobscot Bay Medical Center
Penobscot Nation Health Center
Penquis Health Services
Physical Activity & Nutrition Program
Piscataquis Public Health Council
Pleasant Point Health Center
Portland Gastroenterology Center
Project NOW
Redington Fairview General Hospital
River Valley Healthy Communities
Ross Care EMHC
S.P.R.I.N.T. for Life
Sheepscot Valley Health Ctr
Somerset Heart Health
Southern Maine Medical Center
St Mary's Regional Medical Center
St. John Valley Partnership
St. Mary's Regional Medical Center
Stephens Memorial Hospital
STOP
TLC for Life, Union 74, Nobleboro Central School
Togus VAMC
Town of Fairfield
United Way of Greater Portland
University of Maine at Orono
University of New England
Waldo County General Hospital
Washington County: One Community
Waterville Public Schools
Yarmouth Elementary School
York Hospital

Appendix C:

No Sun for Baby
Parent Survey

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

1) What kind of information on sun safety for your baby did you receive?
(*Please check all that apply)*

☐ Written information
☐ Verbally by healthcare provider
☐ Presentation at a birthing class
☐ Other, please describe: _____

1a. Did you read the written materials on sun protection for babies?

☐ Yes
☐ No, but I plan to.
☐ No and I do not plan to read it.
☐ Did not receive written materials

2) How helpful was the sun safety information you received?

☐ Not at all helpful
☐ Somewhat helpful
☐ Helpful
☐ Very helpful

3) How likely are you to use a sun hat on your baby this summer?

☐ Not at all likely
☐ Somewhat likely
☐ Likely
☐ Very likely

4) How likely are you to dress your baby in clothing that protects his or her body from the sun?

☐ Not at all likely
☐ Somewhat likely
☐ Likely
☐ Very likely

5) How likely are you to keep your baby out of direct sunlight?

☐ Not at all likely
☐ Somewhat likely
☐ Likely
☐ Very likely

Please use this space for additional comments: _____

_____

_____

Appendix D:

No Sun for Baby
Hospital Pre-Survey

No Sun for Baby Program
Hospital Evaluation Form

Thank you for participating in the *No Sun for Baby Program*. Please answer the following questions related to your hospital. Your responses will be used to help evaluate the program after its completion. **Thank you! [Please return this survey no later than February 29, 2008]**

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 Activities at Your Hospital

1) Name of hospital: _____

2) Approximately how many live births occur in your hospital each year? _____
Percentage of parents who receive information about sun safety for their newborn ____

3) Please indicate the type of information on sun safety for newborns your hospital provides to parents:

- ☐ Written educational materials (e.g., brochures)
- ☐ Verbal education about sun safety (e.g., presentation at discharge, birthing class)
- ☐ Gifts promoting sun safety (e.g., sunglasses, sun hats)
- ☐ Other: _____

4) Have you received funding for the *No Sun for Baby Program* in the past?

- ☐ Yes
- ☐ No

Section 2: Current Knowledge about Sun Safety

5) Based on your experience, how much do parents know about sun safety issues for their newborn:

None	A little	Moderate	A great deal	Don't Know
1	2	3	4	DK

6) How much knowledge would you say that you currently have about each of the following:

a. The risks associated with sun exposure to newborns

None	A little	Moderate	A great deal
1	2	3	4

b. Ways to keep newborns protected from the sun

None	A little	Moderate	A great deal
1	2	3	4

7) How **confident are you right now** of your ability to:

a. Tell/teach new parents about the risks of sun exposure to their newborn

Not at all confident		Moderately confident		Very confident
1	2	3	4	5

b. Tell/teach new parents about how to protect their newborn from the sun

Not at all confident		Moderately confident		Very confident
1	2	3	4	5

. c. Incorporate sun safety issues into your hospital's childbirth curriculum

Not at all confident		Moderately confident		Very confident
1	2	3	4	5

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

Appendix E:

No Sun for Baby
Hospital Post-Survey

No Sun for Baby Program
Hospital Evaluation Form

Thank you for participating in the *No Sun for Baby 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 January 9, 2009]**

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) Approximately how many live births occurred over the last calendar year in your hospital?___

2) How many *Sun Safety Kits* were distributed to parents? _____
   a) How many parents have received sun safety information (but not a Kit) _____

3) Please list the specific time period during which you implemented this program (e.g., June – August): _____

4) 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. Sun Hat	1	2	3	4
b. Plastic pail and shovel or hospital/gift bag	1	2	3	4
c. Educational Materials (brochures):				
Play It Safe in the Sun	1	2	3	4
Precious Children (for parents)	1	2	3	4
Sunproofing Your Baby	1	2	3	4
Sun Safety for ME	1	2	3	4
Other: _____	1	2	3	4
d. Evaluation survey	1	2	3	4

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

☐ Yes, please describe:_____

_____

☐ No, please explain: _____

_____

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

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

7) Please rate the following components of the kit.

	Not Useful			Useful
a. Sun Hat	1	2	3	4
b. Pail and Shovel (or gift bag)	1	2	3	4
c. Educational Materials (brochures)	1	2	3	4
d. Evaluation surveys	1	2	3	4

Section 2: Current Knowledge about Sun Safety

8) Based on your experience, how much do parents know about sun safety issues for their newborn?

None	A little	Moderate	A great deal	Don't Know
1	2	3	4	DK

9) How much knowledge would you say that **you currently have** about each of the following?

e. The risks associated with sun exposure to newborns

None	A little	Moderate	A great deal
1	2	3	4

f. Ways to keep newborns protected from the sun

None	A little	Moderate	A great deal
1	2	3	4

10) How **confident are you right now** of your ability to:

a. Tell/teach new parents about the risks of sun exposure to their newborn

Not at all confident		Moderately confident		Very confident
1	2	3	4	5

b. Tell/teach new parents about how to protect their newborn from the sun

Not at all confident		Moderately confident		Very confident
1	2	3	4	5

. c. Incorporate sun safety issues into your hospital's childbirth curriculum

Not at all confident		Moderately confident		Very confident
1	2	3	4	5

Section 3: Feedback on *No Sun for Baby Program*

11) 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/or orientation	1	2	3	4	5
c. Guidance from the Maine Cancer Consortium Skin Cancer Work Group	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

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

Not effective				Very effective
1	2	3	4	5

13) 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: _____

_____

14) 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: _____

_____

15) 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: _____

_____

16) As a result of this grant, have you incorporated sun safety issues into your hospital's childbirth curriculum?

- ☐ Yes
- ☐ No, but I intend to
- ☐ No, and I do not intend to. Please explain: _____

_____

_____

17) Do you intend to continue this program (or sun safety activities)?

- ☐ Yes
- ☐ Maybe, unsure.
- ☐ No, please explain: _____

_____

_____

16a) If yes, how do you intend to continue this program? Please check all that apply.

- ☐ Written educational materials (e.g., brochures)
- ☐ Verbal education about sun safety (e.g., presentation at discharge, birthing class)
- ☐ Gifts promoting sun safety (e.g., sunglasses, sun hats)
- ☐ Other: _____

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

_____

_____

_____

19) What are the three best things about this program and why? _____

_____

_____

_____

_____

_____

20) Please tell us how this program can be improved. _____

_____

_____

_____

_____

_____

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

Appendix F:

Sun Blocks Training Evaluation Survey

Sun Blocks: Building a Foundation for Healthy Skin
Training Program Evaluation

Section #1: Organization of Training

	Very Poor				Excellent
1. How would you rate the organization of the training? (For example, did it flow smoothly or logically from one topic to the next?)	1	2	3	4	5
2. How would you rate the length of the training in relation to the amount of information covered in the training?	1	2	3	4	5
3. How would you rate the value of the training content in reference to the work you do?	1	2	3	4	5

Section #2: Objectives of the Training

4. How would you rate your knowledge of the objectives of the training?	1	2	3	4	5

The training has provided me with the knowledge to be able to:

	Disagree				Agree
5. Explain the scope of sun exposure related problems in the state of Maine.	1	2	3	4	5
6. Describe the importance of routinely practicing proper sun safety with children attending child care centers.	1	2	3	4	5
7. Discuss the components of the proposed sun safety policy.	1	2	3	4	5
8. Assess the UV index and identify appropriate sun protection measures.	1	2	3	4	5
9. Implement the childhood sun safety seasonal teaching plans.	1	2	3	4	5
10. Select suitable support materials for parents and caregivers that enhance the achievement of the Sun Blocks program goal.	1	2	3	4	5

Section #3: Presentation of the Training

	Very Poor				Excellent
11. How would you rate the balance of learning styles addressed in the training?	1	2	3	4	5
12. How would you rate the balance of presentation styles?	1	2	3	4	5
13. How would you rate the overall quality of presentation?	1	2	3	4	5

Sun Blocks: Building a Foundation for Healthy Skin
Training Program Evaluation

Section #4: Overall/Other

14. Did you receive training materials and are they in a format that is useful to you (for example, the USB flash drives)?

15. What was the most useful part of today's training for you?

16. What was the least useful part of today's training for you?

17. What, if any, additional information or skills do you need to feel confident to implement the childhood sun safety teaching plans?

18. What, if any, additional information or skills do you need to establish a sun safety policy at your center?

19. Is there anything you would suggest that we change or do differently in a future training?

20. Additional comments

Appendix G:

Sun Blocks Baseline Survey, Feb. 2008

Sun Blocks Baseline Survey – February 2008

This assessment is sponsored by The Maine Comprehensive Cancer Control Program/Maine Bureau of Health/ Department of Human Services and the Maine Cancer Consortium Skin Cancer Work Group

1. What type of early childcare do you represent?
   - ☐ Child Care Center
   - ☐ Nursery School or Preschool
   - ☐ Family Child Care Home
   - ☐ Head Start or Early Head Start
   - ☐ Other: _____

2. What is your position within your center or program?
   - ☐ Director
   - ☐ Teacher
   - ☐ Caregiver
   - ☐ Administrative or Support Staff
   - ☐ Parent
   - ☐ Other: _____

3. How important do you think sun protection is to a child's overall health?

☐	☐	☐	☐	☐
Not Important	Of Little Importance	Moderately Important	Important	Very Important

4. How often do you apply sunscreen to children before they participate in outdoor activities?

☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Often	Always

5. How often do you encourage children to wear hats when they are participating in outdoor activities?

☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Often	Always

6. How often do you encourage children to wear sunglasses when they are participating in outdoor activities?

☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Often	Always

7. How often do you encourage children to wear sun-protective clothing (i.e. sleeved shirts, pants) when they are participating in outdoor activities?

☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Often	Always

8. How often do you encourage children to play in shaded areas?

☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Often	Always

9. How often do you schedule outdoor activities and events during peak sun hours (10:00 a.m.-4:00 p.m.)?

☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Often	Always

10. I have the **skills** I need to make sure that the children under my care:

a. Wear sunscreen when participating in outdoor activities.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

b. Wear hats, sunglasses or other sun-protective clothing (e.g. sleeved shirts, pants) when participating in outdoor activities.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

c. Avoid exposure to sun during peak sun hours (10:00 a.m.-4:00 p.m.).

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

d. Play in shaded areas.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

11. I have the **resources** I need to make sure that the children under my care:

a. Wear sunscreen when participating in outdoor activities.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

b. Wear hats, sunglasses or other sun-protective clothing (e.g. sleeved shirts, pants) when participating in outdoor activities.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

c. Avoid exposure to sun during peak sun hours (10:00 a.m.-4:00 p.m.).

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

d. Play in shaded areas.

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

12. Does your child care center or program currently have a policy on sun protection?

☐ Yes, we have a formal sun protection policy.
☐ Yes, we have an informal sun protection policy.
☐ No
☐ I don't know

13. Does your childcare center or program provide sun protection training to teachers and staff?

☐ Yes
☐ No
☐ I don't know

14. Does your childcare center or program provide parents with information on sun protection?

☐ Yes
☐ No
☐ I don't know

15. Does your childcare center or program integrate sun protection activities and lessons into curriculum?

- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ NA (Facility provides supervisory care only.)

16. Which of the following best describes when your childcare center or program pays the most attention to sun protection? (Select all that apply)

- ☐ Every day, year-round
- ☐ During summer months
- ☐ During spring months
- ☐ During fall months
- ☐ During winter months
- ☐ Only on very sunny days
- ☐ Other: _____

17. Do any of the following factors prevent your childcare center or program from practicing sun protection? (Select all that apply)

- ☐ Lack of sun protection training
- ☐ Cost or lack of funding
- ☐ Insufficient parent involvement
- ☐ State regulations or local restrictions
- ☐ Allergies or skin reactions
- ☐ Inflexible schedule
- ☐ Center or program is able to routinely practice sun protection
- ☐ Other: _____

18. Would you be interested in working together with other Maine childcare directors and staff to help create a sun protection program for childcare centers in Maine?

- ☐ Yes *(Skip to Question 20)*
- ☐ No
- ☐ Maybe. I need more information. *(Skip to Question 20)*

19. If no, would you be interested in receiving more information on sun protection for your center or program?

- ☐ Yes
- ☐ No

20. If yes, or if you would like to receive more information about this project, please provide a valid email address by which we can contact you. *Please note, this email address WILL NOT be distributed or used for any other purposes beyond this project.*

Email Address: _____@_____

Thank you for your time and participation. It is truly appreciated!

Appendix H:

Sun Blocks Grantee Evaluation Survey June 2009

Sun Block Grantee Evaluation Survey, Jun-2009

Section #1: Demographic Information

Center location (county): _____

Number of children you are licensed for _____

Age range of children who attend your center_____

Do you provide full day or part day care? _____

Are you open year round?_____

What is the current funding source(s) for your center (check all that apply)?

- ☐ Parent Fees
- ☐ State Grants
- ☐ Subsidies
- ☐ Donations
- ☐ Other: _____

Section #2: Sun Protection Practices

How often do you and/or staff engage in the following sun protection practices at your center:

	Never		Sometimes		Always
1. Encourage children to wear hats when they participate in outdoor activities	1	2	3	4	5
2 Encourage children to wear sunglasses when they are participating in outdoor activities	1	2	3	4	5
3. Encourage children to wear sun-protective clothing (i.e. sleeved shirts, pants, etc.) when they are participating in outdoor activities	1	2	3	4	5
4. Encourage children to play in shaded areas	1	2	3	4	5
5. Apply sunscreen to children before they participate in outdoor activities	1	2	3	4	5
6. Re-apply sunscreen when children participate in outdoor activities for extended periods of time	1	2	3	4	5
7. Apply sunscreen before outdoor activities in both the summer and winter months	1	2	3	4	5
8. Schedule outdoor activities and events for children between 10:00 a.m. and 4:00 p.m.	1	2	3	4	5

Section #3: Sun Protection Policy and Programming

9. Does your center have a Sun Protection Policy?
   - ☐ Yes, formal policy
   - ☐ Yes, informal policy
   - ☐ No

10. Does your center train staff on sun protection practices and policy?
    □ Yes □ No

11. Does your center distribute sun protection information to parents?
    □ Yes □ No

12. Does your center provide sun protection activities or lessons for children?
    □ Yes □ No

Section #4: Sun Blocks Program Activities

13. Did you receive the application for a 2008 Childcare Skin Cancer Prevention mini-grant?
    □ Yes □ No

    If Yes, did you respond?
    □ Yes □ No

14. Did you receive Sun Blocks program materials?
    □ Yes □ No **(If no, please end survey here)**

    If yes, how are you utilizing them? _____
    _____

15. Did you attend the Sun Blocks program training?
    □ Yes □ No **(If no, please end survey here)**

    If yes, please indicate, on a scale of 1 to 5, how integral the $100 stipend was in your ability to attend training? (1 being "would have attended without the stipend", 5 being "attendance depended on stipend")

    NA 1 2 3 4 5

    If yes, which elements of the program did your center implement (select all that apply):
    - ☐ Staff Training
    - ☐ Early Childhood Teaching Plans
    - ☐ Policy development
    - ☐ Materials for parents

16. If you implemented staff training, on a scale of 1 to 5 (1 being not at all feasible and 5 being feasible) how feasible was it to implement staff training?

    NA 1 2 3 4 5

17. If you implemented the early childhood teaching plans, on a scale of 1 to 5 (1 being not at all feasible and 5 being feasible) how feasible was it to integrate sun safety lessons into your current curriculum?

NA 1 2 3 4 5

18. If you implemented policy development, on a scale of 1 to 5 (1 being not at all feasible and 5 being feasible) how feasible was it develop a sun protection policy?

NA 1 2 3 4 5

19. If you implemented parent education activities, on a scale of 1 to 5 (1 being not at all feasible and 5 being feasible) how feasible was it to distribute Sun Blocks program materials to parents?

NA 1 2 3 4 5

20. On a scale of 1 to 5 (1 being not at all receptive and 5 being very receptive) how receptive were staff members to the Sun Blocks program training?

NA 1 2 3 4 5

21. On a scale of 1 to 5 (1 being not at all confident and 5 being very confident) how confident are you that your center can sustain the Sun Blocks program over time?

NA 1 2 3 4 5

22. Has your center's physical environment changed over the past year to provide more sun protection for children and staff?

□ Yes □ No

If no, please describe any barriers that prohibited you from doing so. _____
_____
_____
_____

Section #5: Skin Cancer Prevention Mini-Grant Activities

23. Have you completed your activities related to your mini-grant?

□ Yes □ No→What is your anticipated completion date?_____

24. Please provide the estimated number of staff, parent, and children who received skin cancer prevention training, education and or materials.

#of staff _____ #of parents _____ #of children _____

25. How was your mini-grant funding used?

_____
_____
_____

26. Did you receive any type of in-kind contributions or additional funds or resources to support your efforts? If so, please explain the support you received.

_____
_____
_____

27. Did your childcare center develop sun protection guidelines as a result of the mini-grant?

□ Yes □ No

Please attach a copy of your center's guidelines to this survey.

28. What (if any) barriers did you encounter regarding this mini-grant?

_____
_____
_____

29. Is there any additional feedback you would like to provide in relation to your mini-grant or any other aspect of the Sun Blocks program? (Please feel free to attach additional pages if needed)

_____
_____
_____

Thank You for your time, commitment & efforts to prevent skin cancer!

Appendix I:

Sun Blocks Non-Grantee Evaluation Survey June 2009

Sun Blocks Non-Grantee Evaluation Survey, June 2009

Section #1: Demographic Information

Center location (county): _____

Number of children you are licensed for _____

Age range of children who attend your center_____

Do you provide full day or part day care? _____

Are you open year round?_____

What is the current funding source(s) for your center (check all that apply)?

- ☐ Parent Fees
- ☐ State Grants
- ☐ Subsidies
- ☐ Donations
- ☐ Other: _____

Section #2: Sun Protection Practices

How often do you and/or staff engage in the following sun protection practices at your center:

	Never		Sometimes		Always
1. Encourage children to wear hats when they participate in outdoor activities	1	2	3	4	5
2. Encourage children to wear sunglasses when they are participating in outdoor activities	1	2	3	4	5
3. Encourage children to wear sun-protective clothing (i.e. sleeved shirts, pants, etc.) when they are participating in outdoor activities	1	2	3	4	5
4. Encourage children to play in shaded areas	1	2	3	4	5
5. Apply sunscreen to children before they participate in outdoor activities	1	2	3	4	5
6. Re-apply sunscreen when children participate in outdoor activities for extended periods of time	1	2	3	4	5
7. Apply sunscreen before outdoor activities in both the summer and winter months	1	2	3	4	5
8. Schedule outdoor activities and events for children between 10:00 a.m. and 4:00 p.m.	1	2	3	4	5

Section #3: Sun Protection Policy and Programming

9. Does your center have a Sun Protection Policy?
   - ☐ Yes, formal policy
   - ☐ Yes, informal policy
   - ☐ No

10. Does your center train staff on sun protection practices and policy?
   □ Yes □ No

11. Does your center distribute sun protection information to parents?
   □ Yes □ No

12. Does your center provide sun protection activities or lessons for children?
   □ Yes □ No

Section #4: Sun Blocks Program Activities

13. Did you receive the application for a 2008 Childcare Skin Cancer Prevention mini-grant?
   □ Yes □ No

   If Yes, did you respond?
   □ Yes □ No

14. Did you receive Sun Blocks program materials?
   □ Yes □ No **(If no, please end survey here)**

   If yes, how are you utilizing them? _____
   _____

15. Did you attend the Sun Blocks program training?
   □ Yes □ No **(If no, please end survey here)**

   If yes, please indicate, on a scale of 1 to 5, how integral the $100 stipend was in your ability to attend training? (1 being "would have attended without the stipend", 5 being "attendance depended on stipend")

   NA 1 2 3 4 5

   If yes, which elements of the program did your center implement (select all that apply):
   - ☐ Staff Training
   - ☐ Early Childhood Teaching Plans
   - ☐ Policy development
   - ☐ Materials for parents

16. If you implemented staff training, on a scale of 1 to 5 (1 being not at all feasible and 5 being feasible) how feasible was it to implement staff training?

   NA 1 2 3 4 5

17. If you implemented the early childhood teaching plans, on a scale of 1 to 5 (1 being not at all feasible and 5 being feasible) how feasible was it to integrate sun safety lessons into your current curriculum?

NA 1 2 3 4 5

18. If you implemented policy development, on a scale of 1 to 5 (1 being not at all feasible and 5 being feasible) how feasible was it develop a sun protection policy?

NA 1 2 3 4 5

19. If you implemented parent education activities, on a scale of 1 to 5 (1 being not at all feasible and 5 being feasible) how feasible was it to distribute Sun Blocks program materials to parents?

NA 1 2 3 4 5

20. On a scale of 1 to 5 (1 being not at all receptive and 5 being very receptive) how receptive were staff members to the Sun Blocks program training?

NA 1 2 3 4 5

21. On a scale of 1 to 5 (1 being not at all confident and 5 being very confident) how confident are you that your center can sustain the Sun Blocks program over time?

NA 1 2 3 4 5

22. Has your center's physical environment changed over the past year to provide more sun protection for children and staff?

□ Yes □ No

If no, please describe any barriers that prohibited you from doing so. _____

_____

_____

_____

Thank You for your time and participation, it is GREATLY appreciated!

Appendix J:

Department of Education
Final Report Form

Final Report

Complete a final report answering the following questions.
This final report must be postmarked by **June 13, 2008**

1. Please describe the activities you completed for this mini-grant and attach copies of photographs, press announcements or materials developed?

2. What were the major successes your school accomplished in implementing skin cancer prevention activities?

3. What obstacles did you experience, if any, in implementing skin cancer prevention activities and how did you overcome them?

4. Did you have any additional funding or grants to support your sun safety activities? If so, how much and from whom?

5. Approximately how many students and/or staff were reached from your skin cancer prevention activities?

6. Explain your school's process in developing and implementing sun protection guidelines. Attach a copy of the guidelines. If the guidelines are still in progress, please explain the status.

7. Have you noticed any changes in your school environment regarding sun safety?

8. Do you plan on continuing sun safety activities? If so, what is your sustainability plan?

Submit final reports by July 13, 2008 to:

Maine Department of Education
Attn: Peter Spears
23 State House Station
Augusta, ME 04333-0023

Appendix K:

Elementary School Mini Grant Evaluation Survey

Mini-Grants to Support Skin Cancer Prevention in Schools Feedback Form

Directions:

Please take a few minutes to answer to the following questions. Your responses will help us to evaluate the collective efforts of our mini-grant initiative. **Deadline for responding: June 19, 2009**

Questions:

1. Have you completed your activities related to this mini-grant?

   ___ Yes ___ No →

   What is your anticipated completion date? _____
   May we contact you after this date? ___ Yes ___ No

   ---------- Please stop here ----------

2. How was your mini-grant funding used?

   a. What percent of the funds went to the following:
      - Purchase of shade structures (or materials for shade structures) = _____ %
      - Purchase of sun safety education program materials = _____ %
      - Sponsor special event day(s) = _____ %
      - Develop educational materials for students, faculty, staff = _____ %
      - Other_____ _____%

3. Did you receive any type of in-kind contributions or additional funds or resources to support your efforts? If so, please explain the support you received.

4. Please provide information about your school-wide sun protection guidelines.

   a. Did you have guidelines in place before receiving the grant? ____Yes ____No

   b. Did you develop guidelines as a result of the mini-grant? ____Yes ____No

   c. What are your guidelines? (Please attach a copy of your guidelines with this returned survey.)

5. Please provide the estimated number of students and staff who received skin cancer prevention education and or materials. Number of Students_____
   Number of Staff_____

6. In your opinion, what (if any) barriers did you encounter regarding this mini-grant?

7. In your opinion, what (if any) accomplishments did you achieve as a result of this mini-grant?

8. What efforts will you make to sustain the grant activities, i.e. what is your sustainability plan?

9. Is there anything else you would like to tell us about the mini-grant or your efforts as they relate to this grant?

Thank You for your time and commitment to preventing skin cancer!

Appendix L:

Healthy Maine Partnerships Colorectal Cancer Grant Survey

Healthy Maine Partnerships
Colorectal Cancer Screening Awareness Grants
2008/09 Grant Assessment Survey

1. How has your work plan changed since its approval at the end of the first grant year?

2. Have you completed the activities identified in your work plan?
   YES_____ NO_____ Why not?

3. What were the enhancers to the implementation of your grant work plan?

4. What were the barriers to implementing your grant work plan?

5. What partnerships have you formed as a direct result of the grant?

   a. Please provide examples of joint activities accomplished with your partners.

6. What specific targeted audiences did you work with and in what venue (for example, the worksite)? Please fill in the chart below for the priority populations identified in the grant application and add other audiences you may have targeted.

POPULATION (WHO)	LOCATION (WHERE)
Yes or No Community members 50 years and over	
Yes or No Local employers, employees	
Yes or No Healthcare providers	
Yes or No Other audiences	

7. In the Maine Cancer Plan (2006-2010) the Goal for Colorectal cancer is to promote, and optimize the utilization of high-quality colorectal cancer screening and follow-up services. The one objective yet to be fully achieved is to "Increase the proportion of people aged 50 and older who have ever received a screening colonoscopy or sigmoidoscopy to 75% by 2010." Please explain how the work of your coalition has addressed this Cancer Plan goal and objective.

8. Please identify all resources and or materials that you have developed as a result of receiving mini-grant funds? Would you be willing to share those resources/materials with the Maine Comprehensive Cancer Control Program? (If yes, please attach them)

9. The first year of grants indicated the following actions would result in the second year of grant funding, please provide an estimate of the percentage of year two grant time, if any, you devoted to the following activities, and feel free to describe any of the activities want

    a. Public awareness campaign _____%
    Describe:

    b. Education initiatives _____%
    Describe:

    c. Practice Changes _____%
    Describe:

    d. Capacity Building _____%
    Describe:

    e. Strengthening Partnerships _____%
    Describe:

10. Is there anything else you would like to comment about in reference to either the grants or your efforts as they relate to this grant?