# MAINE COMPREHENSIVE CANCER CONTROL PROGRAM

## A REPORT ON THE EVALUATION

**FY 2009-2010**

**AUGUST, 2010**

**Prepared for:**

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

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# 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 Partnership |
| **HPV** | Human Papillomavirus |
| **IRB** | Institutional Review Board |
| **MCCCP** | Maine Comprehensive Cancer Control Program |
| **MCPH** | Maine Center for Public Health |
| **MCRCCP** | Maine Colorectal Cancer Control Program |
| **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 |
| **UV** | Ultraviolet |
| **HMP** | Healthy Maine Partnerships |
| **RDC** | Resource Development Centers |
| **MCCCP** | Maine Comprehensive Cancer Control Program |
| **Maine CDC** | Maine Center for Disease Control and Prevention |
| **CDC** | U.S. Centers for Disease Control and Prevention |
| **MCRCCP** | Maine Colorectal Cancer Control Program |
| **MBCHP** | Maine Breast and Cervical Health Program |
| **MCPH** | Maine Center for Public Health |
| **MCD** | Medical Care Development |
| **MAB** | Medical Advisory Board |

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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 Program. This report provides information on three major areas of the program that have similar goals and objectives. They include the:

1. Maine Cancer Consortium (Consortium)
2. 2006-2010 Maine Comprehensive Cancer Control Plan (Cancer Plan)
3. Maine Comprehensive Cancer Control Program (MCCCP) Activities and Initiatives

In relation to these areas, this report provides an overview of findings related to the final year of implementation of the Cancer Plan, the effectiveness of the Maine Cancer Consortium partnership, and MCCCP-related program activities and accomplishments. Among the MCCCP specific initiatives evaluated and included in this report are:

1. *Sun Blocks Childcare Sun Safety Program*
2. *Colorectal Cancer Screening: Healthy Maine Partnerships*
3. *Maine Colorectal Cancer Control Program*

## Purpose of the Report

The report is intended to inform Consortium members, program staff, and other governmental and nongovernmental stakeholders about the progress, achievements, gaps, and limitations of the MCCCP, and is issued in this 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 MCCCP. 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 for the five years of the plan in reference to successful implementation for all strategies listed in the 2006-2010 Cancer Plan. Overall, for the five years of implementation the results suggest that 200 of the 254 or 79% of the strategies have been achieved either partially or completely. As reflected in the Consortium evaluation findings, the new five-year plan (2011-2015) will also track plan progress on an annual basis.

### Cancer Consortium Findings

The Maine Cancer Consortium, Maine's statewide comprehensive cancer control partnership, conducted a partnership survey in 2010. Additionally, key informant interviews were completed with a half dozen active Consortium members. This report includes a summary of the data collected through both the survey and the interviews. The report also presents findings from the Consortium's Annual Meeting held October 29, 2009. Both the partnership assessment and the Annual Meeting findings provide insight and direction for the continued work of the Consortium.

## 2011-2015 Cancer Plan Development

2010 marks the completion of the second five-year Cancer Plan for the state of Maine. In May of 2009, MCCCP and the Consortium embarked on a year-long process of developing the third Maine Cancer Plan (2011-2015). Therefore, one of the priority program initiatives for 2009-2010 became the development and writing of this Plan. The 2011-2015 Cancer Plan Development section of this report evaluates that year-long process, utilizing evaluation data from the two meetings designated for crafting the plan (the May Planning Meeting and the Consortium Annual Meeting), along with the Partnership Survey and key informant interview questions that addressed satisfaction with the overall planning process and Plan development. Data analysis reveals that the Cancer Plan development process was well received and provided ample opportunities for input from both Consortium and Workgroup members, as well as from an array of specific cancer communities.

## 2009-2010 MCCCP Accomplishments

Maine's Comprehensive Cancer Control Program (MCCCP) just completed year three of implementing its second five-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 section of the report highlights some of the 2009-2010 accomplishments.

## *Sun Blocks* Childcare Sun Safety Program

In the second round of the *Sun Blocks* Childcare Sun Safety Program, the Maine Comprehensive Cancer Control Program (MCCCP) provided mini-grants of up to $1,000 to childcare centers in Maine to promote sun protection practices and increase policy and programming around sun safety and skin cancer prevention. Twenty-one childcare centers were the recipients of this funding and participated in the program, along with some non-funded childcare centers, and a select group of Healthy Maine Partnerships (HMPs) and Resource Development Centers (RDCs). A baseline evaluation survey was administered in August 2009, with follow-up conducted in April 2010. Quantitative findings suggest that the goal to promote sun protection practices, and increase policy and programming around skin cancer prevention was reached, especially among funded childcare centers. Qualitative findings provided rich detail on successes achieved, as well as challenges encountered around primary prevention practices, such as wearing sunglasses, hats, and sun-protective clothing, that were encouraged, but not required. Several childcare centers also conveyed their appreciation for the funding source (if applicable), training and related materials, and the opportunity to promote change and increase awareness and adoption of appropriate skin cancer prevention practices for children through a critical setting.

## Colorectal Cancer Awareness Mini-Grants: Healthy Maine Partnerships

In early 2008 the MCCCP announced the availability of three-year Colorectal Cancer Awareness Mini-Grants to support the Healthy Maine Partnerships with additional resources to enhance their ongoing colorectal cancer prevention and awareness activities. The evaluation results presented in this report reflect the final year grant activities in the five program areas identified during the first grant year. The program areas focused on in the grants included public awareness campaigns, education initiatives, practice changes, capacity building, and strengthening partnerships.

### Maine Colorectal Cancer Control Program

In 2009, the Maine Comprehensive Cancer Control Program (MCCCP) applied for and secured grant funding from the U.S. Centers for Disease Control and Prevention (CDC) to implement a comprehensive colorectal cancer screening program. The Maine Center for Public Health (MCPH) was contracted by Maine CDC to develop and implement a comprehensive evaluation plan. Interviews were conducted with key partners and stakeholders, including program management staff, representatives from participating health systems, and members of the Medical Advisory Board (MAB), in February and March 2010. Evaluation interviews focused on processes around infrastructure development and start-up, and on understanding facilitators, barriers, and lessons learned in order to provide feedback for program improvement. Findings indicated that by the end of Year 1, the Maine Colorectal Cancer Control Program (MCRCCP) established partnerships with the four major health systems across the state to provide screening, diagnostic, and follow-up services, developed infrastructure components, and commenced the implementation of its screening program. These findings and recommendations from Year 1, along with evolving program needs can have useful application in strategic planning for the program, as it works to achieve its goals, and makes strides in reducing financial, geographic, and health access-related barriers to colorectal cancer screening among uninsured and underinsured individuals in Maine.

### Outcome Findings

Outcome findings from several state-level disease surveillance sources are included in this report in the Report Section titled Results Part III with trend data provided, when available. Detailed information on cancer-related outcome measures is available in the comprehensive report developed by the Maine Cancer Consortium's Data Workgroup in 2009, and is available at: http://www.mainecancerConsortium.org/.

### Evaluation Recommendations

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

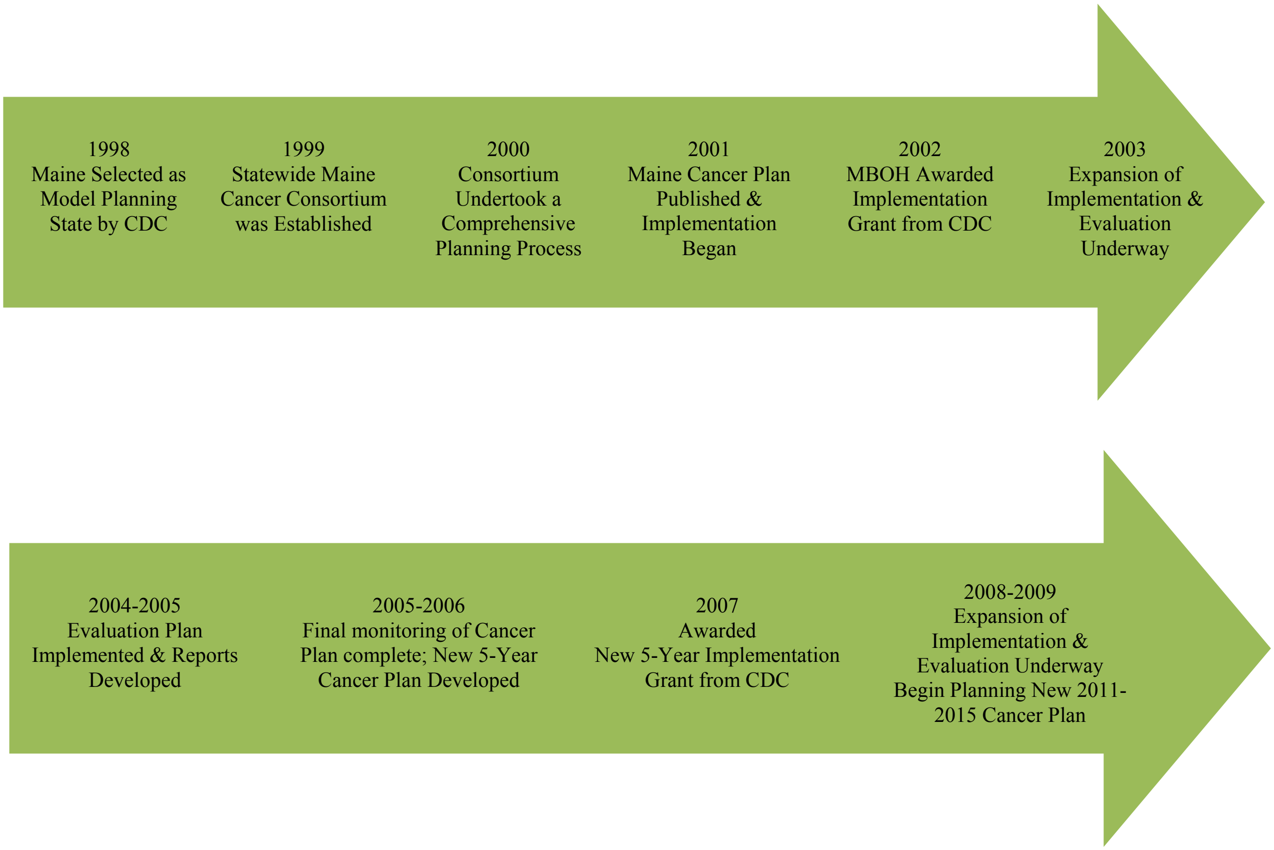
1. Utilize the evaluation findings from the 2011-2015 Cancer Plan Development Process and the 2010 Consortium Partnership Assessment to redesign and enhance the Consortium's structure and membership.
2. Increase Consortium participation in the enhancement of the Cancer Plan's Activity Monitoring Evaluation process.
3. Continue to utilize evaluation results to adapt, enhance and/or expand program initiatives and Consortium team activities to ensure activities are evidence-based.
4. Embed continuous program evaluation wherever appropriate and possible to glean data/evidence on the effectiveness of new and emerging strategies in cancer control.
5. Develop a comprehensive evaluation plan to track outcomes and process for the remaining four years of the Maine Colorectal Cancer Control Program.

# 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 Program (MCCCP). As depicted in Figure 1, the implementation of the Maine Cancer Plan has been underway since 2001. The second five-year Cancer Plan was announced May 18, 2006 with implementation beginning in the fall of 2006 and completion of the plan in 2010. Simultaneously the third five-year plan was designed with a Fall 2010 roll-out. A comprehensive evaluation plan was developed in 2007 and is designed to address the process, outcomes and contextual factors related to the MCCCP.

This report attempts to capture activities, successes, and challenges that have occurred during the previous year (2009 – 2010) of implementation of the MCCCP 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 Comprehensive Cancer Control Plan: 2006-2010. The three areas complement one another and many of the activities overlap.

**Figure 1:** *Maine Comprehensive Cancer Control Program Timeline, 1998-2010*



## Maine Comprehensive Cancer Control Program

The Maine Comprehensive Cancer Control Program 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, a statewide partnership.

The programmatic objectives of MCCCP are:

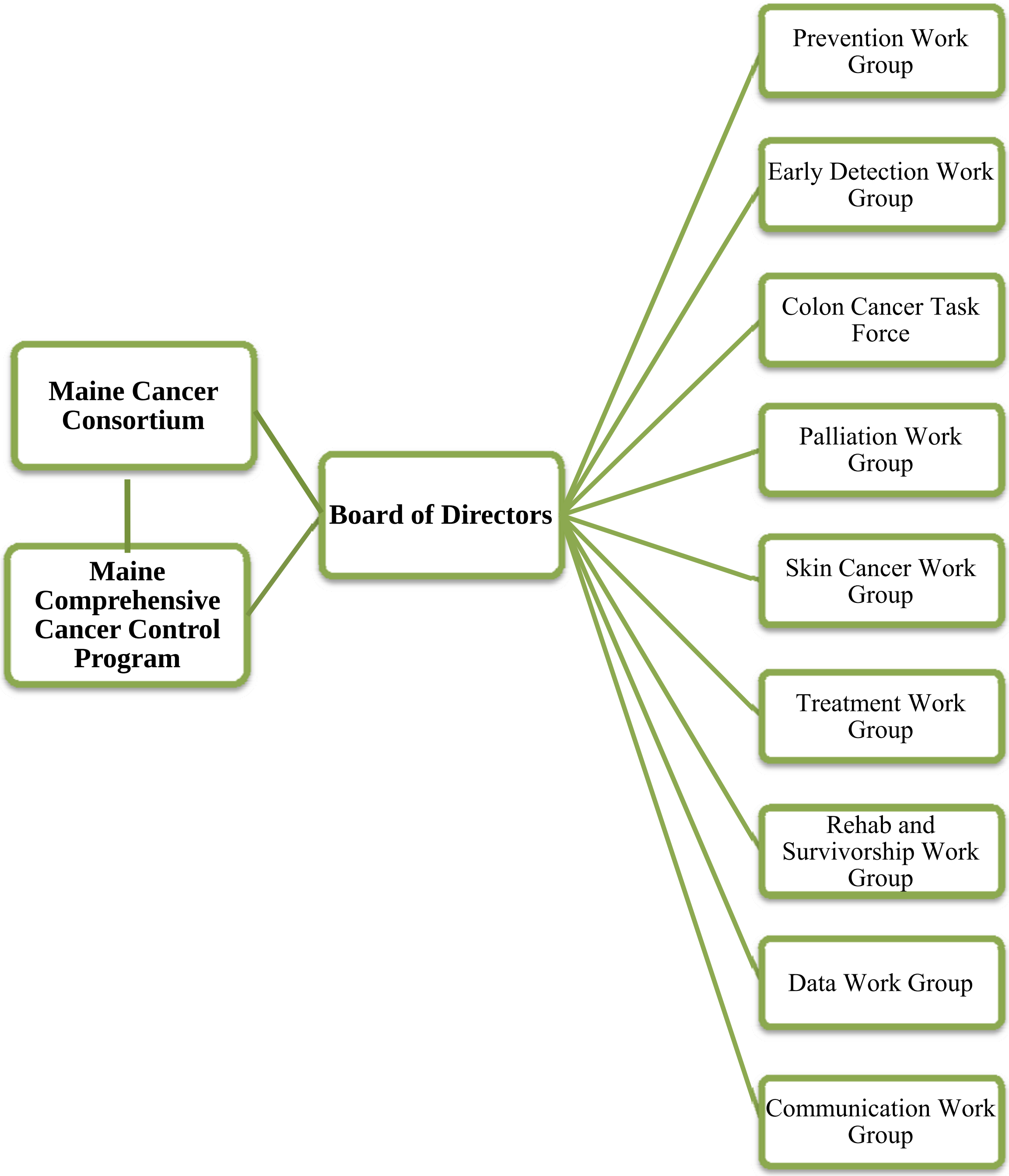
- Improve and expand the collaborative efforts already in place through the Maine Cancer Consortium among stakeholders working on cancer control in Maine.
- Increase the use of the Maine Cancer Plan as the statewide document directing collaborative cancer control efforts.
- Provide technical assistance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

## Maine Cancer Consortium

The Maine Cancer Consortium was created in 1999 and includes representatives from public and private organizations involved in all aspects of cancer prevention, control, and care. An organizational chart (2006-2010) is provided on the next page in Figure 2 (See Appendix A for Consortium membership).

It is worth noting that the Consortium structure presented here will change by the end of 2010. As will be discussed in subsequent sections of this report, both the Consortium Partnership Survey and interviews conducted in the spring of 2010, as well as the Cancer Plan development process that took place over the past year, highlighted the need to revisit, and ultimately redesign, the Maine Cancer Consortium's structure. This evolution does not suggest failure of past structure, but rather reflects growth and support for emerging needs of the organization. So while the structure below reflects the organization of the Consortium under which the activities evaluated in this report took place, moving forward into the 2011-2015 Cancer Plan, the organizational structure for the Consortium will be aligned around cancer-specific teams and overarching areas of expertise (such as policy) or content (such as data collection) required to support each of the teams, as well as the Consortium organization as a whole.

**Figure 2:** *Maine Cancer Consortium Organizational Chart 2006-2010*[1]



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[1] Appendix B to this report reflects the new Consortium Organizational Chart that will be implemented in the fall of

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 first in 2000. The third edition of this plan will be released in the fall of 2010. The purpose of the Plan is to provide a template for what should be done to provide statewide coordination of cancer control efforts in Maine. The nine components of the Maine Cancer Plan are depicted on the next page in Figure 3. This report details the evaluation of the second edition of the plan, 2006-2010.

**Figure 3**: *Maine Cancer Plan Components, Goals, and Objectives: 2006-2010*[2]

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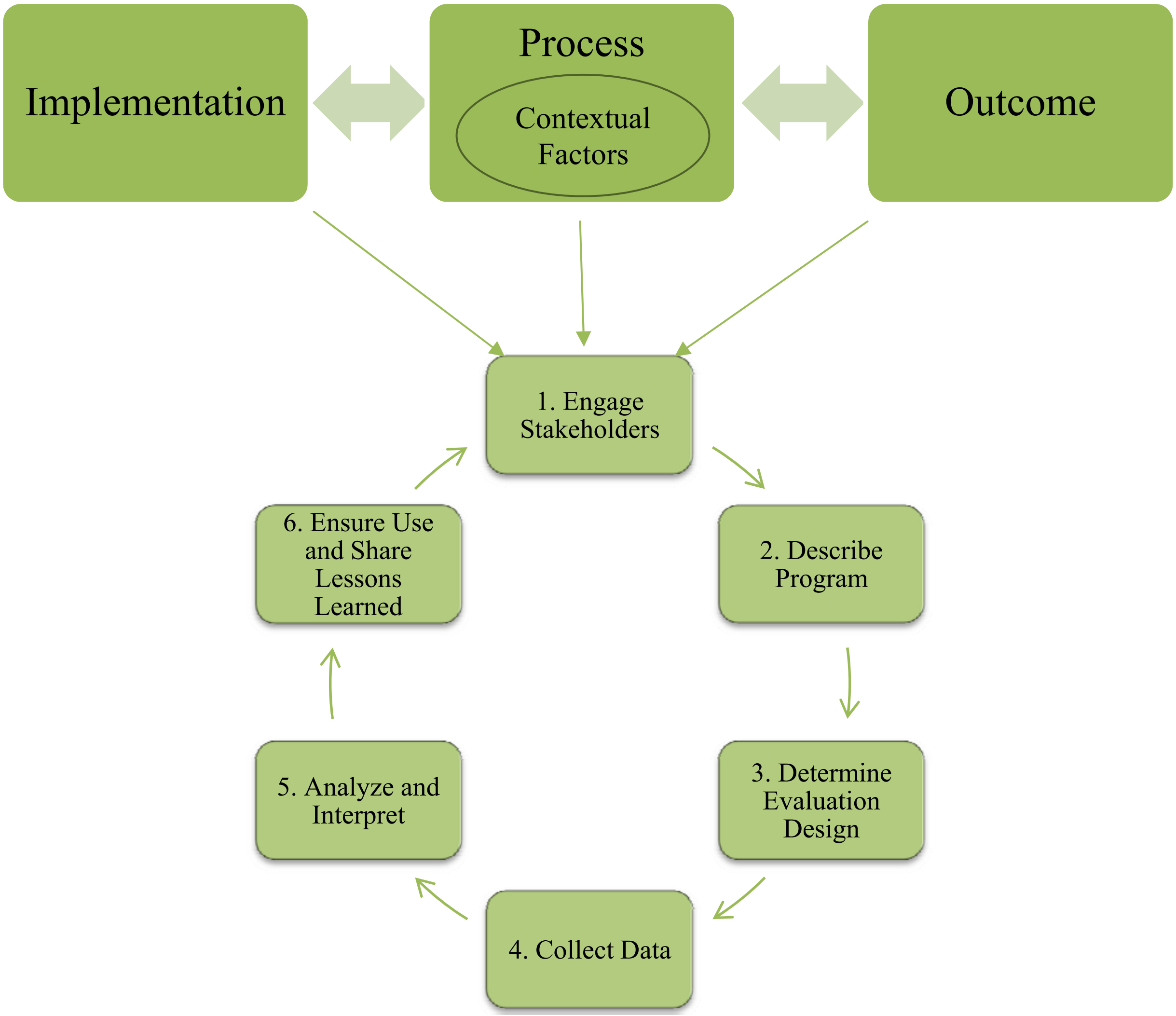
[2] The 2011-2015 Cancer Plan will not necessarily be organized around the same components or goals as the current plan, rather it will be aligned with the new structure of the Consortium.

# 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:** *Comprehensive Cancer Control Evaluation Design*



## Data Collection Methodology

Quantitative and qualitative information was collected as part of this evaluation. Table 1 details the data sources for each component of the evaluation during the 2009-2010 project 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**<br>- Both electronic tool and paper /pencil tracking tool used with Workgroups by MCPH Evaluator | • Developed by Maine Center for Public Health |
| • **Cancer Consortium Partnership Survey**<br>- Electronic survey administered in May 2010<br>- Key Informant Interviews in May/June 2010 | • Developed by Maine Center for Public Health |
| • **Cancer Plan Development Process**<br>- Paper/pencil survey administered at May meeting<br>- Paper/pencil survey administered at Annual Meeting<br>- Electronic survey administered in May 2010<br>- Key Informant Interviews in May/June 2010 | • Developed by Maine Center for Public Health |
| Program-Sponsored Initiatives: Formative Evaluation | |
| • **Program Accomplishments**<br>- Email, program accomplishments updates<br>- Interviews with staff | • Developed by Maine Center for Public Health and Maine Comprehensive Cancer Control Program |
| • ***Sun Blocks* Childcare Sun Safety Program**<br>- Training paper/pencil surveys – administered in August 2009<br>- Pre/Post Paper and pencil mail-in survey administered in May 2010 | • Developed by Maine Center for Public Health and Maine Comprehensive Cancer Control Program |
| • **Colorectal Cancer Community Awareness Mini-Grants (Year Three): Healthy Maine Partnerships**<br>- Electronic Grant Survey administered in June 2010 | • Developed by Maine Center for Public Health |
| • **Maine Colorectal Cancer Control Program**<br>-Partner/stakeholder interviews | • Developed by Maine Center for Public Health |
| Outcome Evaluation | |
| • **Maine Cancer Registry, CDC Wonder**<br>- Secondary data (incidence and mortality) | • Maine-CDC<br>• CDC |
| • **Maine Youth Risk Behavioral Surveillance System**<br>- Secondary data (behaviors) | • Maine-CDC<br>• CDC |
| • **Behavioral Risk Factor Surveillance System**<br>- Secondary data (behaviors) | • Maine-CDC<br>• CDC |
| • **Maine Pregnancy Risk Assessment System**<br>- Secondary data (behaviors) | • Maine CDC<br>• CDC |
| • **Maine Integrated Youth Survey** | • Maine CDC |

# Results Part I: Process

This process component of the results section of this evaluation report focuses on the implementation of activities and strategies designed to bring about changes that are directly linked to program goals as outlined in the 2006-2010 Cancer Plan. Implementation can often be challenging due to uncertainties and other contextual factors that can affect the process. This section of the report provides valuable information that can be used on an ongoing basis to make programmatic improvements during implementation, and can allow for more effective management of individual and group efforts.

## Cancer Plan Implementation: Activity-Monitoring Tool Results

### Methodology and Data Collection

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 (Spring 2010). Historically, administration of the tool has happened at Workgroup/task force meetings. For 2009 activities, the electronic tool allowed the administration of monitoring to take 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 other groups 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, ongoing 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 ongoing as a result of wanting to reinforce the message at every life age. 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 five years ago.

## Activity Monitoring Tool Results

As in previous years, Activity Monitoring Tool meetings in the spring of 2010 were designed to capture the activities pursued and completed over the past year that address the goals, objectives and strategies of the Cancer Plan. Additionally, because it is the final year of the Plan, the MCCCP evaluator used the spring meetings to also capture any activities and successes that may not have been recorded during the AMT process during the life of the Plan. So while activities will continue to be undertaken during the remainder of 2010, these 2010 AMT results provide the most complete picture of the overall success with implementing the 2006-2010 Cancer Plan.

Figure 5 illustrates the overall combined status of strategies (N=130) for all Workgroups and task forces completing the Activity-Monitoring Tool in 2008 or 2009: Early Detection, Colorectal Cancer, Palliative and Hospice, Rehabilitation and Survivorship, Skin Cancer, and Treatment. The figure reflects the 130 strategies that represent just over half (51%) of the total Cancer Plan strategies (254) which were tracked through the AMT process in 2009. The other 124 (49%) strategies were tracked by individual stakeholders and partners either electronically or via a paper tool.

From the AMT collection activities with Workgroups, 75% of their strategies were fully achieved and 5% were partially achieved. Combined, 80% of Workgroup-tracked strategies were at least partially achieved, which realizes the Consortium’s five-year implementation objective of 80% (Objective 17.1, Maine Comprehensive Cancer Control Plan, 2006-2010).

**Figure 5:** *Completion of Strategies for All Workgroups (51% of all Plan strategies)*

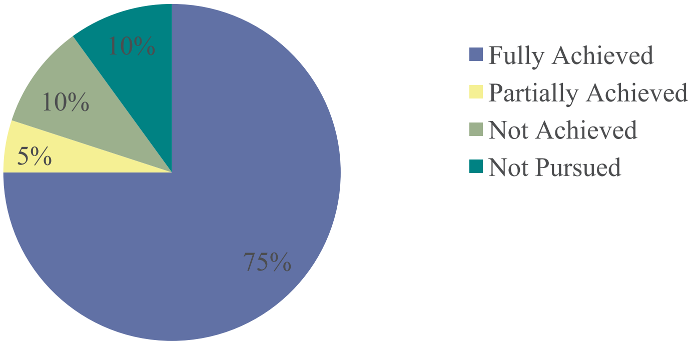
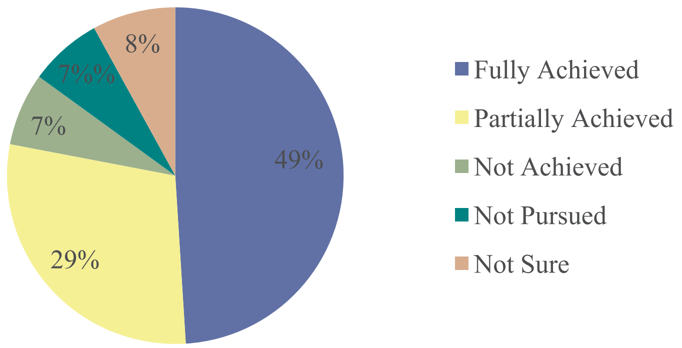


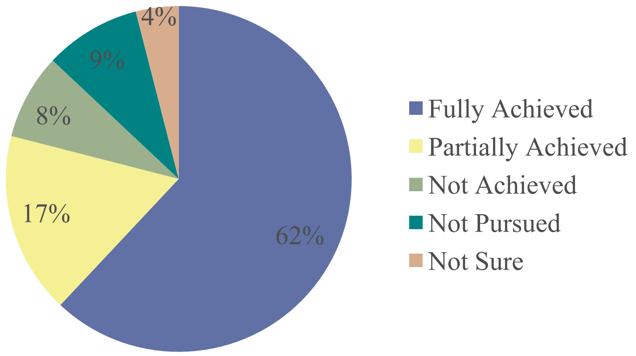
Figure 6 illustrates the overall combined status of all other strategies (N=124) that were also measured via an AMT activity. For this 49% of Cancer Plan strategies, almost half (49%) were reported as fully achieved and 29% were partially achieved. Combined 78% of non-Workgroup-tracked strategies were at least partially achieved, which is only two percentage points off the goal of 80% over the life of the Plan. Thus, for the other half (49%) of the Cancer Plan strategies, the goal target was not achieved but came within 2% of the 2010 implementation objective.

**Figure 6:** *Completion of Strategies tracked by Individual Stakeholders and Partners (49% of total strategies)*



Finally, Figure 7 represents overlaying Figure 5 and Figure 6, i.e. status of all strategies tracked in 2008 or 2009 (both Workgroup and individual stakeholders and partners). As the figure reflects the 2010 plan implementation goal of 80% of strategies being either achieved or partially achieved was missed by one percentage point. Only 79% of the 2010 Cancer Plan Strategies were achieved or partially achieved as of April 2010 when AMT data gathering took place.

**Figure 7:** *Completion of Strategies Reported by All sources (100% of strategies)*



The overall 254 strategies tracked through the AMT efforts in 2009 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 2008 data from the two content areas where 2009 data was not received, Primary Prevention and Palliative and Hospice Care. This being the last report of data for the 2006-2010 Cancer Plan, it is important to have all Workgroup or content areas included.

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

| **Workgroups/Goal Areas** | **Unduplicated Strategies** | **Status** | | | | |
|---|---|---|---|---|---|---|
| | | Fully Achieved | Partially Achieved | Not Achieved | Not Pursued | Not Sure |
| **Cancer Disparities** | **17** | **3** ***(18%)*** | **8** ***(47%)*** | **2** ***(12%)*** | **4** ***(23%)*** | **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** | **19** ***(76%)*** | **2** ***(8%)*** | **0** | **4** ***(16%)*** | **0** |
| Breast Cancer | 11 | 9 | 0 | 0 | 2 | 0 |
| Cervical Cancer | 7 | 5 | 2 | 0 | 0 | 0 |
| Prostate Cancer | 4 | 3 | 0 | 0 | 1 | 0 |
| Genetics | 3 | 2 | 0 | 0 | 1 | 0 |
| **Colorectal Cancer** | **6** | **4** ***(67%)*** | **0** | **0** | **2** ***(33%)*** | **0** |
| **Skin Cancer** | **24** | **24** ***(100%)*** | **0** | **0** | **0** | **0** |
| **Treatment** | **16** | **9** ***(56%)*** | **0** | **0** | **7** ***(44%)*** | **0** |
| **Rehabilitation & Survivorship** | **19** | **14** ***(74%)*** | **0** | **5** ***(26%)*** | **0** | **0** |
| **Palliative & Hospice Care*** | **34** | **23** ***(68%)*** | **4** ***(12%)*** | **7** ***(20%)*** | **0** | **0** |
| **Data and Surveillance** | **13** | **9** ***(69%)*** | **1** ***(8%)*** | **3** ***(23%)*** | **0** | **0** |
| **Implementation** | **12** | **11** ***(92%)*** | **0** | **0** | **1** ***(8%)*** | **0** |
| **Evaluation** | **7** | **7** ***(100%)*** | **0** | **0** | **0** | **0** |
| **Total** | **254** | **157** ***(62%)*** | **43** ***(17%)*** | **21** ***(8%)*** | **22** ***(9%)*** | **11** ***(4%)*** |

***Notes.*** *Data from 2008 AMT data collection process.

## Changes from 2008 AMT Process

In addition to the continued changes in how Cancer Plan implementation activities were monitored, there were also significant changes in the amount of activities moving towards completion as the five-year Cancer Plan comes to closure. Among the noteworthy changes for 2009 are the following:

- Between 2008 and 2009 the overall number of "Fully Achieved" strategies rose by 7% (17 points), and the average rate of increase in the fully achieved category for each Workgroup or goal area reporting in 2009 was 17% with a range of 6% (for Treatment strategies) to 32% (for Rehabilitation and Survivorship strategies). Additionally, ten strategies moved out of "Not Achieved" status between 2008 and 2009.

- Three goal areas exceeded the Cancer Plan goal (80% achievement of strategies) in 2009. Implementation activities remained at 92% of its strategies being fully achieved as was true for 2008. The Skin Cancer Workgroup reported an increase of 12% in the fully achieved category to move that set of strategies to 100% fully achieved as of the 2009 AMT process. Also, Evaluation activities reached 100% of strategies fully achieved for the whole five-year plan.

- Overall 79% 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 before embarking on the new 2011-2015 Cancer Plan. It should also be noted that a tremendous amount of member time in 2009 went into developing the new Cancer Plan (2011-2015) and thus may have diverted some efforts that would have gone to the completion of the current Plan strategies.

## 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 C reflects, the Workgroups and key stakeholders identified several accomplishments over the past year that contributed to the successful implementation of Cancer Plan strategies. While the 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, reflect a strong and expansive commitment to reducing the burden of cancer in Maine over the full five years of the 2006-2010 Cancer Plan.

## 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 Cancer Foundation, 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 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. The exception to this barrier in the past year was the securing of the federal grant for the Comprehensive Colorectal Cancer Program that will compliment the work HMPs have done the past three years around raising awareness of the need for colorectal cancer screening.

Other more general challenges identified include lack of available and timely data, such as appropriate race and ethnicity data, small samples for disparity analysis, and geographical barriers in Maine. Many Workgroups expressed a need to recruit new and/or different members as their work changes. For example, some felt they did not have the most appropriate representation at the table for some of the activities they were undertaking.

## Conclusions

Heading into the final year of the 2006-2010 Cancer Plan, one focus of the Workgroups and key stakeholders has been on developing new goals and objectives for the 2011-2015 Cancer Plan. The 79% achievement success rate of the current plan can help inform the planning process for the new plan. For objectives that carry forward into the new Cancer Plan, the results in this section of the report can provide benchmarks or guidelines for setting new targets. Additionally, building on the strengths and accomplishments of the current plan can provide direction and momentum for activities and initiatives needed over the next five years.

Out of the 2009 AMT process, 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 ongoing processes was identified. Presently most of those get recorded in the "Partially Achieved" category even if achieving an ongoing 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 five-year life span of the Plan, designing measurable objectives to evaluate could account for the ongoing nature of certain strategies and activities. Also, tightening accountability for objectives (for example, having Consortium members responsible for specific goal areas that they work within) may lead to more concise monitoring of the Plan's implementation over the full five years.

Finally, the Consortium's proposed new structure (Appendix B) in concert with the 2011-2015 Plan may provide an opportunity to redesign the overall Activity Monitoring process. As the subsequent sections of this process portion of this report will reflect, a great deal of work has gone into crafting the new 2011-2015 Cancer Plan during the past year, and thus annual monitoring will be especially critical to capturing the progress of the plan. Monitoring will also be crucial in re-energizing the new structure, and guiding any course corrections if needed. As one Board member put it, when speaking about the new Cancer Plan, "*The effort that goes into that [developing the plan] is considerable, but it is really important to get everyone's input into the direction for where Cancer is going in Maine…to get the plan to a broader group of constituents.*"

## Cancer Consortium Findings: 2010 Partnership Assessment Survey

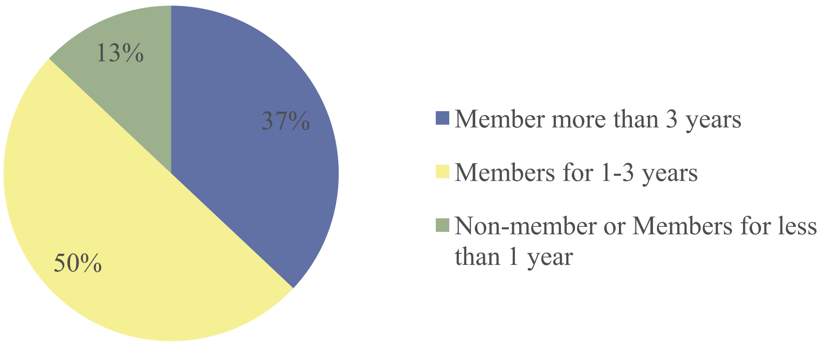
Every two years the MCCCP evaluator conducts a partnership survey of the Consortium membership to assess partnership dynamics, satisfaction, and benefits for members of the Consortium. The Maine Cancer Consortium Partnership Assessment survey (Appendix D) was administered via Survey Monkey in May and June of 2010. Members were selected to participate in the survey if they were either a member of the Consortium Board of Directors or any of the Workgroups, and/or were on the Consortium electronic list-serve. Forty-six responses were collected and provided data in all twelve sections of the survey which addressed: 1) partnership dynamics (such as synergy, leadership, efficiency, management, decision making, and planning), 2) Cancer Plan development, 3) partnership benefits and drawbacks, and 4) overall satisfaction with participation in the Consortium.

The intent of the assessment is to identify how well the Consortium's collaborative structure and process are working and what if any specific areas can benefit from changes or improvements. Because there have been major changes in the Consortium and its partners in the past year, and because 2010 represents the completion of one five-year Cancer Plan and the development of a new five-year Cancer Plan, the evaluator and program staff determined that this year's partnership survey should be augmented with a number of key informant interviews with some of the Consortium members. Therefore, in June of 2010 the MCCCP evaluator interviewed six key informants about a range of topics that arose through the survey assessment process. Appendix E reflects the questions posed during the interviews. The following is a summary of the data provided by the electronic survey respondents and the in-person key informant interviews.

## Demographics of Survey Respondents

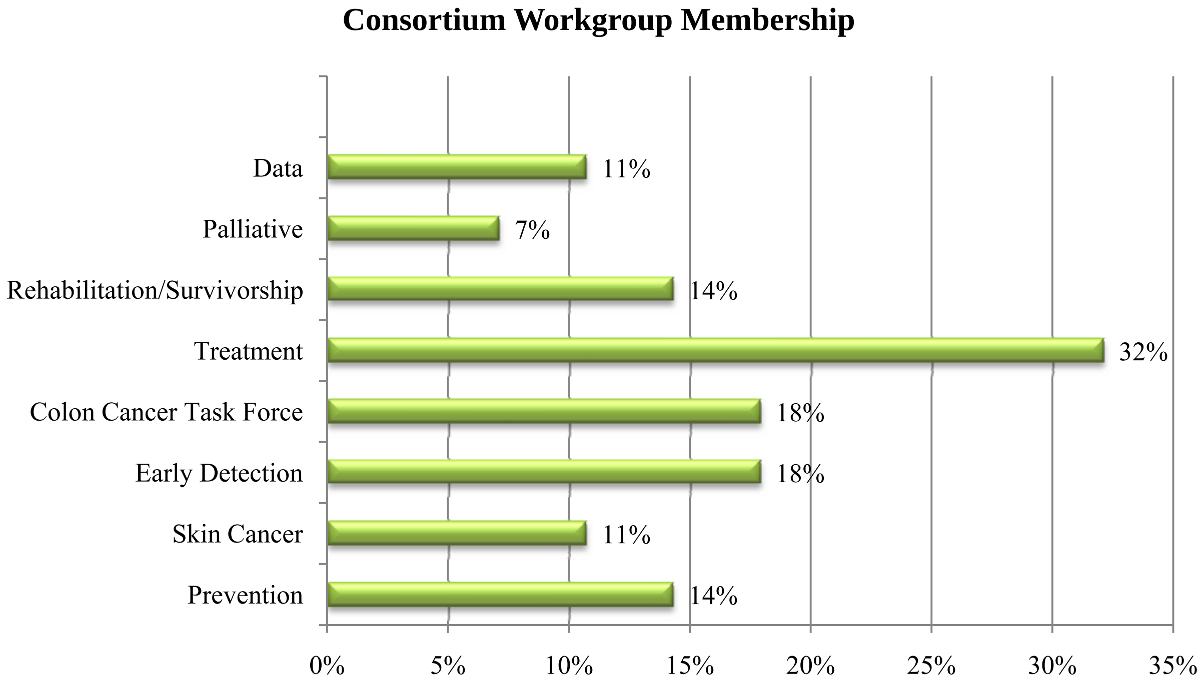
Survey respondents represent an experienced Consortium membership as only three respondents (6.5%) identified themselves as not being a Consortium member (i.e. some program staff may not self-identify as a "member" of the Consortium), and only another three indicated that they have been a member for less than a year. Twenty-three of the respondents (50%) identified as having been a member for one to three years, and another seventeen (37%) chose the "Other" option. Those seventeen "Others" indicated they have been members for an average of at least six years, and a number have been members "S*ince the beginning*."

**Figure 8:** *Length of Consortium Membership*



The survey also inquired about Workgroup membership, to which 28 (64%) responded in the affirmative, with another 5 (11%) indicated they have previously been a member of a Workgroup, although are not so currently. Almost half (46%) of those who belong to a Workgroup have done so for one to three years, with another third (34%) recorded anywhere from five to ten to "S*everal*" years of Workgroup membership, or as one respondent indicated, "*almost since conception*." As Figure 9 on the next page reflects, almost one third (31%) of the Workgroup member respondents belong to the Treatment Workgroup, with Early Detection and Rehabilitation/Survivorship Workgroups each having the next largest (19% for each) representation. Only the Communication Workgroup had no respondents to this survey and thus is not included on the chart on the next page.

**Figure 9:** *Consortium Workgoup Membership of Survey Respondents*



## Partnership Dynamics of the Consortium

### Partnership Synergy

The construct of *partnership synergy* is just one way of looking at how well (or not) a collaborative process is working. Synergy is about how well the partners of the Consortium are working together and enhancing or building upon each other's individual work to make the overall partnership (the Consortium) stronger and more successful. As such the six questions on the survey that address synergy asked about the particular attributes of working together that make the partnership better. Respondents were asked to rate the attributes on a four-point scale where 1 represents "Not well at all," 2 is "Not so well," 3 is "Somewhat well," and 4 is "Extremely well." In this section of the survey eight of the forty-six respondents chose not to answer the synergy questions, which may reflect the lack of a "DK" option of response. That said, for each subsequent section of questions there were also a group of non-responders as overall there were only thirty-three totally completed surveys. These uncompleted responses may indicate taking a serious look at the length of the survey should it be utilized in the future. The quantitative results on partnership synergy questions are listed in the table on the next page.

**Table 3:** *Qualitative Results on Partnership Synergy Questions*

| Synergy Attribute | **Average Rating** (*n*=38)<br>1=not well at all 4= Extremely well |
|---|---|
| **By working together, how well are Consortium partners able to:** | |
| Identify new & creative ways to solve problems | 3.18 |
| Include views and priorities of people affected by the Consortium's work | 3.11 |
| Develop goals that are widely understood and supported among partners | 3.16 |
| Respond to the needs and problems of the community | 2.95 |
| Obtain support from those in the community who can block the Partnership's plans | 2.79 |
| Carry out comprehensive services | 2.89 |

In addition to the six four-scaled questions the survey asked respondents an open-ended question about ideas on how to strengthen collaboration within the partnership. Almost a quarter (24%) of the respondents answered, and representative of the ideas shared include the following:

- Recruiting new members and/or voices as these ideas suggest:

  *"…should recruitment of smaller hospitals/agencies, show that they too are important;"*

  *"…listen to clinicians in rural areas to identify the needs and concerns of their patients;" and,*

  *"Increase activity and numbers that adopt the Cancer Plan into their work."*

- Do the work of the Consortium differently, such as:

  *"We may need to focus our efforts rather than try to be as comprehensive as we have been in the past;"*

  *"…all partners in the partnership should have equal say…;" and*

  *"Improve communication to the members formally. Perhaps by newsletter or communication that comes from the Consortium."*

## Leadership Dynamics

The six questions on leadership dynamics asked about attributes of leaders that promote collaborative work as they relate to the Consortium partnership. The response scale was a five-point scale with 1 being "poor," 2 being "fair," 3 being "good,"4 being "Very good," and 5 being "Excellent." There was also a "DK" option for this set of questions. As with the synergy questions, there were at least eight survey respondents who chose not to answer this set of questions. The leadership questions as a whole reflect that the Consortium's leadership is strong and is rated "good" and "Very good" for all attributes. The lowest rating is for the attribute of recruiting diverse members which may well reflect Maine's lack of diverse populations. The attribute for resolving conflict garnered a large number of "DK" responses which may well reflect that there is little conflict in the Consortium and thus respondents aren't clear about how conflict is resolved since they have not experienced it. The results for the leadership questions are explicated below in Table 4.

**Table 4:** *Qualitative Responses on the Survey Leadership Questions*

| **Leadership Attribute** | **Average Rating** (*n*=38)<br>1=Poor 5= Excellent |
|---|---|
| Taking responsibility for partnership | 3.69 |
| Inspiring or motivating partners | 3.39 |
| Communicating the partnership vision | 3.47 |
| Fostering respect, trust, inclusiveness and openness | 3.75 |
| Resolving conflict among partners | 3.33<br>(exclusive of 37% "DKs") |
| Recruiting diverse people/organizations into the partnership | 3.23 |

## Efficiency Dynamics

The three questions reflected in the chart below attempt to capture how well the Consortium utilizes its members' involvement with the partnership, i.e., how efficiently does the Consortium use its members as resources. On a five-point scale where 1 being "Poor" and 5 being "Excellent" with an option of "DK", the Consortium is quite efficient as it scored "good" on those dynamics members felt they had knowledge about. The high number (sixteen or 43%) of respondents who answered "DK" to the question on use of financial resources, coupled with the nine (25%) non-responses to this question, would suggest limited validity for the results of this particular question. The responses to this set of questions reflect a good use of in-kind resources, however, use of partner's time may be an area of growth that the Consortium wants to look at to make some changes or improvements to better utilize partner's time and expertise on a regular basis. The responses to the questions on the efficiency dynamics of the Consortium are reflected in Table 5.

**Table 5:** *Qualitative Responses on the Efficiency Dynamics of the Consortium*

| Efficiency Dynamics | Average Rating (*n*=37)<br>1=Poor 5= Excellent |
|---|---|
| **How well the Partnership uses its partners':** | |
| Financial resources | 4.68<br>(exclusive of 43% "DK") |
| In-kind resources | 3.76 |
| Partners' time | 2.78 |

## Administration and Management of Partnership

The key administration and management dynamics for a partnership seeking optimum collaborative process address the characteristics of communication, coordination, removing barriers to and providing orientation for participation in the partnership, and evaluation. The survey included five questions that utilized the same five-point scale with 1 being "Poor" and 5 being "Excellent" with a "DK" (Don't Know) option to address these dynamics. As with previous sections of the survey there was a group of non-responders and at least nine respondents chose not to answer the administration/management questions. Additionally in this section, "DK" once again garnered the greatest number of responses for the question on new partner orientation. "DK" also tied with "Fair" for the highest number of responses to the question about coordinating communication outside the partnership. In total the responses to this set of questions on the administration and management activities of the Consortium indicate they are "Good" or "Very Good" in terms of internal communication, organizing partner activities, and evaluation. However there appear to be some areas for growth and change, such as external communication and new partner orientation. The overall Administration and management results are captured below in Table 6.

**Table 6:** *Qualitative Results on Administration and Management Activities*

| Administration/Management Activities | Average Rating (*n*=37)<br>1=Poor 5= Excellent |
|---|---|
| Coordination of communication among partners | 3.28<br>(incl. 30% Good & 27% Very Good) |
| Coordination of communication with people & organizations outside the Consortium | 2.96<br>(exclusive of 25% "DK") |
| Organization of partnership activities (ex: meeting, projects, etc.) | 3.34<br>(incl. 1/3 Very Good) |
| Providing new partner orientation for joining partners | 2.42<br>(exclusive of 35% "DK") |
| Evaluating the progress & impact of the partnership | 3.37<br>(incl. 50% Good or Very Good) |

## Resource Utilization

The Consortium's ability to garner and effectively utilize both financial and non-financial resources is a critical component in the success of the partnership on a number of dimensions. The survey included seven questions that address the range of sufficient resources a collaborative partnership needs to do its work effectively. These questions utilized a five-point scale on which 1 was "None of what it needs" and 5 being "All of what it needs," 2 being "Almost none of what it needs," 3 "Some of what it needs," 4 "Most of what it needs," and "DK" filling in the options. Almost a quarter of the respondents (24%) chose not to answer this section of questions. However, for those respondents who did answer these questions either "Some of what it needs" or "Most of what it needs" got the highest number of responses for all the questions, which indicates the Consortium does well at securing and utilizing sufficient resources to further its goals. Table 7 below reflects the responses to the seven survey questions on the use of Consortium resources.

**Table 7:** *Qualitative Results on Use of Consortium Resources*

| **Non-financial & Financial Resource Items** | **Average Rating** (*n*=35) 1=None 5= All |
|---|---|
| **The extent to which the Consortium has what it needs to work effectively in terms of:** | |
| Skills and Expertise (e.g. leadership, training, evaluation, etc.) | 3.50<br>(20% "DK"; 46% "Some" highest) |
| Data and information | 3.45<br>(43% "most" highest) |
| Connections to target populations | 3.26<br>(49% "Some" highest) |
| Legitimacy and credibility | 3.69<br>(41% "most" highest) |
| Influence and ability to bring people together for meetings/activities | 3.33<br>(43% "Some" highest) |
| Money | 3.24<br>(49% "Some" highest) |
| Space | 3.50<br>(26% "DK"; 26% "Some" highest) |

## Partnership Decision Making

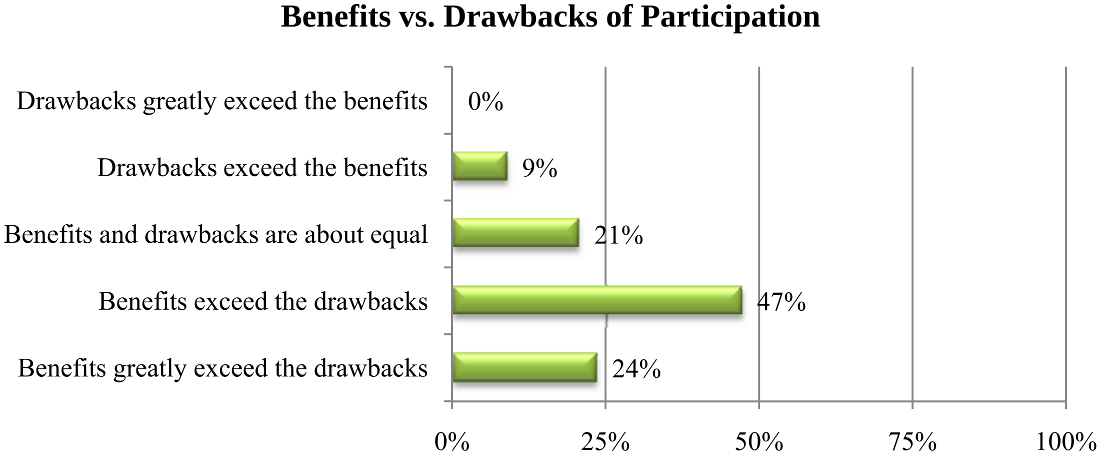
At the heart of most successful partnerships is an equitable and deliberate decision-making process/structure that the partners understand and engage with comfortably. The Consortium received high marks on the partnership survey for the two questions on how well it does in the decision-making arena. The majority of the membership (83%) is either "Very Comfortable" (53%) or "Somewhat Comfortable" (30%) with the way decisions are made in the partnership. Only 3% were "Not Comfortable" and 14% "A Little Comfortable" with the decision making process.

The second question asked about whether partners supported the decisions made by the partnership and provided a five-point scale with 1 being "None of the time" being 1 to 5 being "All of the time." "None" and "Almost none" received no responses, while "Most" got 65% of the responses, "Some" got 29% of the responses, and "All" got 6% of the responses. Thus, at a rate of 70%, partners support Consortium decisions either most or all of the time, which is not surprising since 83% of the partners are comfortable with how those decisions are made.

## Benefits & Drawbacks of Consortium Participation

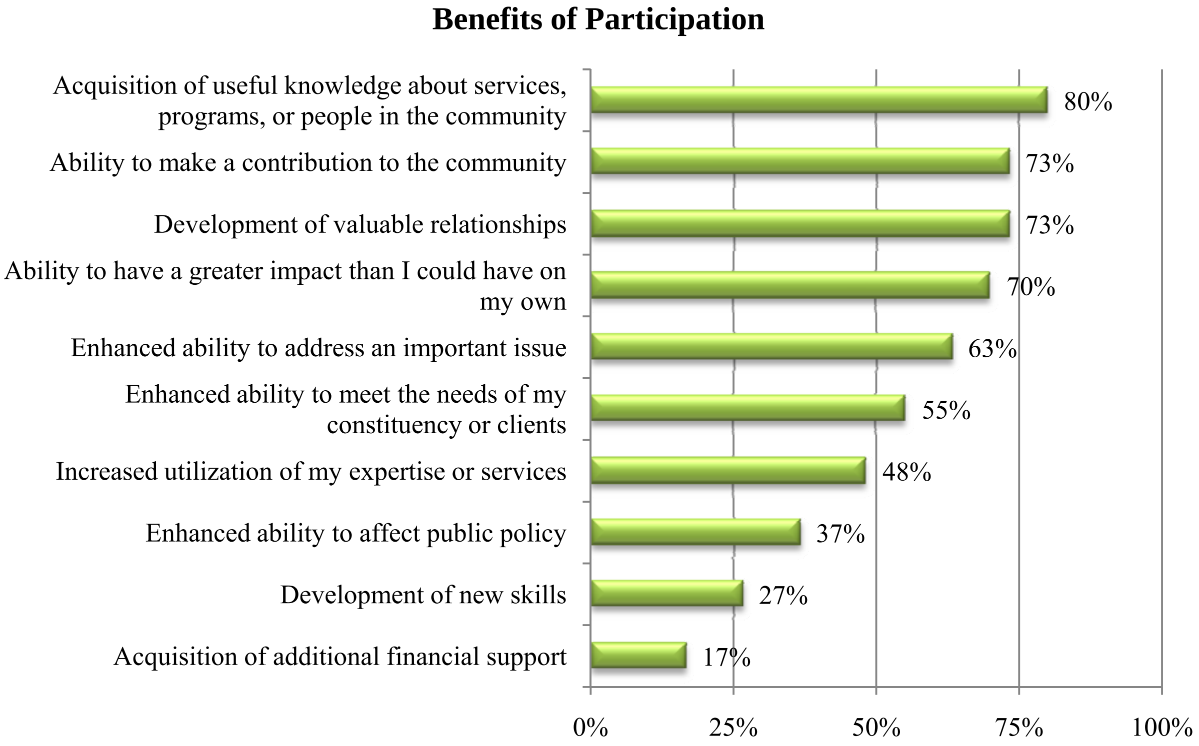
The benefits and drawbacks of any partnership will directly influence the level of time, energy, and participation any individual partner puts into the partnership. The balance of what one gives and what one gets from a commitment to the partnership may be the most important determinant of involvement. As a result of the significance of this partnership dynamic, there were fifteen questions on the partnership survey that pertained to benefits and drawbacks of Consortium participation. Overall, as the graph below indicates, for almost three quarters of the Consortium membership the benefits of participation either "Exceed" (47%) or "Greatly exceed" (24%) the drawbacks of participation. It is commendable that only three respondents perceive the drawbacks as exceeding the benefits, however, the 26% non-response rate to this question poses some concern around why twelve skipped the question entirely.

**Figure 10:** *Benefits vs. Drawbacks of Consortium Participation (n= 34)*



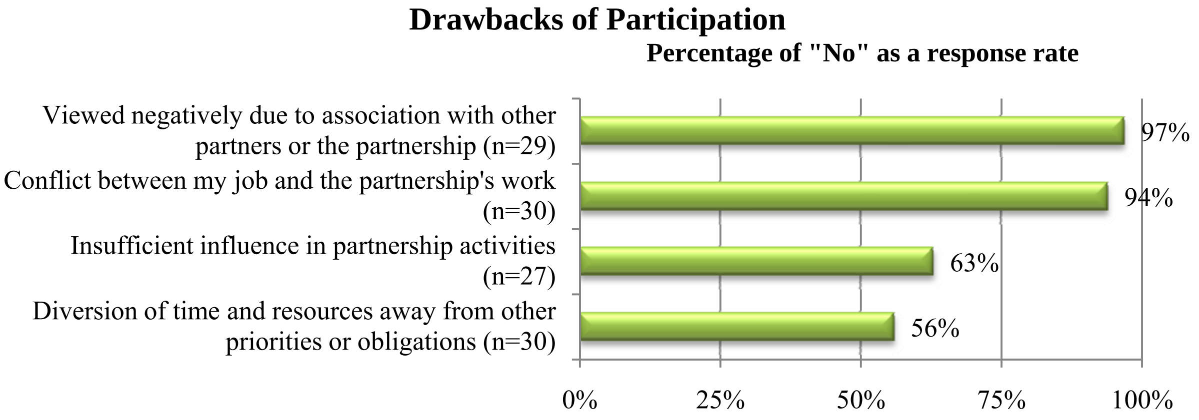
The survey asked members to respond to whether or not they received ten specific benefits (listed on the graph below) as a result of their participation in the Consortium. Answering "Yes" or "No" respondents rated benefits such as development of new skills and valuable relationships, enhanced ability to address public policy and important issues, and acquisition of new knowledge and financial support. The non-response rate for this section of questions was 26% but those who responded indicated that Consortium participation provided clear benefits in reference to acquiring useful knowledge (82% "Yes" response rate), developing valuable relationships (77% "Yes" response rate), and in having a greater impact, contribution, and financial support" (all 74% "Yes" response rate). The benefit least received was the "Increased utilization of my expertise or service" which got only a 55% "Yes" response rate. The overall response rates for the ten specific benefits listed in the survey are reflected in Figure 11.

**Figure 11:** *Benefits of Consortium Participation (n=34)*



The survey also asked members to respond "Yes" or "No" to four potential drawbacks that may result from Consortium participation. As with the benefits section of questions, the drawbacks section had a high non-response rate from 12 (26%) to 15 (33%) non-responders to individual questions. The drawbacks included in the survey are listed in Figure 12 with the "No" response rates indicating members do not actually perceive them as drawbacks of participation. In total for this section of survey questions, negative perceptions from participation received a 97% "No" response rate and "Conflict with the members' job" received a 94% "No" response rate. The one area that may be seen as a drawback is the "Diversion of time and resources away from other priorities" which received a 56% "No" response rate indicating that just under half of the respondents do see this as a drawback.

**Figure 12:** *Drawbacks of Consortium Participation*

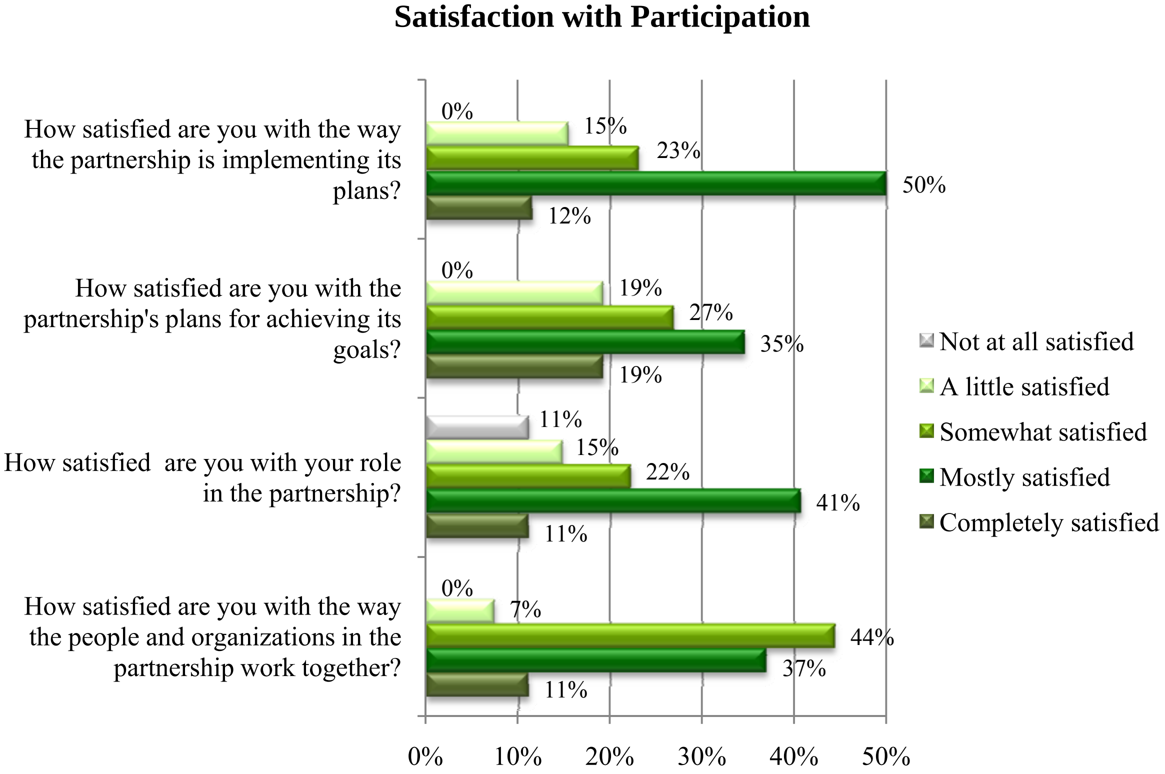


*Draft_Pending Updated Data Sources*

## Satisfaction with Participation

The survey included four questions that asked members to rate their level of satisfaction with how the Consortium is functioning overall. Members were asked how satisfied they are with the way members work together, their role in the Consortium, the Consortium's plans to achieve its goals, and the way the Consortium is implementing its plans. Once again a five-point scale was utilized, with 1 being "Not at all satisfied," 2 being "A little satisfied," 3 being "Somewhat satisfied," 4 being "Mostly satisfied," and 5 being "Completely satisfied." For the satisfaction questions the non-response rate was between 33% (for two questions) and 35% (for two questions). In total for the respondents who answered these four questions, almost half of the members rated satisfaction above 4 for all questions and for three questions almost a fifth of the respondents rated satisfaction at 5. The results for all four satisfaction questions are explicated in Figure 13.

**Figure 13:** *Consortium Participation Satisfaction for Survey Respondents*



## Consortium Structure and Recruitment

The survey contained two open-ended questions asking partners about the current structure of the Consortium, and whether there were changes needed that might enhance involvement of the membership and/or bring in new members to the Consortium. The first statement, "Please share your ideas about any new partners who should be recruited for the Consortium" received twelve narrative responses. While a couple of respondents mentioned *"No realistic ideas"*, most of the replies provided at least one sector, such as the larger community, or discipline, such as cancer-specific practitioners, that they felt should be better engaged with the work of the Consortium. The list of members that might be recruited included the following:

- Rural Physicians;
- Private practices;
- Oncology nurses;
- Lung cancer community;
- Insurance companies and payers;
- Community-based organizations who are not necessarily health focused but who know their communities, community education programs, and support groups;
- Individuals who can assist in data use and evaluation; and
- Individuals involved in Health Care Reform initiatives.

Fourteen of the survey respondents provided narrative responses to the statement, "Please share any thoughts you may have about any alternative partnership structure(s) that would enhance your involvement (or better meet your needs) within the partnership and/or could draw in new (or lapsed) members." A number of responses suggested changes in meetings that would engage more members such as online-meetings, quarterly meetings, and meetings in the northern part of the state.

Another group of responses spoke to the Consortium and Workgroup structure. Some members see the Workgroup structure and its tendency to reinforce silos as a barrier to involvement, and as one respondent put it, *"We need to look at care along a more realistic continuum, where Workgroup activities overlap."* While other respondents felt the task groups needed to be more focused on a specific type cancer, such as breast, lung or prostrate, to garner new membership. Across both positions was the third comment, *"I do not think the structure is the issue, I think the partners just have to work together in a more meaningful way."*

The final group of responses addressed enhancing communications as a vehicle for increasing membership. One suggestion was the establishment of a Speakers Bureau that could address partner localities and increase buy-in, and membership, for the work of the Consortium. Another suggestion was, *"to utilize the Consortium web site more effectively."* In addition to these structural communication strategies, a couple of responses suggested enhancing personal communication through, *"more time for collaboration,"* and *"…personal connection and better outreach will keep people involved."* This final respondent went on to express a sentiment worth taking a second look at: *"I like the ideas most recently discussed at the Board level, of reminding teams that networking (keeping informed of activities in ME) is their primary role and not to do the work of the plan itself, unless that is their day job."*

A similar question about the Consortium's structure was posed to the key informants during their interviews and their responses mirrored much of what the survey results reflected. Interviewees also noted that the Consortium structure is not visible to most people, so it is often thought of as having more resources than it does. A number of key informants spoke about the need for the Consortium to have administrative support or dedicated staff to address some of the structural issues that have come to light this past year. In terms of member involvement and recruiting new members, the interviewees suggested a new structure similar to what has been proposed for 2011, and different kinds of members such as, *"advisory Board capacity rather than Board* *member."* More attention to regional differences and the *"two Maines"* was suggested, as was adopting a structure that can *"accommodate people who want to be involved in different ways."*

## 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."*

The question also suggested that there has been a lot of change within the Consortium and its partners over the past year and asked respondents to comment on the changes if they wished. One of the survey respondents remarked that, *"While those who are leaving have been wonderful and significant contributors, my global view of change, is that change is good…".* Another respondent echoed this sentiment of change as opportunity in saying, *"With all the changes that have taken place, the Consortium has an opportunity to review its charge and be strategic about what its niche is and how to move forward to be more impactful…".* Suggestions about how to make that change included using this time of transition to establish a clear identity, to develop an annual priority and an implementation strategy for the Cancer Plan, to clarify the value of the Consortium to the state of Maine, to establish designated staff and balanced leadership, to recruit new partners, and to get the word out about the work of the Consortium to more people and communities in Maine.

## Key Informant Interview Results

As noted above, this year's Partnership Assessment included both the online survey and six key informant interviews with the chairs of the Consortium Board and Workgroups. It was anticipated that because of the length of the electronic survey, and the fact that it had been a few years since a like tool was administered, the survey response rate would be light. The addition of key informant interviews this year was designed to expand the data base for the assessment in a year when the Consortium is experiencing some transition. Thus, in May and June of 2010, the MCPH evaluator developed a protocol and questions to use for the interviews (Appendix E), with input from MCCCP staff, to assure that key issues and/or concerns were addressed during the interviews. Interviews were conducted in-person and were taped for analysis by the MCPH evaluator. Each interview lasted thirty to sixty minutes at the location of the interviewee's choosing.

The interview questions were crafted to provide more in-depth conversation and information around some of the components of the online survey, such as the Consortium's structure, member composition and recruitment, communication, Cancer Plan development, etc. The interviews were able to provide the robust data necessary to make this year's Partnership Assessment more extensive and comprehensive, and lead to Consortium changes that will enhance its functioning and vitality to the members of the partnership. Additionally, a number of the key informants have a long history with the Consortium, and have served in multiple leadership positions within the Consortium, so were able to provide a uniquely historical and/or global perspective to their responses. These long-view perspectives compliment the 50% of survey respondents who identified themselves as having been Consortium members for less than three years.

As was true with the survey results, key informants feel very positive about the time and commitment they make to the Consortium. They identify their Consortium involvement as a vital extension and enhancement of the work they do in their individual organizations, i.e., their *"day job."* As one interviewee stated, *"It is a good marriage of my day job and the Consortium."* However, they are aware of the need for accountability and balance between Consortium work and their work in their organization, or as one interviewee suggested, *"…have to keep the resources in balance, what you put in has to balance what you get out."* This echoes the online survey results in which 73% of respondents indicated that Consortium membership benefits exceed the drawbacks.

Key informants had much to say about the need to improve the visibility of the Consortium and its work, *"…people don't know who we are or what we do."* Another interviewee spoke about the need for *"more general public involvement in our work…we can't make social change if it is just us* [healthcare professionals]*."* Most key informants identified the Cancer Plan as a vehicle for increasing awareness of the Consortium, both within their individual organizations and in the community at large. Awareness is also seen as a way to bring new energy and members to the Consortium, with the caveat that, regional and/organizational differences and inequities may need to be addressed to accommodate new members. Underutilization of the Consortium website was noted, and using it as a tool to get the Cancer Plan out to more people and to monitor its strategies and activities online, similar to using the Wiki tool for its development, was suggested. Finally, a few informants indicated that internal visibility is a problem in that they don't really know who all the Consortium members are, and thus don't feel aware of all the activities that are happening under the Consortium's umbrella.

The visibility conversations spawned discussion about the function and mission of the Consortium. Informants identified the Consortium's function as one of facilitating and coordinating, not *"doing"* cancer programs and activities across the state. As one interviewee said, *"Systems-level across the state is, and needs to be, the Consortium's focus."* The Consortium is not a program and should not be developing programs, but rather, should be using its leverage to generate resources, *"Making 1+1=5"* as one member put it, for others to develop or implement programs. One interviewee suggested that there is often confusion around this because of the close relationship between MCCCP, which does do programs, and the Consortium and its Workgroups that have historically received mini-grants from MCCCP. A number of informants suggested that having a clear mission and scope of responsibility for the Consortium would go a long way in clarifying any confusion.

As was true with the survey, the key informant interviewees identified a long list of strengths of the Consortium beginning with the people involved with the Consortium, *"Its human resources."* Among the other strengths identified by multiple interviewees were the following:

- The Consortium is respected as a panel of experts on specific topics and provides a venue to discuss the issues important to the cancer community, for example access to care, quality, etc.

- Experience, particularly in terms of this being the third Cancer Plan it has successfully developed.
- *"Its evaluation mechanism, our commitment to evaluation and reporting, without which I would not be able to so involved."*
- Networking is great and the Consortium provides a vehicle for the integration of the work being done across all Workgroups.
- *"Two hallmarks of the Consortium are its outreach to underserved populations and its partnerships."*
- Board participation allows "*…me to learn from others… and informs my work."*

Key informants also talked about the Consortium turning this time of transition into an opportunity to focus on growth and change in several important areas. Many informants acknowledged that the cancer community landscape has changed over the past five years since the last Cancer Plan was developed. There are many new groups/organizations in the field, and members are not as engaged and active with the Consortium. Some long-time members are moving out of the Consortium and other members are just too busy. As one informant said, "*There is only so much you can do and then you have got to move on."* Most see change and growth as good, as well as challenging, and among the ideas shared were the following:

- Taskforces for specific areas that need coordinated action and letting agencies who are in the lead on the topic take the lead for Consortium.
- Expand outreach to Consortium and Workgroup members.
- *"In our zeal to be comprehensive… current horsepower doesn't allow us to be so comprehensive so maybe need to set fewer goals…"*
- *"Consistent Board attendance so we can be more representative of larger cancer community."*
- Consortium staff person as "W*e are currently thinly resourced.*"
- *"Strong communications person on the Board would help."*
- *"Smaller group of active organizations rather than larger group."*
- Better marketing of what the Consortium does and its role as coordinating all that happens in the cancer community.
- *"Because it's a challenge* [restructuring] *is not a reason not to address it."*

## Limitations

The major limitation of the data collected through the electronic survey is the non-response rate for many of the questions. While forty-six people went to the web link to answer the survey, only one question on the survey got the full forty-six answers. A number of questions were skipped by only one or two respondents, but many of the questions were not completed by all the members who started the survey. An average of twelve respondents chose not to answer sixty-two questions. One can surmise that the length of the survey was the culprit, i.e. Consortium members did not have the time required to answer a long survey. That said, it may be worth reviewing which specific questions did not resonate with the membership and whether or not there is another vehicle for obtaining membership input to the functioning of the Consortium's partnership. The membership is comprised of people with expansive jobs, which are getting larger as budgets get cut, so the motivation to carve out the time to complete a 63 question electronic survey may not be present, especially when they get multiple requests from various sources to fill out online surveys.

## Discussion and Recommendations

From an evaluation lens it is critical to the vitality of any partnership to step back from time to time to assess how it is functioning, what it is good at, where it needs to grow, and whether the partners are satisfied with their involvement in the partnership. As the Consortium begins its work on the new Cancer Plan, it will be equally important to track that work on a regular basis in order to assure that all the right resources are in concert to bring the plan to fruition. The 2010 Partnership Assessment process has produced much food for thought in terms of both the Consortium and the Plan, as it has simultaneously reaffirmed the importance and value of the Consortium as a driver and coordinator of the Plan and the work of the greater cancer community.

The proposed new structure of the Consortium, which will be adopted this fall as the Plan gets kicked-off, addresses a number of concerns raised by the membership through the assessment process. Moving away from a Workgroup structure towards issue–specific teams, with a formal way for their intersecting work to be shared, may re-energize many of the members. As noted above, the respondent who commented that, *"The Workgroup model seems to reinforce the silos in health care. We need to look at care along a more realistic continuum, where Workgroup activities overlap,"* may be expressing the sentiment of many, and the new structure will help break down those silos.

The results of the assessment raised a number of other concerns and valid suggestions that go beyond the structural piece. It would be appropriate for the Board to review those and create a list for discussion around if and how they might get addressed. Some ideas, like a newsletter, have been unsuccessfully tried in the past, but revisiting the concept to identify why it didn't work might well lead to an alternative that can successfully improve Consortium communication, a much noted area for growth. Culling through the list of ideas, suggestions, and concerns (some will be beyond the preview of the Consortium) will provide the Board the opportunity to craft improvements that can sustain the vitality of the Consortium and bring in members that may be needed to expand the Board range of expertise. As one respondent noted, being on the Board sometimes feels like, *"We are moving troops through muddy waters, but we always get to the other side and are better for it."*

Finally, the 2010 Partnership Assessment process raised a red flag concerning the type of survey tool that was utilized with the membership. The electronic survey tool may not be the best data collection method or this particular tool may just be too long. Forty-six people started the survey but only thirty-three completed it. These incomplete responses may suggest taking a serious look at the length of the survey should it be utilized in the future. While some members may have skipped just one or two questions, others skipped whole sections. Either way it should be reviewed in terms of how viable an option it is for collecting the data needed to assess the Consortium on a regular basis. The key informant interviews filled in some of the gaps in the survey data, however, they provided only leadership views and not general membership perspectives. When designing the Partnership Assessment process it will be worth the time to revisit the tool, its vehicle of administration, and whether focus groups might provide more or additional data than just the survey tool.

## 2011-2015 Maine Cancer Plan Development

As noted earlier, 2010 marks the completion of the second five-year Cancer Plan for the state of Maine. Beginning in May of 2009, with a Planning Meeting, MCCCP and the Consortium embarked on a year-long process of developing the third Maine Cancer Plan (2011-2015). Thus, one of the priority program initiatives for 2009-2010 became the development and writing of this Plan. MCCCP scheduled two meetings for working on Cancer Plan development, and in an effort to secure optimal input, the MCCCP utilized an online collaboration tool—a Wiki—which allowed for input, ideas, comments, etc. from not only the Consortium but also from community members. This new way of soliciting input appears to have worked well both in expanding input and in allowing revisions and refinements to the plan at a level not previously accomplished.

This section of the Evaluation Report will review the three major vehicles of Cancer Plan development for which evaluation data was collected: (1) the Planning Meeting in May 2009, (2) the Consortium's Annual Meeting in October 2009, and (3) the Consortium Partnership Survey administered in Spring 2010 (included six questions that asked members about their involvement and satisfaction with the Cancer Plan development process). Additionally, comments are included from the key informant interviews done in the spring of 2010 for the Partnership Survey that addressed the questions concerning their feelings about and involvement with the planning process, and whether or not the plan reflects their cancer priorities.

### Methodology and Data Collection

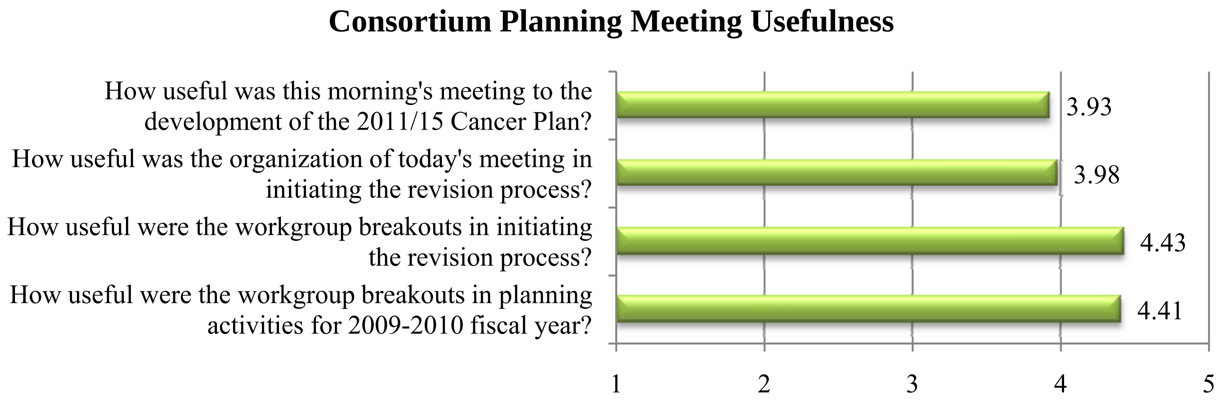
At the May 2009 Planning Meeting, evaluation surveys (Appendix F) were completed by 31 of the 60 participants who attended the meeting for a 52% response rate. At the October 2009 Annual Meeting, a bulk of the evaluation survey (Appendix G) questions focused on satisfaction with the planning process for developing the new Cancer Plan and recommendations on what if any changes were needed to the process. Thirty-nine of the 60 participants who attended the Maine Cancer Consortium's Annual Meeting completed the evaluation survey tool (65% response rate). As noted earlier, there were 46 responses to the electronic Consortium Partnership Assessment Survey (Appendix D) which contained six questions about the Cancer Plan development process. And lastly, each of the six key informant interviewees was asked to comment on the Cancer Plan development process. The following represents the data responses for each of the four data collection opportunities.

### Planning Meeting for 2011-2015 Cancer Plan: May 14, 2009

The focus of the half-day meeting held in May 2009 was to establish a timeline and planning process that would allow completion of the 2011-2015 Cancer Plan. The meeting was attended by 60 participants, 31 of which completed the evaluation survey, providing a response rate of 52%. In advance of the meeting the evaluator provided updated summaries for each of the Workgroups/taskforces concerning where they were in reference to meeting the current Cancer Plan goals, objectives and strategies as compiled through the spring 2009 Activity Monitoring process. This provided the groups the opportunity to asses which goals, objectives, and strategies they may want to carry forward, in whole or partially, into the new Plan.

The evaluation tool was divided into two sections, the first section focused on the usefulness of the morning meeting itself, and the second section focused on next steps for Cancer Plan development as the Consortium moved forward with the development process. The first section consisted of four scaled questions with 1 representing "Not Useful" and 5 representing "Very Useful." All four questions scored well into the high 3 to lower 4 range. Participants found the breakout groups quite useful (4.43 and 4.41) and the overall meeting slightly less useful (3.98 and 3.93). Figure 14 below reflects the average response to each of the four questions.

**Figure 14:** *Average Response to Questions on Usefulness of Meeting*



The second section of the tool posed three multiple choice questions with the option for additional comments, and two open-ended questions concerning ideas for enhancing the process and optimizing the use of their expertise in the development process. The first of the multiple choice questions asked about what kind of plan they would like to see developed, static or dynamic. The first option, "a static five-year plan like the current one," garnered seven positive responses. The second option, "a dynamic plan that is updated as new information emerges," received 21 positive responses. Three respondents did not choose to answer this question and sixteen respondents chose to provide "additional comments" concerning their answer on the format of the plan. The three non-answers were represented by comments such as, "I *don't have enough info to say*." The remaining thirteen comments fell into three broad categories: (1) pro/con and mixed remarks about usefulness of a dynamic plan, (2) comments on monitoring the plan, and (3) comments about Workgroup structure. The following quotes represent the comments from each category:

Pro/Con/Mixed: *"It may be harder to follow but it would allow for adding programs and include new information";*

*"Dynamic plans are difficult to track/measure because of shifting goals and needs. Better "Static" to which new goals can occasionally be added";* and

*"A new dynamic plan may be beneficial. Not enough involvement to warrant a dynamic plan – although in general it may be useful and more effective. More time consuming."*

Monitoring: *"Identify responsible organization for each strategy";* and

*"Annual review by each Workgroup to keep work relevant."*

Structure: *"Separate PC (prostate cancer) Workgroup";*

*"Data/Surveillance Workgroup – questionable if should be a Workgroup";* and

*"…The prevention Workgroup is too diverse for us to be working on anything other than very broad goals…"*

The next multiple choice question ("Yes", "No", and "Other" as options) asked about whether they thought a draft of the new Plan should be presented at regional meeting to get feedback and a clear majority (81%) of respondents answered in the positive. Of the respondents, 13% used the "Other" category indicating "Not sure" as their reason. One (3%) respondent answered "No" and another one did not answer the question.

The last multiple choice question asked if the meeting was a good use of their time and expertise to which a majority (82%) responded in the positive and 18% in the negative. This question provided the option of indicting "Why" they answered as they did to which nine respondents provided a reason. Written responses indicated the "Networking and perspectives" as being why they said yes, and the negative answers reflected the broad nature of the some content areas of groups as this comment indicates:

> *"But would have been better/could be better if prevention Workgroup met together at some interval."*

The last two questions on the survey tool were open-ended questions. The first asked about ideas to enhance the development process and are best represented by these two comments:

> *"Good communication, help and involvement";* and
>
> *"Use HMP Leadership meeting to have input from more HMP – only one community represented today."*

The final question solicited additional ways their expertise could be used in developing the plan. Eight respondents chose to provide ways which are represented by the following comments:

> "*Promotion of goals and objectives*";
>
> *"Recruit new members where specific skill sets are needed (ex: marketing);"* and
>
> *"Call us any time…"*

## Discussion

While the MCCCP had drafted a planning process for developing the new Plan over the remainder of 2009, it is commendable that the program wanted to gather input and ideas for adjusting that plan to assure maximum input, from all members of the Consortium and the community, into the final plan. The responses to the May meeting evaluation tool indicated that most participants found the day a good use of their time and that they want the final plan to be as dynamic as is reasonably possible. Additionally, the day highlighted the diversity of membership in some Workgroups as a challenge and indicated it may reflect a need to revisit the current Workgroup structure to assure that everyone has maximum involvement and responsibility in bringing the plan to reality.

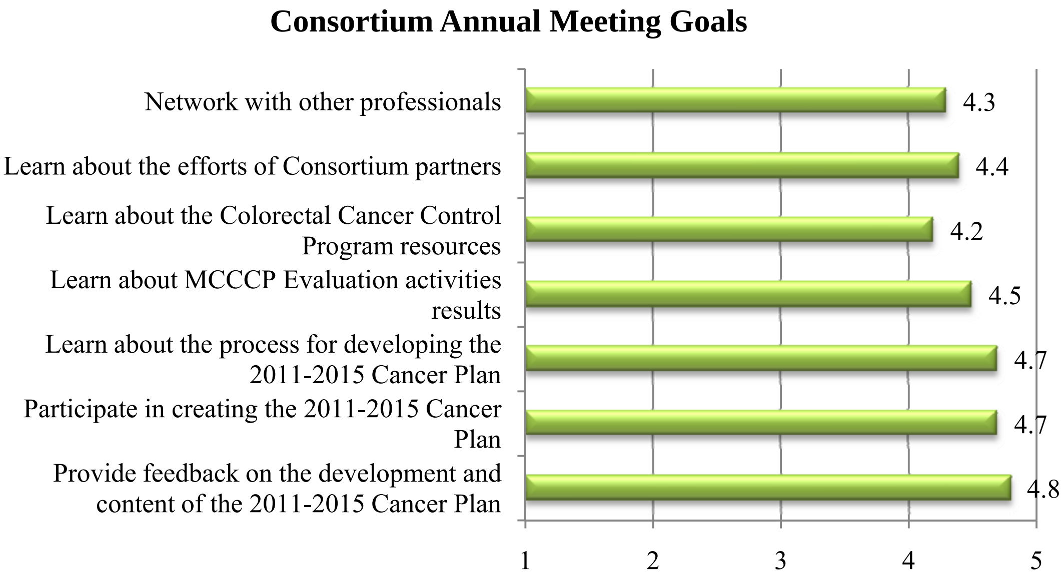
## 2009 Maine Cancer Consortium Annual Meeting: October 29, 2009

The Annual Meeting received excellent ratings on all fronts from the thirty-nine respondents (65% of attendees) who completed the evaluation survey. To a person, all identified that the meeting was a good use of their time and expertise, and was very relevant to their work. The survey tool was divided into four sections that addressed: (1) meeting goals, (2) Cancer Plan development process, (3) demographics of attendees, and (4) other information. The four sections are delineated in this next section of the report.

### Section I: Meeting Goals

For the seven questions in this section the average overall response (for all questions combined) was 4.5 on the five-point scale on which 1 designated “Very Poor” and 5 designated “Excellent”. The highest ranking was garnered by the two questions about the development of the Cancer Plan (4.8 for each) which makes sense in terms of the major meeting goal being to work on developing the 2011-2015 Cancer Plan, i.e., a bulk of the meeting was spent actually working on drafting plan goals, objective, and strategies. Figure 15 provides a breakdown of average score for each question in this section:

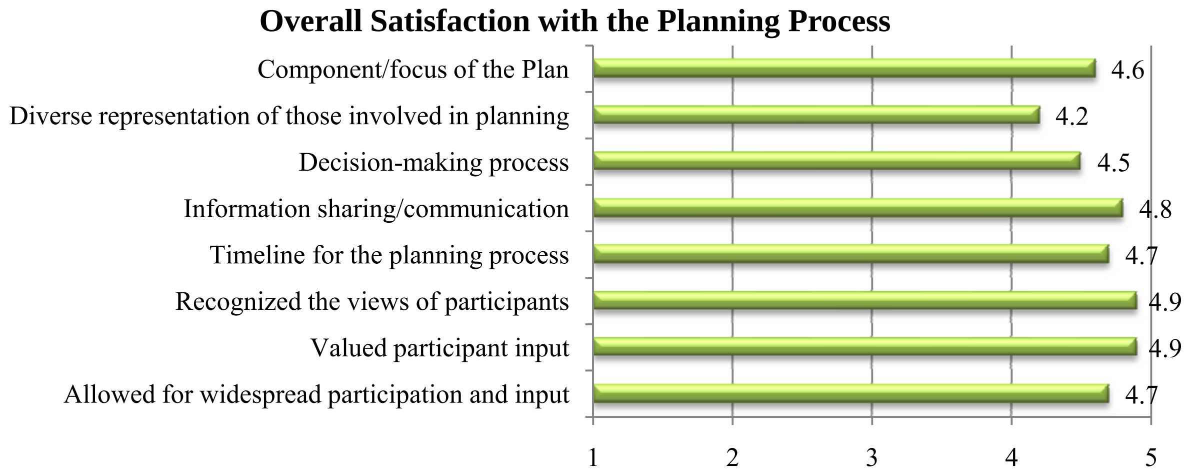
**Figure 15:** *Average Scores on Reaching Meeting Goals*



### Section II: Overall Planning Process for 2011-2015 Cancer Plan

For the eight questions in the second section of the tool the average overall satisfaction response (for all questions combined) was 4.7 on a five-point scale on which 1 represented “Very Dissatisfied” and 5 represented “Very Satisfied,” with the additional options of “DK” and “NA.” The two questions on recognition and value of participant views and input received the highest average ranking of 4.9 for each. The lowest ranking (4.2) was for the question concerning diversity in representation. Figure 16 provides the average score, along with any written comments, for each question in this section of the survey:

**Figure 16:** *Overall Annual Meeting Satisfaction Rating and Respondent Comments*



**Component/focus areas of the Plan**

***Comments:***

- *Still unsure if continuum of disease vs. specific cancer sections is the best format.*

**Diverse representation of those involved in planning**

***Comments:***

- *Glad to have a patient here today. Would like more patients.*
- *Maybe more policy people though.*
- *Question what diverse representation means*
- *Our table was discussing types of cancer that none of us knew much about. Difficult to do so.*

**Decision-making process**

***Comments:***

- *In some ways, I felt like we were undoing work done in previous meetings.*
- *Thought it was odd to change objectives that were written by other people…Would have been helpful to have input early in the Cancer Planning process. I'm guessing not much we can do about it.*

**Recognized the views of participants**

***Comments:***

- *Enjoyed hearing other people's thoughts.*

**Valued participant input**

***Comments:***

*Nice format to identify area of interest and contribute to specific sections of the plan*

**Allowed for widespread participation and input**

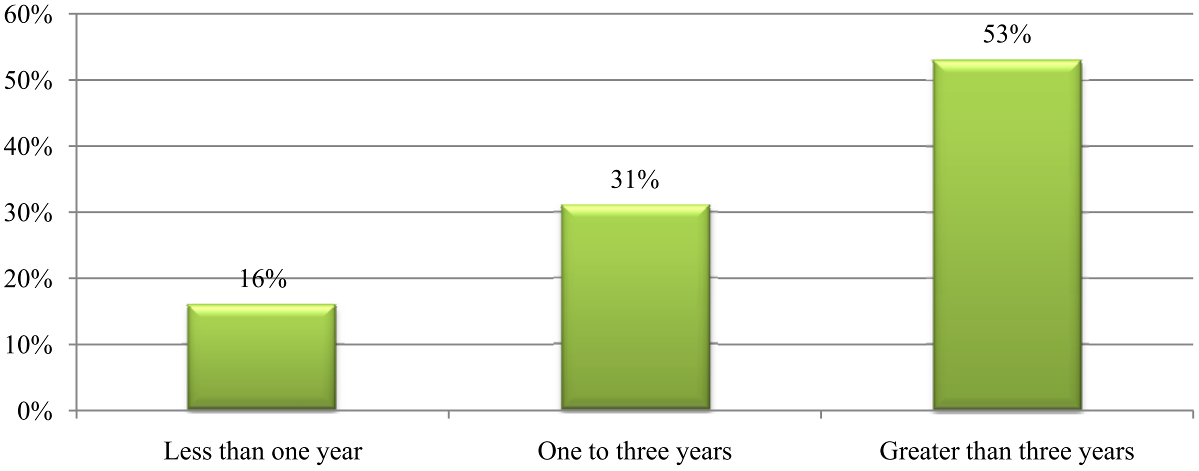
***Comments:***

*Again, great format. Also liked how we had the opportunity to switch group if we had multiple interests.*

**Section III: Group Demographics**

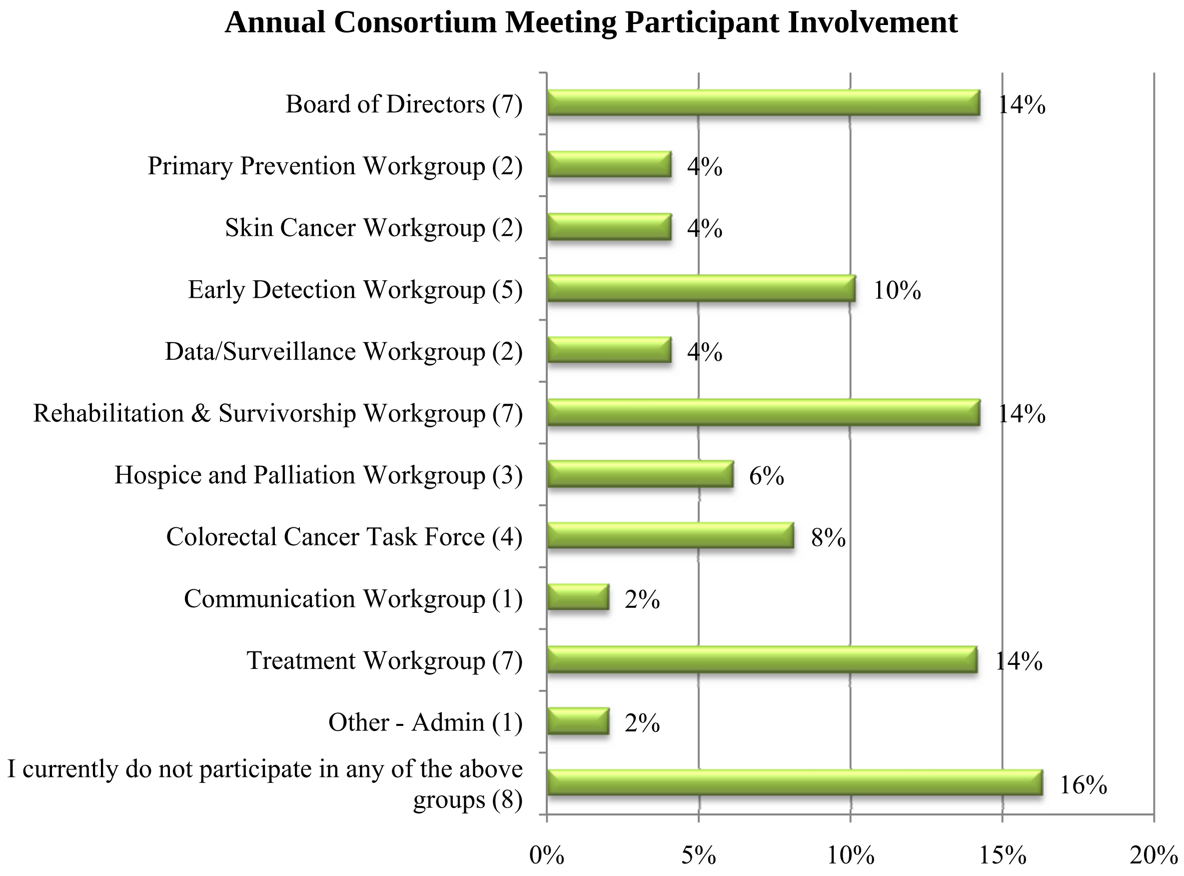
The composition of the attendees at the meeting reflects that all but 18% were Consortium members. Of the thirty-two respondents who identified as Consortium members, over half, 53%, have been members for more than three years, another 31% have been members for one to three years, and 16% have been members for less than one year. Figure 17 below reflects the length of involvement for meeting attendees.

**Figure 17:** *Annual Meeting Participants' Length of Involvement in Consortium (N=32)*



In reference to Board and/or Workgroup/taskforce representation at the meeting, the Board of Directors, Rehabilitation & Survivorship Workgroup, and Treatment Workgroup all had seven members present. Early Detection Workgroup had 5 members, Colorectal Cancer Task Force had four, and the remaining groups had between one and three members represented. Of the respondents, eight identified as not currently involved in any of the groups. Figure 18 on the next page reflects the type of Consortium involvement attendees identified. Lastly, twenty-four respondents indicated they had previously participated in 2011-2015 Cancer Plan activities, while thirteen had not and the reason most often cited for not being previously involved was "N*ot being aware of the process.*"

**Figure 18:** *Type of Consortium Involvement for Annual Meeting Particiapnts*



## Section IV: Other Information

As noted above, participants identified the day as useful and relevant. The "Other Information" section of the survey tool provided four opportunities for attendees to comment further on their overall reactions to the meeting and any ideas about future Plan development meetings. The first question asked about the relevance of the meeting to their work and captured an average response of 4.7 on a five-point scale where 1 indicated "Not at all relevant" and 5 indicated "Very relevant." The question also had a comment section which garnered a couple of written comments:

> *"Lots of good genetic objectives"*; and
>
> *"Very important to be aware of what the issues are."*

The next question asked whether the day's meeting was a good use of their time and it received a resounding 39 "Yes" responses as well as two written responses which included:

> *"Takes me out of my everyday environment and forces me to look at my work from a different perspective"; and*
>
> *"I learned a lot but wondered how much I contributed. Knowing now, I would bring others from my organization."*

The final two questions in this section were open-ended and a sampling of the responses is reflected below:

Question: Are there other ways we might utilize your expertise while developing the 2011-2015 Cancer Plan?

> *"Wish to continue offering input"; and*
>
> *"Our organization would love to be involved in a relevant pilot program."*

Question: What else (if anything) would you like to tell us about the 2011-2015 Cancer Plan process and/or today's meeting?

> *"Well organized. Nice representation;"*
>
> *"Implementation is everything;"*
>
> *"Informative and good for making connections;"*
>
> *"Maybe recruit people from specific disciplines/cancers for their expertise to make sure coverage is good;"*
>
> *"Thanks for all your hard work;" and*
>
> *"It is important to promote all the aspects of the plan. I would be willing to make presentations to relevant groups."*

## Discussion

Since the 2009 Annual Meeting was structured around getting input, ideas and direction for the 2011-2015 Cancer Plan, it may helpful to review some of the comments specific to that planning process. There appear to be two key concerns around the process for developing the 2011-2015 Cancer Plan. The most frequently commented upon concern raises the issue of who is, and has been, involved in the planning process. Respondents indicated the need for additional input from policy makers, survivors "*and those you wish to serve*", patients, and expertise from specific disciplines/cancers to strengthen the content and reach of the plan.

The second concern raised was around the planning process itself and how to bring folks into that process sooner —*"…don't know where all these early detection people were during the rest of the year."* The sense that *"We were undoing work done in previous meetings," "changing objectives that were written by other people,"* and *"discussing types of cancer that none of us knew much about,"* indicates some concern about whether the process is sequential and progressive enough. However, on the other hand, participants clearly appreciated having the opportunity to be involved in writing the plan, and were especially appreciative of using technology process tools as evidenced by the quote, *"using the Wiki/laptop was genius!"*

## Consortium Partnership Survey Cancer Plan Participation Questions

As noted above, beginning in May of 2010, Maine began developing its next five-year Cancer Plan that will direct the work of the Consortium and its partners across the state. The process for developing the new Cancer Plan was different that the one used to develop past plans so the partnership survey included six questions in an attempt to capture how well the new plan development process was engaged with, and received by, the Consortium membership charged with developing that plan.

The survey asked members to rate their involvement in developing the 2011-2015 Cancer Plan on a scale of 1 "Not at all involved" to 4 "Very involved" with an option of "NA" (Not applicable), which no respondents utilized. Just over a quarter (26%) of survey respondents did not answer this question, and the rating average exclusive of the non-respondents was a 3.0 "Somewhat involved" for the four-point scale. For the thirty-four respondents who did answer the question, 50% were "Somewhat involved" and another 30% were "Very involved," and only 8% of respondents were not involved at all. One can then surmise that the remaining five questions may accurately reflect the sentiments of members who were actually somewhat or very involved in the Cancer Plan development process.

On a four-point scale from 1 being "Not well at all" to 4 being "Extremely well," with an "NA" option, members were asked to rate how well they think the new plan reflects the inclusion of diverse perspectives, priorities, and/or populations in the development process. The non-response rate was again 26% for this question and 8% of utilized the "NA" option as well. For the remaining thirty-one respondents the average rating was 3.1 on the four-point scale. Fifteen members rated the question at "Somewhat well," (scale point 3), another ten respondents "Extremely well" (scale point 4), and 5 rated it at "Not so well" (scale point 2). These strong positive responses indicate that the Cancer Plan development process was inclusive.

For the first time, the Cancer Plan development process utilized an electronic online tool called a Wiki to allow for as widespread feedback and participation in the development process as possible. When asked if they agree that using a *Wiki* allowed widespread participation and input into from the partnership, respondents overwhelming agreed. For the thirty-three respondents to this question (thirteen survey respondents did not answer this question) almost three quarters (73%) "Agreed," 18% "Disagreed," and 9% chose the "NA" option.

The survey next asked partners about how comfortable they were with the way decisions were made concerning what goals, objectives and strategies were included in the final plan. Thirty-three members responded to this question (28% non-response rate) on a five-point scale from 1 being "Not at all comfortable" to 5 being "Extremely comfortable" with a NA option (which was utilized). The highest response rate was at scale point 4 "Very comfortable" for over a third (37%) of respondents. A second third (33%) of respondents were "Somewhat comfortable" (scale point 3), and 15% were "Extremely comfortable" with the decision making process. The remaining 15% were either "a little comfortable" or "Not at all comfortable" with how decisions were made. The result of 85% of respondents being either somewhat, very, or extremely comfortable speaks to the success of the decision making process that was utilized during the Cancer Plan development process and that participants felt comfortable with it.

The last scaled question about the Cancer Plan development process on the survey asked partners about their overall satisfaction with the development process during the past year. A five-point scale with 1 being "Not at all satisfied" and 5 being "completely satisfied" was utilized and once again thirty-three respondents answered the question (28% non-response rate) with an average rating of 3.58 for those respondents. Eighty-eight percent of respondents, 27 % were "Somewhat satisfied", 45% were "Mostly satisfied", and 15% were "Completely satisfied" with the overall Cancer Plan development process. The remaining 12% were split between "A little satisfied" and "Not at all satisfied". In concert with the earlier scaled questions it is clear that the process used to develop the new 2011-2015 Cancer Plan was well received by those partners who engaged in the process and answered the survey questions about the process.

The final questions on the development of the Cancer Plan was an open-ended question that asked members to share any ideas they have for enhancing the Cancer Plan development process. Six respondents provided narrative responses to this question that included the following quite specific ideas for how to make the process stronger:

> *"Needs more input from community;"*
>
> *"Politics seemed to be the driver, not risk or incidence….there seems to be a lot of attention given to areas where it's politically correct, even though these areas may only represent a small segment of the population;"* and
>
> *"Wiki was excellent."*

## Key Informant Interview Questions on Cancer Plan Development Process

During the Consortium Assessment process each of the key informant interviewees was asked a series of questions about the Cancer Plan development process that was being completed. The questions addressed the process itself, the new electronic component, and their involvement in the development of the new Plan. Each interviewee spoke eloquently about the importance of the Cancer Plan as the road map for the work their organization takes on over the upcoming years. As such they felt strongly that the process needs to be as expansive as feasibly possible in order to get the greatest amount of input from all areas of the cancer community. In total they felt the development process this year was "W*ell conceived*" and allowed "*plenty of chance for people to engage and have input."* As a result, as one interviewee put it, "*There will be excitement about it."*

Key informants shared that the process for crafting the Maine Cancer Plan gets better each time the Consortium takes on the task. As one respondent indicated the process was, "*more realistic this time in terms of what the Consortium can do."* Interviewees were queried about how involved they were in the process, whether the Plan's priorities reflect their personal or organizational priorities, and whether they feel as if the plan is **their** plan. Most informants were very active in the Plan development process and utilized the Wiki to provide continuous feedback and input to the plan. All but one respondent liked the inclusion of the Wiki feature and reflected that it increased the sense of involvement with the process. Even for the respondent who didn't like the electronic process, s/he felt *"absolutely invited to be involved."*

This high level of involvement with developing the Plan is reflected back in the ownership of the Plan's goals by Consortium partners. All of the informants interviewed agreed that the Plan had at least some of their group or organization's priorities in it. They further indicated that as a result they have a responsibility to move it forward and to garner greater awareness for the plan, its goals, and all that is happening across the state to realize those goals. Finally, a number of interviewees expressed some concern about accountability to the Plan. Projects that are driven by the plan need *"to stay data driven,"* and there must be clear responsibility *("maybe a lead* *agency or individual identified"*) around implementation, i.e., who will implement and how will we know we have addressed an objective.

## Comments and Recommendations on Cancer Plan Development Process

All of the data collected reflects that this year's Cancer Plan development process was much improved over the previous processes utilized for developing the two earlier plans. The majority of folks indicated they felt the ability to provide feedback electronically expanded access and input to the process and the plan. A majority of Plan development participants indicated a need to now present the plan more widely – *"to more people and places."* A majority (75%) of the planning meeting participants indicated they want the Plan to be dynamic even if that may create more work, and a majority of Consortium members feel it is critical to track the work done over the next five years within the framework of the Cancer Plan.

There were many excellent recommendations put forth on how to enhance the Plan development process and/or how to move the plan forward. Through an evaluation lens there are at least three recommendations that merit further discussion and/or potential action in the next year. First, assuring that the Plan objectives are clearly measurable, either incrementally and/or in totality, will make the ongoing tracking of activities within each objective easier and more useful to those working within an objective. Secondly, it may be worthwhile to have each piece of the Plan clearly identified with a responsible or lead team and/or Consortium member organization for the life of the plan's goals/objectives/strategies. Thirdly, it would be a good use of time when kicking-off the new plan in the fall of 2010 to strategize how each of the Consortium member organizations will integrate the priorities of the plan into their existing organizational/agency annual or strategic work plan. This effort would go far in promoting and supporting the overall Cancer Plan priorities, objectives, and activities in a way that could minimize duplication or completion while maximizing collaborative efforts across the Consortium within its new structure and the new Plan's framework.

# Results Part II: Implementation

## 2009-2010 Program Accomplishments

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

- Recognized by legislature as a state program.
- Received five-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 five-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 $57,643 in in-kind contributions from Maine Cancer Consortium members and staff during 2009-2010 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.
- Established and supported infrastructure for the Maine Colorectal Cancer Control Program (MCRCCP).
- Led the development and revision process for Maine's 2011-2015 Cancer Plan.
- Awarded mini-grants totaling over $160,000 to the Healthy Maine Partnerships to advance colorectal cancer screening awareness efforts.
- Provided mini-grants totaling $31,500 to Parks and Recreation Departments to enhance skin cancer prevention and sun safety efforts.
- Provided mini-grants totaling $21,000 to childcare providers to enhance skin cancer prevention and sun safety efforts.
- Provided training and support to 45 childcare providers through implementation of the *Sun Blocks Childcare Sun Safety Program*.
- Provided technical assistance to Care Model efforts by the Healthy Maine Partnerships.

Appendix C provides a more extensive list of activities and accomplishments that have been captured through the Activity Monitoring Tool meetings and electronic data collection over the life of the five-year 2006-2010 Maine Cancer Plan.

## Program-Sponsored Initiatives

### 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. In 2009-2010 the MCCCP again provided direction and support for a key childhood skin cancer prevention program, *Sun Blocks* Childcare Sun Safety Program. The next section of the program evaluation results reflects the continued success of this critical childhood sun safety program as it expands to more and more childcare centers each year.

### *Sun Blocks* Childcare Sun Safety Program

#### *Sun Blocks* Training Evaluation

Trainings for the *Sun Blocks* Childcare Sun Safety Program were held in Bangor and Portland in August 2009. Seventeen persons attended the training in Bangor, and 25 persons attended the training in Portland. Fifteen training evaluation surveys were completed and returned in Bangor (response rate of 88.2%), and 22 in Portland (response rate of 88.0%). The survey is provided as an appendix (Appendix H); descriptive statistics (count, frequency, mean, median) are provided for each question in Sections 1-3, all of which were overwhelmingly favorable.

#### Section 1: Organization of the Training

Location: Bangor (n=15)

| Question | Rating-1 (Very Poor) | Rating-2 | Rating-3 | Rating-4 | Rating-5 (Excellent) |
|---|---|---|---|---|---|
| 1. How would you rate the organization of the training? (Mean= 4.6; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 1<br>6.7% | 4<br>26.7% | 10<br>66.7% |
| 2. How would you rate the length of the training in relation to the amount of information covered? (Mean= 4.7; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 2<br>13.3% | 1<br>6.7% | 12<br>80.0% |
| 3. How would you rate the value of the training content in reference to the work you do? (Mean= 4.9; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 1<br>6.7% | 14<br>93.3% |

Location: Portland (n=22)

| Question | Rating-1 (Very Poor) | Rating-2 | Rating-3 | Rating-4 | Rating-5 (Excellent) |
|---|---|---|---|---|---|
| 1. How would you rate the organization of the training? (Mean=4.8; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 4<br>18.2% | 18<br>81.8% |
| 2. How would you rate the length of the training in relation to the amount of information covered? (Mean=4.8; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 1<br>4.5% | 3<br>13.6% | 18<br>81.8% |
| 3. How would you rate the value of the training content in reference to the work you do?(Mean=4.8; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 4<br>18.2% | 18<br>81.8% |

## Section 2: Objectives of the Training

Location: Bangor (n=15)

| Question | Rating-1 (Very Poor) | Rating-2 | Rating-3 | Rating-4 | Rating-5 (Excellent) |
|---|---|---|---|---|---|
| 4. How would you rate your knowledge of training objectives? (Mean=4.5; Median=4.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 8<br>53.3% | 7<br>46.7% |
| **The training has provided me with the knowledge to be able to:** | **Rating-1 (Disagree)** | **Rating-2** | **Rating-3** | **Rating-4** | **Rating-5 (Agree)** |
| 5. Explain the scope of sun exposure-related problems in Maine. (Mean=4.7; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 1<br>6.7% | 3<br>20.0% | 11<br>73.3% |
| 6. Describe the importance of routinely practicing proper sun safety with children attending childcare centers. (Mean=4.8; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 3<br>20.0% | 12<br>80.0% |
| 7. Discuss the components of the proposed sun safety policy. (Mean=4.7; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 1<br>6.7% | 2<br>13.3% | 12<br>80.0% |
| 8. Assess the UV index and identify appropriate sun protection measures. (Mean=4.9; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 2<br>13.3% | 13<br>86.7% |
| 9. Implement the childhood sun safety seasonal teaching plans. (Mean=4.5; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 1<br>6.7% | 5<br>33.3% | 9<br>60.0% |
| 10. Select suitable support materials for parents and caregivers that enhance the achievement of the Sun Blocks Program. (Mean=4.6; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 6<br>40.0% | 9<br>60.0% |

Location: Portland (n=22)

| **Question** | **Rating-1 (Very Poor)** | **Rating-2** | **Rating-3** | **Rating-4** | **Rating-5 (Excellent)** |
|---|---|---|---|---|---|
| 4. How would you rate your knowledge of training objectives? (Mean=4.4; Median=4.5) | 0<br>0.0% | 0<br>0.0% | 2<br>9.1% | 9<br>40.9% | 11<br>50% |
| **The training has provided me with the knowledge to be able to:** | **Rating-1 (Disagree)** | **Rating-2** | **Rating-3** | **Rating-4** | **Rating-5 (Agree)** |
| 5. Explain the scope of sun exposure-related problems in Maine. (Mean=4.8 ; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 5<br>22.7% | 17<br>77.3% |
| 6. Describe the importance of routinely practicing proper sun safety with children attending childcare centers. (Mean=4.9; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 2<br>9.1% | 20<br>90.9% |
| 7. Discuss the components of the proposed sun safety policy. (Mean=4.7; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 7<br>31.8% | 15<br>68.2% |
| 8. Assess the UV index and identify appropriate sun protection measures. (Mean=4.8; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 5<br>22.7% | 17<br>77.3% |
| 9. Implement the childhood sun safety seasonal teaching plans. (Mean=4.8; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 5<br>22.7% | 16<br>72.7% |
| 10. Select suitable support materials for parents and caregivers that enhance the achievement of the Sun Blocks Program. (Mean=4.9; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 3<br>13.6% | 19<br>86.4% |

## Section 3: Presentation of the Training

Location: Bangor (n=15)

| **Question** | **Rating-1 (Very Poor)** | **Rating-2** | **Rating-3** | **Rating-4** | **Rating-5 (Excellent)** |
|---|---|---|---|---|---|
| 11. How would you rate the balance of learning styles addressed in the training? (Mean=4.7; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 1<br>6.7% | 2<br>13.3% | 12<br>80.0% |
| 12. How would you rate the balance of presentation styles? (Mean=4.8; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 3<br>20.0% | 12<br>80.0% |
| 13. How would you rate the overall quality of the presentation? (Mean=4.8; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 1<br>6.7% | 1<br>6.7% | 13<br>86.7% |

Location: Portland (n=22)

| **Question** | **Rating-1 (Very Poor)** | **Rating-2** | **Rating-3** | **Rating-4** | **Rating-5 (Excellent)** |
|---|---|---|---|---|---|
| 11. How would you rate the balance of learning styles addressed in the training? (Mean=4.7; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 7<br>31.8% | 15<br>68.2% |
| 12. How would you rate the balance of presentation styles? (Mean=4.8; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 5<br>22.7% | 17<br>77.3% |
| 13. How would you rate the overall quality of the presentation? (Mean=4.8 ; Median=5.0) | 0<br>0.0% | 0<br>0.0% | 0<br>0.0% | 4<br>18.2% | 18<br>81.8% |

**Section 4: Overall/Other**

Overall, participants at both sites were very pleased with the training; a few representative comments are listed below for the remained of the questions in the survey.

**14. Did you receive training materials, and are they in a format that is useful to you?**

Participants at the Bangor training:

> *"Great materials to disseminate info to teachers, parents, and children."*
>
> *"Wonderful! Best training I have been to in a long time. Very well organized and informational."*
>
> *"Yes, can't wait to use the flash drive."*

Participants at the Portland training:

> *"Great! Websites etc - all this is a timesaver for director/teacher"*
>
> *"Excellent, loved the flash drive!"*
>
> *"Very useful. Great easy way to share with other staff."*
>
> *"Very useful. I compliment the team for developing such great, useful, organized materials."*

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

Participants at the Bangor training:

> *"Presentation and take-home materials."*
>
> *"Having everything on a drive for ease of use."*
>
> *"Group activities and brainstorming."*
>
> *"The PowerPoint was great. I learned a lot about sun safety that I thought I knew but didn't."*
>
> *"I liked the before/after quiz. Lots of info. Great training."*

Participants at the Portland training:

> *"PowerPoint - great info; also, need for year-round sun protection - Never thought of winter/sunscreen and brim hat."*
>
> *"It all was great. The teaching plans are helpful. We haven't implemented a curriculum for children, but certainly will now."*
>
> *"All of the above - I personally did not realize all of the dangers. As a parent, the SPF information was eye-opening. I am eager to share with folks what I've learned."*
>
> *"The "how to" of a policy."*
>
> *"Collaboration w/ peers - networking."*

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

Participants at the Bangor training:

> *"A list of early childhood centers."*
>
> *"I think I am pretty well-covered to implement this program."*
>
> *"The policy and parent engagement."*

Participants at the Portland training:

*"Willing to try - parents need to get on Board."*

*"I feel confident with all the material, including the PowerPoint and all the facts to share with families."*

*"Websites will be useful."*

*"More ideas @ structures to build/plant for shade. Include dimensions for structures."*

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

Participants at the Bangor training:

*"I will pick up some bucket hats and sunglasses."*

*"Individual training if it could be afforded for programs/parents."*

Participants at the Portland training:

*"Continuing updates, new ideas, what's in new products, government warnings, stats, day care discoveries."*

*"Have a current policy; however, this information will assist in revising the current policy."*

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

Participants at the Bangor training:

*"Reinforce UVA and UVB can cause cancer. Saying UVB-Burn, UVA-DNA-Cancer left me with a touch of confusion."*

*"Do it more often and in more sites."*

Participants at the Portland training:

*"No - great conference; I liked the day also (Friday)."*

*"The clickers were interesting technology, but seemed to slow things down."*

**19. Please indicate the type of organization you were representing at today's training?**

At the Bangor training, the following organizations were in attendance:

- 9 Childcare Providers,
- 5 Healthy Maine Partnerships, and
- 1 Resource Development Center.

At the Portland training, the following organizations were in attendance:

- 16 Childcare Providers,
- 1 Healthy Maine Partnership,
- 2 Resource Development Centers, and
- 1 Outreach Group.

**_Sun Blocks_ Program Evaluation**

## Background

Skin cancer is one of the contributors to cancer-related incidence in Maine.[3] Exposure to harmful levels of ultraviolet (UV) radiation during childhood and adolescence increases the risk of developing basal and squamous cell carcinoma as adults.[4,5] Teaching young children and adolescents how to protect their skin from the sun, and creating environments to support these positive behaviors can result in reduced exposure to harmful UV radiation, as well as aid in the development of life-long sun safety habits. Since many young children in Maine are under the care of a childcare provider during peak sun hours, this setting provides a key avenue to reach a significant number of children, as well as to educate and inform their parents on sun-protection efforts to reduce the risk of skin cancer.

In the second year of implementation of the *Sun Blocks* Childcare Sun Safety Program, the Maine Comprehensive Cancer Control Program (MCCCP) provided mini-grants of up to $1,000 to childcare centers in Maine to promote sun protection practices, and increase policy and programming around sun safety and skin cancer prevention. The application process was open to any state-licensed childcare center, regardless of the level of skin cancer prevention and sun safety activities at the time of application. Twenty-one childcare centers were the recipients of this funding and participated in the program, along with some non-funded childcare centers, and a select group of Healthy Maine Partnerships (HMPs) and Resource Development Centers (RDCs). Program materials and training 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 early childhood teaching plans, and gaining parental support.

## Design & Methodology

The Maine Center for Public Health (MCPH) was contracted by Maine CDC to implement the Year 2 evaluation of the *Sun Blocks* Childcare Sun Safety Program to determine outcomes associated with sun protection practices, successful processes, and areas for improvement. A baseline evaluation survey was administered in-person at the Annual *Sun Blocks* Childcare Sun Safety Program Trainings in August 2009, which were attended by 17 persons in Bangor and 25 persons in Portland, respectively. Surveys were completed by members of the following groups: Group A: mini-grant-funded childcare centers, Group B: non-funded childcare centers, and Group C: HMPs and RDCs. As part of the assignment, Group A members received program materials, training, and mini-grants of $1,000; Group B members received program materials and training; and Group C members participated due to organizational interest, and only received information through the training. For program follow-up in April 2010, three versions of the follow-up survey were created, and shared electronically with members from each of these groups, with a two-week deadline to complete the surveys online.

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[3] U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999–2006 Incidence and Mortality Web-based Report*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2010. Available at: www.cdc.gov/uscs.

[4] Gallagher RP, Hill GB, Bajdik CD, Coldman AJ, Finchman S, McLean DI, et al. *Sunlight exposure, pigmentation factors, and risk of non-melanocytic skin cancer.* Archives of Dermatology 1995; 131(2): 157-169.

[5] Gritz ER, Tripp MK, James AS, Harrist RB, Mueller NH, Chamberlain RM, and Parcel GS. *Effects of a Preschool Staff Intervention on Children’s Sun Protection: Outcomes of Sun Protection is Fun!* Health Education & Behavior 2007; 34: 562-577.

Questions on the baseline and follow-up survey instruments (Appendices I-K) mirrored the original "Maine Daycare Sun Protection Questionnaire," administered in February 2008,[6] with regards to the sections on sun protection practices, sun protection policy and programming, and mini-grant activities (if applicable). Baseline and follow-up survey data were entered, managed, and analyzed in Microsoft Excel 2007.

## Findings

This section provides response rates and demographic information for both baseline and follow-up evaluation surveys, followed by a comparative summary of findings related to sun protection practices.

### Response Rates

The response rates for the baseline survey administered in August 2009 are presented in Table 8; please note that Group A includes mini-grant-funded childcare centers, Group B includes non-funded childcare centers, and Group C includes HMPs and RDCs. Some members of these groups were no-shows at the training (n=4) or did not complete a survey (n=3).

**Table 8:** *Baseline survey response information*

| **Group A** | | | **Group B** | | | **Group C** | | |
|---|---|---|---|---|---|---|---|---|
| Completed | Total | Response Rate | Completed | Total | Response Rate | Completed | Total | Response Rate |
| 21 | 21 | 100.0% | 8 | 12 | 66.7% | 9 | 12 | 75.0% |

Web-links to the follow-up survey were sent to contacts for the three groups in April 2010. Active follow-up was conducted for childcare centers in Group A since completion of the follow-up survey was a requirement as funding recipients. One childcare center in Group A did not complete a follow-up survey due to illness during the data collection period. The response rates for the follow-up survey administered are presented in Table 9.

**Table 9:** *F/U survey response information*

| **Group A** | | | **Group B** | | | **Group C** | | |
|---|---|---|---|---|---|---|---|---|
| Completed | Total | Response Rate | Completed | Total | Response Rate | Completed | Total | Response Rate |
| 20 | 21 | 95.2% | 9 | 12 | 75.0% | 7 | 12 | 58.3% |

### Demographic Information

A. Baseline Survey ($N_{baseline}$=38)

- Across all groups at baseline, 63.2% (n=24) identified their facility as a childcare centers, 10.5% (n=4) identified as a Head Start or Early Head Start, 15.8% (n=6) identified as a Nursery School or Preschool, 10.5% (n=4) identified as a Family Childcare Home, and 26.3% (n=10) identified as HMPs and RDCs. Graph 1 below provides a comparison of the types of centers that responded to the surveys.

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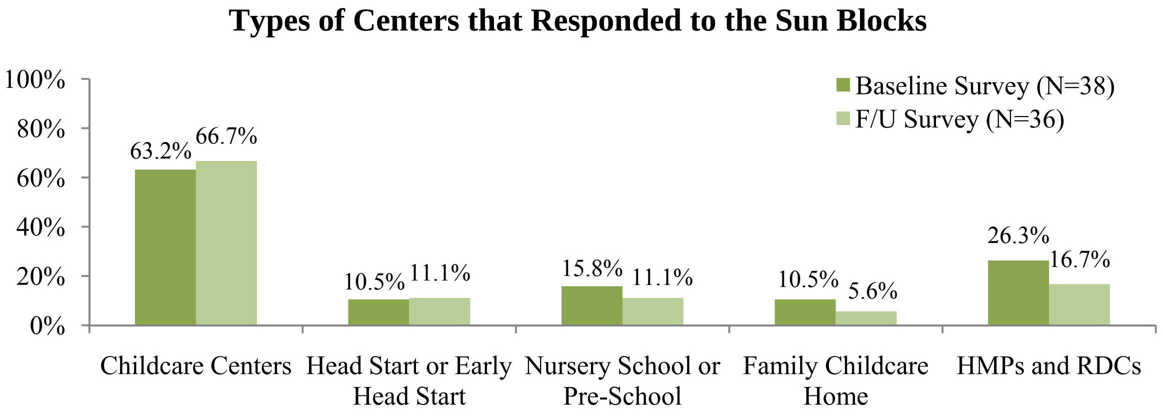
[6] Fletcher, A.G. (2008). *Sun Blocks: Building a Foundation for Healthy Skin. A Strategic Program for Improving Childhood Sun Protection Within State-Licensed, Facility-Based Childcare Centers in Maine.* Boston, MA: Tufts University School of Medicine, Department of Public Health and Family Medicine;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

- Survey responses obtained across all groups covered 13 of the 16 counties in Maine; not included were Franklin, Hancock, and Somerset counties.
- Over fifty percent (n=15) of the 29 funded and non-funded childcare centers in the sample cared for 26-50 children at their facilities on a regular basis.
- Over ninety-six percent (n=28) of the 29 funded and non-funded childcare centers in the sample cared for children in the 3-5 years age bracket; 69.0% (n=20) also cared for children aged 0-2 years, and 44.8% (n=13) cared for children aged 6 years and older.
- Only six percent (n=2) of the 29 funded and non-funded childcare centers in the 2009-2010 sample also received mini-grant funding in 2008-2009.

**Figure 19:** *Types of centers that responded to the Sun Blocks baseline and f/u surveys*



*Source: 2009-2010 Sun Blocks Program Survey Data*

B. Follow-up Evaluation Survey ($N_{f/u}$=36)

- Across all groups at follow-up, 66.7% (n=24) identified their facility as a childcare centers, 11.1% (n=4) identified as a Head Start or Early Head Start, 11.1% (n=4) identified as a Nursery School or Preschool, 5.6% (n=2) identified as a Family Childcare Home, and 16.7% (n=6) identified as HMPs and RDCs. Graph 1 above provides a comparison of the types of centers that responded to the surveys.
- Survey responses obtained across all groups covered 12 of the 16 counties in Maine; not included were Franklin, Hancock, Piscataquis and Somerset counties.
- Fifty percent (n=15) of the 30 funded and non-funded childcare centers in the sample cared for 26-50 children at their facilities on a regular basis.
- Over ninety-three percent (n=28) of the 30 funded and non-funded childcare centers in the sample cared for children in the 0–2 years age bracket; 83.33% (n=25) also cared for children aged 3-5 years, and 56.7% (n=17) cared for children aged 6 years and older.
- Over thirteen percent (n=4) of the 30 funded and non-funded childcare centers in the 2009-2010 sample also received mini-grant funding in 2008-2009.
- Across all three groups, 88.9% (n=32) had attended the Sun Blocks program training in August 2009 in either Bangor or Portland.

**Comparative Findings from the Baseline and F/U Evaluation Surveys**

This section provides a comparative summary of findings of baseline and follow-up evaluation survey responses, by group.

**Table 10:** *Comparison of quantitative baseline and follow-up evaluation survey data for select questions*

| | Group A | | Group B | |
|---|---|---|---|---|
| | **Baseline** | **F/U** | **Baseline** | **F/U** |
| ***Sun Protection Practices*** | | | | |
| Apply sunscreen to children before outdoor activities. | 81.0% (17) | 100.0% (20) | 87.5% (7) | 100.0% (9) |
| Require children to wear hats for outdoor activities. | 23.8% (5) | 30.0% (6) | 12.5% (1) | 55.6% (5) |
| Require children to wear sunglasses for outdoor activities. | 9.5% (2) | 20.0% (4) | 0.0% (0) | 0.0% (0) |
| Require children to wear sun-protective clothing for outdoor activities. | 4.8% (1) | 35.0% (7) | 12.5% (1) | 22.2% (2) |
| Require children to play in shaded areas. | 42.9% (9) | 40.0% (8) | 62.5% (5) | 22.2% (2) |
| Schedule outdoor activities and events for children between 10:00 a.m. and 4:00 p.m. | 71.4% (15) | 90.0% (18) | 62.5% (5) | 100.0% (9) |
| ***Sun Protection Policy and Programming*** | | | | |
| Have formal policy regarding sun protection. | 33.3% (7) | 80.0% (16) | 75.0% (6) | 88.9% (8) |
| Provide educational lessons to children attending center. | 95.2% (20) | 100.0% (20) | 100.0% (8) | 55.6% (5) |
| Distribute sun protection information to parents. | 38.1% (8) | 100.0% (20) | 62.5% (5) | 88.9% (8) |
| Has adequately-shaded play area. | 23.8% (5) | 75.0% (15) | 62.5% (5) | 44.4% (4) |

*Note 1: Group A: Mini-Grant Funded Childcare Centers; Group B: Non-Funded Childcare Centers.*
*Note 2: For denominator data, please refer to Tables 8 and 9.*

**Group A: Mini-Grant Funded Childcare Centers**
This section is divided into (i) sun protection practices, and (ii) sun protection policy and programming, and (iii) sun protection mini-grant activities. Qualitative responses to questions are provided in narrative format below, and if comparison data are available, these were included in Tables 10-11.

**Table 11:** *Comparison of quantitative baseline and follow-up evaluation survey data for Group A only*

| Question | Baseline | F/U |
|---|---|---|
| ***Sun Protection Practices*** | | |
| Apply sunscreen to children before outdoor activities. | 81.0% (17) | 100.0% (20) |
| Require children to wear hats for outdoor activities. | 23.8% (5) | 30.0% (6) |
| Require children to wear sunglasses for outdoor activities. | 9.5% (2) | 20.0% (4) |
| Require children to wear sun-protective clothing for outdoor activities. | 4.8% (1) | 35.0% (7) |
| Require children to play in shaded areas. | 42.9% (9) | 40.0% (8) |
| Schedule outdoor activities and events for children between 10:00 a.m. and 4:00 p.m. | 71.4% (15) | 90.0% (18) |
| ***Sun Protection Policy and Programming*** | | |
| Have formal policy regarding sun protection. | 33.3% (7) | 80.0% (16) |
| Provide educational lessons to children attending center. | 95.2% (20) | 100.0% (20) |
| Distribute sun protection information to parents. | 38.1% (8) | 100.0% (20) |
| Has adequately-shaded play area. | 23.8% (5) | 75.0% (15) |

*Note 1: Group A: Funded Childcare Centers.*
*Note 2: For denominator data, please refer to Tables 8 and 9.*

**Sun Protection Practices**

When asked about the successes and/or challenges of the requirement that children wear hats during outdoor activities, some respondents had this to offer:

> *"We purchased sun hats from Oriental Trading Co and allowed each child to decorate his/her hat. Worn during outdoor play."*
>
> *"Keeping them on their heads. Getting parents to be consistent and bring them in."*
>
> *"Part of the grant was to purchase hats, so children enrolled right now will have hats, but in the past many parents did not provide them."*
>
> *"We provide hats for the children when they go outside. Some children are resistant as they have sensory challenges but we work with them to make sure they are safe."*

> *"We ask children to wear hats every day we go outside but at times that can be a challenge due to the nature of their play."*
>
> *"We try to have all kids come in with their own hats because of lice reasons."*

When asked about the successes and/or challenges of the requirement that children wear sunglasses during outdoor activities, some respondents had this to offer:

> *"Often times these are forgotten - much harder enforce!"*
>
> *"Getting the children to keep them on and getting parents to provide them."*
>
> *"I don't have sunglasses for each and they would argue over the glasses unless they were the same."*
>
> *"All children don't have them. Safety issues of falling, stumbling, cutting face."*
>
> *"It is difficult to have the little ones leave the sunglasses on, however the older kids are very good about leaving the sunglasses on. I have to keep putting them on the little children, and we try to stay out of the sun as much as possible using the early play time and later afternoon play time after the sun has moved to the front of the house."*
>
> *"The sunglasses are great but it sometimes blocks their peripheral vision and makes it difficult for them to have a clear view of the play equipment. Also they fall off when physical sports are being played."*

When asked about the successes and/or challenges of the requirement that children wear sun-protective clothing during outdoor activities, some respondents had this to offer:

> *"Most families are poor and don't have access to sun protective clothing."*
>
> *"I do not allow tank tops on hot days - the shirts have to have short sleeves."*
>
> *"I keep long sleeve shirts for the kids, and when the sun is out strong, we put long sleeves on. The kids don't seem to mind it. We also use a sprinkler on hot days to cool the kids off, but we have them keep on a t-shirt during this time."*
>
> *"Parents often dress children in short shorts, sandals, tank tops. Parent education is key but impossible to enforce restrictions."*
>
> *"It's difficult for the administration to dictate to parents how to dress their children for care each day."*

When asked about the successes and/or challenges of getting children at the center to play in shaded areas, some respondents had this to offer:

> *"Our yard is small, children move and cannot be in shade 100% of time"*
>
> *"We don't have a shaded area… yet. (We received a grant this year!)"*
>
> *"Shade is going to be more available due to the grant funding. Children play in the shaded areas either when they are asked to do so or when they go on their own to those areas."*
>
> *"Children are encouraged, not required unless they show signs that they are overheating."*
>
> *"On real hot days, we go outside earlier to avoid the REALLY hot sun, due to the lack of shade. Our shade structure is due to be installed May 2010."*

Circumstances that limited outdoor activity included high heat and humidity, poor air quality, UV index, and lunch and rest breaks. In addition, precautions, if any, that caregivers at the center had taken for children engaging in outdoor activities during these hours included shaded stations for water breaks, sunscreen application, water play, hats and sunglasses in some cases, limits on time outdoors if too hot, and activities in the shade.

**Sun Protection Programming**

At follow-up in April 2010, respondents were asked about aspects of the program that were most useful or beneficial to their centers. Examples provided were the one-day program training and related materials, policy information, teaching plans, and mini-grant funding for planning, supplies, and structures for policy implementation.

Respondents were also asked about aspects of the program that were least useful or beneficial to their centers. Examples provided were early childhood teaching plans, enforcing content of formal written policy with staff and families, parent materials, and the fact that all staff could not attend the training in August 2009.

Eighty percent of respondents (n=16) reported that the physical environment of their childcare center had changed over the past year (since the training in August 2009) to provide more sun protection for children and staff. Successes and/or challenges involved were exemplified in the quotes below:

> *"We were able to turn this mini-grant into a major project by approaching our local Home Depot. They gave us an additional $4,000 grant and a volunteer skilled carpenter who created the unique designs and put in more than 250 hours of labor at no cost to us. Team Depot (i.e. Home Depot Foundation) volunteers helped him on this project and we now have greatly enhanced sun safety on our playground with these beautiful structures."*

Gazebos help make playground sun-safe

Jun 15, 2010

**AUGUSTA** — The Children's Center at 1 Alden Ave. recently unveiled two new gazebos on its unique playground for children of all abilities. The exceptional structures were specially designed for the center by Steve Kent, a skilled carpenter at Home ...

An article in Capitol Weekly highlighted new sunshades built with mini-grant funds.

*Draft_Pending Updated Data Sources*

*”We have provided sun protection areas on the playground with umbrellas and canopies. The challenge has been that on windy days they blow down/away. We have found this to be a safety issue at times.”*

*“We were able to plant 6-8' Southern Pine trees on our playground area for more shade. They're beautiful!!”*

*“We are working towards building the sun shelter, we needed to raise donations and in-kind support to get the structure we wanted and not be forced to just buy canvas canopies which would not last. We expect/hope the shelter will be completed this summer and in the meantime have trees to shade & we won't be going out during peak times of 10-2 on sunny/high UV index days.”*

*“With the grant money we were able to provide 2 awnings for shade over the deck area, it's been a wonderful help for the infants and toddlers, however we lack shade on the playground. We have been discussing with parents what we need to do to resolve the issue.”*


Sunshade at The Children’s Center in Augusta built with mini-grant funds.

Lastly, respondents were asked to provide additional feedback on the *Sun Blocks* program. All additional feedback was overwhelmingly positive, and some sample quotes are provided below:

***“I*** *enjoyed all of the training and would like to be able to attend the one this year. It also gave me extra insight into sun safety, however, I am very aware of what the sun can do, as I have had skin cancer removed and I now watch the little ones very closely. But there were some aspects I was not aware of.*”

*“It was a great opportunity to learn more about this subject and provide this information to our parents. We have new parents each year and will continue to use the info and handouts from the binder with all new parents. It also made staff much more aware of the hazards of sunburn and not using sun screen. Helped reinforce the necessity for all children having sun screen on.”*

*“What a wonderful opportunity. With just a few restrictions, I felt I could best use the funding where the team thought it could serve the most children. We are now serving the entire school, not just the child care children.”*

*“I find the hardest thing is getting parents to provide all the necessary materials, sunscreen, hats, glasses and I do provide sun screen if the parent cannot - but do not have the resources to provide all the protection for everyone.”*

> *"While $1,000.00 is better than no money, it's impossible to build anything for that amount and I worry about other programs who are not fortunate to be under the umbrella of an Agency with the capability of organizing and acquiring materials/in-kind services/money to do more than purchase some canvas-type structures that will deteriorate in weather or be easier to vandalize if the program is located where others have access during hours the program is not opened. I'd also like to see more examples/ideas in the children's curriculum section that relate to hands on/child centered possibilities to be used in all the classroom "play" centers throughout the day/week/year (block area, dramatic play, creative art, science, literacy etc). These types of things came up during the breakout sections when I took the training and the ideas we came up with were GREAT when I did the training with my staff last September."*
>
> *"I can honestly say that my center was not very sun-safe before this program 2 years ago. I have implemented more and more every year. I enjoy going as a re-fresher to remind me of what I have forgotten the years past. I look forward to this every year. I really want to bring my staff this year...."*

**Sun Protection Mini-Grant Activities**

Fifty percent (n=10) of the mini-grant recipients had completed activities related to their mini-grant by mid-April 2010; for those who had not, anticipated completion dates were provided in May/June 2010 in time for summer programs.

Respondents were asked to describe how their center utilized the mini-grant funding. Examples provided included building shade structures, policy adoption, material dissemination and education, and purchase of hats, buckets, sunscreen; sample quotes are provided below:

> *"I purchased a canopy for the Sand lot, and am going to purchase another one for the back yard. I also purchased bucket hats for the children."*
>
> *"We were able to provide the following: Four 6-8' southern pine trees, all the labor included. Bucket hats for children, special enrichment around the songs about sun safety, sunglasses and continuing education for parents and children."*
>
> *"We will hold a family involvement day in May and parents will help us complete the sun shades."*
>
> *"We printed and distributed the Sun Blocks parent guide."*

Sunshades like the one shown, were built thanks to in-kind contributions and additional resources in addition to mini-grant funds.

A few respondents (n=3, 15.0%) reported receiving some type of in-kind contributions or additional funds/resources to support their center's efforts. These included volunteer labor, agency support, and donated supplies.

*Draft_Pending Updated Data Sources*

> *"The structure would cost $15,000 plus. Using the $1000 from the mini-grant and $3000 that our agency has set aside in the budget, all other supplies/labor are donated as follows: architectural plans designed by Kleinschmidt Associates; steel beams and roof supports provided by Cianbro; roof decking and shingles provided by Hammond Lumber."*

Eighty percent of respondents (n=16) developed sun protection guidelines as a result of the mini-grant.

**Group B: Non- Funded Childcare Centers**
This section is divided into (i) sun protection practices, and (ii) sun protection policy and programming. Qualitative responses to questions are provided in narrative format below, and if comparison data are available, these were included in Tables 11 and 12.

**Table 12:** *Comparison of quantitative baseline and follow-up evaluation survey data for Group B only*

| Question | Baseline | F/U |
|---|---|---|
| ***Sun Protection Practices*** | | |
| Apply sunscreen to children before outdoor activities. | 87.5%<br>(7) | 100.0%<br>(9) |
| Require children to wear hats for outdoor activities. | 12.5%<br>(1) | 55.6%<br>(5) |
| Require children to wear sunglasses for outdoor activities. | 0.0%<br>(0) | 0.0%<br>(0) |
| Require children to wear sun-protective clothing for outdoor activities. | 12.5%<br>(1) | 22.2%<br>(2) |
| Require children to play in shaded areas. | 62.5%<br>(5) | 22.2%<br>(2) |
| Schedule outdoor activities and events for children between 10:00 a.m. and 4:00 p.m. | 62.5%<br>(5) | 100.0%<br>(9) |
| ***Sun Protection Policy and Programming*** | | |
| Have formal policy regarding sun protection. | 75.0%<br>(6) | 88.9%<br>(8) |
| Provide educational lessons to children attending center. | 100.0%<br>(8) | 55.6%<br>(5) |
| Distribute sun protection information to parents. | 62.5%<br>(5) | 88.9%<br>(8) |
| Has adequately-shaded play area. | 62.5%<br>(5) | 44.4%<br>(4) |

*Note 1: Group B: Non-Funded Childcare Centers.*
*Note 2: For denominator data, please refer to Tables 8 and 9.*

**Sun Protection Practices**
When asked about the successes and/or challenges of the requirement that children wear hats during outdoor activities, some respondents had this to offer:

> *"Children are encouraged to wear them if they bring them in, it is not a requirement and cost is a big issue as we work with low income families primarily."*
>
> *"Every time we go out even if it is cloudy. We feel this keeps the children accustomed to wearing their hats all the time when outdoors. Parents don't always remember the hats so we provide hats at the center and are washed after each use by a child."*
>
> *"The P/S children and older love the hats. Keeping hats on Toddlers at all times is very hard."*

When asked about the successes and/or challenges of the requirement that children wear sunglasses during outdoor activities, some respondents had this to offer:

> *"Another cost issue - children can wear them - it is not mandatory."*
>
> *"Low-income families - may not be a priority"*
>
> *"Not all children bring sunglasses and some children have them and do not like to wear them. We role model sunglass wearing, and encourage the children to wear sunglasses."*
>
> *"Our children are so young they tend to break sunglasses or they get lost, Most do not keep them on. If they come with a band they claim it is uncomfortable and remove them."*

When asked about the successes and/or challenges of the requirement that children wear sun-protective clothing during outdoor activities, some respondents had this to offer:

> *"Cost issue - I have not seen any of our children at this center wear sun-protective clothing."*
>
> *"We post it for parents to read but very few provide the proper attire."*
> *"We try to have the families provide these materials. Some bring them and some do not. I can tell you that I have been in business for over 25 years and very rarely have I had a child receive a severe sunburn. I take as many precautions as I can and have changed some philosophies since the training last year. This is an area I personally need to focus on for the children's protection and it is through educating all families that I could accomplish this."*

When asked about the successes and/or challenges of getting children at the center to play in shaded areas, some respondents had this to offer:

> *"As often as we can. When I had my family child care my whole back yard was shaded by trees and it was so beautiful. This is the thing I miss the most about my outdoor play*

> *space at my child care center. This is an area I am working on. If I had received the grant money last year that is where the money would have gone immediately. I would have put in shaded areas for all of us to utilize."*
>
> *"We do not require the kids to play in shaded areas but most of them gravitate toward them ... we make it inviting. Our infants are always in shaded areas but they are also not mobile. We have purchased equipment through the sun safety grant that helped add shade to our playground and is inviting for kids to use."*

At baseline, 75% (n=6) of respondents reported that there were circumstances under which they were sure to keep children at the childcare center out of the sun, compared to 77.8% (n=7) at follow-up. Circumstances included high heat and humidity outside, poor air quality, news alerts, extreme conditions, high UV index, and ozone advisories. In addition, precautions, if any, that caregivers at the center had taken for children engaging in outdoor activities during these hours included requiring children to take water breaks, sunscreen application, water play, hats and sunglasses in some cases, activities in the shade, and limiting outdoor activities to short periods during summer months.

**Sun Protection Programming**

At follow-up in April 2010, respondents were asked about aspects of the program that were most useful or beneficial to their centers. Examples included training materials for staff and parents, and early childhood teaching plans.

Respondents were also asked about aspects of the program that were least useful or beneficial to their centers. Two respondents noted their disappointment at not receiving mini-grant funding.

Only thirty-three percent of respondents (n=3) reported that the physical environment of their childcare center had changed over the past year (since the training in August 2009) to provided more sun protection for children and staff. Examples of successes and/or challenges involved are provided below:

> *"I am working toward improving the physical environment. Finances are the biggest obstacle in creating the environment. We have just started our third year of business and building up enrollment while trying to maintain employees has been a huge task. My husband and I are currently working on a shade play area in the back of our property. This will take some time to accomplish, as the property we purchased was very overgrown and had lots of tires and broken glass everywhere. We are also going to transplant some trees into our fenced in play areas. This will involve getting some heavy equipment to help out because we want to plant trees that are at least seven feet tall and have a well developed root base and trunk system."*
>
> *"We have had an extremely positive experience with Sun Safety. We are very specific with new and old families about how seriously we take sun protection and have them sign a release regarding sunscreen application (which they are responsible for providing). If they do not agree with the application of sunscreen for whatever reason (typically allergies) then they are required to provide protective clothing... i.e. hat, long sleeves, long pants. Because our children are so young sunglasses have not really worked out*

> *well but we continue to try :). Parents for the most part are positive and supportive as they do not want their children getting sunburned. Most of my staff have been through the training as well because I feel it is not only educational but informative. I would highly recommend this training for anyone who works with children as education is the key. If funding were available, I would encourage this training be used for physicians as well, and to somehow incorporate yearly or bi-annual screenings of children and adults either Center based or through family practice. I know it's a lot to ask for but it is a disease that can be prevented."*

Lastly, respondents were asked to provide additional feedback on the *Sun Blocks* program. All additional feedback was positive, and some sample quotes are provided below:

> *"The information was so helpful to hear. I have not only used it in my professional life but also in my personal. Thank you for the opportunity."*

> *"I was happy to come away with very useful information and surprised to find so much that I didn't know about."*

> *"Job well done to the individuals and programs who started this initiative! I recommend it to other programs all the time as the information and materials are completely appropriate and user friendly. The opportunity for failure is minimal."*

**Group C: HMPs and RDCs**
Since this group was not directly involved in the program, their questions on the baseline and follow-up surveys were considerably fewer, and mostly qualitative in nature.

At baseline, members of this group were how they found out about the *Sun Blocks* program. The majority (88.9%; n=8) had heard about the program through an e-mail from the Maine Comprehensive Cancer Control Program.

At baseline, members of this group were asked to describe their work in relation to childhood sun safety, and their interest in the *Sun Blocks* program. Responses included facilitating training for and providing materials to childcare providers in their counties, presenting sun safety information at elementary schools, day camps, public schools, and youth-serving organizations, policy development, and community education, including cancer-specific health outreach work.

At follow-up, members of this group were asked to describe any work undertaken since the training in August 2009 in relation to childhood sun safety. These included education, policy updates, trainings, and information dissemination, and are exemplified in the quotes below:

> *"Ongoing sun safety education with […] YMCA, the largest daycare facility in […] County."*

> *"Updated sun safety policy at […] Head Start to be more comprehensive and address primary sun protection strategies. Conducted training with Child Care Options Home-Based child care providers; included overview on sun safety and importance of policy implementation."*

> *"We provided sun safety materials from the American Cancer Society and Maine Cancer Consortium to Head Start and Broadreach"*

> *"Have added resources to our child care provider lending library, put information in our newsletters, information available at our annual child care symposium"*

At follow-up, 57.1% (n=4) of HMPs and RDCs in the sample reported that their center or organization distributed sun protection information to parents.

At follow-up, members of this group were asked about the most useful aspects of the *Sun Blocks* program for their organizations. Examples provided were teaching materials for parent education, early childhood teaching plans, policy templates, and training materials.

> *"All the resources given were great to use with child care providers and the families they work with, easy to use"*

At follow-up, members of this group were asked about the least useful aspects of the *Sun Blocks* program for their organizations. Examples provided were the need for more information on Vitamin D absorption and synthesis in relation to sun exposure, and teaching plans for those who did not work directly with children. In addition, two respondents in this group noted "mini-grant support," which was interpreted as no opportunity for mini-grant support.

## Discussion & Recommendations

The quantitative findings provided in the preceding section suggest that the goal to promote sun protection practices, and increase policy and programming around skin cancer prevention was reached, especially for childcare centers in Group A. Qualitative findings for the second round of funding provided rich detail on successes achieved, as well as challenges encountered around primary prevention practices, such as wearing sunglasses, hats, and sun-protective clothing, that were encouraged, but not required. That said, grantees and other childcare centers appeared to have risen to the occasion in many instances, as indicated through sample quotes. Several childcare centers also conveyed their appreciation for the funding source (if applicable), training and related materials, and the opportunity to promote change and increase awareness and adoption of appropriate skin cancer prevention practices for children through a critical setting. In addition, findings from both rounds of the *Sun Blocks* Childcare Sun Safety Program, although different in design, indicated that knowledge and behaviors related to skin cancer prevention in the childcare setting were being positively impacted, and opportunities provided through participation in annual trainings, curriculum development, and program materials were key to making a difference.

Recommendations for future *Sun Blocks* programming include (i) continued funding to enhance and sustain changes to the physical environment, and to purchase items such hats and sunglasses, (ii) sharing success stories in obtaining additional funding or in-kind support, and (iii) promoting strategies to gain parental support, especially for certain primary prevention practices. Additional feedback and recommendations gathered at the Annual Stakeholders Meeting in Augusta in June 2010 included, but were not limited to (i) developing teaching plans that account for developmental stage differences in children, especially 3-5 year olds, (ii) purchasing certain bulk items in advance to avoid back order delays, (iii) contacting local optometrists for inexpensive suggestions on providing sunglasses for children who wear prescription eye glasses, (iv) role modeling of positive behaviors by staff, (v) contacting local businesses for in-kind support, such as Home Depot and L.L. Bean’s community giving program, and (vi) requesting a contact list of former mini-grant recipients to obtain advice and share suggestions.

## Colorectal Cancer Initiatives

Colorectal cancer is the second leading cause of death for men and women in Maine. Many deaths from colorectal cancer are preventable through screening as polyps that could potentially grow into cancer can be removed during a colonoscopy. In 2010, two specific colorectal cancer programs were implemented through MCCCP. First, the Healthy Maine Partnerships (HMP) completed the third year of their three-year Colorectal Cancer Awareness Mini-Grants. Second, the MCCCP successfully secured a five-year CDC grant to increase colorectal screening rates in Maine. This section of the report presents the results of these two colorectal cancer initiatives.

### Colorectal Cancer Awareness Mini-Grants to Healthy Maine Partnerships

#### Background

In early 2008 the Maine Comprehensive Cancer Control Program (MCCCP) announced the availability of funds to support the Healthy Maine Partnerships (HMPs) with additional resources to enhance their ongoing colorectal cancer prevention and awareness activities. The purpose of the Colorectal Cancer Awareness Mini-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 three-year mini-grants, HMPs 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 approved district-wide colorectal Cancer Plan priorities in years two and three.

#### Design & Methodology

Year one activities of community assessment and identification of barriers to screening inspired recommendations and actions for elimination of those barriers. Therefore, in the first year of funding, each of the districts was asked to develop a district-wide colorectal cancer awareness plan for addressing the barriers that were identified in their community assessments. Funding for years two and three then allowed 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.

The recommendations and actions for addressing the barriers identified during assessment 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. In grant year three, the independent program evaluator specifically reviewed:

- HMPs efforts within the five broad categories;
- Barriers and enhancers to plan implementation;
- Partnerships formed;
- Populations reached; and
- Plan objectives achieved.

Additionally, since it is the final year of the three year funding cycle, this evaluation also reviewed the overall impact the full three years of the mini-grants had on HMP communities.

Seven of the 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 the final year of the funding cycle. As with much of the work done by the HMPs, 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.

**Data Collection**
In the final grant year thirteen of the fourteen funded HMPs returned the evaluation survey tool (Appendix L) sent out electronically to HMPs directors in May 2010. The 93% response rate is only slightly down from the 100% response rate in 2009. [Note: The fourteenth survey tool was returned after the deadline, and after the program analysis was completed, so its data is not reflected in this report's analysis/results.] Across all the districts less than a quarter of the grantees, only three of thirteen (23%) engaged in all five grant activity areas, again down slightly from the 29% of grantees who engaged in all activities in grant year two. As would be expected for a grant to do community-based awareness, all grantees (100%) directed some portion of their efforts and activities this year in the areas of public awareness and strengthening partnerships.

Seventy-seven percent (77%) of the grantees engaged in capacity building activities, a substantial rise from year two in which 64% of grantees engaged in capacity building activities. Sixty-two percent (62%) dedicated grant resources to education initiatives during year three, about the same as the 64% in year two. Almost half of the grantees (46%) undertook activities to affect practice change, which represents another major shift in activity focus from year two when 36% of grant time was directed to practice change activities. It is not surprising that capacity building and practice change activities had the greatest increase in year three as they are both activities that can result in sustainability.

Table 13 on the next page captures the grantee's responses to a question asking them to estimate the percentage of their year three grant time allocated in each of the five programmatic areas. As the chart reflects, well over half of grant time (61%) for all grantees (based on average of individual HMPs percentages provided) was devoted to activities in the areas of public awareness campaigns and building/strengthening partnerships. Within that 61% of grant time expended, an average of 42% of time was spent on public awareness activities and an average of 19% of time was spent on partnership activities. While education initiatives garnered close to a third (29%) of the average activity time, they did so for only eight of thirteen (62%) grantees versus the thirteen of thirteen (100%) that engaged in public awareness and partnership activities.

**Table 13:** *Percentage of Time Spent on Five Programmatic 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% | 42% | 10% to 95% | What You Do Matters website, radio PSAs and newspaper/ newsletter inserts; display ads at health practices |
| Strengthening Partnerships | 100% | 19% | 5% to 40% | New media partnerships for showing CRC ad at Cinemagic theaters; New partnership with Medical staff secretaries |
| Capacity Building | 77% | 17% | 5% to 30% | Peer to peer training initiatives in concert with awareness campaigns; Central county-wide referral point developed |
| Education Initiatives | 62% | 29% | 20% to 40% | Worksite, civic and church group presentations, and professional presentations by physicians/nurses; Senior Life Expo |
| Practice Changes | 46% | 15% | 5% to 40% | Develop clinical criteria, policy guidelines, and referral system; FQHC promotion of screening program |

## Evaluation Results

### *Workplan Implementation*

For the thirteen grantees that returned the evaluation survey, it is clear from those surveys that the communities/districts focused their activities on implementing the plans they had originally developed. Grantees were asked how their workplan had changed over the three years and less than half (46%) indicated they had made changes and another 15% had "tweaked" or made minimal changes to their original plan. For a number of HMPs the changes to their original plans were needed because of community dynamics beyond the control of the grant and resulted in adjustments or adaptations in their year one plans. There appear to be three aspects to the changes: (1) worksites/employers barriers; (2) lack of access to screening services; and (3) changes to outreach efforts. Examples of reasons for making plan changes included:

- Employer/worksite resistance caused changes in work plans such as: "W*e have realized that worksite wellness activities need to be well developed in order to introduce policy work. None of our worksites were interested in implementing a policy…"*
- Original work plan reflected the lack of access to screening services, which has now changed with, "*Federal implementation of health insurance coverage for colonoscopies. Development of Care Partners model at [hospital] affords individuals with no insurance to have preventative procedures."*
- Grantees stated that changes to original work plan outreach activities were made *"To increase our efforts to reach a larger portion of our target audience by expanding our outreach efforts."*

Similarly, when asked if they had reached their initial grant goals and objectives identified in year one, 85% felt they had completed their initial goals, and one (8%) indicated that the pending uncompleted goals would be complete by the end of the grant cycle (June 30, 2010). Therefore, over the three years, 93% either completed or will complete their three year goals by the end of the grant year. It should be noted that the other 7% of respondents represents the HMP that did not answer the questions on overall completion of grant goals.

***Community/External Supports to Grant Work***

Grantees were asked to identify enhancers to implementing their grant activities and a large range of community and external supports were 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. HMPs reported that the relationships they had been building within the medical facilities (such as health centers, physician practices, etc.) over the three years of the grant really came to fruition in the final year. As a number mentioned, *"The ability to work closely with the health care centers,"* was a key dynamic of grant success.

A critical element of successful partnerships is collaboration and many grantees commented on its significance in building relationships, such as: *"Collaboration has been key to implementing our year three work plan…"* Collaboration that resulted in resource sharing was also expressed: *"Our work was enhanced through the collaborative spirit and networking of the district HMPs around sharing of all forms of media for health promotion messaging."* Additionally, partnering for the integration of programs and materials both within their programs and across district-wide programs (with other HMPs), as well as being able to utilize existing materials, was seen as enhancing their work by allowing for Boarder outreach to more targeted populations: *"Networking local colorectal screening activities with Maine CDC grant* [Maine Colorectal Cancer Control Program]*."*

Probably the greatest enhancer in year three was the addition of the MCRCCP grant resources to provide screenings to those who would not otherwise get them. The frustration expressed in year two around raising awareness of the importance of screening and then not having resources to provide necessary screenings to the uninsured or under-insured, was addressed with the securing of the federal grant and establishment of MCRCCP. This new statewide program can provide those screenings, and as one grantee stated, MCRCCP enhanced their current grant implementation, *"Free screening program has helped launch a broader and more successful promotional campaign."*

### *Barriers to Grant Work*

Grantees were also asked to identify any barriers to implementing their workplans. Ten of the thirteen respondents (77%) identified at least one barrier, two (15%) identified no barriers, and one respondent did not answer this question. The most common barriers were time (lack of as well as timeliness concerns when collaborating with others), money/funding, and resistance from specific groups they had targeted in their plans, for example employees at worksites. A sampling of comments concerning barriers follows:

> *"…staff leave…created a limited time period in which to complete our activities…"*
>
> *"The lack of provider engagement made it difficult to implement practice changes."*
>
> *"Limited budget"*
>
> *"…worksites are often working with competing priorities…they want to make health related education available…they were hesitant regarding policy work."*

### *Partnerships Developed*

The survey included two questions pertaining to the partnerships that have resulted from the mini-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 healthcare system, including physicians, hospitals, rural health centers, FQHCs, and other health care providers. The next most frequent partnerships were forged with local and district-wide businesses. Table 14 captures a sampling of the range and type of partnerships that were developed with some of the many activities these partnerships carried out. It is important to note that partnerships are fostered and strengthened over time. Many of these partners listed on the chart span multiple grant years, and will hopefully continue to do the CRC awareness activities beyond the life of this community-based grant opportunity.

**Table 14:** *Range and Type of Partnerships Developed Through Grant Activities*

| Partnerships Developed | Types of Activities Accomplished |
|---|---|
| Primary Care and Health Care Providers | Provider tool kits and outreach tools;<br>Provider trainings |
| Physicians | Educate patients; Provide screenings; Establish protocols & referral systems;<br>*Ask Your Doctor* campaign |
| Hospitals | Educational sessions;<br>Hospital provided doctors and nurses for professional trainings and presentations; |
| Federally Qualified Health Centers | Disseminate educational materials; promote/refer for screenings; educate patients on free screening opportunities under MCRCCP |
| Local newspapers | Weekly banner ads for Healthy Waldo County |
| County-wide Networks | Spectrum Generations Regional Council; CHC as county-wide physician referral service |
| Worksite Wellness Coordinators | Awareness, educational and policy materials;<br>Employee educational sessions & displays;<br>Employer/employee health fairs |
| Community Partners (such as libraries, YMCAs, etc.) | Educational materials and presentations |
| Food pantries, senior food programs, & Farmer's Markets | Educational materials on free screenings |
| Media | Multi-media campaign; Movie theater distribution |
| Local Health Department | Joint website message development |

### *Priority Populations Reached*

The colorectal screening grant application identified three priority populations it hoped the HMPs would reach as they completed their workplans: (1) community members over 50 years of age; (2) local employees and employers; and (3) healthcare providers. Additionally, individual HMPs had priority populations they hoped to reach beyond those identified in the grant application. While priority populations were often the same, only the population of community members 50 years or older, was targeted by 100% of respondents. Twelve of the thirteen HMPs (92%) worked with healthcare providers, eleven (85%) worked with employers and employees, and eight grantees (62%) identified specific populations in addition to the mini-grant priorities. Table 15 details the populations HMPs worked with and some of the places where they did that work.

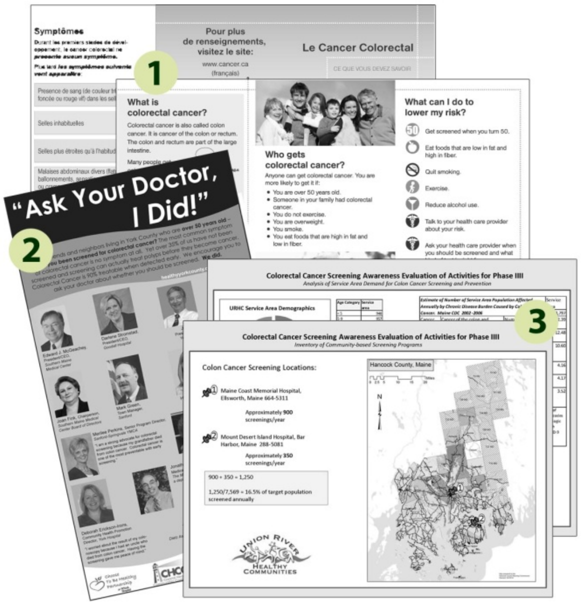
**Table 15:** *Populations impacted by HMPs outreach*

| |
|---|
| **Population: Community members 50 years and over**<br>100% of HMP targeted some of their activities to this group (increased by 7% from year two). |
| **Venues:** Elderly housing; meals for ME; FQHCs; movie theaters; Seniority Program; Spectrum Generations; Senior News subscriber locations; Kiwanis; food banks; CAP agencies; municipalities/town offices; newsletters; website; newspapers; business worksites; radio spots & PSAs; wellness/health fairs, ex: Teacher Wellness Day reached 650 teachers; banks; health care provider offices. |
| **Population: Healthcare providers**<br>92% of HMP targeted some of their activities to this group (virtually the same as in year two). |
| **Venues:** Physician practices; health clinics/centers/rural health centers; hospitals; health and primary care provider office ; FQHCs; healthcare system; hospitals |
| **Population: Local employers and employees**<br>85% of HMP targeted some of their activities to this group (increased substantially (14%) from year two). |
| **Venues:** Employee newsletters; worksite wellness programs & bi-monthly worksite wellness group; chambers of commerce; Rotary and Kiwanis Club meetings; wellness fairs; worksite toolkits distribution; local colleges & state university; worksite presentations such as at Jackson Lab, GE, etc.; Maine State Housing Authority; grocery stores; movie theaters; employee of community organizations. |
| **Population: Other priority populations**<br>62% of HMP targeted some of their activities to groups such as Women's groups, church groups, ME tourism Bureau, ME Indian Education, and more (this was the only population category that experienced a decrease (9%) from year two). |
| **Venues:** Senior church group; Women's groups; quilting group; restaurants; health source corners; peer to peer outreach; town offices; libraries; DMV; recreation centers; SMAA members; HMP partners; general public households (incl. 3392 in Bucksport). |

### Materials and Resources Developed

These being colorectal cancer screening awareness grants, it is evident that HMPs 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



### Overall Impact of Three-year Mini-Grants

As noted earlier 93% of HMPs (the other 7% did not respond to questions about overall impact) will meet the goals set out in year one of the grants. Overwhelmingly, grantees felt positive about the impact of the grants in terms of raising awareness of the importance of early detection and the need to get screened. The mini-grants also allowed some HMPs to develop clinical guidelines, referral processes, and in one case promote a local fund to pay for colonoscopy services. A number of HMPs felt strongly about the relationships they have forged as part of implementing this mini-grant. As one HMPs stated, *"The new relationships have rolled into many more initiatives that have been successful in the service area."*

The mini-grants were also seen as providing venues for both empowering patients to talk with their doctors about screening, and *"the activities encouraged doctors to talk to their patients about receiving CRC screenings as well."* Additionally, grantees identified the impact these awareness grants had on securing federal funds for Maine's new Colorectal Cancer Control Program (MCRCCP). Many had noted in year two that one frustration with the awareness mini-grants is the lack of funding for needed screenings identified in their community assessments. Thus, the HMPs awareness mini-grants are seen as laying the foundation for the MCRCCP, and a number of grantees noted the need to assure coordination of the current educational activities (begun under the awareness mini-grants) with the educational activities planned for the MCRCCP.

***Overall Grant Administration***

In addition to the question asked about the overall impact of the mini-grants, the survey asked about the ease of administration of the awareness grants over the three years. All grantees responded positively to this question. Any frustrations with the grant that were noted had to do with the funding limits of the mini-grant and/or with the lack of funding for actual screenings, rather than with how MCCCP administered the mini-grants. The following comments represent a sampling of the comments provided by grantees about grant administration:

> *"CDC staff was very helpful in managing the contract."*
>
> *"Reporting/application requirements were not burdensome."*
>
> *"…the grant was easy to oversee and administer.", and*
>
> *"It's been challenging to work with such a limited budget."*

When asked what might be done differently in future mini-grant funding for colorectal cancer awareness, funding and coordination issues were cited. Increased funding and braiding of funding (into overall HMPs contract) were suggested by some grantees. However, the bulk of the responses to this question focused on improving coordination with other current HMPs activities, as well as with the new MCRCCP grant activities. Additionally, grantees noted a desire to share grant activities and information statewide (for example: monthly conference calls for grantees), and to assure that materials and resources developed with these grants funds don't become redundant under subsequent grants. Among the grantee comments were:

> "*Do not reinvent the materials that are already available. New materials only confuse participants…"*, and
>
> *"If there is another opportunity to fund CRC awareness, perhaps there could be a list of resources and how to access them."*

***Conclusions***

From an evaluation perspective the Colorectal Cancer Screening Awareness Grant program has realized its purpose *"to develop projects in communities across Maine to increase awareness of the importance of screening for colorectal cancer, especially among adults over the age of fifty"* The HMPs grantees worked hard to complete the workplans they developed in year one, and for the most part have been successful in completing those plans. Any areas still needing attention lay outside the purview of these grants, for example, funding to cover the cost of screenings for the uninsured - an area being addressed under the new MCRCCP grant.

Across the Board the grantees felt the mini-grant program and its staff are supportive of their work. Many grantees commented that the MCCCP provides not only financial support but also knowledge, expertise, and direction when asked. Thus, for future community colorectal cancer grant offerings the CDC administration of mini-grants can remain the same. The one area that will need to be clearly delineated is the coordination of any future HMPs grants with the MCRCCP grant activities. The confusion about the two colorectal grant funding streams identified in this year's evaluation may be addressed with the inclusion of HMPs grantees on the MCRCCP Public Education and Outreach Advisory Group, a group formed under the MCRCCP to address the issue of coordination and synthesis in colorectal cancer awareness activities in Maine. However, the continued coordination of activities, materials, resources, referral systems, etc. across the two grants should be carefully monitored in the upcoming year.

Grantees acknowledged the opportunities this grant program provided to increase awareness in their communities and to build local capacity. The partnerships formed and the doors that were opened were appreciated and expanded wherever possible. The words of one grantee may capture this sentiment best:

> *"We have blanketed our District with messages about the importance of colorectal cancer screening and educated our community members regarding colorectal cancer itself…We have developed closer relationships with the hospitals, Cancer Committees, and physicians in our community."*

When looking at the three years in total, the evaluations from each year reveal a natural progression in the focus of grant time and activities from community assessment and identification of barriers to public awareness activities and tackling of barriers. In year three there was a shift in grant activities to addressing practice change that will have long term impact on how healthcare practitioners talk about and address the need for screenings. The HMPs have done a good job of laying the foundation for the increased provision of screenings under the MCRCCP grant and it is worthwhile for them to continue to do the work in their communities on public awareness and connecting the uninsured and underinsured to resources for screenings. As one of the grantee relayed:

> *"Once assessment was completed, advisory group members focused their attention on access to colorectal screening services. In retrospect this focus area was timely…the preliminary work done by advisory Board members and local health center staff on creating the colorectal fund has paved the way to link these same procedures to the health system's colorectal screening grant program."*

The goal for the HMPs mini-grants to, *"Increase screening rates for colorectal cancer by raising awareness of appropriate screening across Maine"* requires more resources than the awareness grants possess. That said, the steady increase in the proportion of people over 50 receiving screenings (from 61.9% in 2005 to 72.6% in 2008) reflects the success of the screening awareness mini-grant activities as one dynamic of that increase. Further, the MCRCCP building upon and being supported by the work of the HMPs mini-grants is from the evaluator's point of view, exactly the correct and logical use of mini-grant funds by Maine's CDC and its Comprehensive Cancer Program.

## Maine Colorectal Cancer Control Program

### Background

Colorectal cancer is the fourth leading cause of cancer-related incidence and mortality in Maine.[7] Although colorectal cancer screening has proven effective in reducing incidence and mortality by removal of premalignant polyps and through early detection and treatment of cancer, only 63.3% [95% CI: 61.7-64.9] of Maine adults aged 50 years and older have had a sigmoidoscopy or colonoscopy in the past five years.[8,9] Reasons for under-screening in Maine include rural geography, limited access to health resources and screening capacity, limited/no health insurance, lack of state funding for colorectal cancer screening, and possibly even confusion over multiple testing options, required patient effort to prep for exam, and lack of understanding about colon cancer risk.

In 2009, the Maine Comprehensive Cancer Control Program (MCCCP) at the Maine Center for Disease Control and Prevention (Maine CDC) applied for and secured grant funding from the U.S. Centers for Disease Control and Prevention (CDC) in order to implement a comprehensive colorectal cancer screening program over the course of five years, also known as the Maine Colorectal Cancer Control Program (MCRCCP). MCCCP originally requested $1.5 million per year in order to implement the program; however, it was awarded $850,000. This necessitated major changes to the proposed budget and work plan, including reducing the projected number of screenings at the health system level, and in the absence of full funding, a reduced capacity to support the work of the participating health systems, and needs of the state's underserved groups.

The priority population for this program comprised of men and women aged 50-64 years, who were considered to be at average-risk for colorectal cancer, and living at or below 250% of the federal poverty level. The goal of the program was to increase the proportion of the defined priority population that received colorectal cancer screenings by 10% by the end of the five years (Baseline 40%),[10] and reduce financial, geographic, and health access-related barriers to colorectal cancer screening among uninsured and under-insured groups in Maine. In order to implement the program, MCCCP partnered with the four major health systems across the state to provide screening, diagnostic, and follow-up services, and to ensure access in all regions across the state. Additional partners of the program included the Maine Cancer Consortium's Colorectal Cancer Task Force, Maine Cancer Registry, Maine Breast and Cervical Health Program (MBCHP), Maine's Federally Qualified Health Centers, Maine's Tribal Communities, American Cancer Society, and the local Healthy Maine Partnerships throughout the state.

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[7] U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999–2006 Incidence and Mortality Web-based Report*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2010. Available at: www.cdc.gov/uscs.

[8] Winawer SJ, Zauber AG, HO MN, et al. *Prevention of colorectal cancer by colonoscopic polypectomy*. The National Polyp Study Workgroup. New England Journal of Medicine 1993; 329:1977-81.

[9] Centers for Disease Control and Prevention (CDC). *State Cancer Profiles and Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008**.**

[10] Centers for Disease Control and Prevention (CDC). *State-Level Survey of Endoscopic Capacity (SECAP) Data.* Atlanta, Georgia: U.S. Department of Health and Human Service; 2007**.**

**Design and Methodology**

The Maine Center for Public Health (MCPH) was contracted by Maine CDC to develop and implement a comprehensive evaluation plan for the five-year Maine Colorectal Cancer Control Program that would utilize process and outcome measures to determine successful processes, areas for improvement, and program sustainability options. In Year 1, the primary focus was infrastructure development and program start-up. The program evaluator at MCPH worked collaboratively with the state program and contracted program management staff from Medical Care Development (MCD) to develop a process evaluation framework for Year 1 that mirrored the steps in CDC's Framework for Program Evaluation in Public Health, as well as a logic model (Appendix M) that described resources, activities, outputs, and outcomes of interest to the overall five-year program.[11] In addition, guidance provided by CDC Evaluators in Atlanta through documents such as the Social Ecological Model and Program Framework, were also used to ensure that a comprehensive evaluation framework and logic model was developed for the program in Maine.

As part of the Year 1 process evaluation, customized interview guides (Appendices N, O, & P) were developed with input from state program staff, and administered in-person and via telephone by the program evaluator to key partners and stakeholders, including program management staff, representatives from participating health systems, and members of the Medical Advisory Board (MAB), between February and March 2010. The purpose was to evaluate processes around infrastructure development and start-up in Year 1 of the MCRCCP, and to understand facilitators, barriers, and lessons learned in order to provide feedback for program improvement. All interviews were recorded with permission from the interviewees, and later transcribed and analyzed for emerging themes. A systematic approach was utilized in summarizing qualitative data: for example, if half or more than half of the key informants shared an opinion, it was summarized as a theme. In select cases, if an opinion was shared by fewer than half of the key informants, but was determined to be important and/or relevant to addressing a particular question, it was included. Given the limited sample size and possibility of inadvertently revealing the identity of a partner/stakeholder, quantifiers rather than numeric descriptions were used when and where possible.

**Findings and Discussion**

This section primarily includes findings from the partner and stakeholder interviews. In addition to these process evaluation findings, data for select clinical indicators in Year 1 are also presented in this report; these were solicited from the MCRCCP data coordinator for screenings conducted since implementation began on March 1, 2010.

### *Findings from the Partner and Stakeholder Interviews by Group*

The following section provides summaries of findings for the three groups of interviewees, i.e. (i) program management staff from Maine Center for Disease Control and Prevention (Maine CDC) and Medical Care Development (MCD), (ii) representatives from the four participating health systems, and (iii) members of the Medical Advisory Board (MAB).

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[11] Centers for Disease Control and Prevention. *Framework for Program Evaluation in Public Health.* Morbidity and Mortality Weekly Report 1999; 48 (No. RR-11).

**Group 1**
The key informants in this group comprised of two program staff from Maine CDC, the state's public health agency and MCRCCP grantee, and three program management staff from MCD, the state's program management contractor for the MCRCCP grant.

At the beginning of the interview, all key informants in this group were asked to describe their current role with the program. For the key informants from Maine CDC, while one provided the "higher-level vision" and had developed the design for the screening program, secured grant funding and coordinated subsequent contracting processes, the other key informant stepped in to take the lead role in day-to-day work once grant funding was secured, and provided program oversight on various aspects of MCRCCP grant implementation. The key informants from MCD cited their roles and responsibilities as integrating the big picture into the details, and working with staff from Maine CDC to develop algorithms for various processes, work on policy manuals and training materials, serve as a liaison and respond to queries from participating health systems, serve in a data coordinator capacity, and develop the data warehouse for the grant. In addition, some key informants from both Maine CDC and MCD noted institutional history with the Maine CDC, through the Maine Comprehensive Cancer Control Program (MCCCP), Maine Breast and Cervical Health Program (MBCHP), and Colon Cancer Taskforce.

Next, key informants were asked which components of program infrastructure were already in existence prior to the start of the grant. Several key informants listed entities such as MCCCP, MCD, Maine Cancer Consortium, and health systems and associated staff as components that were already in existence. Components that were specifically developed for the grant or had to be tailored accordingly for the grant included relationships with the health systems, roles and responsibilities of program coordinators at each participating health system, contracting processes, and screening and enrollment algorithms and protocols. From a data collection and monitoring system perspective, several components were not in existence, with the exception of the defined data structure from CDC. In addition, one key informant cited that, given the delays in receiving software from CDC, their group decided to develop a web-based application for secure data entry, and provided trainings on this web-based system to and solicited user input from the participating health systems.

Key informants from Maine CDC were specifically asked how the grant program is being integrated into or collaborating with the Comprehensive Cancer Program at the state. As per these key informants, the MCRCCP was originally intended to be a colorectal cancer screening project under the existing Maine Comprehensive Cancer Control Program, with colorectal cancer education covered by MCCCP. However, the MCRCCP evolved over a short period of time, and is now its own program as per CDC requirements. The program is not presently integrated into MCCCP in terms of funding streams and reporting; however, it is collaborating with MCCCP through common staff connections, and the outreach work of the Maine Cancer Consortium and Healthy Maine Partnerships.

Key informants were then asked whether the program was designed to be easily incorporated into existing service delivery systems at the participating health systems. Some key informants answered in the affirmative, and cited as examples (i) the existing toll-free lines and work with the American Cancer Society, (ii) using existing processes to serve patients and provide care, and (iii) focusing on specific populations that were not eligible or did not receive care previously.

Other key informants highlighted differences or newer aspects such as (i) the new payer role for health systems requiring them to pay providers themselves, (ii) using a similar framework to the Maine Breast and Cervical Health Program, but with different execution, and (iii) from a data collection and monitoring perspective, using a different system from existing software at health systems in order to standardize collection and reporting across all participating health systems.

When asked whether the grant program adapted to fit local service delivery structures at the participating health systems, all key informants agreed that the program adapted in some way, shape or form, such as through communication requests and volunteer Workgroups for billing and reimbursement. Some key informants agreed that vision versus reality may be different once implementation begins, with examples cited of (i) health systems in the payer role, and (ii) differences between the participating health systems that limited standardization of certain processes.

Key informants were also asked about facilitators and/or successes in the start-up phase of the program, from their partner/stakeholder perspective. Facilitators and/or successes cited included:

- Securing CDC grant funding as an incentive to participating health systems and to fund the program coordinator role;
- Partnerships with Maine CDC, MCD, Maine Cancer Registry, Colon Cancer Task Force, and participating health systems that cover approximately 90% of the state;
- Overall responsiveness of partners and stakeholders, as well as previous experiences of several key partners and the added value of their connections;
- Guidance received from CDC through webinars and the reverse site visit to Atlanta;
- Opportunity for face-to-face interaction and collaboration between the four program coordinators; and lastly,
- Maine legislative mandate that requires insurance companies to cover colon cancer screening for eligible persons.

When asked about challenges encountered in the start-up phase of the program, from their partner/stakeholder perspective, some key informants cited successes above that were originally challenges, such as (i) getting participating health systems on the same page, (ii) moving secured grant funding through state contracting channels, and (iii) having to put certain work out to contract due to insufficient internal staffing capacity and inability to hire at the state. All key informants cited delays in receiving finalized information from CDC, such as policy and procedure documents, and clinical data elements, as a significant challenge that had to be overcome. Additional barriers and/or challenges cited included:

- Change in program focus from provision of colorectal cancer screenings to primarily colorectal cancer education, and having to adapt the initial proposal to meet these new funding requirements;
- Multiple layers of communication between CDC and on-the-ground work of the participating health systems; and lastly,
- Program set-up that is heavily-dependent on participating health systems, but with infrastructure funding restricted to $45,000 per health system, irrespective of service area.

Key informants were then asked about "lessons learned" as part of the infrastructure-building process, and any successes that can be built upon moving forward and/or challenges that need to be addressed moving forward. Specific lessons learned included:

- Importance of fostering existing relationships and building newer ones with program partners and stakeholders;
- Utilizing resources that are available through partners and stakeholders;
- Realizing that partnerships may be affected in the long-term by trying to integrate too many groups, such as Federally Qualified Health Centers and Maine Tribes, into the program in Year 1;
- Remembering to not have too ambitious plans, given that there are several stakeholder groups vital to decision-making, and a snowball effect in terms of delays, is a challenge to work around; and
- Need for additional staffing capacity and support at Maine CDC in order to apply for and work on similar grants, or as an alternative, consider the possibility of a different model when applying for grants.

In addition, most of the key informants echoed that with program implementation yet to occur, it was too early to assess challenges and issues, but if and when they arise, these challenges and issues will have to be appropriately addressed, and in a timely manner.

Key informants were next asked about things that may need to change in order to improve management and delivery of the grant program. The majority of key informants cited the following: (i) need to reduce delays from CDC that otherwise impact local processes and decisions, (ii) streamlining communication with health systems and program coordinators to make it less confusing, (iii) hiring additional internal staff at Maine CDC for program management and grants administration, (iv) standardizing program coordinator trainings, (v) understanding and finding a balance with regards to the health system environment in Maine in terms of politics and operational models for four very different health systems, and (vi) obtaining a concise definition of roles and responsibilities for internal program management in order to coordinate existing and newer efforts. In addition, one key informant was encouraged by the evaluation process, and hoped it would answer this question.

Key informants were also asked about the infrastructure available to sustain activities beyond the grant funding period. Most of the key informants agreed that some pieces, such as relationships built with health systems and knowledge obtained through guidelines that were developed and shared with the four health systems, were sustainable; however, without a common funding source, eligibility criteria for screening would likely be different, and each health system would most likely administer separate screening programs. Many key informants agreed that sustaining working relationships required funding, and there was a need to leverage additional resources from the state. As one key informant stated, *"Definitely time and people, which boils down to money. Time and people to manage these systems as they grow, as more people get added and more interest in it. Lots of spinning plates to manage."* Two key informants also stated that additional internal capacity was required within Maine CDC to sustain a program of this magnitude. In addition, one key informant cited integration with the MBCHP as an example of ensuring long-term sustainability.

Lastly, key informants were asked for any concluding thoughts or comments on the start-up process for the program. Since screenings had not commenced at the time of these interviews, the majority of key informants stated that it would be hard to anticipate issues moving into implementation, but were interested to know how the screening process would turn out by June 2010 in lieu of the public awareness campaign, as well as how smoothly the health system-level set-up would function once screenings started on March 1, 2010.

**Group 2**

The key informants in this group comprised of four health system administrators and four program coordinators from the participating health systems, namely Central Maine Healthcare Corporation, Eastern Maine Health System, MaineGeneral, and MaineHealth Associates. Please note that interviewees in this group were interviewed a few days to three weeks into program implementation, and their responses are indicative of this timeframe.

At the beginning of the interview, the key informants in this group were asked to describe their current role with the program. Four of the key informants served in administrator roles at the four participating health systems, and three of these key informants were involved in the pre-award grant writing process. Other responsibilities for this subset included providing a big-picture health system perspective and ongoing support to program coordinators, and serving as a post-award liaison for business office functions related to the grant award. The other four key informants served in program coordinator roles at the four participating health systems. All of these key informants were involved in the day-to-day working of the grant, including serving as a point of contact for patients and direct services, community building with partners, coordinating meetings and communications, working with providers, determining eligibility of participants, enrollment and data entry, and participant follow-up. Only one key informant who served in a program coordinator role was also involved in the grant writing process. Three of the four key informants worked part-time (≤ 24 hours per week) on the MCRCCP, with two working in clinical nursing roles as well.

Next, key informants were asked which screening infrastructure components were already in existence prior to the start of the grant. Responses varied, but most health systems cited refinements to existing infrastructure components. One health system had previous experience with screening for eligibility, and was able to utilize their existing billing and financial infrastructure with only the addition of a new code option in the data entry field; newer aspects included outreach to increase knowledge and awareness of the grant-specific funding source, eligibility criteria, and the limited screening slots available to the health system. Another health system stated that several components had to be refined post-award such as billing and reimbursement systems, processes to identify patients, and contracts with providers. A third health system already had the colonoscopy screening infrastructure in place, but had to work on expanding services to underserved populations, establishing appropriate billing and reimbursement systems, and factoring in roles and responsibilities for the program coordinator position. A fourth health system cited infrastructure in place through their existing free care program, but newer components to meet grant-specific billing and reimbursement requirements for multiple departments within their health system, which ended up being complicated and time-consuming. This was exemplified in the quote: ***"Maine is generally ahead of other states in terms of having a process or system in place for providing free care services to low-income*** *persons, which would include screenings such as colonoscopies, but it is not just screening services. Nothing remotely similar existed for billing and reimbursements..."*

Key informants were also asked <u>whether the resources provided to support infrastructure were adequate.</u>

- Fiscal support was cited by the majority of key informants as inadequate, given the considerable amount of work required of health systems, and in-kind contributions being made by health systems to support commitments to screening patients. As one key informant stated, *"We are concerned what (costs) the health system will continue to absorb moving forward…"* Another key informant added *"…concerned about the equal distribution of $45K, given that two health systems serve the majority of districts and others only one or so. Same with the number of slots. Surprised from a planning perspective that thought was not given to rural/urban and other factors."*
- Training was cited by most of the health systems as adequate in terms of the opportunity for program coordinators to attend and interact face-to-face at the conference in Bethesda, MD, but it was also noted that the program coordinators had different backgrounds and expertise.
- Staffing was cited as adequate by most of the health systems, with regards to timeliness of responses to queries. However, one health system cited some confusion about roles and responsibilities of staff at Maine CDC and MCD, and some health systems noted that there tended to be vagueness in some responses, and additional assistance could be provided, such as standardization of the voucher system for bowel prep.
- In addition, most health systems noted that program staff appeared to be learning along with health system staff, and one health system stated they were disappointed by the limited flexibility of program leadership, *"For what the program is trying to offer and the infrastructure available, maybe a bit too ambitious. Either focus on patient navigation with no financial reimbursement or straight-forward financial reimbursement offered without patient navigation, and left it up to providers and health systems to screen patients because those two components together are the overwhelming piece."*

Key informants were also asked <u>how enrollees heard/are hearing about the program.</u>

- One health system reported that their enrollees heard about the program through (i) providers, (ii) free care program, and (iii) the toll-free number. The program coordinator for this health system noted that flexibility in contacting people after-hours in order to screen for eligibility was crucial.
- Another health system reported (i) radio, (ii) newspapers and/or flyers in health system offices, and (iii) the toll-free number. The program coordinator at this health system described at length the sheer volume of calls, need for logistical support for calls, and the fact that the system had a significantly larger geographic area. In addition, concern was also raised about the resources invested in marketing, given that it raises expectations, but screening slots remain limited.
- A third health system used (i) the toll-free number, and (ii) word-of-mouth through their existing program, which served a feeder, but was found to be insufficient. The program coordinator at this health system cited networking as the bulk of their advertising, but also noted the unavailability of flyers/brochures/promotional materials to share during such encounters.

- A fourth health system cited (i) newspapers, and (ii) radio. The program coordinator at this health system voiced concerns about having a wide press release for a program that was not immediately expandable.

Key informants were also asked whether the program was designed to be easily incorporated into existing service delivery systems at the participating health systems. Health systems had varying responses to this question, which are described below:

- One health system reported that the program was easily incorporated, citing less-complicated changes to their billing system and existing working relationships as strengths, along with the fact that non-network providers had not been participating yet, thereby reducing the possibility for issues. In addition, the data collection and monitoring system was described as fairly intuitive and efficient since it complemented existing data systems.
- Another health system reported that the program was easily incorporated from a provider perspective, but not from a payer perspective, with the provider contracts being a new piece. In addition, the data collection and monitoring system was described as user-friendly.
- A third health system reported strengths as a central physical location for all screening services, and one billing system for easy navigation, but also noted that some degree of manual manipulation from the billing department was still required.
- A fourth health system described the complexities of their billing system, and existing automated database used for intake and eligibility, which did not allow for easy assimilation into MCRCCP system. This health system also invested resources to develop billing and call volume spreadsheets.

Key informants were also asked whether the grant program adapted to fit local service delivery structures at the participating health systems. One key informant noted that they had not asked the program to adapt, while another key informant stated that there was limited flexibility in the beginning period with regards to equitable division of the 60 slots per health systems; however, some flexibility was reported with regards to program coordinators attending a conference in Bethesda, MD and the provision of some discretionary funds to the health systems.

Key informants were also asked about facilitators and/or successes in the start-up phase of the program, from their partner/stakeholder perspective. Facilitators and/or successes cited included:

- Good amount of awareness on the issue of colorectal cancer screening in under- and un-insured groups in Maine through needs assessments and the work of local HMPs;
- Great amount of buy-in, cooperation, flexibility, and support within health systems, as well as culture of providing care to under-served – one key informant stated, *"For our health system, cancer is seen as a major health issue… this program is aligned with our priorities"*;
- Core team from Maine CDC and MCD who have pushed things along;
- Opportunity for program coordinators to attend and interact with each other at the conference in Bethesda, MD and continue communication on a routine basis during program implementation;
- Established relationships and materials developed for colorectal cancer outreach, such as worksite and provider packets; and

- Providers interested in reducing financial barrier for patients, costs of which can vary from $700 - $5000, through these free screenings.

Key informants were also asked about challenges encountered in the start-up phase of the program, from their partner/stakeholder perspective. Challenges cited included:

- Multiple layers of bureaucracy (Health Systems→MCD→Maine CDC→CDC) causing delays and impacting work on the ground – one key informant stated, *"Supposed to start Oct. 1, some delay has caused some providers thought we were withholding information (because they knew about this since July 2009); providers having to want to begin screening as per March 1 – they have no idea that it is a federal-level issue. Other providers wanting to start asap – do not understand completely. Trying to convey that we are first doing a pilot to work out kinks before rolling out"*;
- Grant application process did not provide sufficient time and information to make informed decisions and to process the big picture;
- Trying to convey to providers and other interested parties that there are limited slots per health system for the remainder of Year 1, in response to numerous requests following the press release – one key informant stated, *"We can't screen everyone. We would love to, but we can't. It's been frustrating"*;
- Need for weekly e-mail updates on the numbers being reached by and across all health systems since there does not appear to be a global awareness of the volume of calls coming in and a plan if and when targets are exceeded;
- Trying to effectively communicate that ultimately the program targets are for the entire state, not just individual health systems – one key informant stated, *"It's easier to point out what is not going well, but … good thing… people are calling and actually want to be screened. But as a new program and new coordinator, need to show that perception among providers/partners/patients/communities is positive and the start is good"*;
- Planning routine, in-person meetings with all program coordinators to discuss progress and work out operational issues, given that the program set-up is different at each health system;
- Limited value of conference calls that involve many participants serving in different roles and varied agenda items;
- Restricted participation in the Medical Advisory Board meetings or conference calls, without any debriefings or meeting minutes shared with program coordinators working on the ground – one key informant stated, *"No regular meetings (between program coordinator and MAB physician representative) and not in constant communication with him. It is more reasonable to hear directly from MAB via minutes or through participation in calls"*; and lastly,
- Initially unaware that some local Healthy Maine Partnerships had previously received grants for colorectal cancer awareness, and this lack of communication was a challenge in ensuring collaboration.

Key informants were also asked about "lessons learned" as part of the infrastructure-building process, and any successes that can be built upon moving forward and/or challenges that need to be addressed moving forward. Specific lessons learned were:

- The payer piece for health systems was significant, especially around provider contracts for patients whose primary care provider was not in a health system's network. Several health systems noted that it would have been simpler and less time-consuming to have one payer for the entire state, and one contract with any primary care provider;

- Need to have appropriate press releases and awareness, given that health systems were not sure how to serve all persons already identified and those on waiting lists – as an example, one key informant stated, *"…need to give appearance of smooth operation. Glad it is happening now, rather than later. Trying to convey to patients that this is a new program, so expect bumps along the way… grateful patients tend to be the most forgiving; patients would not have had the procedure otherwise."*;
- Flexibility is critical -- as an example, one key informant cited the program coordinator role, which had evolved in a short period of time from the original job description, *"I knew what I knew, but did not know what else was out there."*;
- Need staff from MCD to serve as facilitators during conference calls in order to manage issues that arise, such as the reoccurring need for some attendees to be brought up to speed;
- Need program coordinator-specific conference calls instead of the larger group calls in order to address specific issues pertaining to the day-to-day work of program coordinators and to be more effective; and lastly,
- Try to anticipate larger issues, and dealing with these issues effectively when they arise.

With regards to things that may need to change in order to improve management and delivery of the grant program, some key informants highlighted (i) the importance of limiting program promotion until the health systems were ready to begin screenings, (ii) political versus intellectual conflicts and implications around absorbing costs of treating uninsured, and (ii) the need for clear and continuous communication between health systems and the state. One key informant stated, *"Is there a different expectation to screen by June 30? Sixty or fewer since it actually started in March, not January… what do we do about the distribution across all health systems… number of patients, capacity, 250÷4 – arbitrary… example, what if [health system] wants to do 100 screenings?"*

Key informants were also asked about the infrastructure available to sustain activities beyond the grant funding period. Key informants from two health systems cited their existing free care programs; however, there were significant limitations with regards to associated costs, including the fact that some free care programs did not cover screenings. Key informants from two health systems cited changes to the current payment system, such as centralized billing, as necessary in order to ensure long-term sustainability. One key informant cited the importance of funding as a critical piece to cover the high costs of surgery since the health system would not want to continue as a payor in the post-grant period, and bear the financial burden.

In conclusion, key informants were asked for any concluding thoughts or comments on the start-up process for the program. Key informants provided comments on specific processes and the value of evaluating these processes in Year 1, as well as the need for clearer communication. Some quotes are included below:

> *"Good project and really worthwhile, given number of people who get diagnosed in the age group…glad Maine got the money."*

> *"A federal program, which is funneled through the state, but work done by communities and hospitals and health systems… we need to see how we can add value, and why it is a good thing overall, instead of only putting focus on financial reimbursement since it is not as compelling for us, and not the central focus when we have internal conversations about this grant."*

**Group 3**
The third group interviewed comprised of two physician members from the Medical Advisory Board (MAB) for the Maine Colorectal Cancer Control Program.

At the beginning of the interview, the key informants in this group were asked to describe the role of the Medical Advisory Board in the start-up phase of the program. Both key informants saw the initial role of the MAB as providing oversight to the program to help define and clarify relevant protocols, procedures, and flow diagrams. Moving forward into program implementation, they saw a likely benefit to the program with the MAB serving an active role as a central review committee to (i) address issues regarding enrollment and screening processes, (ii) oversee the quality of screening data obtained, (iii) ensure that protocol is being followed, and (iv) ensure relatively equal access throughout the state.

In addition, key informants were also asked to describe their role on the Medical Advisory Board for the program. One key informant served in a leadership role on the Board, and another key informant saw their role on the Board as a physician member to facilitate and clarify information on the operational side of the program, as well as to provide scientific evidence behind screening recommendations.

Next, key informants were asked whether the Medical Advisory Board meeting process provided a conducive environment to contribute to discussions and voice opinions. Both key informants agreed that the MAB meeting environment was conducive to discussions, and emphasized pre-existing familiarity among MAB members.

> *"Physicians, whether in-person or on the phone, have no reticence in speaking out. I think they are used to that."*

Key informants were also asked whether serving on the Medical Advisory Board for the program was a good use of their time. Overall, both key informants noted that serving on the MAB was a good use of their time; however both added caveats. One key informant noted that the meeting location in Augusta, and time of day during which meetings were scheduled limited their involvement in-person. Another key informant noted that initially the MAB set-up involved a lot of communication and involvement above and beyond the time allotted, but with additional personnel support available to the Board, it became manageable.

Next, key informants were asked to list facilitators and/or successes in the start-up phase of the program, from their partner/stakeholder perspective. Specific facilitators and/or successes cited were:

- Experience, and skills of members of the MAB, as well as commitment to the issue of colorectal cancer screening for under- and un-insured groups in Maine;
- Funding and guidance provided by CDC, as well as the reverse site visit to Atlanta; and
- Increased personnel capacity for program management.

Key informants were also asked about challenges encountered in the start-up phase of the program, from their partner/stakeholder perspective. Specific challenges cited were:

- Gaps and delays in guidance and receipt of funding from CDC, which subsequently resulted in delays in state-level decision-making;
- Getting all four health systems to participate in the program;
- Recruiting physician representatives from the participating health systems for the MAB;
- Underlying frustration across the MAB and program about populations not covered in Year 1; and lastly,
- Having to operate from multiple programmatic roles and perspectives, in one instance.

Key informants were also asked about "lessons learned" as part of the Medical Advisory Board process, and any successes that could be built upon moving forward and/or challenges that needed to be addressed moving forward. One key informant identified the need for an entity to get the program on its feet, and to identify how the program would work, as integral to the success of the MAB. Another key informant highlighted the need to focus efforts on priority populations in Washington, Aroostook, and also Piscataquis counties moving forward in the program. In addition, the need to secure federal funding for the program was also cited as a challenge to address moving forward since no funding was presently available through the state.

Lastly, key informants were asked for any concluding thoughts or comments on the start-up process for the program. One key informant spoke highly of the state's ability to secure grant funding, and make strides in the right direction over the past several years to be able to coordinate such an effort, given financial and resource constraints of colorectal cancer screening among under- and un-insured groups in the state.

***Key Findings from Partner and Stakeholder Interviews across All Groups***

Across all groups, most key informants described the following as facilitators or successes of the program in Year 1:

- Awareness of the issue of colorectal cancer screening in under- and un-insured groups and responsiveness of partners and stakeholders to working on this issue;
- Securing grant funding for Maine through US CDC;
- Establishing partnerships between Maine CDC, MCD, and participating health systems;
- Wealth of experience of several key partners and stakeholders; and
- Buy-in, commitment, and support within participating health systems.

Across all groups, most key informants described the following as barriers or challenges of the program in Year 1:

- Gaps and delays in guidance from US CDC and multiple layers of bureaucracy that subsequently resulted in delays on the ground;
- Communicating effectively in a statewide program with multiple layers/numerous partners; and
- Inadequate funding per health system to carry a complex screening program.

Across all groups, most key informants described the following as "lessons learned" in Year 1:

- Remembering not to have too ambitious plans and being flexible, given that a snowball effect in terms of delays, is a challenge to work around;
- Having a one-payer system across the state would have simplified processes undertaken by each health system in terms of contracts, billing and reimbursement; and
- Trying to anticipate larger issues, and deal with them effectively when they arise.

**Update Since Completion of the Partner and Stakeholder Interviews**

As part of the evaluation process involving feedback for program improvement, findings and recommendations from these interviews were shared with program staff at Maine CDC as this report was being compiled, and action has been taken by Maine CDC on several items of concern, such as convening program coordinators, increasing funds to support infrastructure within each health system, increasing distribution of MAB minutes to program coordinators, and integration of HMP community awareness mini-grants with the MCRCCP through the Public Education and Outreach Advisory Group (meets quarterly).

In addition to the process evaluation component described in this report, clinical outcome data were also collected since screenings were implemented. Table 16 provides a summary of findings for select clinical and service quality indicators, related to the screening population, timeliness and completeness of clinical follow-up, for the period starting March 1, 2010 and ending June 30, 2010:

**Table 16:** *Clinical and Service Quality Data for Year 1 Implementation of the Maine Colorectal Cancer Control Program.*

| **Indicator** | **Central Maine Health System** | **Eastern Maine Health System** | **Maine General Medical Center** | **Maine Health** | **Total** | **CDC Benchmark or Program Target** |
|---|---|---|---|---|---|---|
| Number of calls received to the toll-free number. | 45 | 208 | 83 | 109 | 445 | |
| Number of persons enrolled (as of Jun-29, 2010). | 16 | 75 | 20 | 46 | 157 | |
| Percent of new clients screened who are at average risk for colorectal cancer. | NA | NA | NA | NA | NA | ≥75% |
| Percent of average risk new clients screened who are aged 50 years and older. | NA | NA | NA | NA | NA | ≥95% |
| Number of persons screened with colonoscopy. | 9 | 41 | 7 | 12 | 69 | 250 |
| Number of persons screened with FIT. | 0* | 0* | 0* | 0* | 0* | |
| Number of FIT testing requiring f/u diagnostic colonoscopy. | 0* | 0* | 0* | 0* | 0* | |
| Percent of positive tests (FOBT/FIT) followed up with colonoscopy within 90 days. | 0%* | 0%* | 0%* | 0%* | 0%* | ≥80% |
| Percent of abnormal test results with diagnostic follow-up completed. | NA | NA | NA | NA | NA | ≥90% |
| Number of CRC cases detected overall. | NA | NA | NA | NA | NA | |
| Number of polyps detected and removed. | NA | NA | NA | NA | NA | |
| Percent of diagnosed cancers with treatment initiated. | NA | NA | NA | NA | NA | ≥90% |
| Percent of cancers diagnosed with treatment initiated within 60 days. | NA | NA | NA | NA | NA | ≥80% |

***Data Source:*** Primarily from the CCDE Database; call-related information obtained from program coordinators at each participating health system.

***Notes:***
* =FIT offered, but not utilized in Year 1 of implementation.
NA=Data not available at the time of compilation of this report.

**Recommendations**

As mentioned earlier, findings from these interviews were shared with program staff at Maine CDC, and action has been taken on several items. In addition, recommendations include:

***For future public health program start-ups in Maine:***

- Place careful thought and consideration on the time needed for start-up processes since most of Year 1 may be consumed by start-up, and not program implementation;
- Knowledge of and passion for a certain issue factor into the responsiveness of partners and stakeholders working together;
- Establish meaningful relationships with partners and stakeholders to secure buy-in, commitment, and support;
- Anticipate delays when working on a multi-layered, statewide program, and remember that program flexibility is key;
- Pay attention to and act on administrative barriers such as staff with competing programmatic responsibilities, cumbersome contracting processes, etc.;
- Integrating program infrastructure requirements with pre-existing service delivery systems has its benefits; and lastly,
- As best as possibly, anticipate big-picture issues, and deal with them effectively when they arise.

***For Year 2 and beyond of the Maine Colorectal Cancer Control Program:***

- Strengthen relationships between Maine CDC, MCD, and participating health systems, and continue to meet evolving needs;
- Reduce, as best as possible, the negative impact of delays that result from a multi-layered, statewide program;
- Provide a clear description of program management roles and responsibilities to key partners, and serve as effective facilitators when convening large groups for this multi-layered, statewide program;
- Focus patient recruitment efforts on target populations in Washington and Aroostook counties, as outlined in the grant application;
- Consider the implications of health reform legislation on public health practice as it pertains to the Maine Colorectal Cancer Control Program, and colorectal cancer screenings in Maine, in general; and lastly,
- Continue evaluation efforts to improve understanding of the service delivery model and program implementation through the duration of the Maine Colorectal Cancer Control Program.

**Conclusion**

By the end of Year 1, the Maine Colorectal Cancer Control Program established partnerships with the four major health systems across the state to provide screening, diagnostic, and follow-up services, developed infrastructure components, and commenced the implementation of its screening program. Findings and recommendations from Year 1, along with evolving program needs can have useful application in strategic planning for the program, as it works to achieve its goals, and make strides in reducing financial, geographic, and health access-related barriers to colorectal cancer screening among un- and under-insured groups in Maine.

# Results Part III: Outcomes

Outcome evaluation is an important component of any comprehensive evaluation plan. In the previous two sections of the report, the process evaluations focused on 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 originally 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/. In addition, the cancer incidence and mortality findings can be accessed through the Maine Cancer Registry website http://www.maine.gov/dhhs/bohdcfh/mcr/.

## 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 the American Lung Association tracks others. Outcome data for this report is 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. 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 Behavioral Risk Factor Surveillance System (BRFSS) or Maine Youth Risk Behavior Survey (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.

## Intermediate Outcomes: Prevention

This section provides prevention data for select cancers. Relevant goals from the Maine Cancer Plan are listed before each table. Table 17 provides data for tobacco use among you and adults in Maine.

**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 17:** *Intermediate Outcomes: Tobacco Use in Youth and Adults in Maine.*

| Measurable Objectives | 2001-2005 Cancer Plan[1] | | 2006-2010 Cancer Plan | | | | |
|---|---|---|---|---|---|---|---|
| | 2002 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
| Reduce proportion of Maine adults aged 18 and older who use tobacco products to 18% by 2010.[2] | 23.6% | 20.8% | 20.9% | 20.2% | 18.2% | 17.2% | NA |
| Reduce cigarette smoking among pregnant and postpartum women to 15% by 2010.[3]<br>o Pregnant women who smoked during last 3 months of pregnancy. | 15.9% | 17.5% | 17.1% | 19.9% | 19.5% | ^ | ^ |
| o Postpartum women who smoked after pregnancy. | 21.6% | 23.4% | 20.9% | 23.5% | 25.3% | ^ | ^ |
| Reduce tobacco use of 9-12th graders to 15% by 2010.[4] | -- | 16.2% | -- | 14.0% | -- | 18.1% | -- |
| Reduce tobacco use of 6 -8th graders to 5.5% by 2010. | -- | 7.5% | -- | 5.5% | -- | NA | -- |
| To increase the proportion of current adult smokers who receive advice to quit smoking from a health care professional by 2010. | 78.1%[5] | -- | NA | 64.3%[7] | 58.8%[7] | NA | NA |
| Reduce involuntary exposure to secondhand smoke for all Maine residents[6]<br>o Proportion of Maine adults who reported no hours of exposure in a typical week to secondhand smoke at their workplace. | -- | NA | NA | 80.7%[7] | 81.3%[7] | NA | NA |
| o Proportion of Maine adults who reported their workplace policy did not allow smoking in any indoor public or common areas. | 87.5%[5] | NA | NA | 86.7%[7] | 84.6%[7] | NA | NA |
| o Proportion of Maine adults who reported they did not allow smoking anywhere in their homes. | 63.3%[5] | NA | NA | 79.8%[7] | 83.0%[7] | NA | 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] Maine BRFSS findings accessed online through the Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. http://www.cdc.gov/brfss/index.htm

[3] Maine PRAMS findings accessed online through the Maine Center for Disease Control and Prevention. *Maine Pregnancy Risk Assessment Systems (PRAMS).* Maine Department of Health and Human Services, Office of Data, Research, and Vital Statistics. http://www.maine.gov/dhhs/boh/phs/odrvs/prams/index.shtml

[4] Maine Youth Risk Behavior Survey findings accessed online through the Centers for Disease Control and Prevention (CDC). *Youth Risk Behavior Surveillance System Data.* Atlanta, Georgia: U.S. Department of Health and Human Services. http://www.cdc.gov/HealthyYouth/yrbs/index.htm

[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 2007and 2008 data not comparable to previous years from Maine Tobacco survey.

-- = Survey only administered in odd years.

^ = Weighted data not received from CDC; should be available in Fall 2010 and Fall 2011, respectively.

NA= Data not available at the time of compilation of this report.

The tobacco use results suggest that the rate of current adult smokers has declined since 2002. Youth smoking rates have generally 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 14.0% in 2007, however, the rate reported in 2009 was 18.1%. 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. Finally, the data suggest that since 2000 progress has been made in terms of exposure to secondhand smoke, with 83.0% of adults banning smoking in their homes in 2008, up from 63.0% 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 for 2009-2010 may help elucidate further changes in tobacco-related behavior.

Table 18 provides prevention-related findings for physical activity, nutrition, and overweight/obesity among adults in Maine. The relevant goal is listed below:

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

**Table 18:** *Intermediate Outcomes in Physical Activity and Nutrition, Overweight/Obesity for Adults in Maine.*

| Measurable Objectives | 2001-2005 Cancer Plan[1] | | 2006-2010 Cancer Plan | | | | |
|---|---|---|---|---|---|---|---|
| | 2002 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
| Increase to 30% the proportion of adults who consume five or more servings of fruits and vegetables per day by 2010. | 29.4% | 28.7% | -- | 28.6% | -- | 27.9% | -- |
| Reduce the proportion of adults that are overweight to 35% by 2010 | 38.0% | 36.9% | 36.6% | 37.7% | 36.0% | 37.7% | NA |
| Reduce the proportion of adults that are obese to 20% by 2010. | 20.7% | 22.7% | 23.1% | 25.2% | 25.9% | 26.4% | NA |
| Increase to 80% the proportion of adults who participate in any physical activities in the past month. | 74.2% | 77.7% | 79.1% | 79.7% | 77.2% | 78.8% | NA |
| 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. | -- | 54.1% | -- | 56.0% | -- | 56.2% | -- |

***Data Source:*** Maine BRFSS data accessed online through the Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. http://www.cdc.gov/brfss/index.htm

***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.

-- = Data only collected in odd years.

NA= Data not available at the time of compilation of this report.

According to the 2009 BRFSS, while Maine's rates of overweight and obese adults (64.1%) are comparable to national rates (63.1%), Maine has the highest adult obesity rate in New England. While the data suggest the rate of Maine adults who are overweight has remained fairly stable, the rate of obesity for those 18 and older has increased slightly since 2002.

Table 19 provides prevention-related findings for physical activity, nutrition, and overweight/obesity among youth in Maine. The relevant goal is listed below:

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

**Table 19:** *Intermediate Outcomes in Physical Activity and Nutrition, Overweight/Obesity for Youth in Maine.*

| Measurable Objectives | 2001-2005 Cancer Plan[1] | | 2006-2010 Cancer Plan | | | | |
|---|---|---|---|---|---|---|---|
| | 2002 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
| Increase to 35% the proportion of youth (high school students) who consume five or more servings of fruits and vegetables per day by 2010. | -- | 18.9% | -- | 20.4% | -- | NA | -- |
| Reduce the proportion of high school students who are overweight[2] to 5% by 2010. | -- | 10.9% | -- | 12.8% | -- | 12.5% | -- |
| Reduce the proportion of high school students who are at risk[3] for being overweight to 10% by 2010. | -- | 14.4% | -- | 13.1% | -- | 15.1% | -- |
| Increase to 80% the proportion of high school students who engage in vigorous physical activity three or more days per week for 20 minutes or more each time by 2010. | -- | 62.3% | -- | 59.7% | -- | NA | -- |
| Increase to 80% the proportion of middle school students who engage in vigorous physical activity three or more days per week for 20 minutes or more each time by 2010. | -- | 74.7% | -- | 72.7% | -- | NA | -- |

***Data Source:*** Maine Youth Risk Behavior Survey findings accessed online through the Centers for Disease Control and Prevention (CDC). *Youth Risk Behavior Surveillance System Data.* Atlanta, Georgia: U.S. Department of Health and Human Services. http://www.cdc.gov/HealthyYouth/yrbs/index.htm . In addition, some findings from the 2007 Maine YRBS report were accessed through the Maine Department of Education website.

***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/Obese: students who, using self-reported height and weight, were >= 95th percentile for body mass index, by age and sex, based on reference data.

[3] At risk for being overweight: students who were >= 85th percentile but < 95th percentile for body mass index, by age and sex, based on reference data.

-- = Data only collected in odd years.

NA= Data not available at the time of compilation of this report.

Table 20 provides prevention-related findings for skin cancer in Maine. The relevant goal is listed below:

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

**Table 20:** *Intermediate Outcomes: Sun Safety Practices Among Youth in Maine.*

| Measurable Objectives | 2001-2005 Cancer Plan[1] | | 2005-2010 Cancer Plan | | | | |
|---|---|---|---|---|---|---|---|
| **Sun Safety** | **2002** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** |
| 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% | -- | 14.1% | -- | NA | -- |

***Data Source:*** Maine Youth Risk Behavior Survey – accessed online through Maine Department of Education. Data for this question were not available on the CDC YRBS website by State.

***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.
-- = Data only collected in odd years, starting 2005.
* = Baseline data as reported in the Maine Cancer Plan.
NA= Data not available at the time of compilation of this report.

Table 19 provides prevention-related findings for cervical cancer among youth in Maine. The relevant goal is listed below:

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

**Table 21:** *Intermediate Outcomes: Sexual Health Behaviors of Youth in Maine.*

| Measurable Objectives | 2001-2005 Cancer Plan[1] | | 2006-2010 Cancer Plan | | | | |
|---|---|---|---|---|---|---|---|
| **Sexual Health Behaviors** | **2002** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** |
| Increase abstinence to 60% among sexually active 9-12th graders by 2010. (Q: Had sexual intercourse with at least one person in the three months before the survey? 100-% reporting "Yes") | -- | 66.5% | -- | 66.6% | -- | 64.7% | -- |
| Increase condom use at last intercourse to 63% among sexually active 9-12th graders by 2010. | -- | 58.6% | -- | 58.9% | -- | 60.5% | -- |

***Data Source:*** Maine Youth Risk Behavior Survey findings accessed online through the Centers for Disease Control and Prevention (CDC). *Youth Risk Behavior Surveillance System Data.* Atlanta, Georgia: U.S. Department of Health and Human Services. http://www.cdc.gov/HealthyYouth/yrbs/index.htm

***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.
-- = Data only collected in odd years since 2001.
NA= Data not available at the time of compilation of this report.

Data on sexual behavior were only available for high school students (Grades 9-12) in Maine through the Maine Youth Behavioral Risk Survey (MYRBS); the Behavioral Risk Factor Surveillance System (BRFSS) does not collect sexual behavior data for Maine adults.[12] Condom use at last intercourse among sexually active high school students remained relatively stable between 2003 and 2009. Abstinence behavior (i.e. high school students reporting no sexual intercourse in the three months preceding the survey) decreased between 2003 and 2009.

## Intermediate Outcomes: Detection

This section provides screening data for select cancers collected through the Maine Behavioral Risk Factor Surveillance System, and presented in Table 22. Relevant goals from the Maine Cancer Plan are listed below:

**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 22:** *Screening Behavior Data for Select Cancers in Maine.*

| **Measurable Objectives** | **2001-2005 Cancer Plan[1]** | | **2006-2010 Cancer Plan** | | | | |
|---|---|---|---|---|---|---|---|
| | **2002** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** |
| **Screening Behavior: Breast Cancer[1]** | | | | | | | |
| 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% | 76.0%[3] | 72.0% | -- | 76.0%[4] | -- | NA |
| *Alternate indicator:* Mammogram only within last 2 years for women 40 and older.[4] | 82.2%[5] | | 81.8%[5] | | 83.3%[5] | -- | NA |
| 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% | 60.1%[3] | 61.5% | -- | 62.5%[4] | -- | NA |
| *Alternate indicator:* Mammogram only within last 2years for women over 50.[4] | 84.7%[5] | | 84.3%[5] | | 85.1%[5] | -- | NA |

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[12] The Maine Cancer Surveillance Report, 2009. Produced by the Maine Cancer Consortium's Data Work Group.

*Table 22 Continued*

| Measurable Objectives | 2001-2005 Cancer Plan[1] | | 2006-2010 Cancer Plan | | | | |
|---|---|---|---|---|---|---|---|
| | 2002 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
| **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% | 95.2%[2] | 97.0% | -- | 95.6% | -- | NA |
| 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% | 87.9%[3] | 89.1%[5] | -- | 86.3%[5] | -- | NA |
| **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%[5] | 61.9% | 64.2%[5] | NA | 72.6%[5] | NA | 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] The data source is University of Southern Maine reports generated from Maine BRFSS data, and collected by Maine Breast and Cervical Health Program.

[3] The data were 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.

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

[5] Maine BRFSS data accessed online through the Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. http://www.cdc.gov/brfss/index.htm

* Baseline data as reported in the Maine Cancer Plan.

NA = Data not available at the time of compilation of this report. Questions pertaining to colorectal cancer screening on the Maine BRFSS were only asked in even years since 2002.

-- = Data from the Women's Health Module of BRFSS only available for even years since 2000.

Breast cancer screening rates through mammography have not changed significantly this decade, and cervical cancer screening rates have also remained stable in the same time period. Screening rates for colorectal cancer have significantly increased, with a 34.8% increase in sigmoidoscopy/colonoscopy screenings between 2002 and 2008; this may reflect the attention, both nationally and at the state-level that colorectal cancer screening has received. 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 Maine Colorectal Cancer Control Program will likely impact the colorectal screening rates statewide in subsequent years.

## Long-Term Outcomes

Cancer is the second leading cause of death in Maine, and represents a substantial burden for Mainers.[13] Although overall cancer mortality is declining due to improvements in prevention, detection and treatment of many types of cancer, Maine continues to have overall cancer incidence and mortality rates higher than the national rates, with the highest annual incidence rate for all cancers combined in the U.S in 2006. Within this context, the MCCCP's long-term outcomes refer to reducing both incidence and mortality for all types of cancer.

Tables 23 and 24 provide cancer incidence and mortality data for those cancers addressed in the Maine Comprehensive Cancer Control Plan. Since 1997, overall cancer incidence and mortality rates have been higher in Maine, compared to the U.S.[11] Overall age-adjusted incidence rates (all sites) have been increasing in Maine over the past decade, to a rate of 515 per 100,000 in 2007.[11] Overall cancer mortality rates have decreased in Maine over the past decade, to a rate of per 100,000 in 2007, with lung, breast, and prostate cancers continuing to be leading causes of cancer-related mortality in Maine.[11] In addition, age-adjusted incidence and mortality rates for cancer sites that are not sex-specific, such as lung and colorectal, tend to be significantly higher in males compared to females.[11]

**Table 23:** *Age-Adjusted Cancer Incidence Rates in Maine by Site and Sex.*

| Objectives | 2002 Baseline | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|
| All sites | 500.8 | 490.7 | 504.5 | 517.7 | 536.1 | 515.0 |
| Male | 589.9 | 571.0 | 587.6 | 593.2 | 620.6 | 598.4 |
| Female | 439.2 | 433.7 | 441.6 | 464.9 | 475.7 | 454.8 |
| Lung & Bronchus | 75.9 | 75.9 | 77.2 | 78.0 | 80.2 | 77.8 |
| Male | 96.0 | 96.2 | 96.7 | 95.1 | 98.3 | 94.7 |
| Female | 60.7 | 60.7 | 63.0 | 65.3 | 67.5 | 65.1 |
| Colon & Rectum | 61.2 | 55.3 | 55.2 | 54.4 | 50.3 | 49.0 |
| Male | 74.3 | 67.3 | 61.6 | 63.1 | 57 | 53.6 |
| Female | 51.8 | 46.4 | 49.0 | 47.0 | 45.2 | 45.2 |
| Melanoma of the Skin | 20.7 | 21.8 | 22.0 | 23.1 | 21.3 | 22.4 |
| Male | 24.1 | 27.6 | 27.0 | 27.3 | 24.9 | 24.6 |
| Female | 18.6 | 17.4 | 18.4 | 20.2 | 18.5 | 21.0 |
| Breast (Female) | 126.3 | 126.3 | 122.1 | 130 | 69.9 | 69.7 |
| Cervix Uteri (Female) | 7.1 | 8.0 | 8.9 | 6.3 | NA | NA |
| Prostate (Male) | 162.2 | 156.7 | 165.4 | 151.1 | NA | NA |
| Oral Cavity & Pharynx | 12.4 | 12.1 | 12.1 | 10.1 | 12.3 | 11.9 |
| Male | 19.5 | 17.7 | 19.6 | 15.4 | 19.8 | 17.4 |
| Female | 6.5 | 7.0 | 5.6 | 5.7 | 5.8 | 7.2 |
| Urinary Bladder | 27.1 | 30.5 | 27.7 | 26.6 | 30.3 | 29.0 |
| Male | 46.7 | 54.7 | 46.5 | 43.7 | 51.3 | 48.5 |
| Female | 12.2 | 12.4 | 13.0 | 14.0 | 14.3 | 14.4 |

***Data Source:*** Maine Incidence: Maine Cancer Registry, 1995-2008 NPCR-CSS Call for Data – as presented in the Maine Annual Cancer Report, published in June 2010.

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[13] The Maine Cancer Surveillance Report, 2009. Produced by the Maine Cancer Consortium's Data Work Group.

***Notes:*** Rates calculated per 100, 000 population, and age-adjusted to the 2000 US Standard Population.
At the time of compilation of this report, the most recent data available were for 2007.

**Table 24:** *Age-Adjusted Cancer Mortality Rates in Maine by Site and Sex.*

| **Objectives** | **2002 Baseline** | **2003** | **2004** | **2005** | **2006** |
|---|---|---|---|---|---|
| All sites | 213.9 | 204.1 | 205.8 | 204.7 | 194.3 |
| Male | 267.9 | 243.8 | 252.0 | 253.7 | 240.7 |
| Female | 177.3 | 178.1 | 173.7 | 171.2 | 162.9 |
| Lung & Bronchus | 63.2 | 62.3 | 61.1 | 60.2 | 61.5 |
| Male | 81.4 | 79.5 | 78.2 | 77.5 | 77.6 |
| Female | 49.8 | 49.9 | 48.9 | 47.6 | 49.9 |
| Colon & Rectum | 21.7 | 19.2 | 17.6 | 17.6 | 17.1 |
| Male | 27.6 | 21.7 | 17.6 | 21.0 | 21.0 |
| Female | 17 | 17.2 | 17.5 | 15.1 | 14.1 |
| Melanoma of the Skin | 3.5 | 2.5 | 2.9 | 2.6 | 3.3 |
| Male | 5.9 | 3.6 | 4.1 | 3.6 | 4.7 |
| Female | 1.7 | 1.7 | 1.8 | 1.9 | 2.3 |
| Breast (Female) | 23.9 | 27.3 | 21.3 | 22.4 | 21.4 |
| Cervix Uteri (Female) | 2.1 | 1.8 | 2.0 | 1.9 | 1.7 |
| Prostate (Male) | 26.4 | 27.6 | 26.9 | 25.9 | 23.9 |
| Oral Cavity & Pharynx | 2.8 | 2.7 | 3.3 | 2.4 | 2.4 |
| Male | 4.2 | 4.0 | 5.0 | 4.3 | 2.9 |
| Female | 1.6 | 1.5 | 1.8 | 0.9 | 2.0 |
| Urinary Bladder | 5.1 | 5.0 | 6.0 | 5.4 | 6.1 |
| Male | 8.4 | 7.4 | 11.7 | 9.9 | 9.5 |
| Female | 2.7 | 3.2 | 3.0 | 2.2 | 3.9 |

***Data Source:*** Maine and U.S. Mortality: National Center for Health Statistics, All COD, Public-Use with State, Total U.S. (1969-2006) – as presented in the Maine Annual Cancer Report, published in June 2010

***Notes:*** Rates calculated per 100, 000 population, and age-adjusted to the 2000 U.S. Standard Population.
At the time of compilation of this report, the most recent data available were for 2006.

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. 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. In addition, the *Maine Annual Cancer Report* on 2007 Cancer Incidence and 2006 Cancer Mortality can be accessed through the Maine Cancer Registry website http://www.maine.gov/dhhs/bohdcfh/mcr/.

# Overall Evaluation Recommendations: MCCCP, MRCCP, Cancer Plan, and Consortium

1. **Utilize the evaluation findings from the 2011-2015 Cancer Plan Development Process and the 2010 Consortium Partnership Assessment to redesign and enhance the Consortium's structure and membership.**
    - Revitalize Consortium membership around the new team centered organizational structure in concert with the Consortium's announcement of the 2011-2015 Cancer Plan goals, objectives and strategies.
    - 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 part to the new plan there may be some key people who will need to be recruited to join the Consortium.

2. **Increase Consortium's Participation in the Enhancement of the Cancer Plan's Activity Monitoring Evaluation process.**
    - Engage Consortium and team members in discussions concerning adapting or redesigning the evaluation of, and data collection process for, the goals, objectives, and strategies identified in the 2011-2015 Cancer Plan.
    - Adapt activity-monitoring tool. Suggestions include:
        - Work with Consortium and team members to develop a database for tracking activities that can be reviewed, adjusted as necessary, and expanded upon annually. Also, consider making available online 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 "Ongoing".
        - Enhance monitoring of the Consortium's team activities through the development of annual work plans for each team. Have members track activities on an ongoing basis.
        - Pilot and/or solicit feedback on any new monitoring tool from a sample of Consortium members before using any tool system wide.

3. **Continue to utilize evaluation results to adapt, enhance and/or expand program initiatives and team activities.**
    - Develop outcome evaluation of select 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 ongoing program initiatives.
    - 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 and third years.
    - 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.

5. **Building on the year one process evaluation for the Maine Colorectal Cancer Control Program, develop a comprehensive evaluation plan to track outcomes and process for the remaining four years of the program.**
    - Share year one evaluation report with stakeholders and confirm what process activities will need to be evaluated in subsequent years.
    - Design evaluation plan for the program’s public awareness campaign.
    - Track clinical outcomes annually for the program.

# Report Appendices List

A. Maine Cancer Consortium Membership
B. Proposed Maine Cancer Consortium Organizational Chart
C. Program Accomplishments from AMT Activities
D. Partnership Assessment Survey
E. Consortium Partnership Key Informant Interview Protocol
F. May Meeting Evaluation Survey Tool
G. Consortium Annual Meeting Evaluation Survey Tool
H. *Sun Blocks* Training Survey
I. *Sun Blocks* Baseline Survey
J. *Sun Blocks* Grantee Evaluation Survey
K. *Sun Blocks* Non-grantee Evaluation Survey
L. Healthy Maine Partnerships Colorectal Cancer Grant Survey
M. MCCCP Logic Model
N. Year One Process Evaluation Guide For Group 1: Program Management
O. Year One Process Evaluation Guide For Group 2: Health Systems
P. Year One Process Evaluation Guide For Group 3: Medical Advisory Board

# Appendix A:

# Maine Cancer Consortium Membership

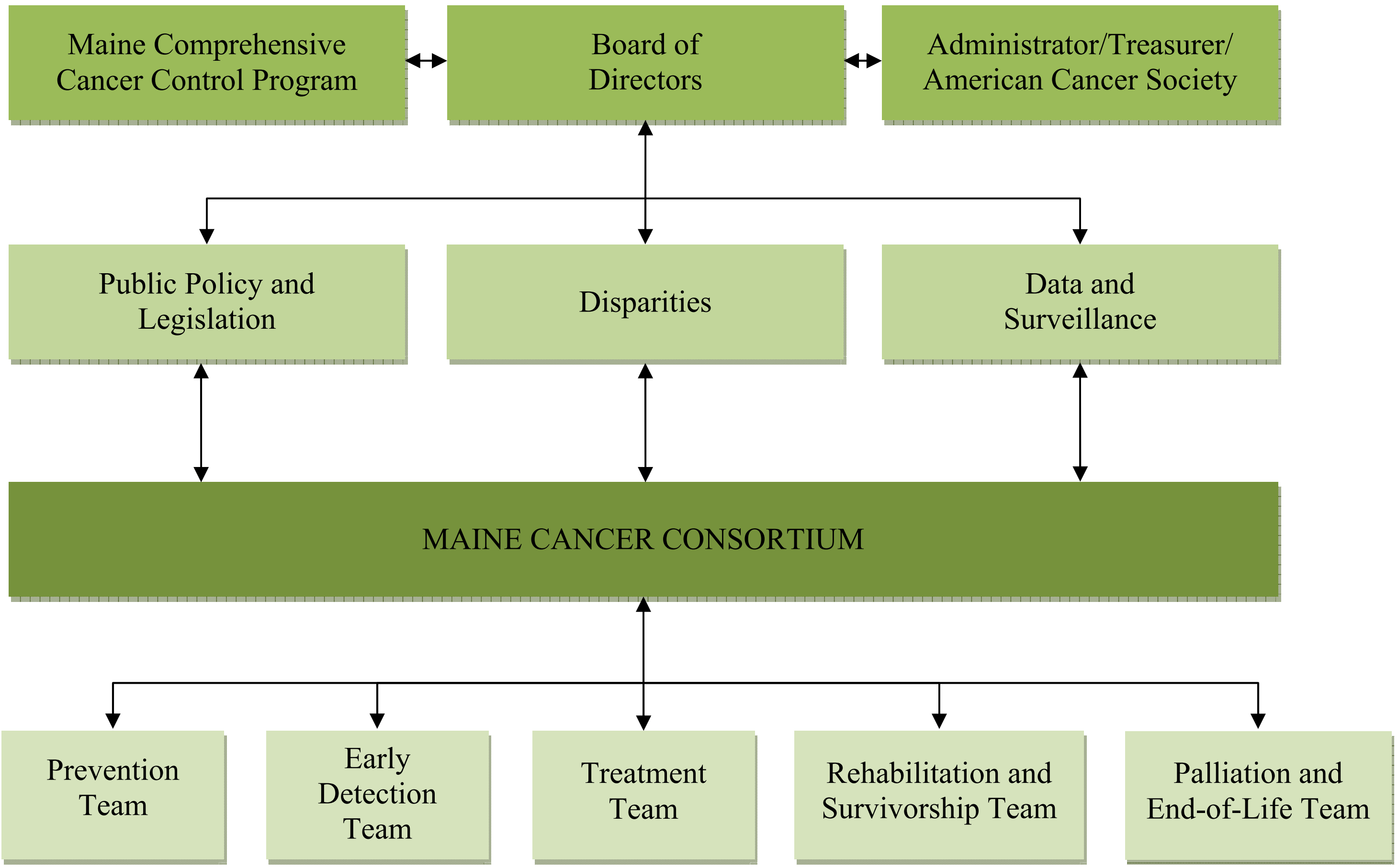
2-1-1 Maine
ACCESS Health
American Cancer Society
Androscoggin Home Care and Hospice
Bennett Breast Care Center
Beth C. Wright Cancer Resource Center
Body Smart program, Molly Ockett Middle School
BRFSS Program
Burgess Advertising
Calais Hospital
Cancer Care Center
Cancer Community Center
CancerCare of Maine
Cape Elizabeth High School
Central Maine Medical Center
Children with Special Health Needs
City of Portland, Public Health Division
CLEAN: Maine
Coalition Against Tobacco, Sanford Schools
Coastal Healthy Communities Coalition
Communities Promoting Health
Community Health Promotion Program
Coordinated Care Services
DHHS, Public Health Nursing
Dermatology Associates
Division of Health Engineering
Eastern Maine Medical Center
Family Planning Association of Maine
Franklin Memorial Hospital
Genetech BioOncology
Goodall Hospital
Harold Alfond Center for Cancer Care
Health Reach Network
Healthy Acadia
Healthy Aroostook
Healthy Living Project
Healthy Maine Partnerships
Healthy Peninsula Project
Healthy Waldo County
JTG Foundation
Kennebec Pharmacy & Home Care
Maine Academy of Family Physicians
Maine Association of Mental Health Services
Maine Breast & Cervical Health Program
Maine Cancer Foundation
Maine Cancer Registry
Maine CDC
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 Hospice Council
Maine Hospital Association
Maine Medical Center
Maine Municipal Association
Maine Primary Care Association
MaineHealth
MaineHealth Learning Resource Center
Mayo Regional Hospital
Melanoma Foundation NE
Mercy Hospital
Mid Coast Hospital
Mid Coast Medical Group
Millinocket Regional Hospital
Muskie School of Public Service
Novartis
Office of Minority Health
Partnership for a Healthy Community
Partnership for a Healthy Penobscot
Partnership for a Tobacco-Free Maine
Patrick Dempsey Center for Cancer Hope and Healing
Penobscot Bay Medical Center
Penquis Health Services
Physical Activity & Nutrition Program
Piscataquis Public Health Council
Pleasant Point Health Center
Portland Gastroenterology Center
Project NOW, MSAD #21, Kelly Middle School
Redington Fairview General Hospital
River Valley Healthy Communities
Ross Care EMHC
S.P.R.I.N.T. for Life
Sheepscot Valley Health Center
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
The Aroostook Medical Center
TLC for Life, Union #74, Nobleboro Central School
Togus VAMC
Town of Fairfield
United Way
University of Maine at Orono
University of ME at Augusta
University of New England
University of Southern Maine
Waldo County General Hospital
Washington County: One Community
Waterville Public Schools
Yarmouth Elementary School
York Hospital

# Appendix B:

# Proposed Maine Cancer Consortium Organizational Chart

# NEW MAINE CANCER CONSOTIUM ORG. CHART

(Effective October 2010)



# Appendix C:

# Program Accomplishments from AMT Activities

## Cancer Consortium Workgroups & Task Forces

## ACTIVITIES and ACCOMPLISHMENTS
## Cumulative 2006-2010

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.
- 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.

## 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.

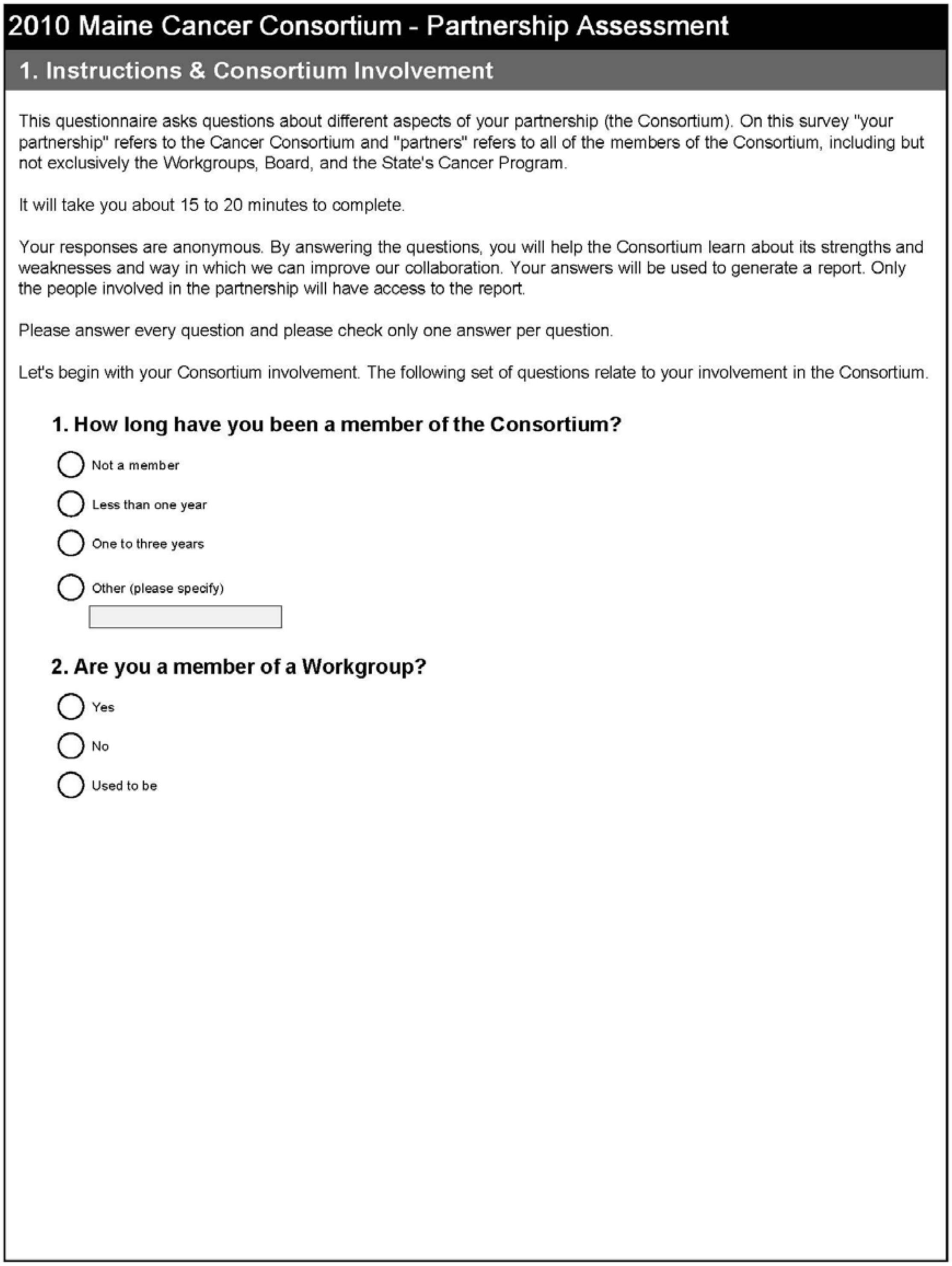
- Worked with ME School Nurse Association on sun safety issues.
- MFNE conducted “Teens & Tanning Forum” at Fenway Park with Maine students
- Office of Minority Health at Me CDC – OMH is taking lead on raising awareness of cancer disparities.
- Working with Maine Native American Tribes to develop a Chronic 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 D:

# Partnership Assessment Survey



# 2010 Maine Cancer Consortium - Partnership Assessment

## 1. Instructions & Consortium Involvement

This questionnaire asks questions about different aspects of your partnership (the Consortium). On this survey "your partnership" refers to the Cancer Consortium and "partners" refers to all of the members of the Consortium, including but not exclusively the Workgroups, Board, and the State's Cancer Program.

It will take you about 15 to 20 minutes to complete.

Your responses are anonymous. By answering the questions, you will help the Consortium learn about its strengths and weaknesses and way in which we can improve our collaboration. Your answers will be used to generate a report. Only the people involved in the partnership will have access to the report.

Please answer every question and please check only one answer per question.

Let's begin with your Consortium involvement. The following set of questions relate to your involvement in the Consortium.

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

○ Not a member

○ Less than one year

○ One to three years

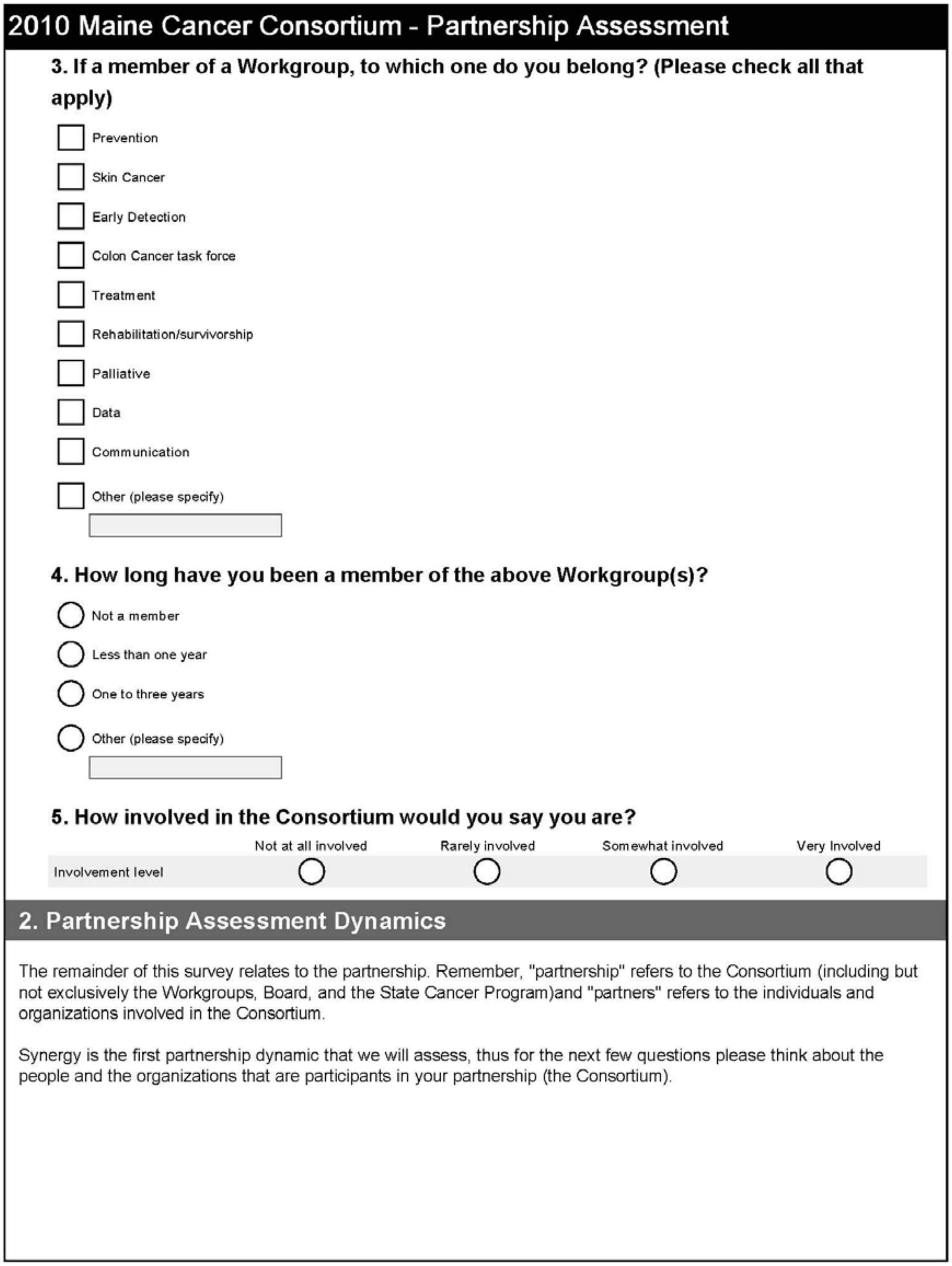
○ Other (please specify)

**2. Are you a member of a Workgroup?**

○ Yes

○ No

○ Used to be



## 2010 Maine Cancer Consortium - Partnership Assessment

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

☐ Prevention
☐ Skin Cancer
☐ Early Detection
☐ Colon Cancer task force
☐ Treatment
☐ Rehabilitation/survivorship
☐ Palliative
☐ Data
☐ Communication
☐ Other (please specify)

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

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

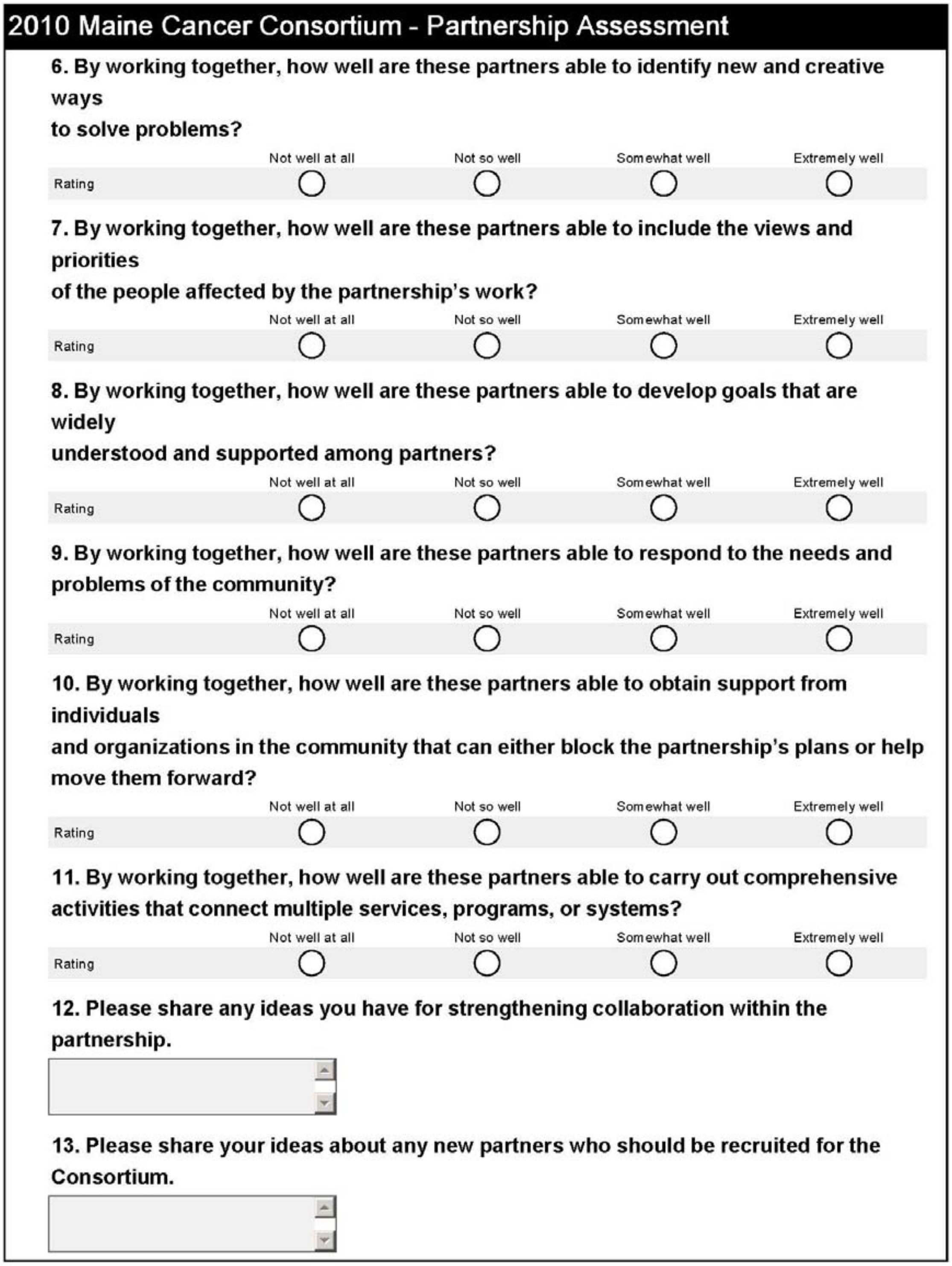
**5. How involved in the Consortium would you say you are?**

| | Not at all involved | Rarely involved | Somewhat involved | Very Involved |
|---|---|---|---|---|
| Involvement level | ○ | ○ | ○ | ○ |

## 2. Partnership Assessment Dynamics

The remainder of this survey relates to the partnership. Remember, "partnership" refers to the Consortium (including but not exclusively the Workgroups, Board, and the State Cancer Program)and "partners" refers to the individuals and organizations involved in the Consortium.

Synergy is the first partnership dynamic that we will assess, thus for the next few questions please think about the people and the organizations that are participants in your partnership (the Consortium).



## 2010 Maine Cancer Consortium - Partnership Assessment

**6. By working together, how well are these partners able to identify new and creative ways to solve problems?**

| | Not well at all | Not so well | Somewhat well | Extremely well |
|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ |

**7. By working together, how well are these partners able to include the views and priorities of the people affected by the partnership's work?**

| | Not well at all | Not so well | Somewhat well | Extremely well |
|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ |

**8. By working together, how well are these partners able to develop goals that are widely understood and supported among partners?**

| | Not well at all | Not so well | Somewhat well | Extremely well |
|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ |

**9. By working together, how well are these partners able to respond to the needs and problems of the community?**

| | Not well at all | Not so well | Somewhat well | Extremely well |
|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ |

**10. By working together, how well are these partners able to obtain support from individuals and organizations in the community that can either block the partnership's plans or help move them forward?**

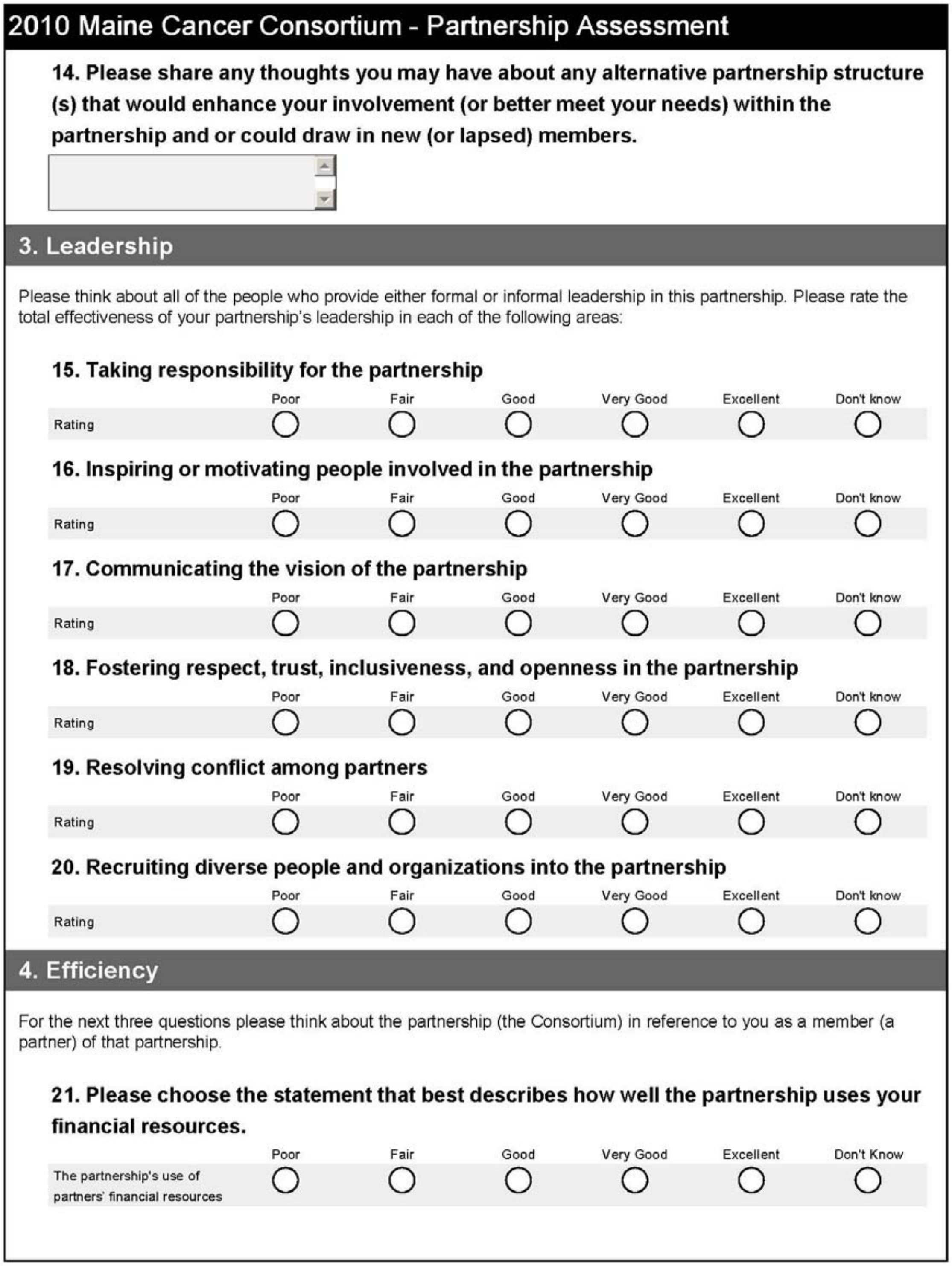
| | Not well at all | Not so well | Somewhat well | Extremely well |
|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ |

**11. By working together, how well are these partners able to carry out comprehensive activities that connect multiple services, programs, or systems?**

| | Not well at all | Not so well | Somewhat well | Extremely well |
|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ |

**12. Please share any ideas you have for strengthening collaboration within the partnership.**

**13. Please share your ideas about any new partners who should be recruited for the Consortium.**



## 2010 Maine Cancer Consortium - Partnership Assessment

**14. Please share any thoughts you may have about any alternative partnership structure (s) that would enhance your involvement (or better meet your needs) within the partnership and or could draw in new (or lapsed) members.**

### 3. Leadership

Please think about all of the people who provide either formal or informal leadership in this partnership. Please rate the total effectiveness of your partnership's leadership in each of the following areas:

**15. Taking responsibility for the partnership**

| | Poor | Fair | Good | Very Good | Excellent | Don't know |
|---|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ | ○ |

**16. Inspiring or motivating people involved in the partnership**

| | Poor | Fair | Good | Very Good | Excellent | Don't know |
|---|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ | ○ |

**17. Communicating the vision of the partnership**

| | Poor | Fair | Good | Very Good | Excellent | Don't know |
|---|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ | ○ |

**18. Fostering respect, trust, inclusiveness, and openness in the partnership**

| | Poor | Fair | Good | Very Good | Excellent | Don't know |
|---|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ | ○ |

**19. Resolving conflict among partners**

| | Poor | Fair | Good | Very Good | Excellent | Don't know |
|---|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ | ○ |

**20. Recruiting diverse people and organizations into the partnership**

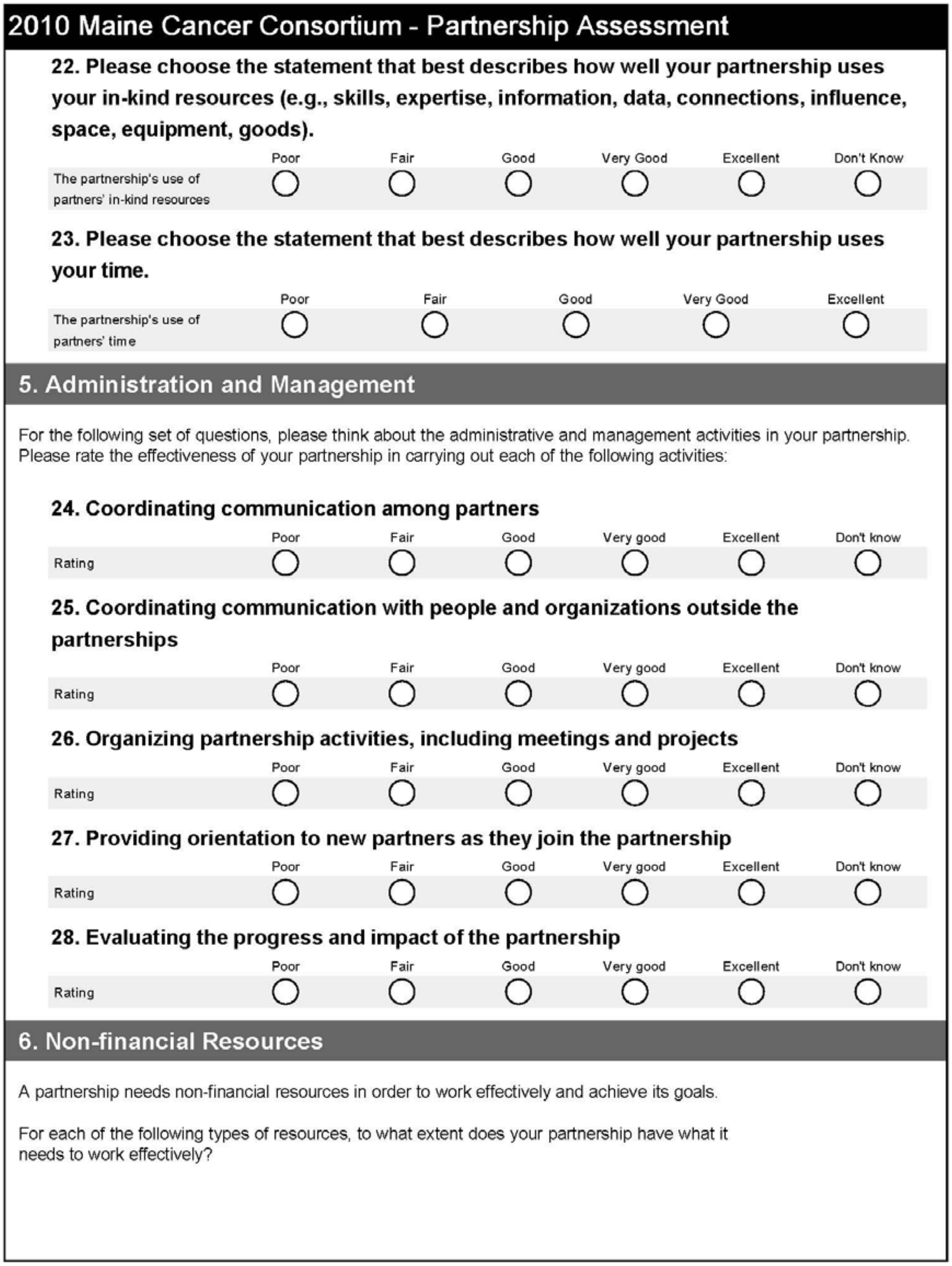
| | Poor | Fair | Good | Very Good | Excellent | Don't know |
|---|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ | ○ |

### 4. Efficiency

For the next three questions please think about the partnership (the Consortium) in reference to you as a member (a partner) of that partnership.

**21. Please choose the statement that best describes how well the partnership uses your financial resources.**

| | Poor | Fair | Good | Very Good | Excellent | Don't Know |
|---|---|---|---|---|---|---|
| The partnership's use of partners' financial resources | ○ | ○ | ○ | ○ | ○ | ○ |



## 2010 Maine Cancer Consortium - Partnership Assessment

**22. Please choose the statement that best describes how well your partnership uses your in-kind resources (e.g., skills, expertise, information, data, connections, influence, space, equipment, goods).**

| | Poor | Fair | Good | Very Good | Excellent | Don't Know |
|---|---|---|---|---|---|---|
| The partnership's use of partners' in-kind resources | ○ | ○ | ○ | ○ | ○ | ○ |

**23. Please choose the statement that best describes how well your partnership uses your time.**

| | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| The partnership's use of partners' time | ○ | ○ | ○ | ○ | ○ |

## 5. Administration and Management

For the following set of questions, please think about the administrative and management activities in your partnership. Please rate the effectiveness of your partnership in carrying out each of the following activities:

**24. Coordinating communication among partners**

| | Poor | Fair | Good | Very good | Excellent | Don't know |
|---|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ | ○ |

**25. Coordinating communication with people and organizations outside the partnerships**

| | Poor | Fair | Good | Very good | Excellent | Don't know |
|---|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ | ○ |

**26. Organizing partnership activities, including meetings and projects**

| | Poor | Fair | Good | Very good | Excellent | Don't know |
|---|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ | ○ |

**27. Providing orientation to new partners as they join the partnership**

| | Poor | Fair | Good | Very good | Excellent | Don't know |
|---|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ | ○ |

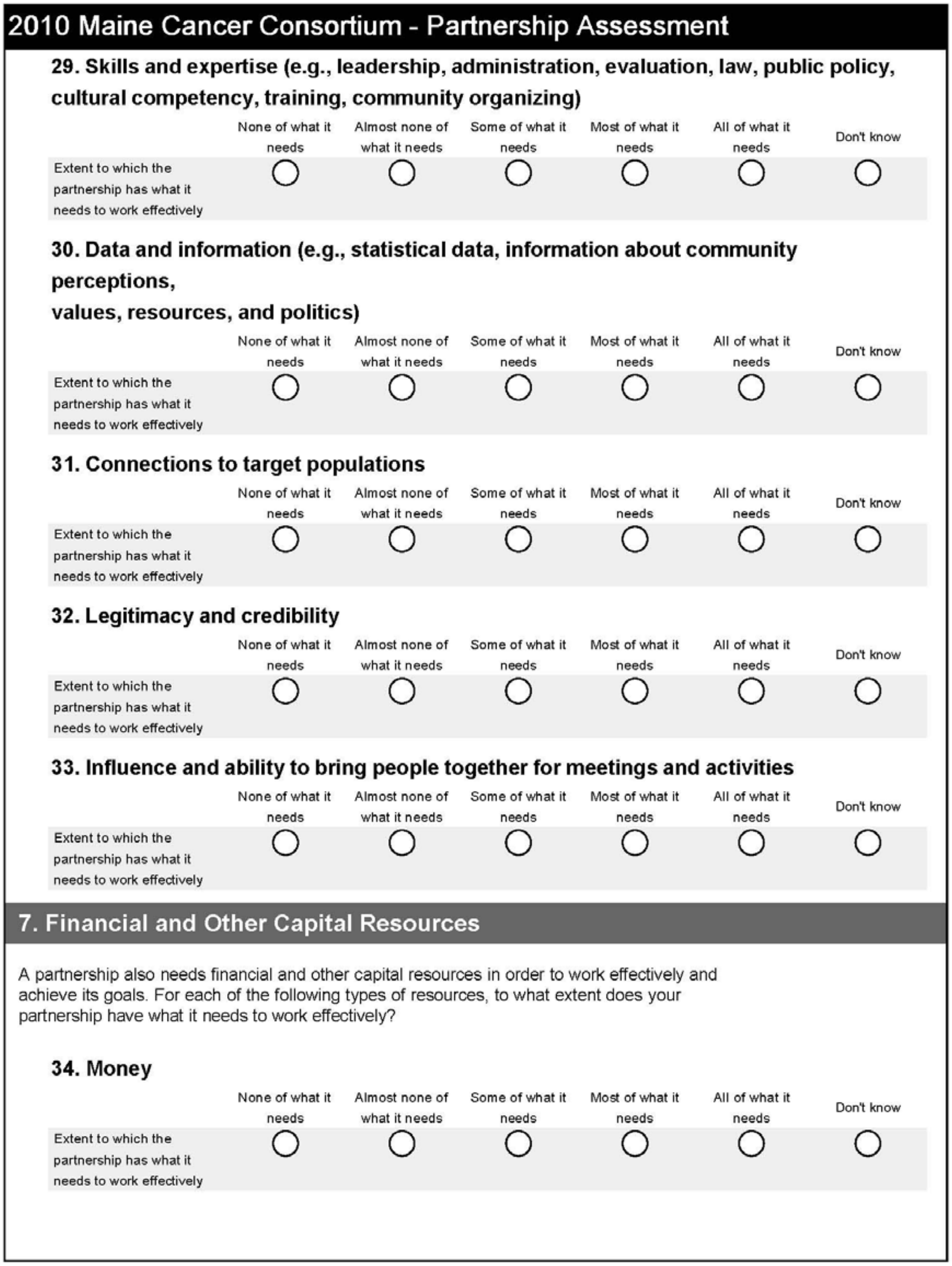
**28. Evaluating the progress and impact of the partnership**

| | Poor | Fair | Good | Very good | Excellent | Don't know |
|---|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ | ○ |

## 6. Non-financial Resources

A partnership needs non-financial resources in order to work effectively and achieve its goals.

For each of the following types of resources, to what extent does your partnership have what it needs to work effectively?



## 2010 Maine Cancer Consortium - Partnership Assessment

**29. Skills and expertise (e.g., leadership, administration, evaluation, law, public policy, cultural competency, training, community organizing)**

| | None of what it needs | Almost none of what it needs | Some of what it needs | Most of what it needs | All of what it needs | Don't know |
|---|---|---|---|---|---|---|
| Extent to which the partnership has what it needs to work effectively | ○ | ○ | ○ | ○ | ○ | ○ |

**30. Data and information (e.g., statistical data, information about community perceptions,**
**values, resources, and politics)**

| | None of what it needs | Almost none of what it needs | Some of what it needs | Most of what it needs | All of what it needs | Don't know |
|---|---|---|---|---|---|---|
| Extent to which the partnership has what it needs to work effectively | ○ | ○ | ○ | ○ | ○ | ○ |

**31. Connections to target populations**

| | None of what it needs | Almost none of what it needs | Some of what it needs | Most of what it needs | All of what it needs | Don't know |
|---|---|---|---|---|---|---|
| Extent to which the partnership has what it needs to work effectively | ○ | ○ | ○ | ○ | ○ | ○ |

**32. Legitimacy and credibility**

| | None of what it needs | Almost none of what it needs | Some of what it needs | Most of what it needs | All of what it needs | Don't know |
|---|---|---|---|---|---|---|
| Extent to which the partnership has what it needs to work effectively | ○ | ○ | ○ | ○ | ○ | ○ |

**33. Influence and ability to bring people together for meetings and activities**

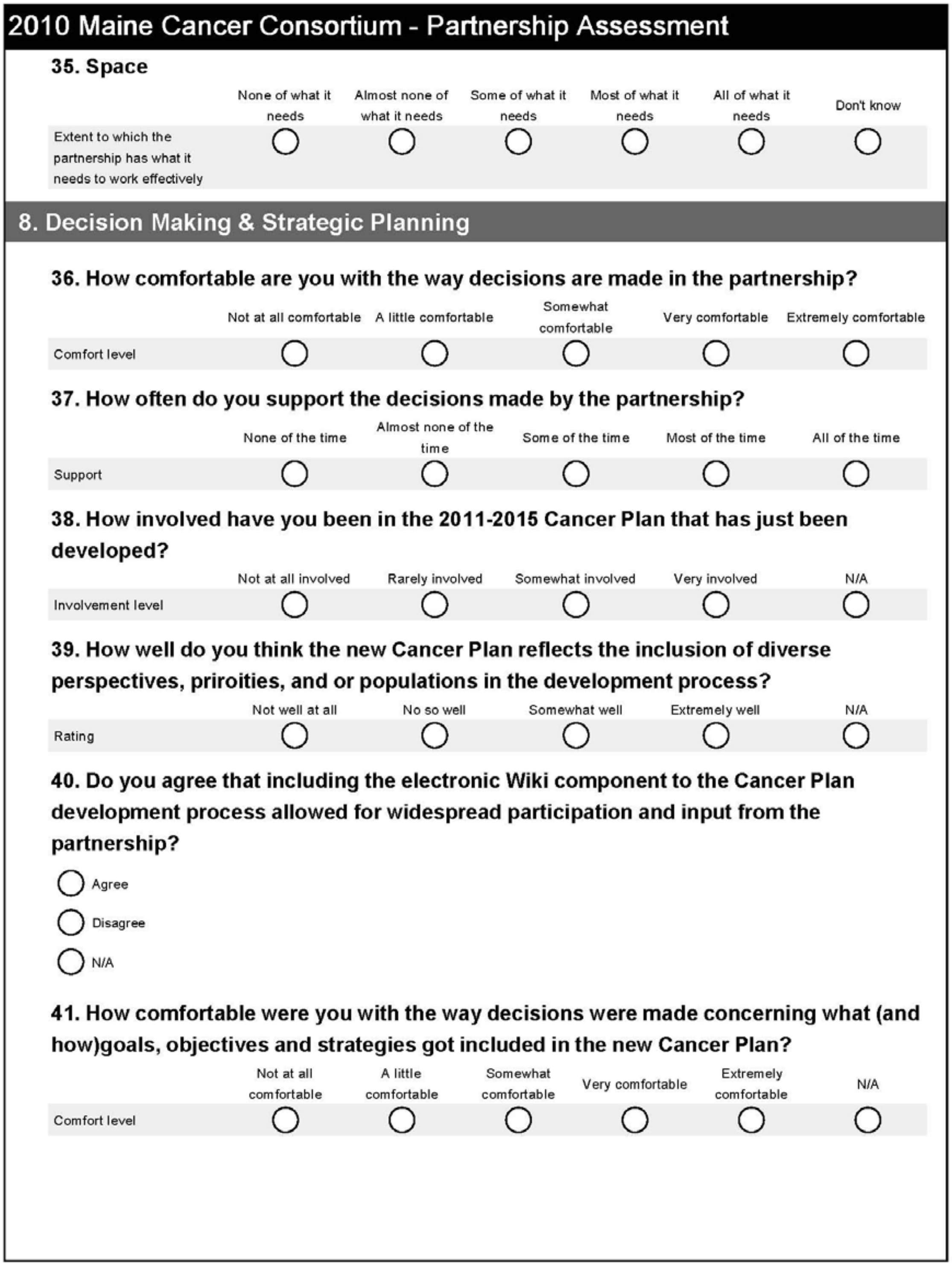
| | None of what it needs | Almost none of what it needs | Some of what it needs | Most of what it needs | All of what it needs | Don't know |
|---|---|---|---|---|---|---|
| Extent to which the partnership has what it needs to work effectively | ○ | ○ | ○ | ○ | ○ | ○ |

### 7. Financial and Other Capital Resources

A partnership also needs financial and other capital resources in order to work effectively and achieve its goals. For each of the following types of resources, to what extent does your partnership have what it needs to work effectively?

**34. Money**

| | None of what it needs | Almost none of what it needs | Some of what it needs | Most of what it needs | All of what it needs | Don't know |
|---|---|---|---|---|---|---|
| Extent to which the partnership has what it needs to work effectively | ○ | ○ | ○ | ○ | ○ | ○ |



## 2010 Maine Cancer Consortium - Partnership Assessment

**35. Space**

| | None of what it needs | Almost none of what it needs | Some of what it needs | Most of what it needs | All of what it needs | Don't know |
|---|---|---|---|---|---|---|
| Extent to which the partnership has what it needs to work effectively | ○ | ○ | ○ | ○ | ○ | ○ |

### 8. Decision Making & Strategic Planning

**36. How comfortable are you with the way decisions are made in the partnership?**

| | Not at all comfortable | A little comfortable | Somewhat comfortable | Very comfortable | Extremely comfortable |
|---|---|---|---|---|---|
| Comfort level | ○ | ○ | ○ | ○ | ○ |

**37. How often do you support the decisions made by the partnership?**

| | None of the time | Almost none of the time | Some of the time | Most of the time | All of the time |
|---|---|---|---|---|---|
| Support | ○ | ○ | ○ | ○ | ○ |

**38. How involved have you been in the 2011-2015 Cancer Plan that has just been developed?**

| | Not at all involved | Rarely involved | Somewhat involved | Very involved | N/A |
|---|---|---|---|---|---|
| Involvement level | ○ | ○ | ○ | ○ | ○ |

**39. How well do you think the new Cancer Plan reflects the inclusion of diverse perspectives, priroities, and or populations in the development process?**

| | Not well at all | No so well | Somewhat well | Extremely well | N/A |
|---|---|---|---|---|---|
| Rating | ○ | ○ | ○ | ○ | ○ |

**40. Do you agree that including the electronic Wiki component to the Cancer Plan development process allowed for widespread participation and input from the partnership?**

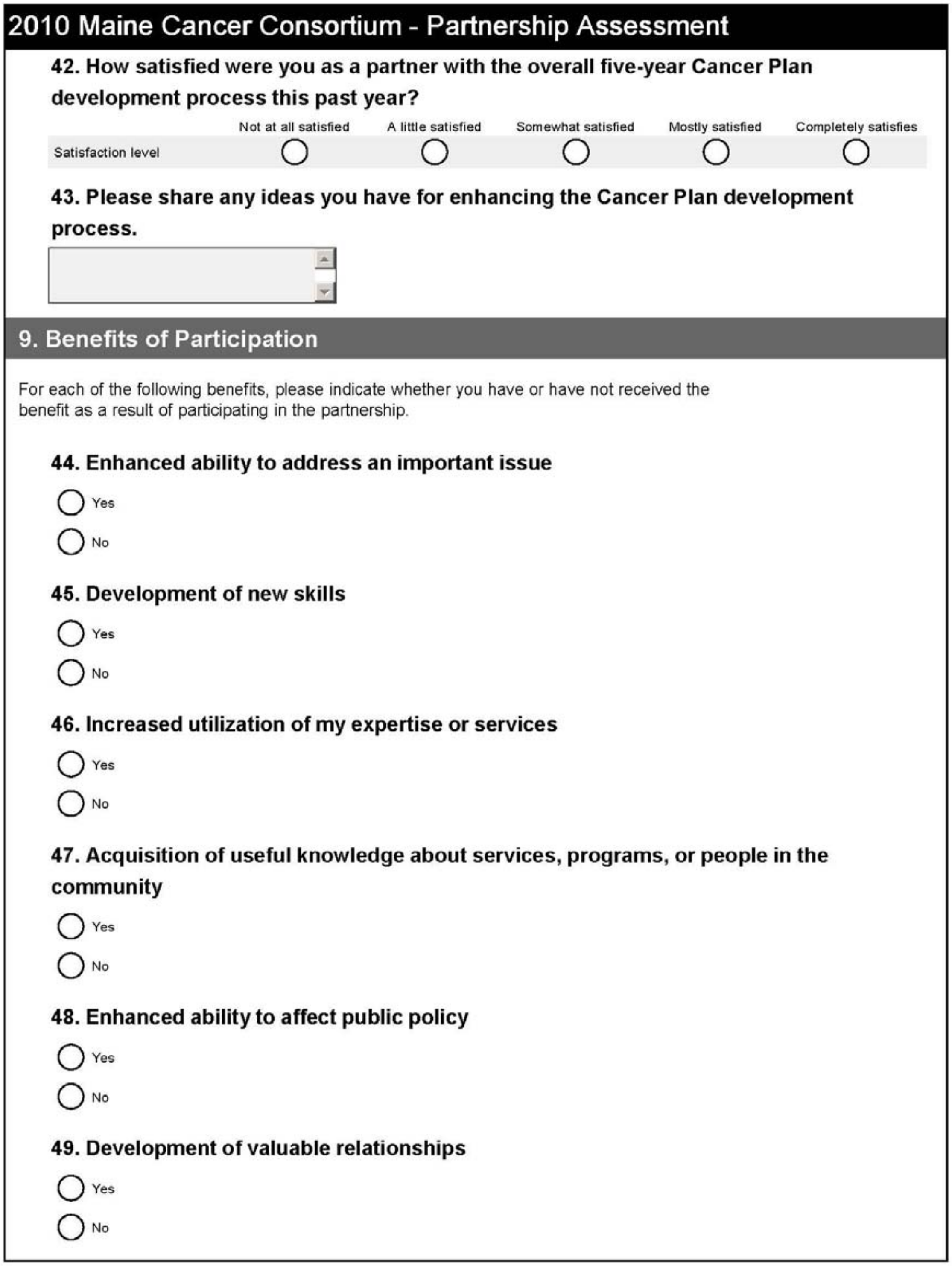
○ Agree

○ Disagree

○ N/A

**41. How comfortable were you with the way decisions were made concerning what (and how)goals, objectives and strategies got included in the new Cancer Plan?**

| | Not at all comfortable | A little comfortable | Somewhat comfortable | Very comfortable | Extremely comfortable | N/A |
|---|---|---|---|---|---|---|
| Comfort level | ○ | ○ | ○ | ○ | ○ | ○ |



## 2010 Maine Cancer Consortium - Partnership Assessment

**42. How satisfied were you as a partner with the overall five-year Cancer Plan development process this past year?**

| | Not at all satisfied | A little satisfied | Somewhat satisfied | Mostly satisfied | Completely satisfies |
|---|---|---|---|---|---|
| Satisfaction level | ○ | ○ | ○ | ○ | ○ |

**43. Please share any ideas you have for enhancing the Cancer Plan development process.**

## 9. Benefits of Participation

For each of the following benefits, please indicate whether you have or have not received the benefit as a result of participating in the partnership.

**44. Enhanced ability to address an important issue**

○ Yes
○ No

**45. Development of new skills**

○ Yes
○ No

**46. Increased utilization of my expertise or services**

○ Yes
○ No

**47. Acquisition of useful knowledge about services, programs, or people in the community**

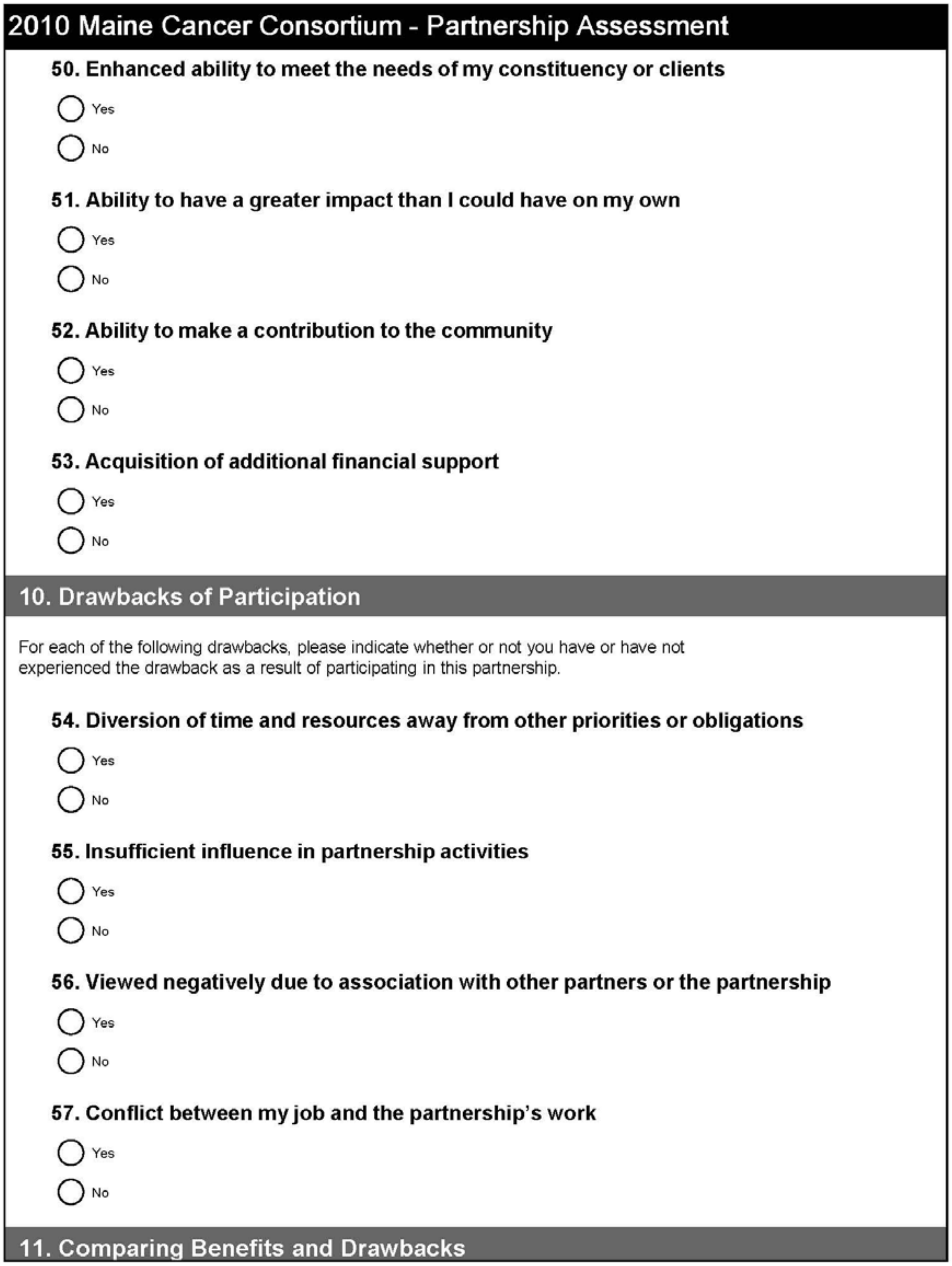
○ Yes
○ No

**48. Enhanced ability to affect public policy**

○ Yes
○ No

**49. Development of valuable relationships**

○ Yes
○ No



## 2010 Maine Cancer Consortium - Partnership Assessment

**50. Enhanced ability to meet the needs of my constituency or clients**

○ Yes
○ No

**51. Ability to have a greater impact than I could have on my own**

○ Yes
○ No

**52. Ability to make a contribution to the community**

○ Yes
○ No

**53. Acquisition of additional financial support**

○ Yes
○ No

### 10. Drawbacks of Participation

For each of the following drawbacks, please indicate whether or not you have or have not experienced the drawback as a result of participating in this partnership.

**54. Diversion of time and resources away from other priorities or obligations**

○ Yes
○ No

**55. Insufficient influence in partnership activities**

○ Yes
○ No

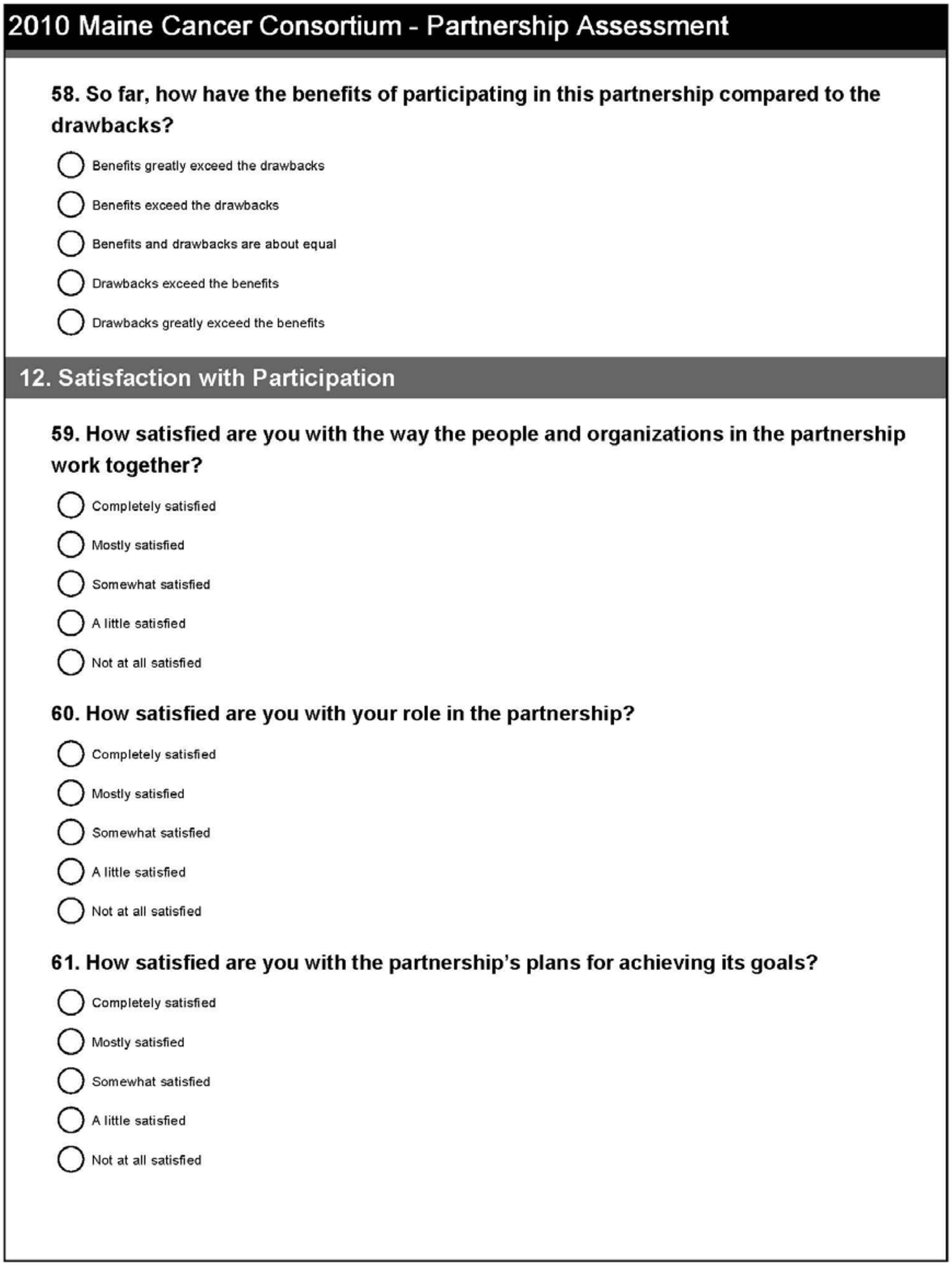
**56. Viewed negatively due to association with other partners or the partnership**

○ Yes
○ No

**57. Conflict between my job and the partnership's work**

○ Yes
○ No

### 11. Comparing Benefits and Drawbacks



## 2010 Maine Cancer Consortium - Partnership Assessment

**58. So far, how have the benefits of participating in this partnership compared to the drawbacks?**

○ Benefits greatly exceed the drawbacks
○ Benefits exceed the drawbacks
○ Benefits and drawbacks are about equal
○ Drawbacks exceed the benefits
○ Drawbacks greatly exceed the benefits

### 12. Satisfaction with Participation

**59. How satisfied are you with the way the people and organizations in the partnership work together?**

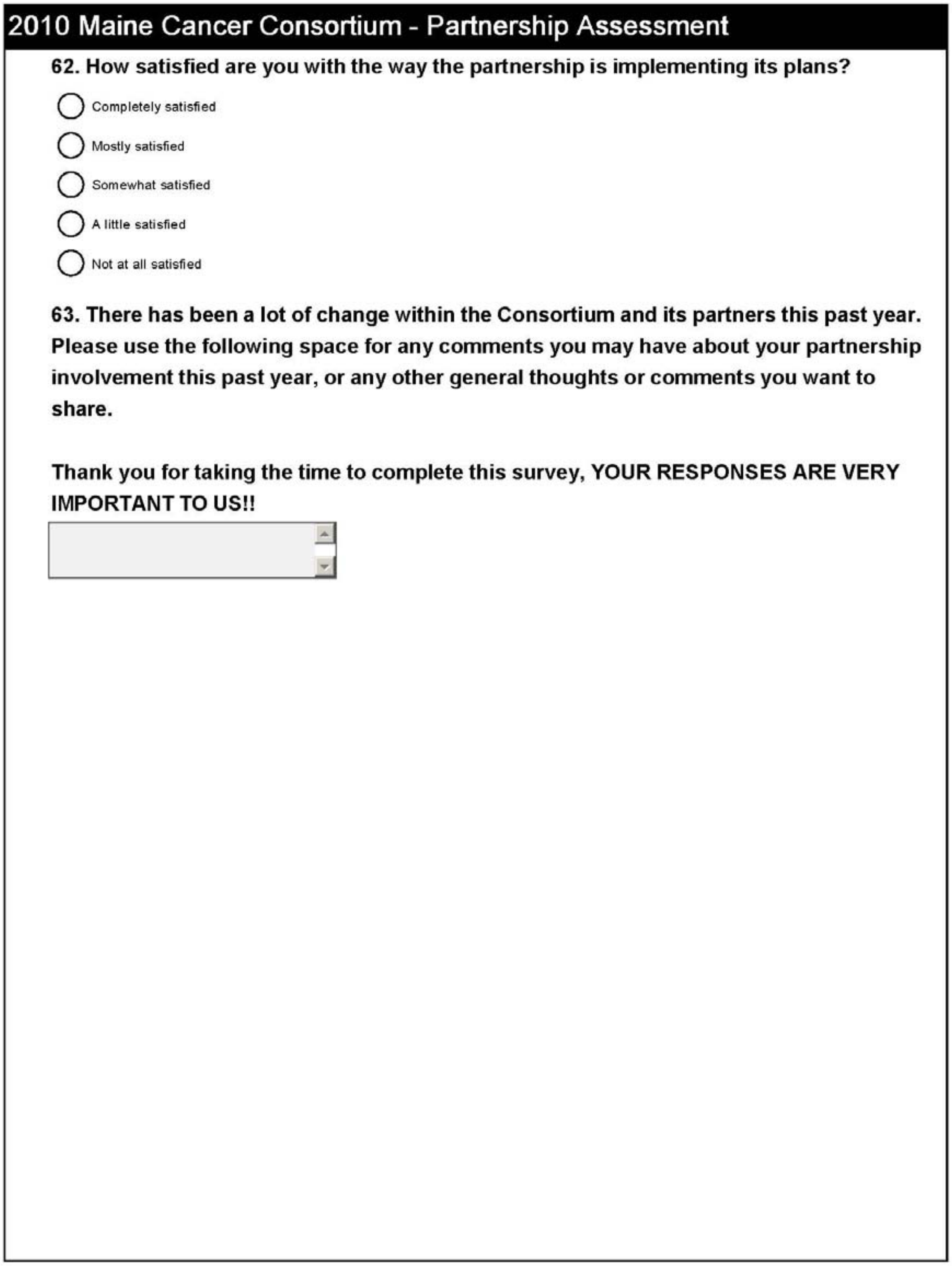
○ Completely satisfied
○ Mostly satisfied
○ Somewhat satisfied
○ A little satisfied
○ Not at all satisfied

**60. How satisfied are you with your role in the partnership?**

○ Completely satisfied
○ Mostly satisfied
○ Somewhat satisfied
○ A little satisfied
○ Not at all satisfied

**61. How satisfied are you with the partnership's plans for achieving its goals?**

○ Completely satisfied
○ Mostly satisfied
○ Somewhat satisfied
○ A little satisfied
○ Not at all satisfied



**2010 Maine Cancer Consortium - Partnership Assessment**

**62. How satisfied are you with the way the partnership is implementing its plans?**

○ Completely satisfied
○ Mostly satisfied
○ Somewhat satisfied
○ A little satisfied
○ Not at all satisfied

**63. There has been a lot of change within the Consortium and its partners this past year. Please use the following space for any comments you may have about your partnership involvement this past year, or any other general thoughts or comments you want to share.**

**Thank you for taking the time to complete this survey, YOUR RESPONSES ARE VERY IMPORTANT TO US!!**

# Appendix E:

# Consortium Partnership Key Informant Interview Protocol

## Maine Cancer Consortium Membership Evaluation
## Protocol & Questions for Key Informant Interviews

**I.** To complement and enhance the bi-annual Maine Cancer Consortium Membership Survey administered electronically in May 2010, six key informant interviews will be conducted with selected members of the Consortium Board and/or Consortium Workgroups.

**II.** RA Spence will conduct the interviews either in person or via phone (only if in-person cannot be negotiated) and will tape them with permission and/or take detailed notes. All data from the interviews will then be analyzed and intersected with the results from the electronic membership survey.

**III. Interview text and questions will include the following:**

The purpose of the partnership survey is to capture the dynamics of the Cancer Consortium collaboration/partnership, specifically the relationship between the Consortium and its individual members. As a partner (member) of the Consortium I'd like to ask a few questions about how you see your role in the Consortium, about the Consortium itself (such as its strengths & weaknesses), and about how you see either the Consortium or your role in it changing in the future.

1. Let's begin with your role in the Consortium, how do you see your role as a Consortium partner, i.e. what is the relationship between your work as a partner and the work of the Consortium?

   Probes: How do you see the work you do as a partner supporting the work you do within the Consortium?

   Does the structure of the Consortium support your role as a partner, or does the Consortium structure impede your work as a partner?

2. How might the structure of the Consortium (and/or its Workgroups) change to better support or enhance the work you do on a daily basis, and the work you do within the Consortium?

   Probes: Is there an alternative Consortium structure that would better meet your participation needs as a partner? And/or that would draw in new or lapsed partners?

   What could improve collaboration at the Consortium level and/or bring in new collaborators (partners)?

3. Is your participation in the Consortium valuable to you as a partner and how does it enhance (or not) your work individually as a partner?

<u>Probe:</u> Benefits of Consortium participation? Drawbacks of Consortium participation?

4. What do you see as the strengths of the Consortium, its Board and its Workgroups? The weaknesses or areas for growth or improvement?

5. Do you have ideas about how to "reenergize" the Consortium so it better supports its members and attracts new members?

6. Can you share with me your thoughts about the Consortium leadership in terms of how it functions (i.e. structure, communications, etc.)?

<u>Probes:</u> Do you feel your partnership voice is heard?

Do conflicts between partners get resolved in a positive way?

What do you see as the strengths and weaknesses of the Consortium leadership structure?

How about the Communications structure and the decision-making structure?

7. The Consortium is just completing the new 5-year Cancer Plan, as an individual member does the plan feel like it is YOUR plan? Does it reflect your partner priorities?

<u>Probes:</u> How do you feel about the process for developing the plan this time?

How involved were you as a partner in developing the plan?

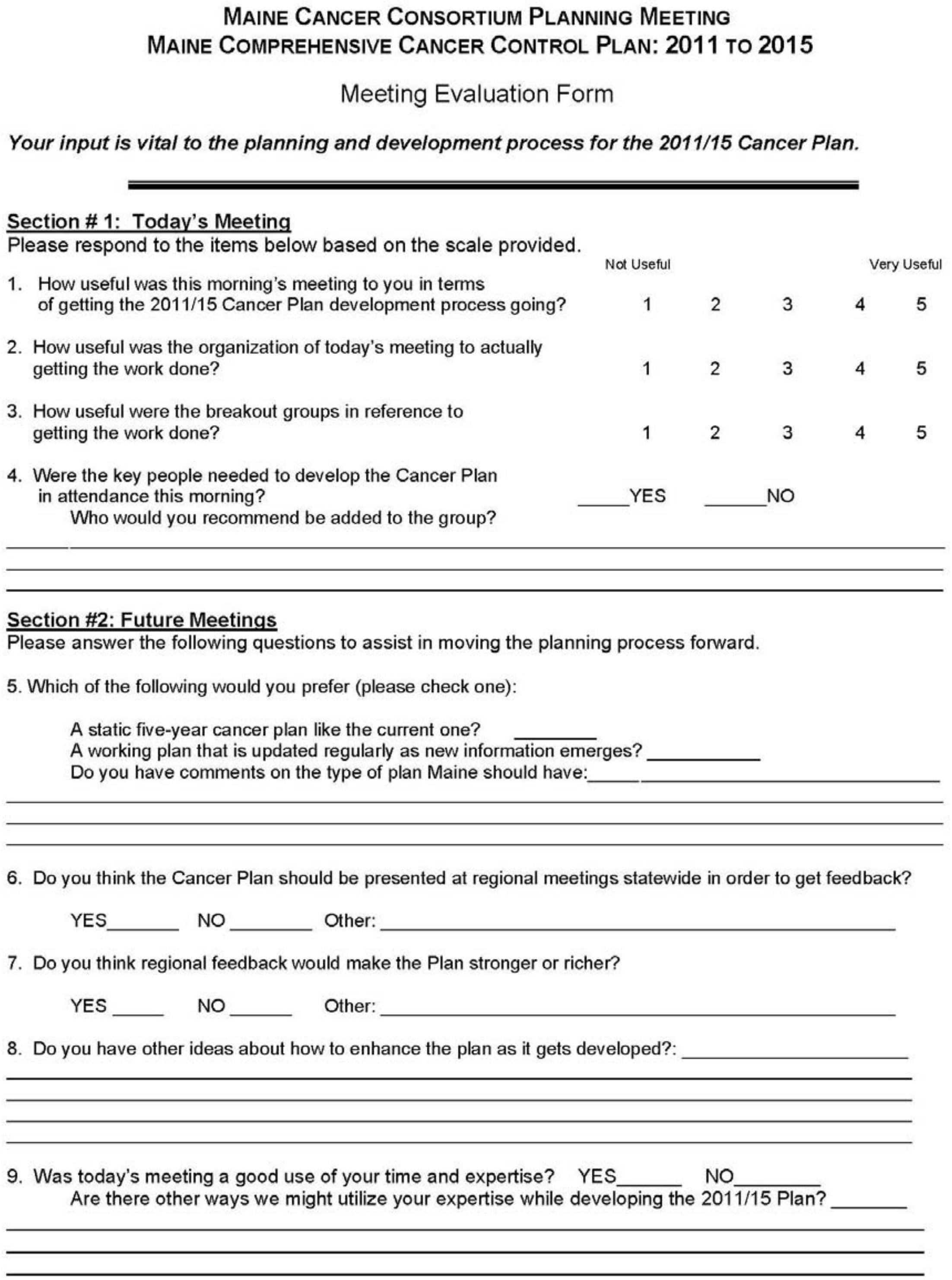
Did you use the Wiki process? If so, how was it useful?

8. How would you describe your overall satisfaction with your experience as a member/partner in the Consortium?

9. Anything else you want to say, or any question you had hoped I would ask but didn't?

# Appendix F:

# Cancer Plan
# May Meeting Evaluation
# Survey Tool



## MAINE CANCER CONSORTIUM PLANNING MEETING
## MAINE COMPREHENSIVE CANCER CONTROL PLAN: 2011 TO 2015

### Meeting Evaluation Form

***Your input is vital to the planning and development process for the 2011/15 Cancer Plan.***

---

**Section # 1: Today's Meeting**

Please respond to the items below based on the scale provided.

| | Not Useful | | | | Very Useful |
|---|---|---|---|---|---|
| 1. How useful was this morning's meeting to you in terms of getting the 2011/15 Cancer Plan development process going? | 1 | 2 | 3 | 4 | 5 |
| 2. How useful was the organization of today's meeting to actually getting the work done? | 1 | 2 | 3 | 4 | 5 |
| 3. How useful were the breakout groups in reference to getting the work done? | 1 | 2 | 3 | 4 | 5 |

4. Were the key people needed to develop the Cancer Plan in attendance this morning? _____YES ______NO

Who would you recommend be added to the group?

**Section #2: Future Meetings**

Please answer the following questions to assist in moving the planning process forward.

5. Which of the following would you prefer (please check one):

A static five-year cancer plan like the current one? ________
A working plan that is updated regularly as new information emerges? ___________
Do you have comments on the type of plan Maine should have:_____ _____________________________

6. Do you think the Cancer Plan should be presented at regional meetings statewide in order to get feedback?

YES_______ NO ________ Other: ____________________________________________

7. Do you think regional feedback would make the Plan stronger or richer?

YES _____ NO ______ Other: ____________________________________________

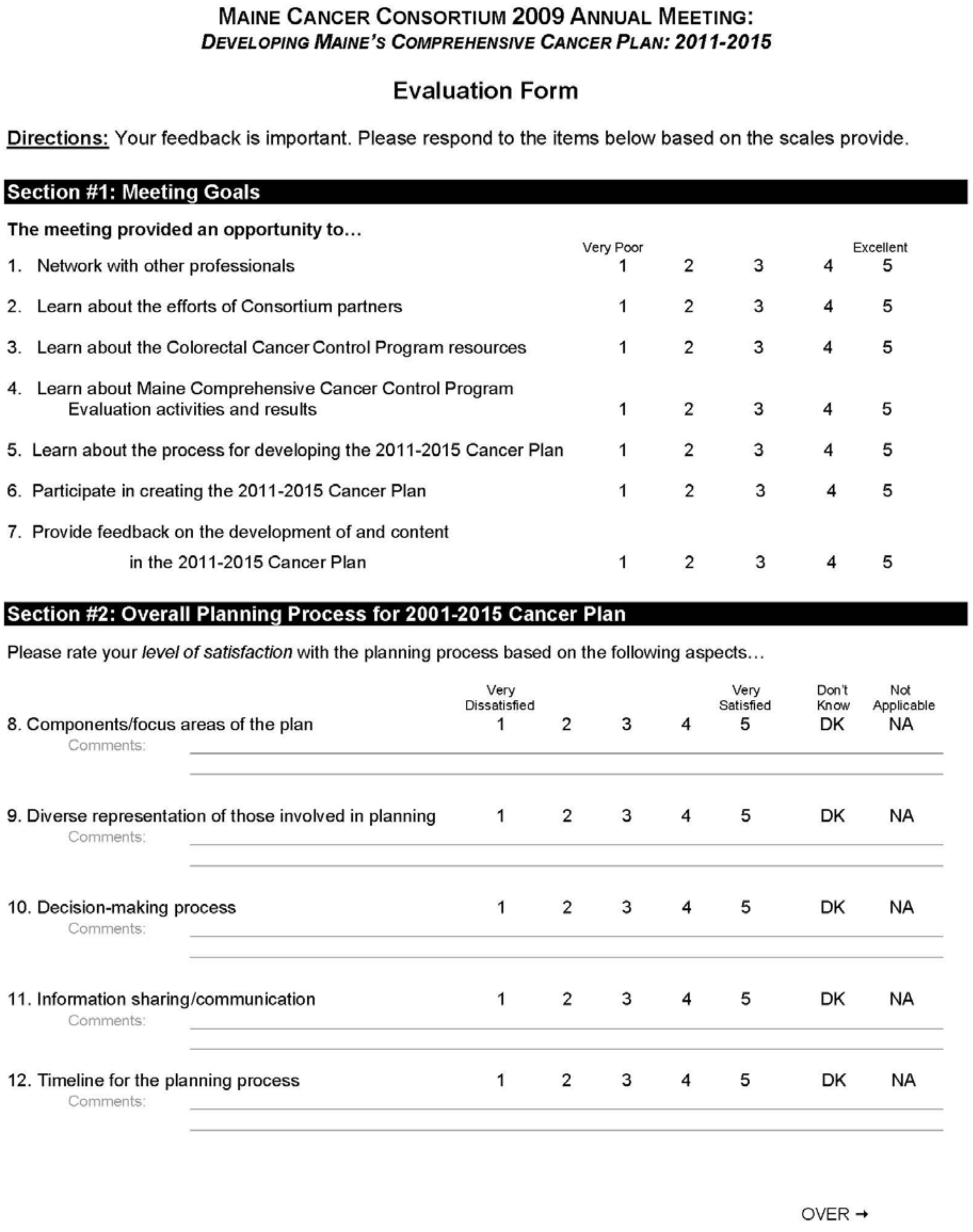
8. Do you have other ideas about how to enhance the plan as it gets developed?: ______________________

9. Was today's meeting a good use of your time and expertise? YES______ NO________

Are there other ways we might utilize your expertise while developing the 2011/15 Plan? _______

# Appendix G:

# Consortium Annual Meeting Evaluation Survey Tool



## MAINE CANCER CONSORTIUM 2009 ANNUAL MEETING:
### *DEVELOPING MAINE'S COMPREHENSIVE CANCER PLAN: 2011-2015*

### Evaluation Form

**Directions:** Your feedback is important. Please respond to the items below based on the scales provide.

## Section #1: Meeting Goals

**The meeting provided an opportunity to…**

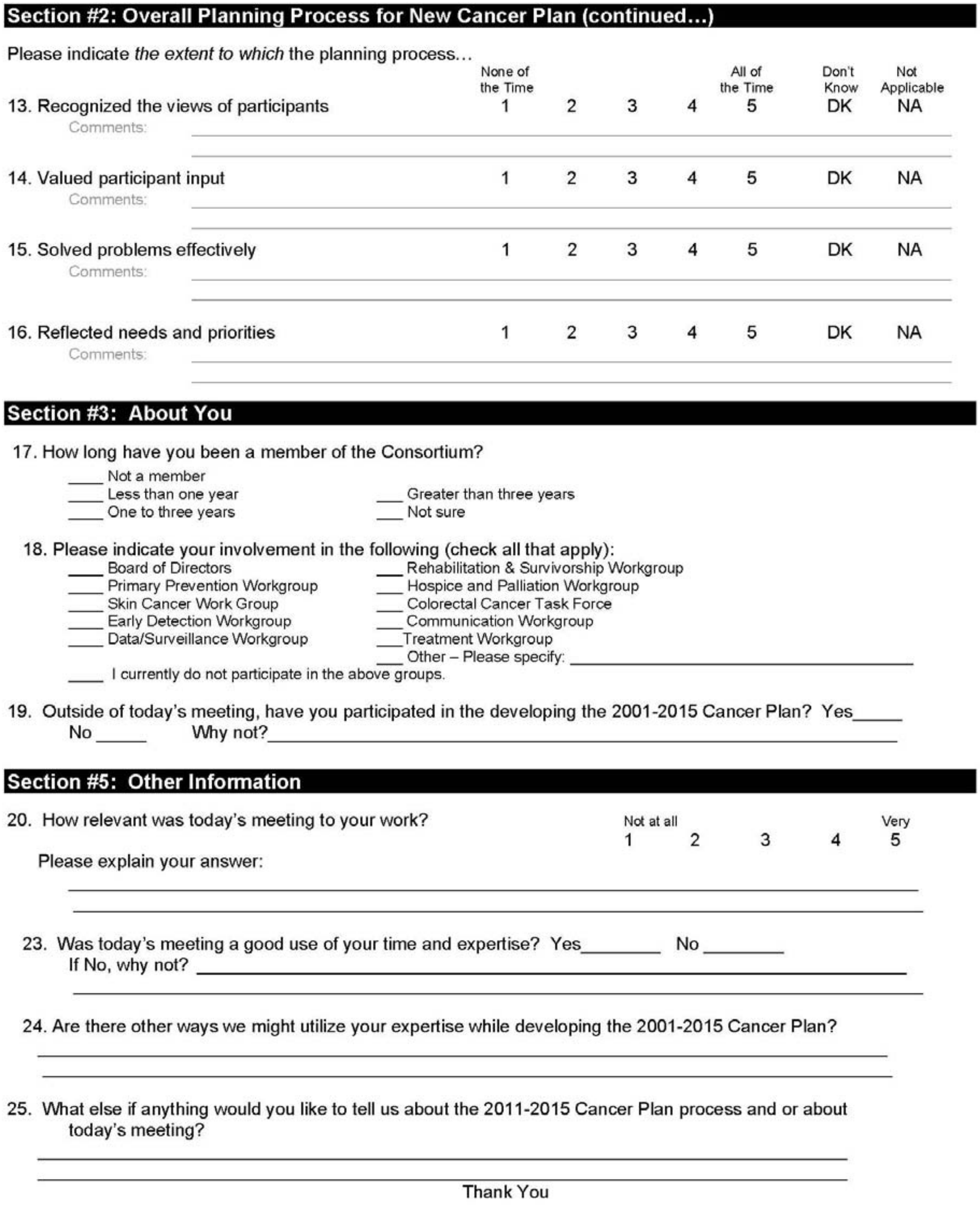
| | Very Poor<br>1 | 2 | 3 | 4 | Excellent<br>5 |
|---|---|---|---|---|---|
| 1. Network with other professionals | 1 | 2 | 3 | 4 | 5 |
| 2. Learn about the efforts of Consortium partners | 1 | 2 | 3 | 4 | 5 |
| 3. Learn about the Colorectal Cancer Control Program resources | 1 | 2 | 3 | 4 | 5 |
| 4. Learn about Maine Comprehensive Cancer Control Program Evaluation activities and results | 1 | 2 | 3 | 4 | 5 |
| 5. Learn about the process for developing the 2011-2015 Cancer Plan | 1 | 2 | 3 | 4 | 5 |
| 6. Participate in creating the 2011-2015 Cancer Plan | 1 | 2 | 3 | 4 | 5 |
| 7. Provide feedback on the development of and content in the 2011-2015 Cancer Plan | 1 | 2 | 3 | 4 | 5 |

## Section #2: Overall Planning Process for 2001-2015 Cancer Plan

Please rate your *level of satisfaction* with the planning process based on the following aspects…

| | Very Dissatisfied | | | | Very Satisfied | Don't Know | Not Applicable |
|---|---|---|---|---|---|---|---|
| 8. Components/focus areas of the plan | 1 | 2 | 3 | 4 | 5 | DK | NA |
| Comments: | | | | | | | |
| 9. Diverse representation of those involved in planning | 1 | 2 | 3 | 4 | 5 | DK | NA |
| Comments: | | | | | | | |
| 10. Decision-making process | 1 | 2 | 3 | 4 | 5 | DK | NA |
| Comments: | | | | | | | |
| 11. Information sharing/communication | 1 | 2 | 3 | 4 | 5 | DK | NA |
| Comments: | | | | | | | |
| 12. Timeline for the planning process | 1 | 2 | 3 | 4 | 5 | DK | NA |
| Comments: | | | | | | | |

OVER →



## Section #2: Overall Planning Process for New Cancer Plan (continued…)

Please indicate *the extent to which* the planning process…

| | None of the Time | | | | All of the Time | Don't Know | Not Applicable |
|---|---|---|---|---|---|---|---|
| 13. Recognized the views of participants | 1 | 2 | 3 | 4 | 5 | DK | NA |
| Comments: ______________________ | | | | | | | |
| 14. Valued participant input | 1 | 2 | 3 | 4 | 5 | DK | NA |
| Comments: ______________________ | | | | | | | |
| 15. Solved problems effectively | 1 | 2 | 3 | 4 | 5 | DK | NA |
| Comments: ______________________ | | | | | | | |
| 16. Reflected needs and priorities | 1 | 2 | 3 | 4 | 5 | DK | NA |
| Comments: ______________________ | | | | | | | |

## Section #3: About You

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

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

18. Please indicate your involvement in the following (check all that apply):

____ Board of Directors
____ Primary Prevention Workgroup
____ Skin Cancer Work Group
____ Early Detection Workgroup
____ Data/Surveillance Workgroup
___ Rehabilitation & Survivorship Workgroup
___ Hospice and Palliation Workgroup
___ Colorectal Cancer Task Force
___ Communication Workgroup
___Treatment Workgroup
___ Other – Please specify: ______________________
____ I currently do not participate in the above groups.

19. Outside of today's meeting, have you participated in the developing the 2001-2015 Cancer Plan? Yes_____
No ______ Why not?______________________

## Section #5: Other Information

20. How relevant was today's meeting to your work?

| Not at all | | | | Very |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

Please explain your answer:
______________________
______________________

23. Was today's meeting a good use of your time and expertise? Yes________ No ________
If No, why not? ______________________
______________________

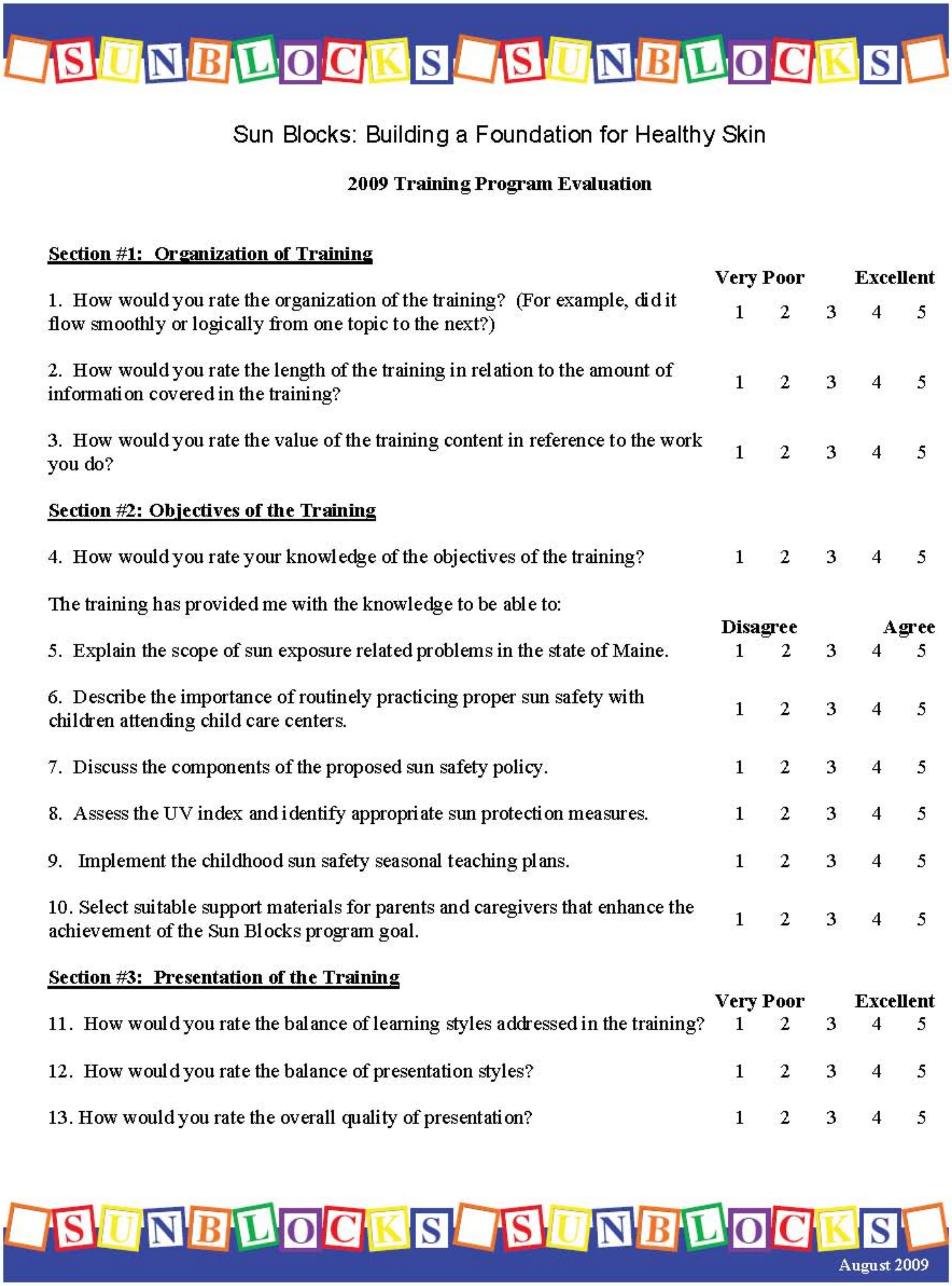
24. Are there other ways we might utilize your expertise while developing the 2001-2015 Cancer Plan?
______________________
______________________

25. What else if anything would you like to tell us about the 2011-2015 Cancer Plan process and or about today's meeting?
______________________
______________________

Thank You

# Appendix H:

# *Sun Blocks* Training Survey



## Sun Blocks: Building a Foundation for Healthy Skin

### 2009 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 |

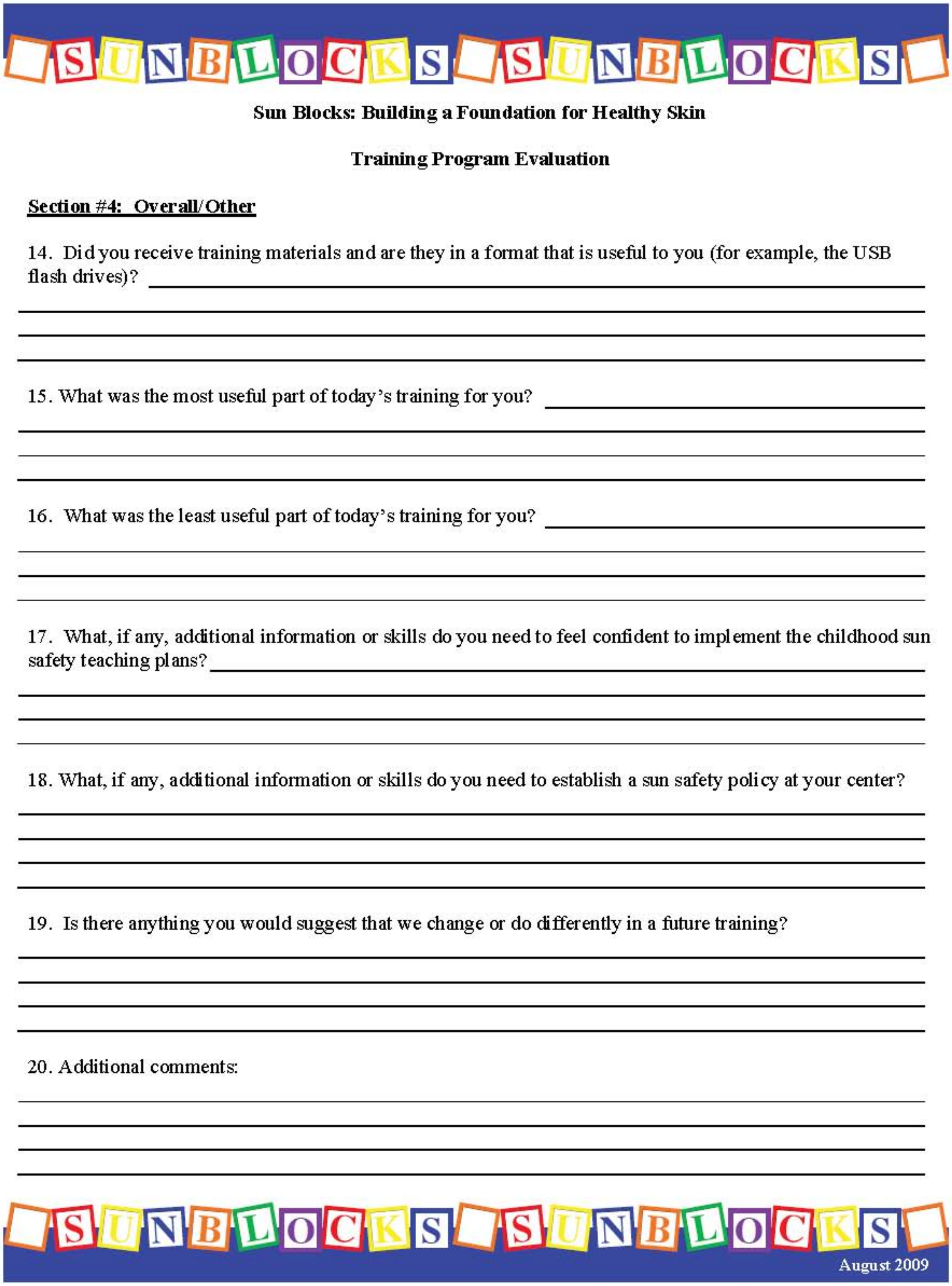
The training has provided me with the knowledge to be able to:

| | 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 |

August 2009



**Sun Blocks: Building a Foundation for Healthy Skin**

**Training Program Evaluation**

**<u>Section #4: Overall/Other</u>**

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:

August 2009

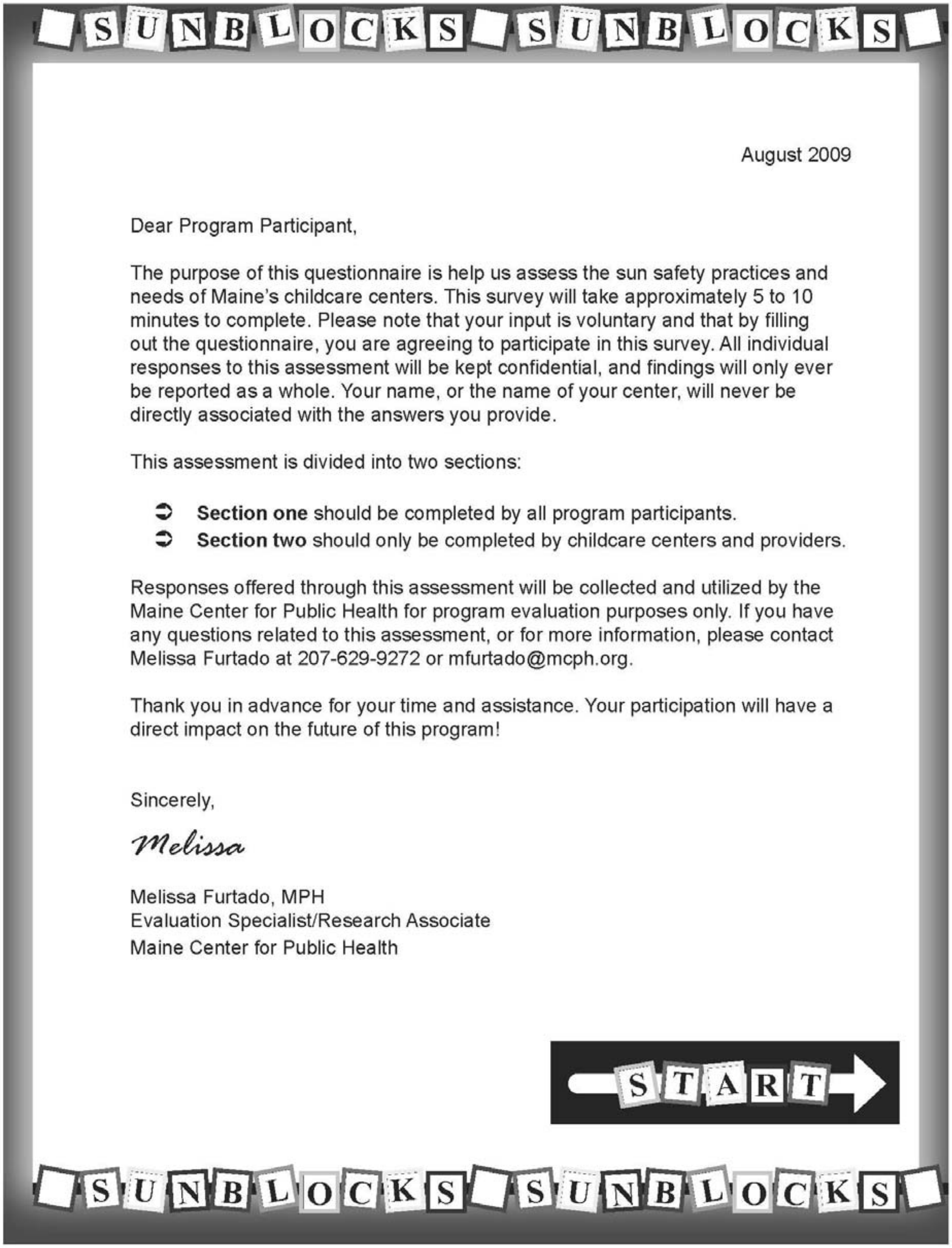
# Appendix I:

# *Sun Blocks* Baseline Survey

# Program Participation Survey

Sponsored by the Maine Comprehensive Cancer Control Program
Maine Center for Disease Control and Prevention, Department of Health and Human Services

## August 2009



August 2009

Dear Program Participant,

The purpose of this questionnaire is help us assess the sun safety practices and needs of Maine's childcare centers. This survey will take approximately 5 to 10 minutes to complete. Please note that your input is voluntary and that by filling out the questionnaire, you are agreeing to participate in this survey. All individual responses to this assessment will be kept confidential, and findings will only ever be reported as a whole. Your name, or the name of your center, will never be directly associated with the answers you provide.

This assessment is divided into two sections:

- **Section one** should be completed by all program participants.
- **Section two** should only be completed by childcare centers and providers.

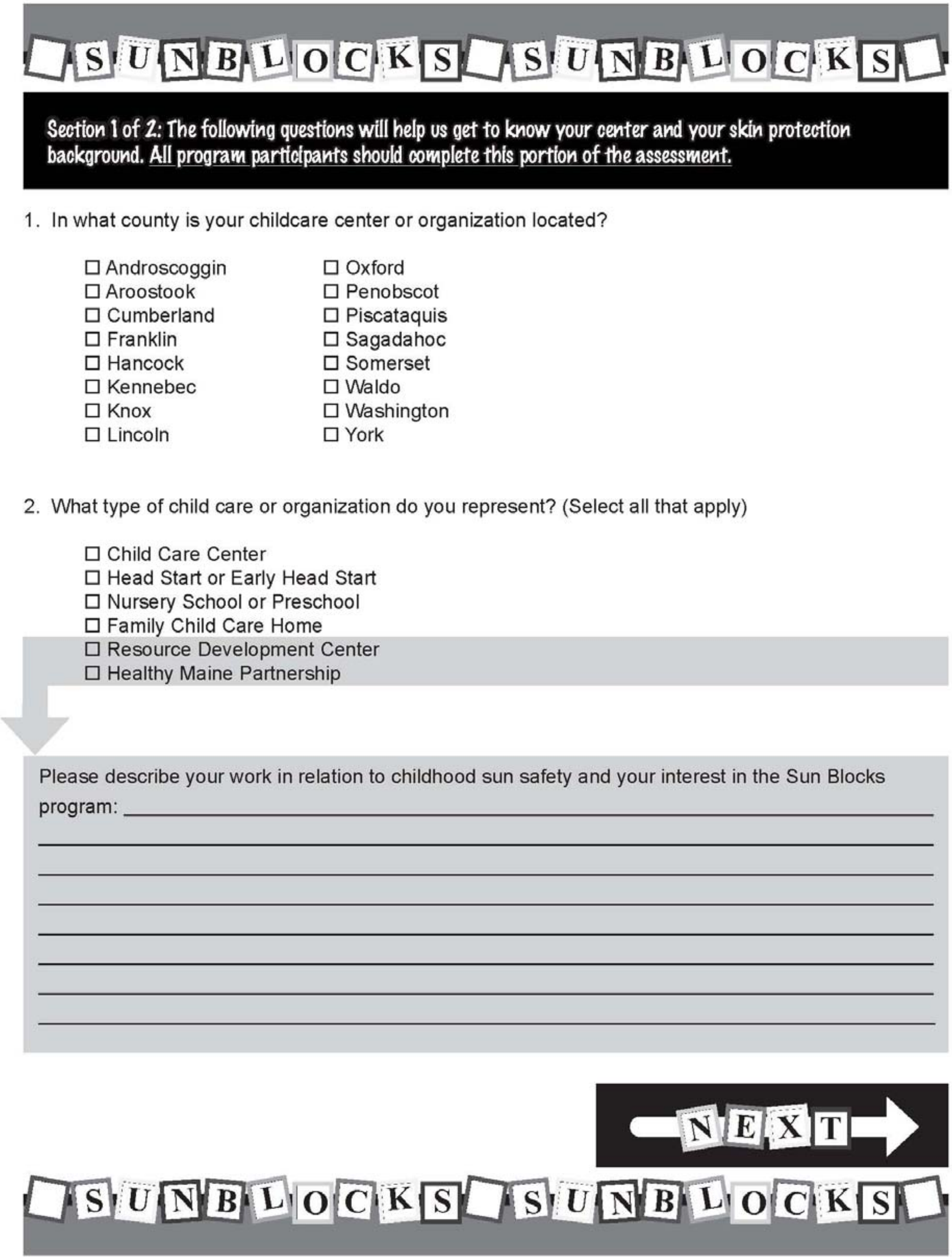
Responses offered through this assessment will be collected and utilized by the Maine Center for Public Health for program evaluation purposes only. If you have any questions related to this assessment, or for more information, please contact Melissa Furtado at 207-629-9272 or mfurtado@mcph.org.

Thank you in advance for your time and assistance. Your participation will have a direct impact on the future of this program!

Sincerely,

Melissa

Melissa Furtado, MPH
Evaluation Specialist/Research Associate
Maine Center for Public Health



SUNBLOCKS SUNBLOCKS

**Section 1 of 2: The following questions will help us get to know your center and your skin protection background. All program participants should complete this portion of the assessment.**

1. In what county is your childcare center or organization located?

☐ Androscoggin
☐ Aroostook
☐ Cumberland
☐ Franklin
☐ Hancock
☐ Kennebec
☐ Knox
☐ Lincoln
☐ Oxford
☐ Penobscot
☐ Piscataquis
☐ Sagadahoc
☐ Somerset
☐ Waldo
☐ Washington
☐ York

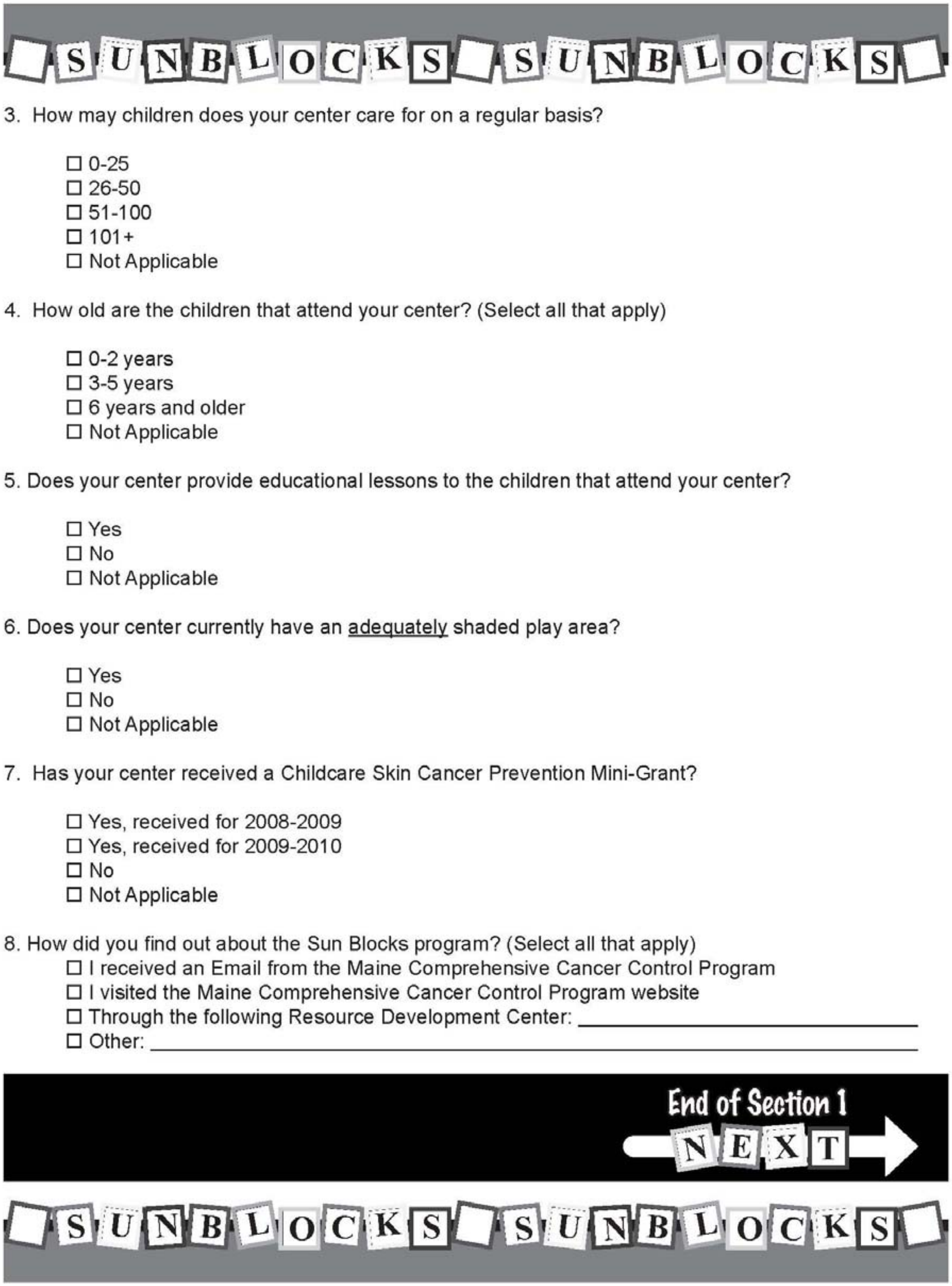
2. What type of child care or organization do you represent? (Select all that apply)

☐ Child Care Center
☐ Head Start or Early Head Start
☐ Nursery School or Preschool
☐ Family Child Care Home
☐ Resource Development Center
☐ Healthy Maine Partnership

Please describe your work in relation to childhood sun safety and your interest in the Sun Blocks program: ____________________

NEXT

SUNBLOCKS SUNBLOCKS



SUNBLOCKS SUNBLOCKS

3. How may children does your center care for on a regular basis?

☐ 0-25
☐ 26-50
☐ 51-100
☐ 101+
☐ Not Applicable

4. How old are the children that attend your center? (Select all that apply)

☐ 0-2 years
☐ 3-5 years
☐ 6 years and older
☐ Not Applicable

5. Does your center provide educational lessons to the children that attend your center?

☐ Yes
☐ No
☐ Not Applicable

6. Does your center currently have an <u>adequately</u> shaded play area?

☐ Yes
☐ No
☐ Not Applicable

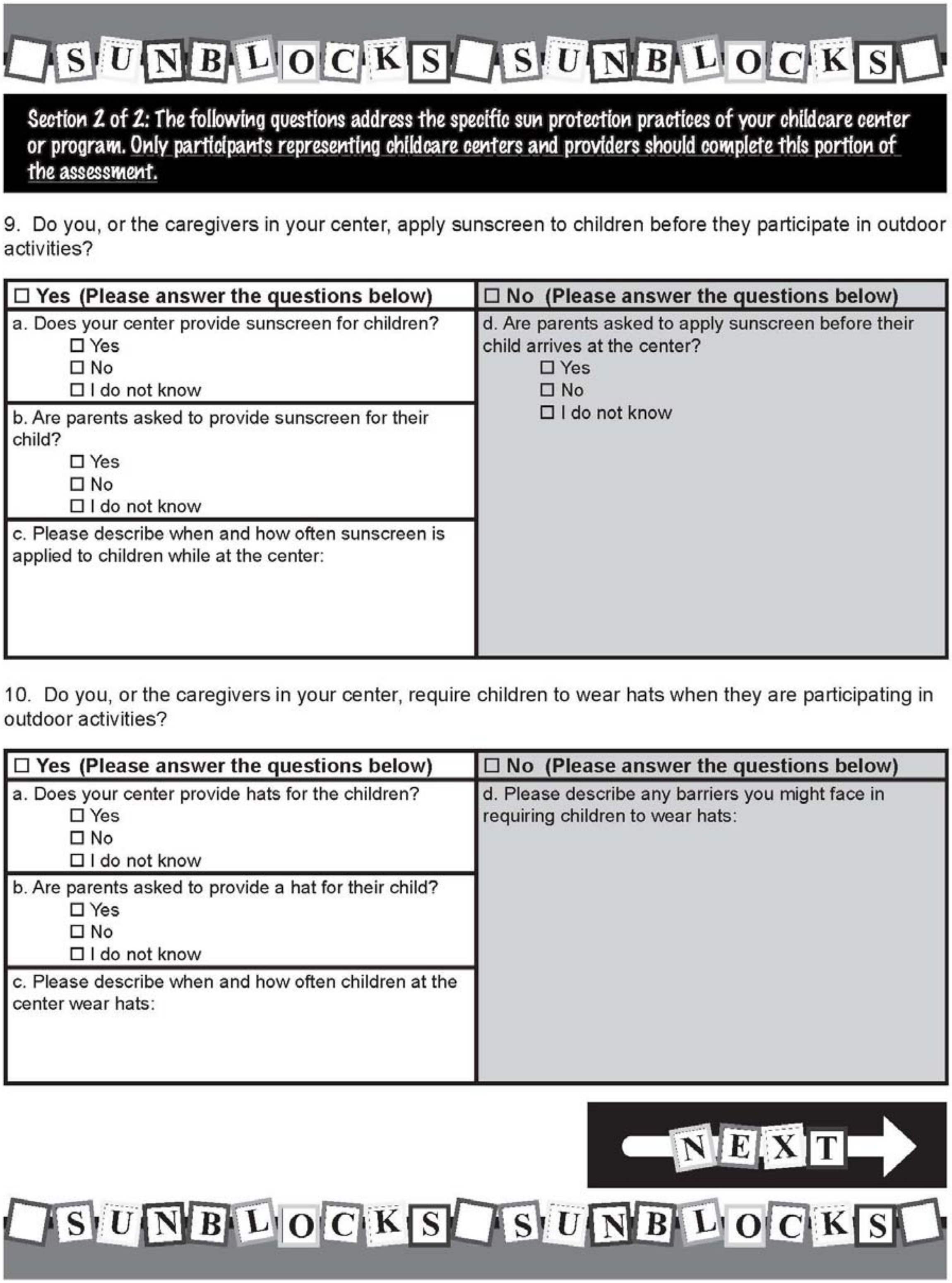
7. Has your center received a Childcare Skin Cancer Prevention Mini-Grant?

☐ Yes, received for 2008-2009
☐ Yes, received for 2009-2010
☐ No
☐ Not Applicable

8. How did you find out about the Sun Blocks program? (Select all that apply)
☐ I received an Email from the Maine Comprehensive Cancer Control Program
☐ I visited the Maine Comprehensive Cancer Control Program website
☐ Through the following Resource Development Center: ______________________
☐ Other: ______________________

End of Section 1
NEXT

SUNBLOCKS SUNBLOCKS



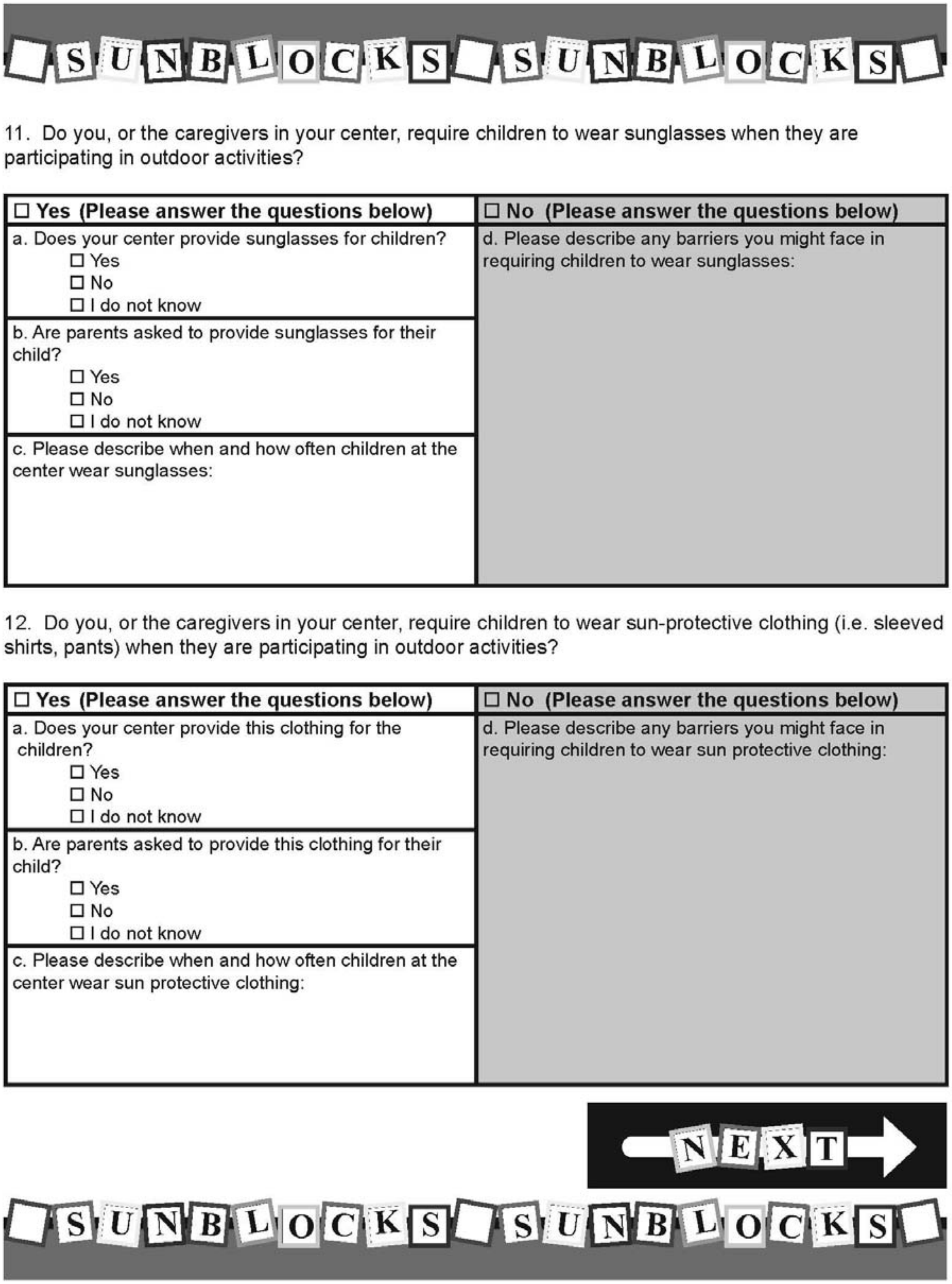
**Section 2 of 2:** The following questions address the specific sun protection practices of your childcare center or program. Only participants representing childcare centers and providers should complete this portion of the assessment.

9. Do you, or the caregivers in your center, apply sunscreen to children before they participate in outdoor activities?

| ☐ **Yes (Please answer the questions below)** | ☐ **No (Please answer the questions below)** |
|---|---|
| a. Does your center provide sunscreen for children?<br>☐ Yes<br>☐ No<br>☐ I do not know | d. Are parents asked to apply sunscreen before their child arrives at the center?<br>☐ Yes<br>☐ No<br>☐ I do not know |
| b. Are parents asked to provide sunscreen for their child?<br>☐ Yes<br>☐ No<br>☐ I do not know | |
| c. Please describe when and how often sunscreen is applied to children while at the center: | |

10. Do you, or the caregivers in your center, require children to wear hats when they are participating in outdoor activities?

| ☐ **Yes (Please answer the questions below)** | ☐ **No (Please answer the questions below)** |
|---|---|
| a. Does your center provide hats for the children?<br>☐ Yes<br>☐ No<br>☐ I do not know | d. Please describe any barriers you might face in requiring children to wear hats: |
| b. Are parents asked to provide a hat for their child?<br>☐ Yes<br>☐ No<br>☐ I do not know | |
| c. Please describe when and how often children at the center wear hats: | |



SUNBLOCKS SUNBLOCKS

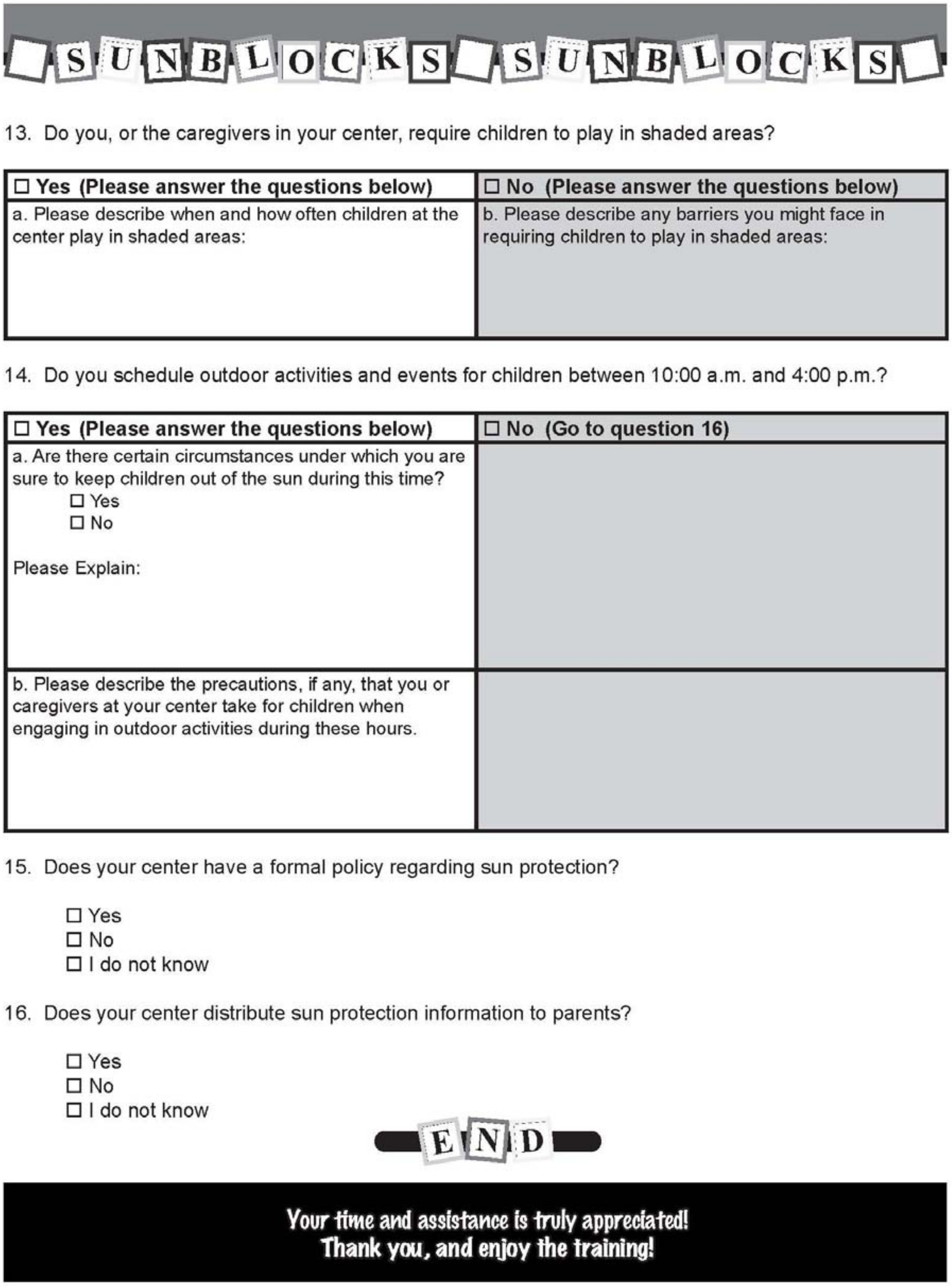
11. Do you, or the caregivers in your center, require children to wear sunglasses when they are participating in outdoor activities?

| ☐ **Yes (Please answer the questions below)** | ☐ **No (Please answer the questions below)** |
|---|---|
| a. Does your center provide sunglasses for children?<br>☐ Yes<br>☐ No<br>☐ I do not know | d. Please describe any barriers you might face in requiring children to wear sunglasses: |
| b. Are parents asked to provide sunglasses for their child?<br>☐ Yes<br>☐ No<br>☐ I do not know | |
| c. Please describe when and how often children at the center wear sunglasses: | |

12. Do you, or the caregivers in your center, require children to wear sun-protective clothing (i.e. sleeved shirts, pants) when they are participating in outdoor activities?

| ☐ **Yes (Please answer the questions below)** | ☐ **No (Please answer the questions below)** |
|---|---|
| a. Does your center provide this clothing for the children?<br>☐ Yes<br>☐ No<br>☐ I do not know | d. Please describe any barriers you might face in requiring children to wear sun protective clothing: |
| b. Are parents asked to provide this clothing for their child?<br>☐ Yes<br>☐ No<br>☐ I do not know | |
| c. Please describe when and how often children at the center wear sun protective clothing: | |

SUNBLOCKS SUNBLOCKS



SUNBLOCKS SUNBLOCKS

13. Do you, or the caregivers in your center, require children to play in shaded areas?

| ☐ **Yes (Please answer the questions below)** | ☐ **No (Please answer the questions below)** |
|---|---|
| a. Please describe when and how often children at the center play in shaded areas: | b. Please describe any barriers you might face in requiring children to play in shaded areas: |

14. Do you schedule outdoor activities and events for children between 10:00 a.m. and 4:00 p.m.?

| ☐ **Yes (Please answer the questions below)** | ☐ **No (Go to question 16)** |
|---|---|
| a. Are there certain circumstances under which you are sure to keep children out of the sun during this time?<br>☐ Yes<br>☐ No<br>Please Explain: | |
| b. Please describe the precautions, if any, that you or caregivers at your center take for children when engaging in outdoor activities during these hours. | |

15. Does your center have a formal policy regarding sun protection?

☐ Yes
☐ No
☐ I do not know

16. Does your center distribute sun protection information to parents?

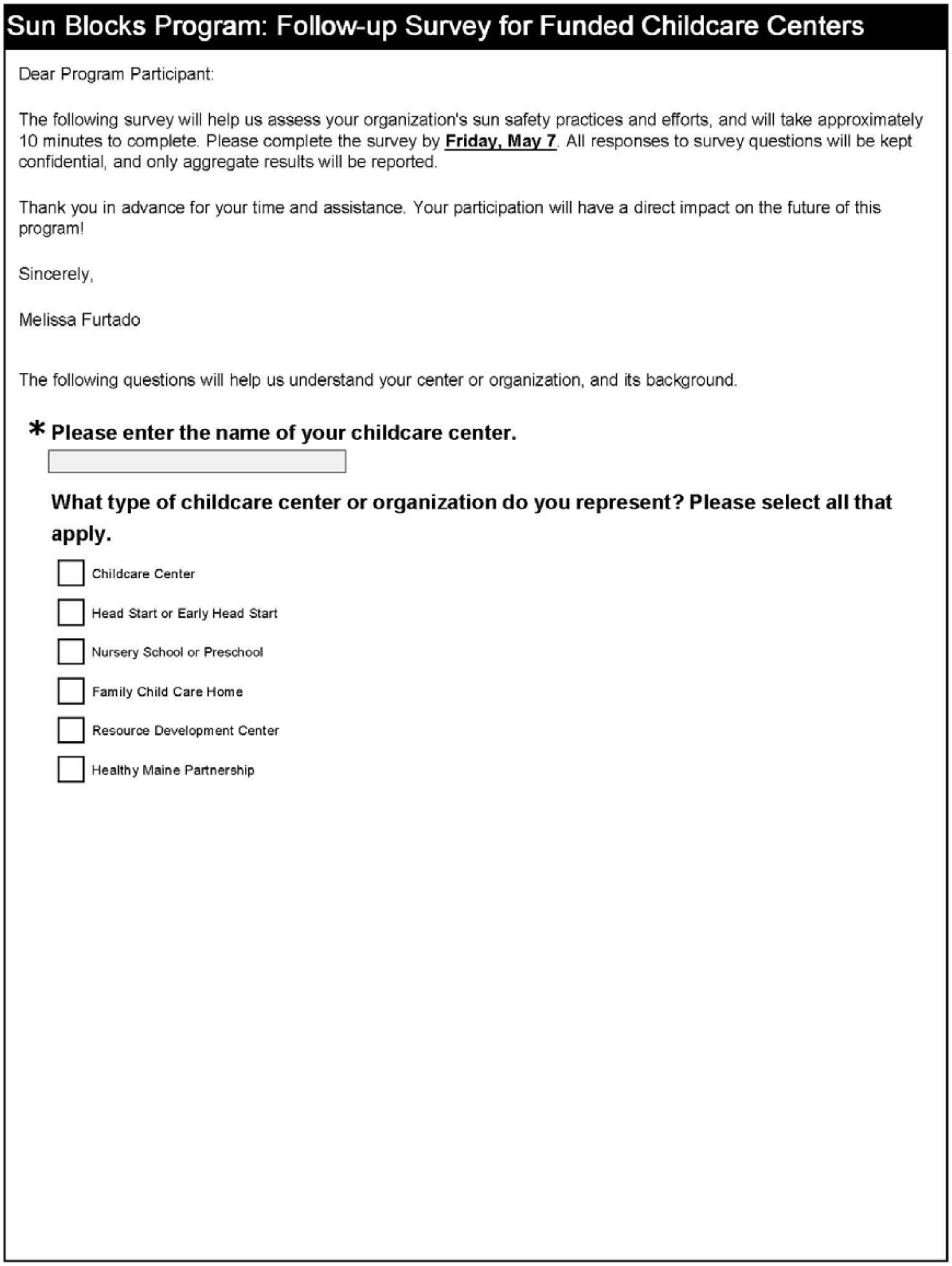
☐ Yes
☐ No
☐ I do not know

END

**Your time and assistance is truly appreciated!**
**Thank you, and enjoy the training!**

# Appendix J:

# *Sun Blocks* Grantee Evaluation Survey



## Sun Blocks Program: Follow-up Survey for Funded Childcare Centers

Dear Program Participant:

The following survey will help us assess your organization's sun safety practices and efforts, and will take approximately 10 minutes to complete. Please complete the survey by **Friday, May 7**. All responses to survey questions will be kept confidential, and only aggregate results will be reported.

Thank you in advance for your time and assistance. Your participation will have a direct impact on the future of this program!

Sincerely,

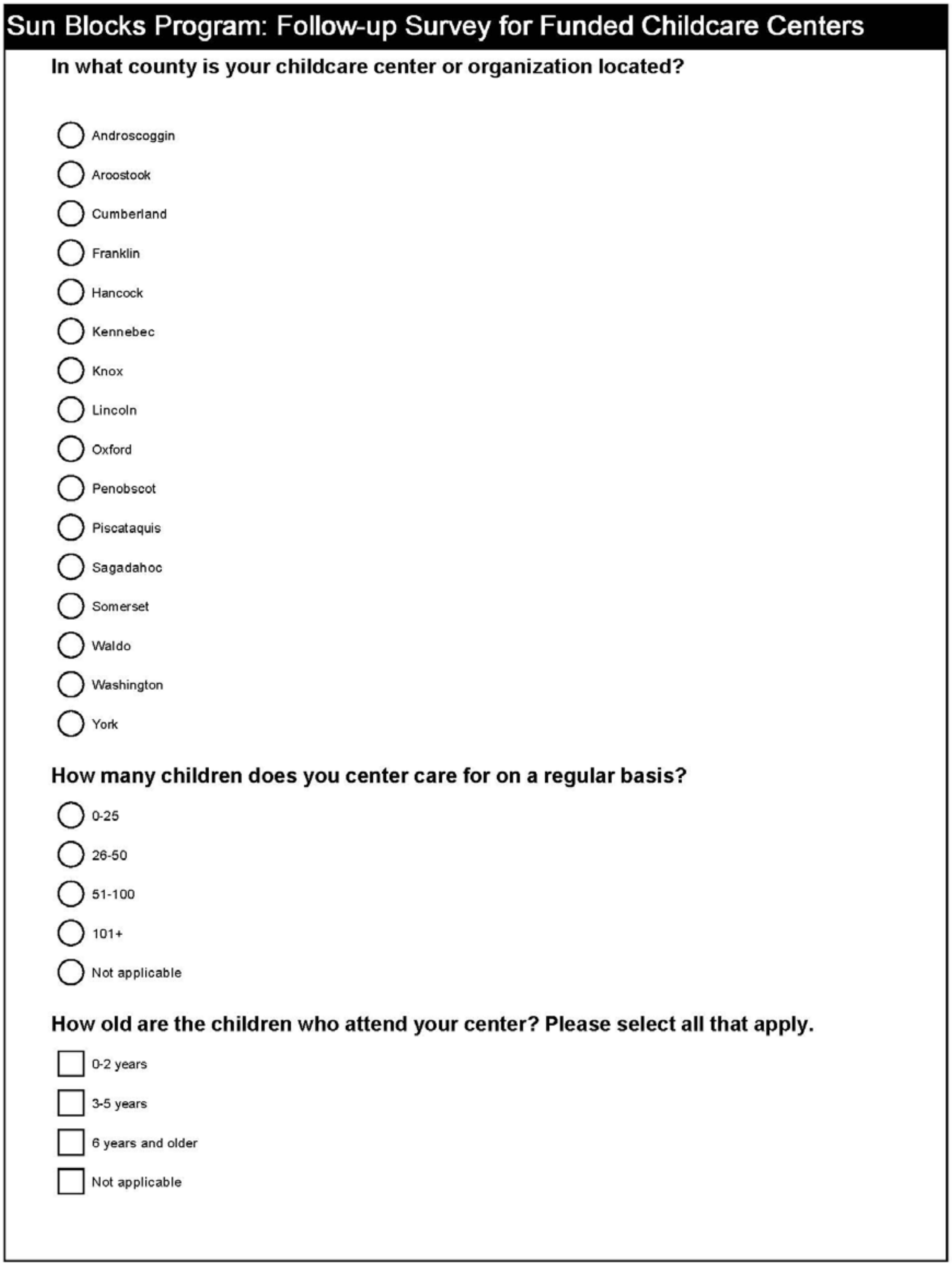
Melissa Furtado

The following questions will help us understand your center or organization, and its background.

*** Please enter the name of your childcare center.**

**What type of childcare center or organization do you represent? Please select all that apply.**

☐ Childcare Center
☐ Head Start or Early Head Start
☐ Nursery School or Preschool
☐ Family Child Care Home
☐ Resource Development Center
☐ Healthy Maine Partnership



## Sun Blocks Program: Follow-up Survey for Funded Childcare Centers

**In what county is your childcare center or organization located?**

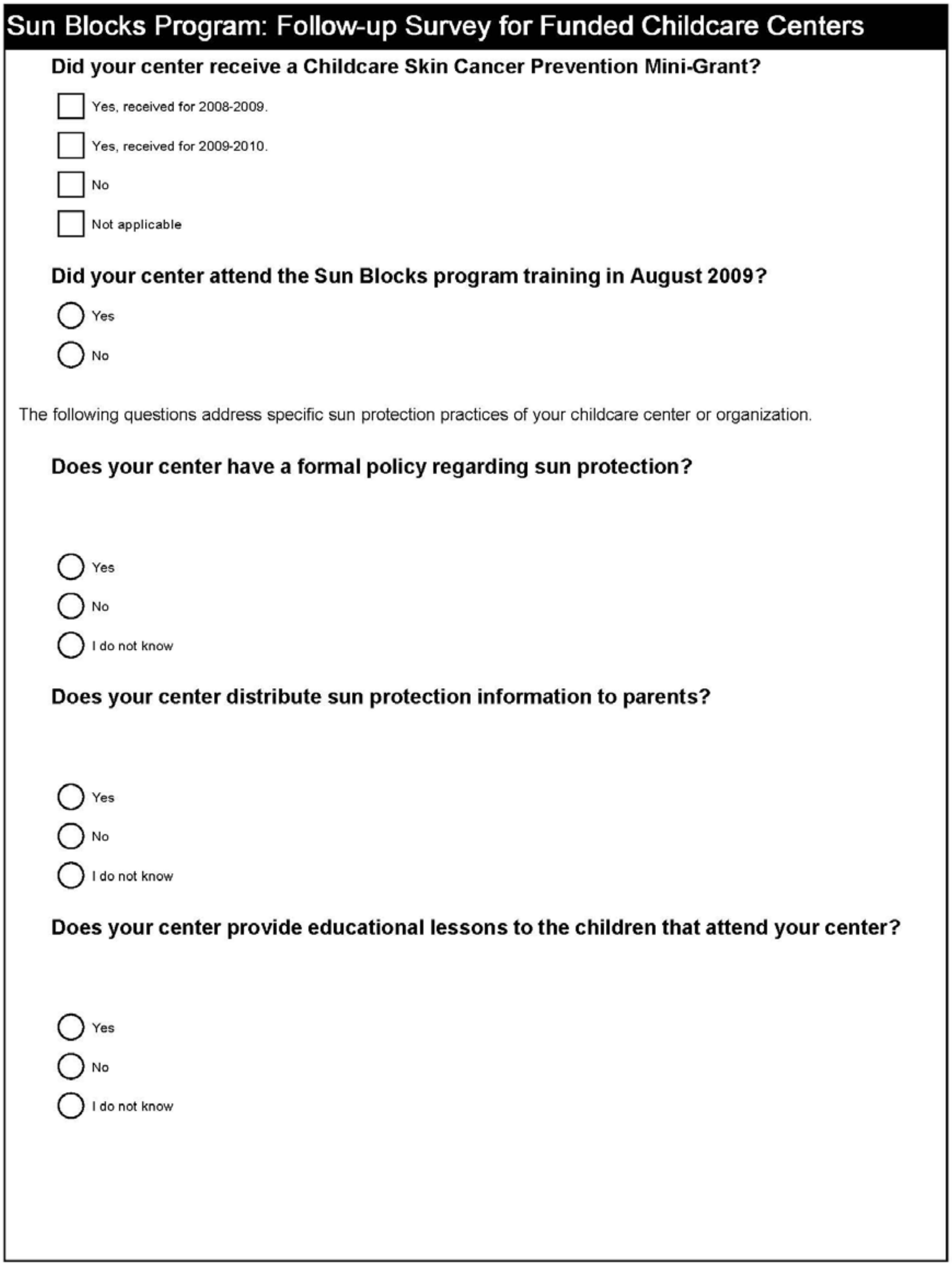
○ Androscoggin
○ Aroostook
○ Cumberland
○ Franklin
○ Hancock
○ Kennebec
○ Knox
○ Lincoln
○ Oxford
○ Penobscot
○ Piscataquis
○ Sagadahoc
○ Somerset
○ Waldo
○ Washington
○ York

**How many children does you center care for on a regular basis?**

○ 0-25
○ 26-50
○ 51-100
○ 101+
○ Not applicable

**How old are the children who attend your center? Please select all that apply.**

☐ 0-2 years
☐ 3-5 years
☐ 6 years and older
☐ Not applicable



## Sun Blocks Program: Follow-up Survey for Funded Childcare Centers

**Did your center receive a Childcare Skin Cancer Prevention Mini-Grant?**

☐ Yes, received for 2008-2009.
☐ Yes, received for 2009-2010.
☐ No
☐ Not applicable

**Did your center attend the Sun Blocks program training in August 2009?**

○ Yes
○ No

The following questions address specific sun protection practices of your childcare center or organization.

**Does your center have a formal policy regarding sun protection?**

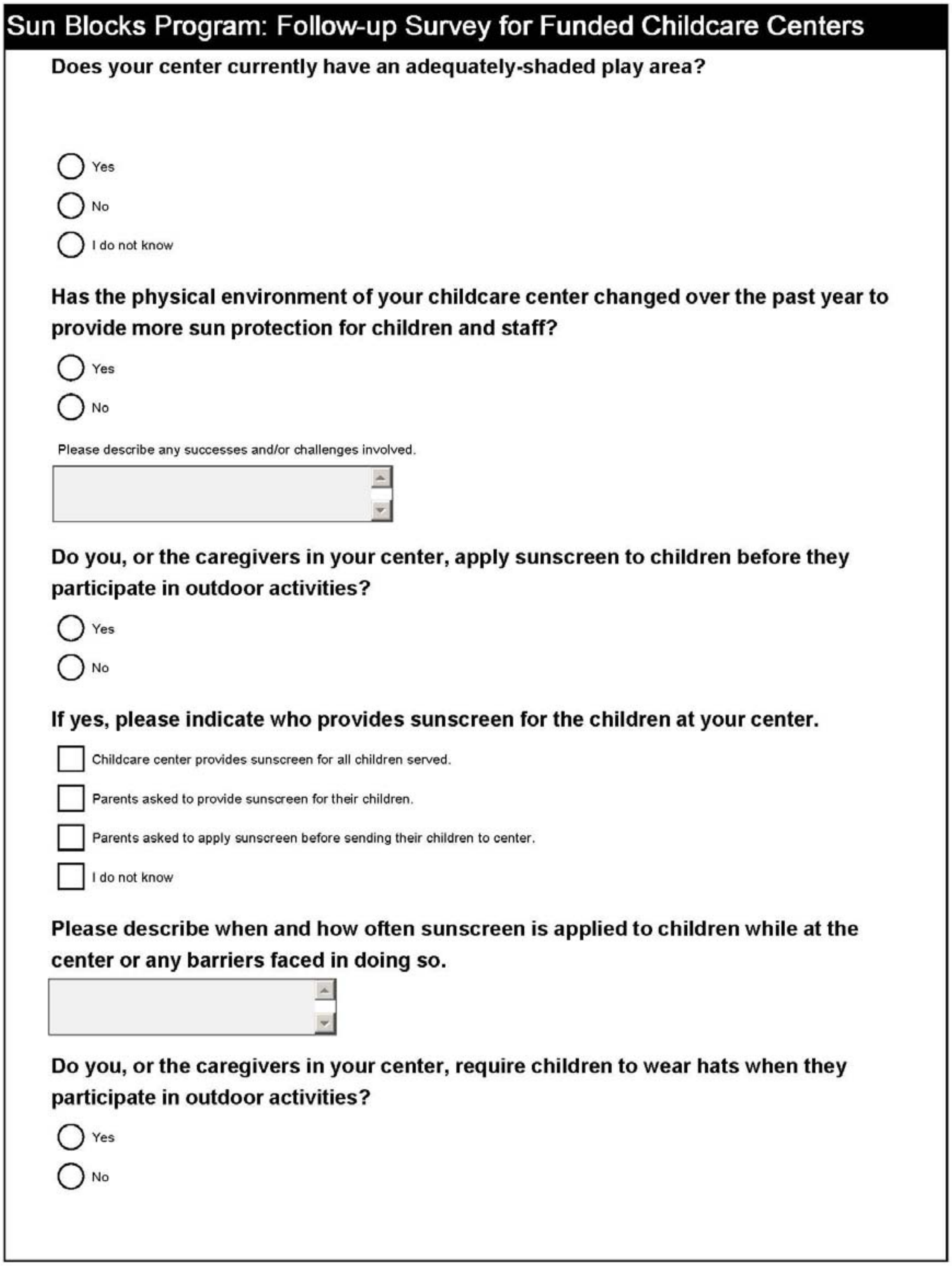
○ Yes
○ No
○ I do not know

**Does your center distribute sun protection information to parents?**

○ Yes
○ No
○ I do not know

**Does your center provide educational lessons to the children that attend your center?**

○ Yes
○ No
○ I do not know



## Sun Blocks Program: Follow-up Survey for Funded Childcare Centers

**Does your center currently have an adequately-shaded play area?**

○ Yes
○ No
○ I do not know

**Has the physical environment of your childcare center changed over the past year to provide more sun protection for children and staff?**

○ Yes
○ No

Please describe any successes and/or challenges involved.

**Do you, or the caregivers in your center, apply sunscreen to children before they participate in outdoor activities?**

○ Yes
○ No

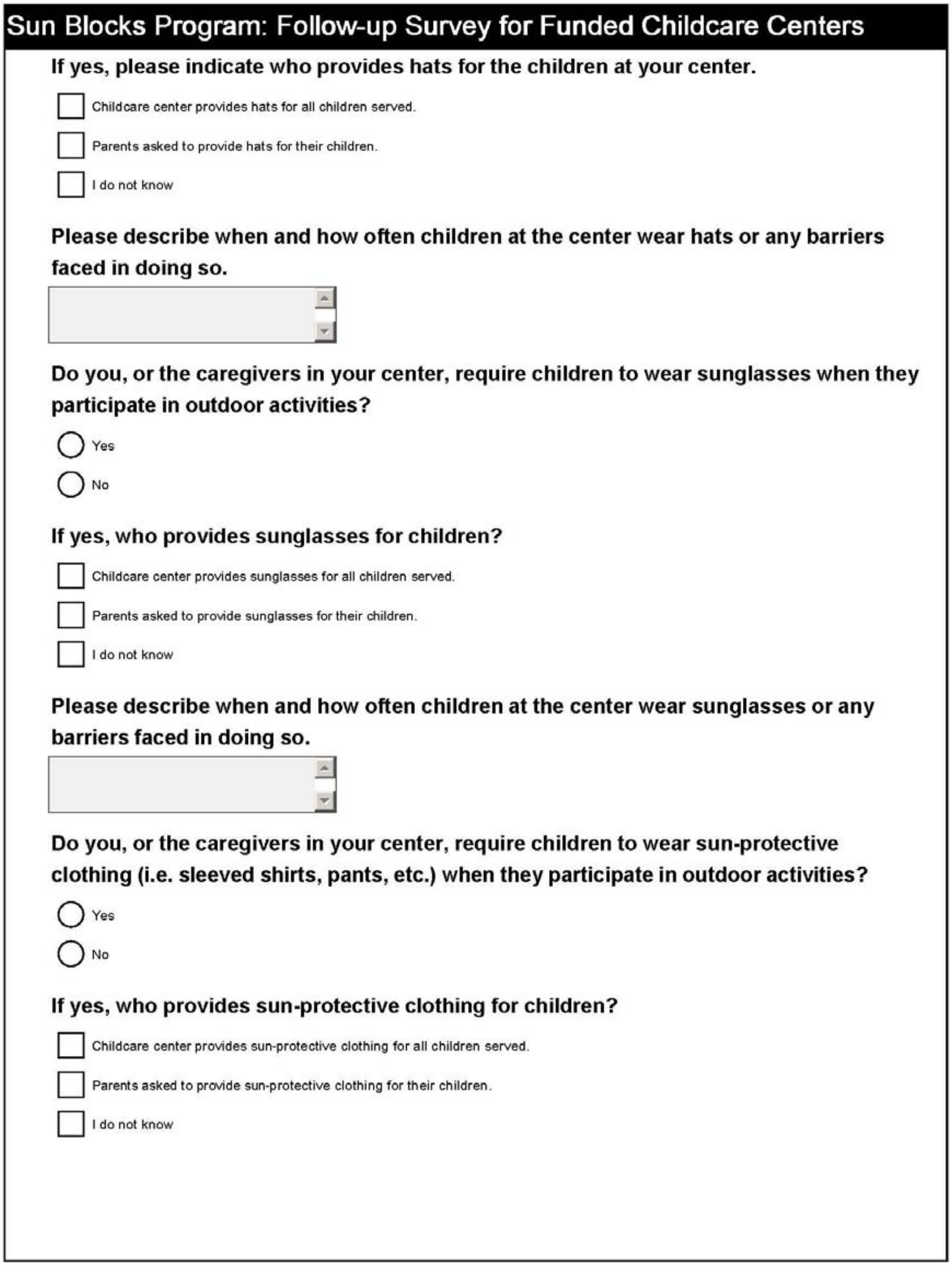
**If yes, please indicate who provides sunscreen for the children at your center.**

☐ Childcare center provides sunscreen for all children served.
☐ Parents asked to provide sunscreen for their children.
☐ Parents asked to apply sunscreen before sending their children to center.
☐ I do not know

**Please describe when and how often sunscreen is applied to children while at the center or any barriers faced in doing so.**

**Do you, or the caregivers in your center, require children to wear hats when they participate in outdoor activities?**

○ Yes
○ No



## Sun Blocks Program: Follow-up Survey for Funded Childcare Centers

**If yes, please indicate who provides hats for the children at your center.**

☐ Childcare center provides hats for all children served.

☐ Parents asked to provide hats for their children.

☐ I do not know

**Please describe when and how often children at the center wear hats or any barriers faced in doing so.**

**Do you, or the caregivers in your center, require children to wear sunglasses when they participate in outdoor activities?**

○ Yes

○ No

**If yes, who provides sunglasses for children?**

☐ Childcare center provides sunglasses for all children served.

☐ Parents asked to provide sunglasses for their children.

☐ I do not know

**Please describe when and how often children at the center wear sunglasses or any barriers faced in doing so.**

**Do you, or the caregivers in your center, require children to wear sun-protective clothing (i.e. sleeved shirts, pants, etc.) when they participate in outdoor activities?**

○ Yes

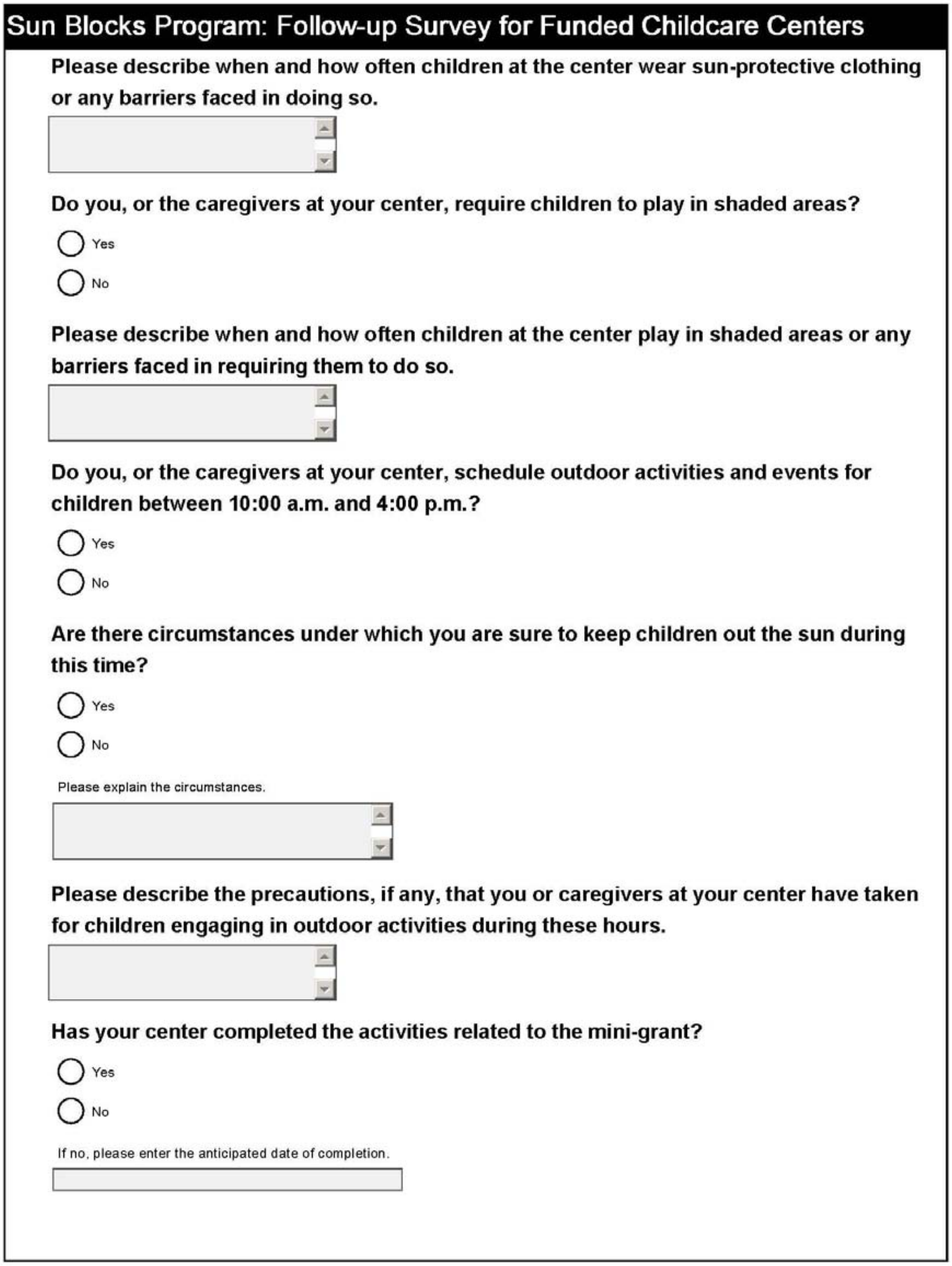
○ No

**If yes, who provides sun-protective clothing for children?**

☐ Childcare center provides sun-protective clothing for all children served.

☐ Parents asked to provide sun-protective clothing for their children.

☐ I do not know



**Sun Blocks Program: Follow-up Survey for Funded Childcare Centers**

**Please describe when and how often children at the center wear sun-protective clothing or any barriers faced in doing so.**

**Do you, or the caregivers at your center, require children to play in shaded areas?**

○ Yes

○ No

**Please describe when and how often children at the center play in shaded areas or any barriers faced in requiring them to do so.**

**Do you, or the caregivers at your center, schedule outdoor activities and events for children between 10:00 a.m. and 4:00 p.m.?**

○ Yes

○ No

**Are there circumstances under which you are sure to keep children out the sun during this time?**

○ Yes

○ No

Please explain the circumstances.

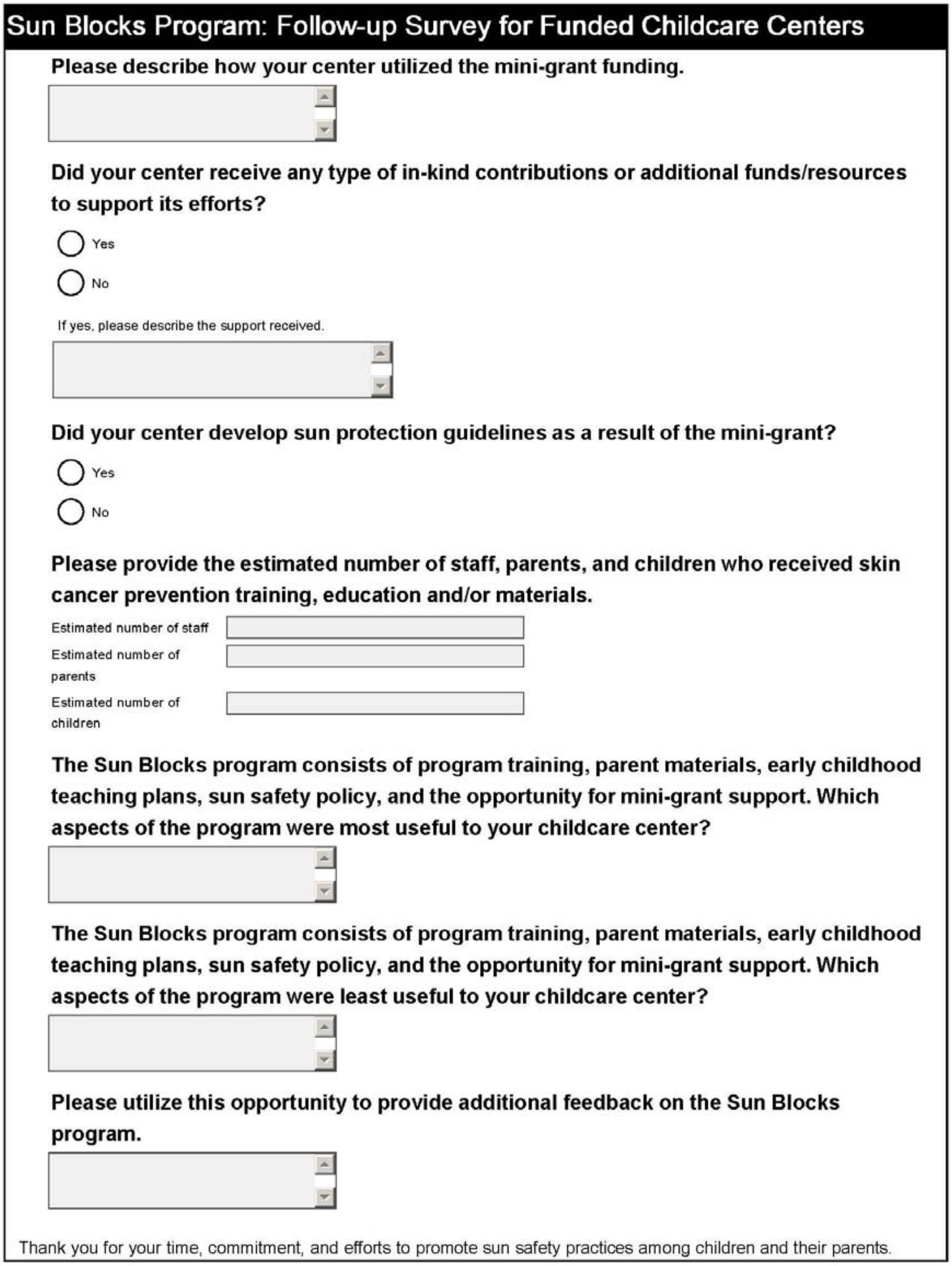
**Please describe the precautions, if any, that you or caregivers at your center have taken for children engaging in outdoor activities during these hours.**

**Has your center completed the activities related to the mini-grant?**

○ Yes

○ No

If no, please enter the anticipated date of completion.



## Sun Blocks Program: Follow-up Survey for Funded Childcare Centers

**Please describe how your center utilized the mini-grant funding.**

**Did your center receive any type of in-kind contributions or additional funds/resources to support its efforts?**

○ Yes

○ No

If yes, please describe the support received.

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

○ Yes

○ No

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

Estimated number of staff

Estimated number of parents

Estimated number of children

**The Sun Blocks program consists of program training, parent materials, early childhood teaching plans, sun safety policy, and the opportunity for mini-grant support. Which aspects of the program were most useful to your childcare center?**

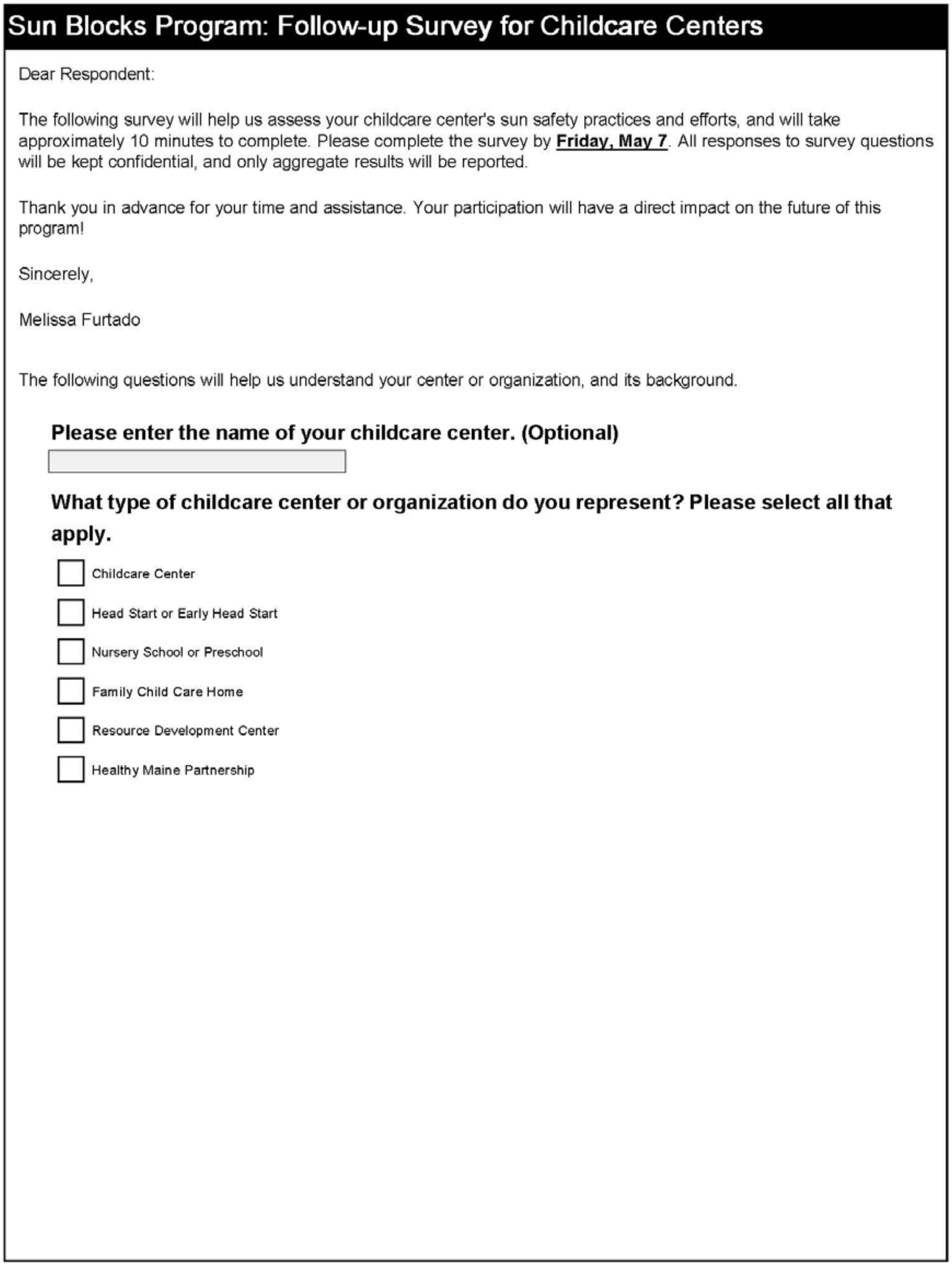
**The Sun Blocks program consists of program training, parent materials, early childhood teaching plans, sun safety policy, and the opportunity for mini-grant support. Which aspects of the program were least useful to your childcare center?**

**Please utilize this opportunity to provide additional feedback on the Sun Blocks program.**

Thank you for your time, commitment, and efforts to promote sun safety practices among children and their parents.

# Appendix K:

# Sun Blocks Non-grantee Evaluation Survey



## Sun Blocks Program: Follow-up Survey for Childcare Centers

Dear Respondent:

The following survey will help us assess your childcare center's sun safety practices and efforts, and will take approximately 10 minutes to complete. Please complete the survey by **Friday, May 7**. All responses to survey questions will be kept confidential, and only aggregate results will be reported.

Thank you in advance for your time and assistance. Your participation will have a direct impact on the future of this program!

Sincerely,

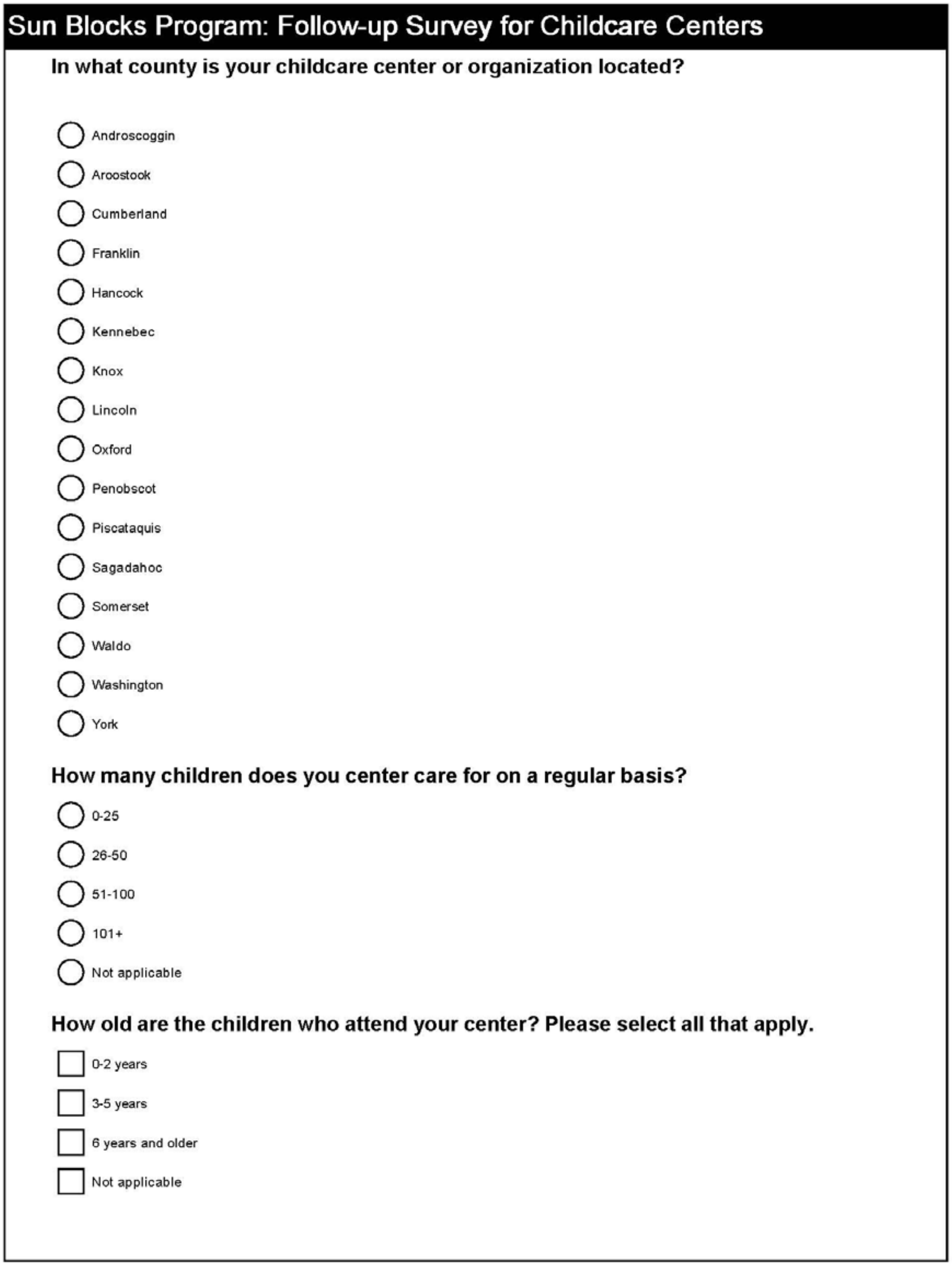
Melissa Furtado

The following questions will help us understand your center or organization, and its background.

**Please enter the name of your childcare center. (Optional)**

**What type of childcare center or organization do you represent? Please select all that apply.**

- ☐ Childcare Center
- ☐ Head Start or Early Head Start
- ☐ Nursery School or Preschool
- ☐ Family Child Care Home
- ☐ Resource Development Center
- ☐ Healthy Maine Partnership



## Sun Blocks Program: Follow-up Survey for Childcare Centers

**In what county is your childcare center or organization located?**

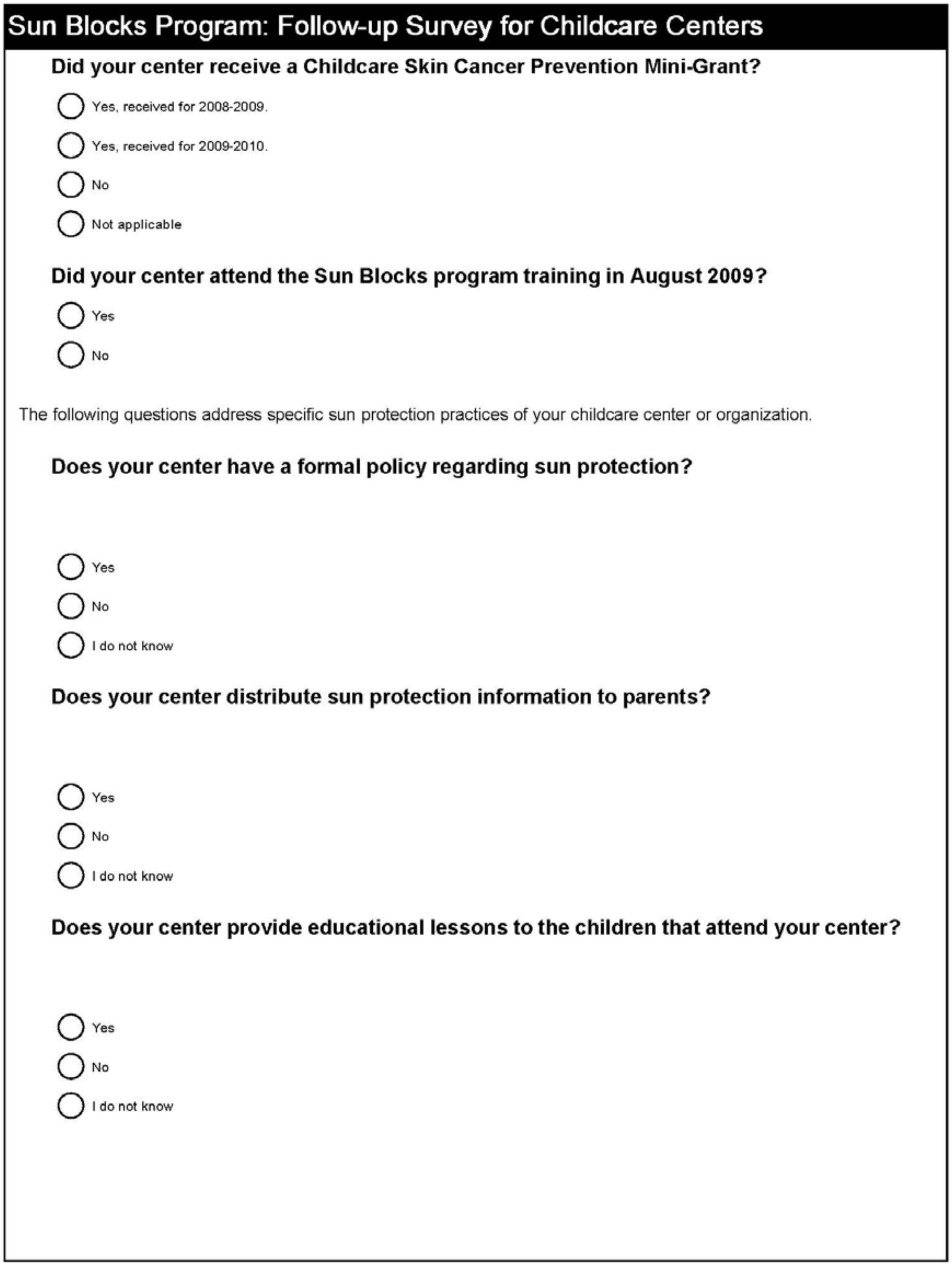
- ○ Androscoggin
- ○ Aroostook
- ○ Cumberland
- ○ Franklin
- ○ Hancock
- ○ Kennebec
- ○ Knox
- ○ Lincoln
- ○ Oxford
- ○ Penobscot
- ○ Piscataquis
- ○ Sagadahoc
- ○ Somerset
- ○ Waldo
- ○ Washington
- ○ York

**How many children does you center care for on a regular basis?**

- ○ 0-25
- ○ 26-50
- ○ 51-100
- ○ 101+
- ○ Not applicable

**How old are the children who attend your center? Please select all that apply.**

- ☐ 0-2 years
- ☐ 3-5 years
- ☐ 6 years and older
- ☐ Not applicable



## Sun Blocks Program: Follow-up Survey for Childcare Centers

**Did your center receive a Childcare Skin Cancer Prevention Mini-Grant?**

○ Yes, received for 2008-2009.
○ Yes, received for 2009-2010.
○ No
○ Not applicable

**Did your center attend the Sun Blocks program training in August 2009?**

○ Yes
○ No

The following questions address specific sun protection practices of your childcare center or organization.

**Does your center have a formal policy regarding sun protection?**

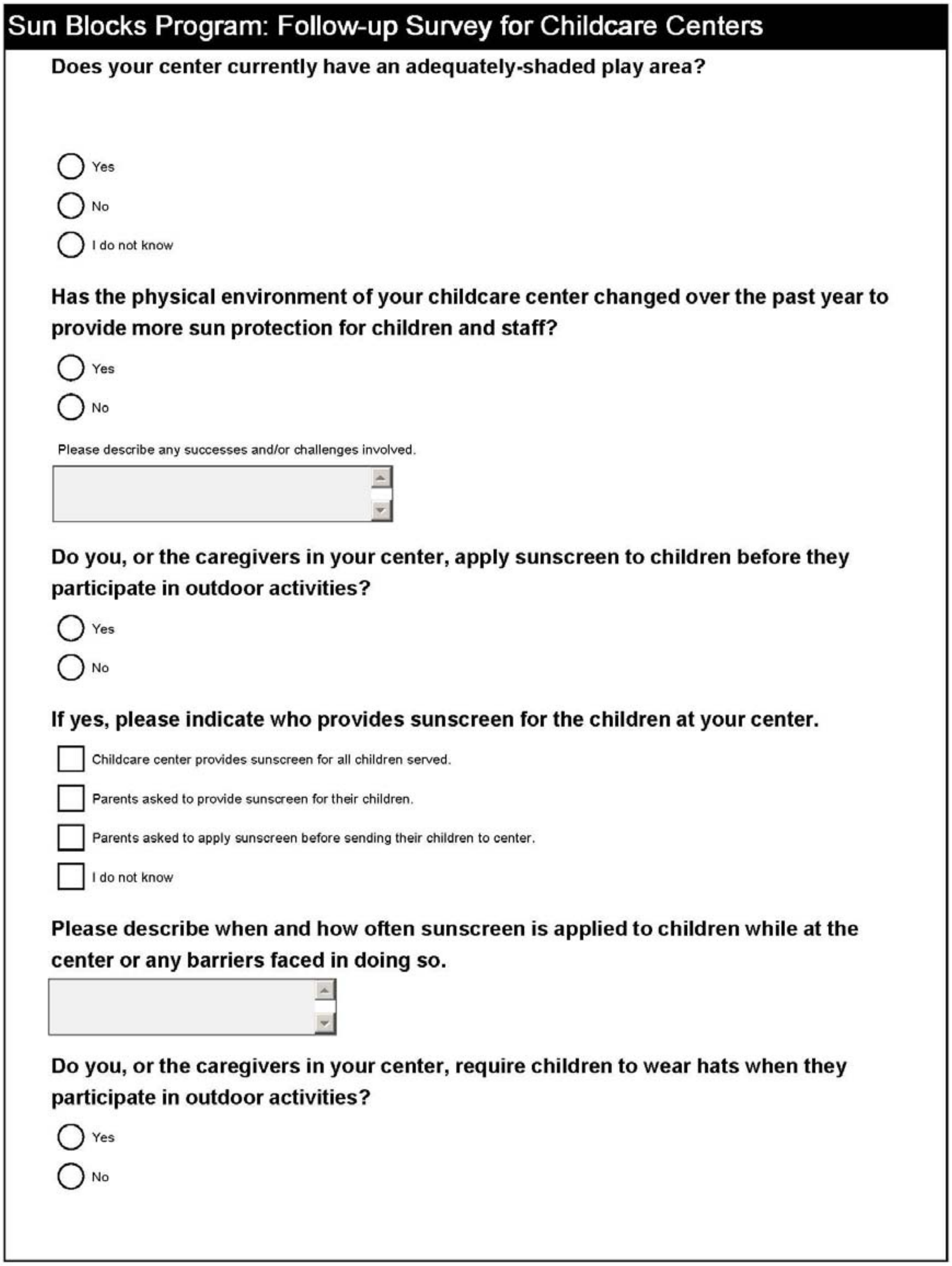
○ Yes
○ No
○ I do not know

**Does your center distribute sun protection information to parents?**

○ Yes
○ No
○ I do not know

**Does your center provide educational lessons to the children that attend your center?**

○ Yes
○ No
○ I do not know



## Sun Blocks Program: Follow-up Survey for Childcare Centers

**Does your center currently have an adequately-shaded play area?**

○ Yes
○ No
○ I do not know

**Has the physical environment of your childcare center changed over the past year to provide more sun protection for children and staff?**

○ Yes
○ No

Please describe any successes and/or challenges involved.

**Do you, or the caregivers in your center, apply sunscreen to children before they participate in outdoor activities?**

○ Yes
○ No

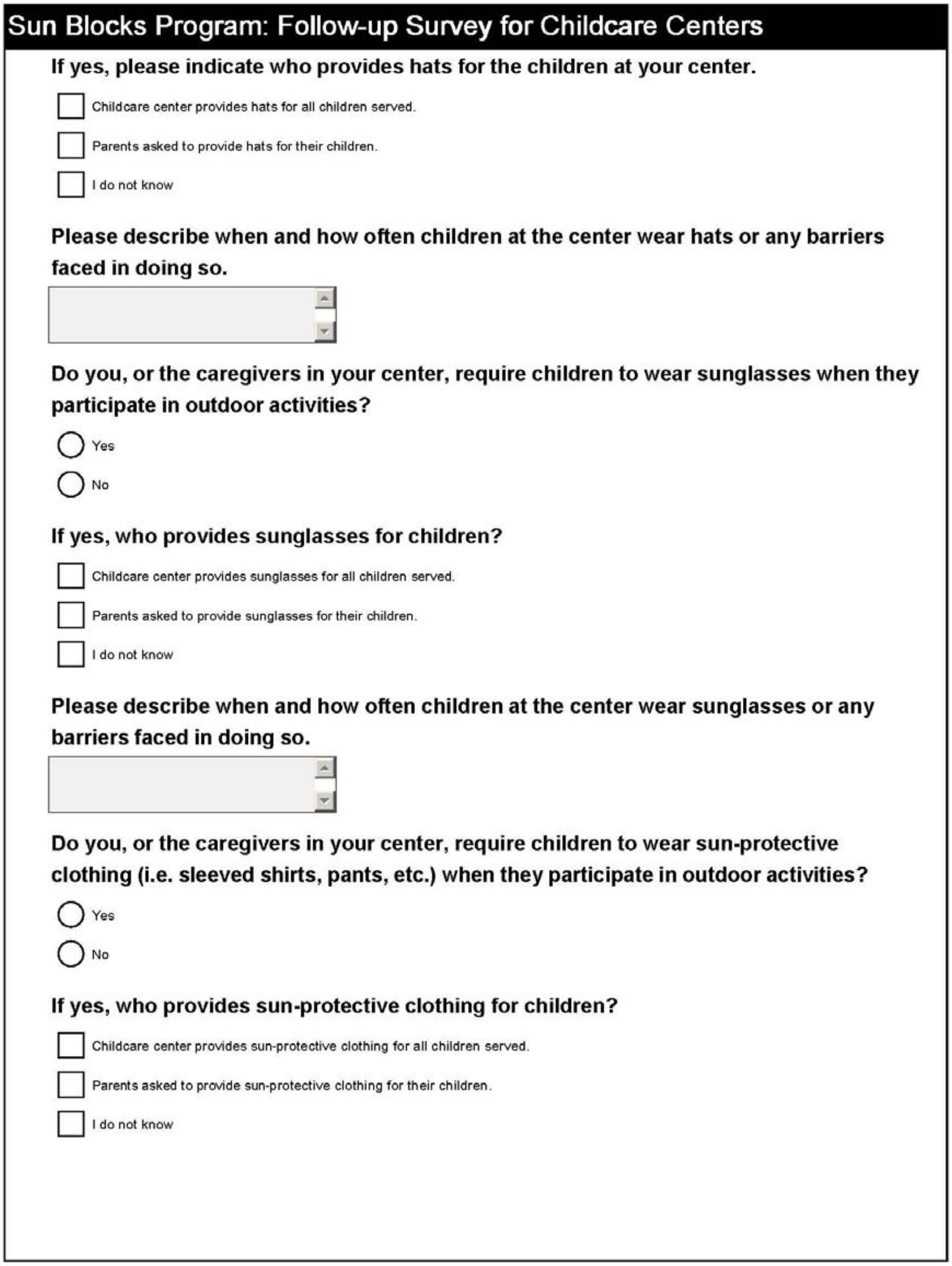
**If yes, please indicate who provides sunscreen for the children at your center.**

☐ Childcare center provides sunscreen for all children served.
☐ Parents asked to provide sunscreen for their children.
☐ Parents asked to apply sunscreen before sending their children to center.
☐ I do not know

**Please describe when and how often sunscreen is applied to children while at the center or any barriers faced in doing so.**

**Do you, or the caregivers in your center, require children to wear hats when they participate in outdoor activities?**

○ Yes
○ No



## Sun Blocks Program: Follow-up Survey for Childcare Centers

**If yes, please indicate who provides hats for the children at your center.**

☐ Childcare center provides hats for all children served.
☐ Parents asked to provide hats for their children.
☐ I do not know

**Please describe when and how often children at the center wear hats or any barriers faced in doing so.**

**Do you, or the caregivers in your center, require children to wear sunglasses when they participate in outdoor activities?**

○ Yes
○ No

**If yes, who provides sunglasses for children?**

☐ Childcare center provides sunglasses for all children served.
☐ Parents asked to provide sunglasses for their children.
☐ I do not know

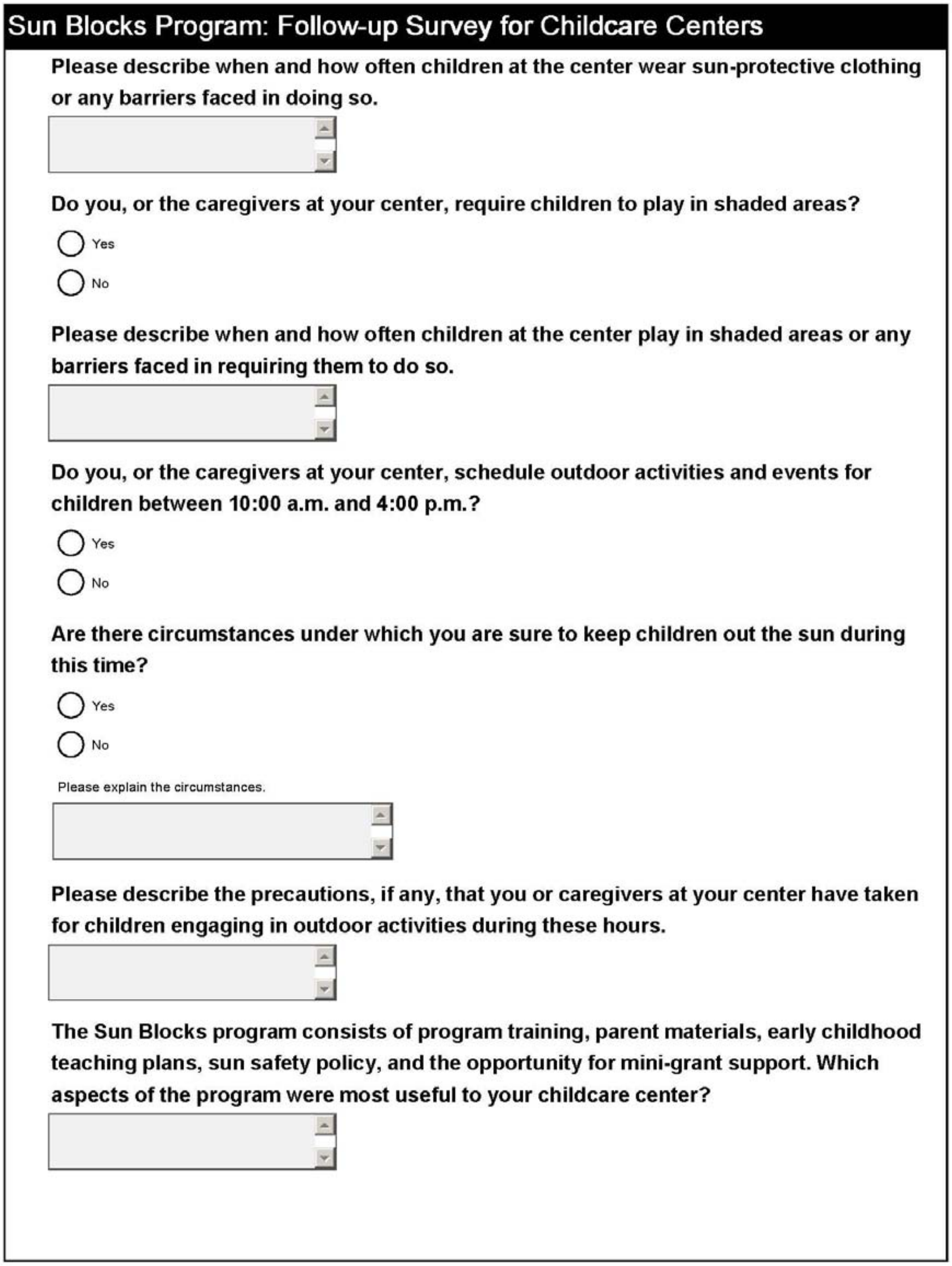
**Please describe when and how often children at the center wear sunglasses or any barriers faced in doing so.**

**Do you, or the caregivers in your center, require children to wear sun-protective clothing (i.e. sleeved shirts, pants, etc.) when they participate in outdoor activities?**

○ Yes
○ No

**If yes, who provides sun-protective clothing for children?**

☐ Childcare center provides sun-protective clothing for all children served.
☐ Parents asked to provide sun-protective clothing for their children.
☐ I do not know



## Sun Blocks Program: Follow-up Survey for Childcare Centers

**Please describe when and how often children at the center wear sun-protective clothing or any barriers faced in doing so.**

**Do you, or the caregivers at your center, require children to play in shaded areas?**

○ Yes

○ No

**Please describe when and how often children at the center play in shaded areas or any barriers faced in requiring them to do so.**

**Do you, or the caregivers at your center, schedule outdoor activities and events for children between 10:00 a.m. and 4:00 p.m.?**

○ Yes

○ No

**Are there circumstances under which you are sure to keep children out the sun during this time?**

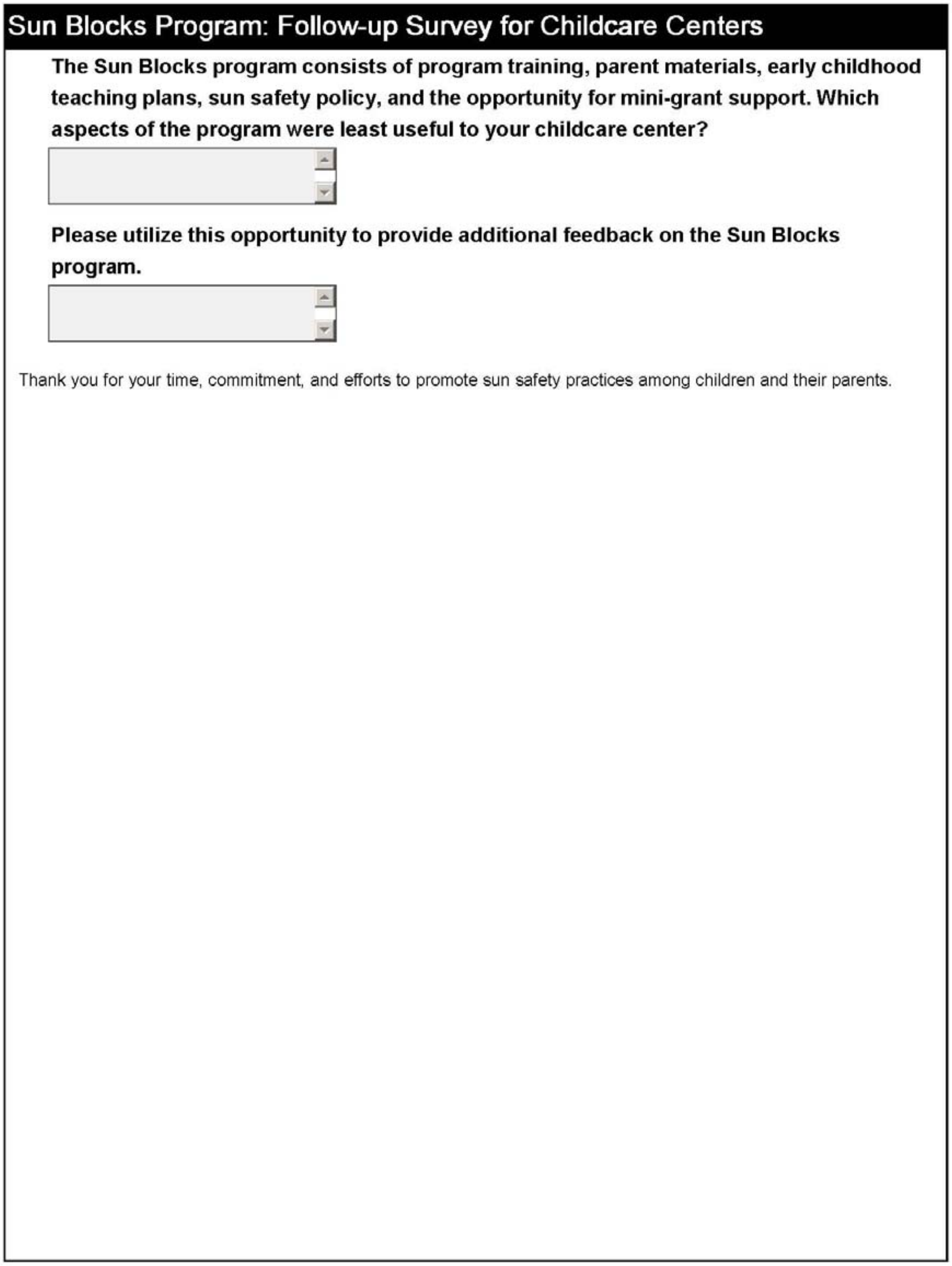
○ Yes

○ No

Please explain the circumstances.

**Please describe the precautions, if any, that you or caregivers at your center have taken for children engaging in outdoor activities during these hours.**

**The Sun Blocks program consists of program training, parent materials, early childhood teaching plans, sun safety policy, and the opportunity for mini-grant support. Which aspects of the program were most useful to your childcare center?**



**Sun Blocks Program: Follow-up Survey for Childcare Centers**

**The Sun Blocks program consists of program training, parent materials, early childhood teaching plans, sun safety policy, and the opportunity for mini-grant support. Which aspects of the program were least useful to your childcare center?**

**Please utilize this opportunity to provide additional feedback on the Sun Blocks program.**

Thank you for your time, commitment, and efforts to promote sun safety practices among children and their parents.

# Appendix L:

# Healthy Maine Partnerships Colorectal Cancer Grant Survey

# Healthy Maine Partnerships: Colorectal Cancer Screening Awareness
# 2009/2010 Grant Assessment Survey

## SECTION I: Grant Year Three Activities

Please answer the questions in this section based on your third year grant work and activities only.

1. Have you completed the year three activities identified in your grant work plan?
   YES__________
   NO___________ Why not?

2. What were the enhancers to the implementation of your year three work plan?

3. What were the barriers to implementing your year three work plan?

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

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

5. What specific targeted audiences [population] did you work with and in what venue [locations such as the worksite, the hospital, etc.]? 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<br>Community members 50 years and over | |
| Yes or No<br>Local employers, employees | |
| Yes or No<br>Healthcare providers | |
| Yes or No<br>Other audiences | |

6. Please identify all resources and/or materials that you have developed in grant year three 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)
7. Please provide an estimate of the percentage of year three 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:

## SECTION II: Overall Impact of Three-year Grant

Please answer the questions in this section based all the grant work/activities you have done over the three years of funding.

8. How (and for what reasons) did your work plan change over the three years of the grant?

9. Have you reached the initial grant goals and objectives you identified at the start of the grant in year one?

YES_____
NO_____ Why not?

10. Please identify the impact your overall [all three years] grant activities have had in your community?

11. Overall, has this three year grant been easy to administer? Why or why not?

12. What would you recommend should be done differently if there is another round of funding specifically for Colorectal Cancer Screening Awareness?

13. 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?

# Appendix M:

# MCCCP Logic Model

This program logic model is based on the Socio-Ecological Model and Framework of the Federal Colorectal Cancer Program. The goal is to evaluate processes and describe outcomes associated with start-up and implementation of the Maine Colorectal Cancer Control Program in Years 1-5. This will involve process and outcome measures, and will utilize qualitative and quantitative methods. Data will be collected over the entire duration of the program (Years 1-5), and analyzed and reported out at specific times. Both process and outcome components will be geared towards determining successful processes, areas for improvement, and program sustainability measures.

**List of Acronyms**

| | |
|---|---|
| ACS | American Cancer Society |
| CDC | Centers for Disease Control and Prevention |
| CRC | Colorectal Cancer |
| FIT | Fecal Immunochemical Test |
| FQHC | Federally Qualified Health Center |
| HMP | Healthy Maine Partnership |
| MAB | Medical Advisory Board |
| MBCHP | Maine Breast and Cervical Health Program |
| MCC | Maine Cancer Consortium |
| MCCCP | Maine Comprehensive Cancer Control Program |
| MCD | Medical Care Development |
| MCPH | Maine Center for Public Health |
| MCRCCP | Maine Colorectal Cancer Control Program |
| ME-CDC | Maine Center for Disease Control and Prevention |

## I. MCRCCP Logic Model

| RESOURCES | ACTIVITIES | OUTPUTS | OUTCOMES | | |
|---|---|---|---|---|---|
| | | | SHORT-TERM (YEARS 1-2) | INTERMEDIATE (YEARS 3-5) | LONG-TERM (YEAR 5+) |
| Maine CDC<br>o MCRCCP<br>o MCCCP<br>o MBCHP<br>MCD<br>**Key Partners**<br>US CDC<br>Health Systems:<br>o Central Maine<br>o Eastern Maine<br>o MaineGeneral<br>o MaineHealth (inc. Care Partners)<br>MAB<br>Enrollees<br>MCC CRC Task Force<br>Maine Cancer Registry<br>Maine Primary Care Assn.<br>FQHCs<br>Maine Tribes<br>ACS<br>HMPs<br>Marketing & Media Advisory Group<br>Contractors<br>o Evaluation<br>o Marketing and Media Advisory Group<br>o Media Campaign | Contracts with health systems and other partners<br>Establish and convene MAB<br>Establish policies & protocols<br>Establish data collection and monitoring systems<br>Patient recruitment<br>Promote screening via campaign to increase rates in persons over 50 years old<br>Provide CRC screening services to priority population<br>Collect, monitor, and evaluate clinical data for "average risk" persons<br>Collect and monitor cost data<br>Facilitate CRC diagnostic access and referral for complications/treatment<br>Collaborate with disparate population partners<br>Work with Marketing and Media Advisory Group on CRC screening awareness | #contracts established<br>#persons recruited and enrolled per health system<br># "average risk" persons screened (vs. overall)<br># persons screened per health system (and overall) using:<br>o Colonoscopy<br>o FIT<br>$ paid for screening kits<br># FIT returned<br># positive tests (FIT) requiring f/u colonoscopy<br># polyps detected and removed, and # persons w/ polyps detected & removed<br># cancers diagnosed<br># referrals for treatment<br>CRC incidence in:<br>o Priority population<br>o General population<br>#campaigns conducted<br>#materials distributed and/or reach (marketing contractor) | Increased CRC screening rates<br>Increased knowledge and adherence among patients around CRC screening<br>Increased knowledge, adoption, quality, and capacity among health systems around CRC screening<br>Increased community knowledge of, awareness of, and access to CRC screening | Increased CRC screening rates<br>Decreased disparities in CRC screening rates<br>Increased community and provider awareness about CRC screening<br>Increased knowledge, adoption, quality, and capacity of health systems around CRC screening<br>Increased statewide resources for CRC prevention and control<br>Reduced disparities in CRC burden, screening, and access to care | Decreased CRC incidence<br>Decreased late-stage CRC<br>Decreased CRC Mortality<br>Decreased disparities in CRC incidence and mortality<br>Policy formulation/implementation/ modification |

# Appendix N:
# Year One Process
# Evaluation Guide
# For
# Group 1: Program Management

**Group 1:**
Program management (Maine CDC, MCD)

**Purpose:**
Conduct interviews with key partners and stakeholders of the Maine Colorectal Cancer Control Program as part of the qualitative approach to understanding processes around infrastructure development/start-up in Year 1 of the grant.

**Interviewees:**

- Maine CDC
- MCD

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[Introduction] Thank you for agreeing to participate in this interview. The Maine Center for Public Health is currently contracted by MCCCP at Maine CDC to evaluate the MCRCCP Grant. As part of the evaluation, we are conducting interviews with key partners and stakeholders to evaluate processes around infrastructure development/start-up in year 1 of the grant. Today, I will be asking you questions as part of the overall evaluation effort designed to measure progress and provide feedback for program improvement. At this time, I would like to check if you received an e-mail from me on [date] with information regarding the interview format, disclosure and implications of your participation in this interview? [Obtain response] Do you have any questions about the content of the e-mail that should be addressed before we begin? [Obtain response, and then proceed with questions]

**How would you describe your current role with the MCRCCP Grant?**
How long have you been involved with MCRCCP? MCCCP?

**Which components of the MCRCCP infrastructure were already in existence prior to the start of the grant?**
What components had to developed (ex. new collaborations)?
Who are the external stakeholders/partners?
What are the roles of external stakeholders/partners?

**How is MCRCCP being integrated into/collaborating with MCCCP?** (only Maine CDC staff)
Can you give me an example?
Can you explain that further?

**Was the MCRCCP designed to be easily incorporated into existing service delivery systems at the four participating health systems?**
Can you give me an example?
Can you explain that further?
What about MCRCCP data collection and monitoring systems? (only Eric Dimbleby)

**Did the MCRCCP adapt to fit local service delivery structures at the four participating health systems?**
Can you give me an example?
Can you explain that further?
What about MCRCCP data collection and monitoring systems? (only Eric Dimbleby)

**From your perspective, what were facilitators in the MCRCCP start-up phase?**
Can you give me an example?

Can you explain that further?
What was successfully implemented? Why?

**From your perspective, what were challenges in the MCRCCP start-up phase?**
Can you give me an example?
Can you explain that further?
What was not implemented? Why?
What has been done, but has not worked?

**Overall, what were the "lessons learned" as part of the infrastructure building process?**
Can you think of successes that you can build upon moving forward?
Can you think of challenges that you will need to address moving forward?

**Are there things that may need to change in order to improve management and delivery of the MCRCCP?**
Can you explain that further?
How would that change affect success?
What about the challenges you mentioned that have not been resolved? (only ask if relevant)

**What infrastructure is available to sustain activities beyond the MCRCCP funding period?**

**Is there any question that I should have asked?**
And your response to that question would be…?

**Do you have anything you would like to add to complete the interview?**

Thank you for your time, and I appreciate your willingness to share your perspective.

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# Appendix O:

# Year One Process Evaluation Guide For Group 2: Health Systems

**Group 2:**
Health Systems (Central Maine, Eastern Maine, MaineGeneral, MaineHealth)

**Purpose:**
Conduct interviews with key partners and stakeholders of the Maine Colorectal Cancer Control Program as part of the qualitative approach to understanding processes around infrastructure development/start-up in year 1 of the grant.

**Interviewees:**
- Health System Administrators
- MCRCCP Coordinators

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[Introduction] Thank you for agreeing to participate in this interview. The Maine Center for Public Health is currently contracted by MCCCP at Maine CDC to evaluate the MCRCCP Grant. As part of the evaluation, we are conducting interviews with key partners and stakeholders to evaluate processes around infrastructure development/start-up in year 1 of the grant. Today, I will be asking you questions as part of the overall evaluation effort designed to measure progress and provide feedback for program improvement. At this time, I would like to check if you received an e-mail from me on [date] with information regarding the interview format, disclosure and implications of your participation in this interview? [Obtain response] Do you have any questions about the content of the e-mail that should be addressed before we begin? [Obtain response, and then proceed with questions]

**How would you describe your current role with the MCRCCP?**
How long have you been involved with the MCRCCP?
To what degree do you feel “In the loop” about grant activities?

**What screening infrastructure components (ex. health system capacity, clinical resources, and partnerships) were already in existence?**
What components had to be developed (ex. billing; reimbursement system)?

**Were the resources provided to support infrastructure (ex. fiscal support, training, staff availability) adequate?**
Can you give me an example?
Can you explain that further?
In particular, were the availability of and assistance from program staff at MCD adequate? Can you give me an example? Can you explain that further?

**How did enrollees hear about the program?** (only MCRCCP coordinators???)
Can you give me an example?
Can you explain that further?
How is the 1-877 number working for your health system? Has your health system experienced any challenges with it?

**Was the MCRCCP designed to be easily incorporated into the existing service delivery structure(s) at your health system?**
Can you give me an example?
Can you explain that further?

What about MCRCCP data collection and monitoring systems? (only MCRCCP coordinators)

**Did the MCRCCP adapt to fit local service delivery structures at your health system?**

Can you give me an example?
Can you explain that further?
What about MCRCCP data collection and monitoring systems? (only MCRCCP coordinators)

**From your perspective, what were facilitators in the MCRCCP start-up phase?**

Can you give me an example?
Can you explain that further?
What was successfully implemented (ex. in-reach and out-reach, patient navigation, recruitment strategies? Why?

**From your perspective, what were challenges in the MCRCCP start-up phase?**

Can you give me an example?
Can you explain that further?
What was not implemented? Why?
What has been done, but has not worked?

**Overall, what were the "lessons learned" as part of the infrastructure building process?**

Can you think of successes that you can build upon moving forward?
Can you think of challenges that you will need to address moving forward?

**Are there things that may need to change in order to improve management and delivery of the MCRCCP?**

Can you explain that further?
How would that change affect success?
What about the challenges you mentioned that have not been resolved? (only ask if relevant)

**What local infrastructure is available to sustain activities beyond the MCRCCP funding period?**

**Is there any question that I should have asked?**

And your response to that question would be…?

**Do you have anything you would like to add to complete the interview?**

Thank you for your time, and I appreciate your willingness to share your perspective.

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# Appendix P:

# Year One Process Evaluation Guide For Group 3: Medical Advisory Board

**Group 3:**
Medical Advisory Board

**Purpose:**
Conduct interviews with key partners and stakeholders of the Maine Colorectal Cancer Control Program as part of the qualitative approach to understanding processes around infrastructure development/start-up in year 1 of the grant.

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[Introduction] Thank you for agreeing to participate in this interview. The Maine Center for Public Health is currently contracted by MCCCP at Maine CDC to evaluate the MCRCCP Grant. As part of the evaluation, we are conducting interviews with key partners and stakeholders to evaluate processes around infrastructure development/start-up in year 1 of the grant. Today, I will be asking you questions as part of the overall evaluation effort designed to measure progress and provide feedback for program improvement. At this time, I would like to check if you received an e-mail from me on [date] with information regarding the interview format, disclosure and implications of your participation in this interview? [Obtain response] Do you have any questions about the content of the e-mail that should be addressed before we begin? [Obtain response, and then proceed with questions]

**How would you describe the role of the MAB in the start-up phase of the MCRCCP?**

**How would you describe your role as an MAB member for the MCRCCP?**
How long have you been involved with the MCRCCP?
To what degree do you feel "In the loop" about MCRCCP activities?

**In terms the MAB meeting process, were you comfortable in contributing to discussions? Voicing your opinions?**
Why or why not? What factors would have made for a more conducive MAB meeting process?

**Would you consider serving on the MAB for the MCRCCP as a good use of your time?**
Why or why not? What would have made it a good use of your time?

**Was the work of the MAB a worthwhile contribution to the MCRCCP?**
Why or why not? What would have made it a worthwhile contribution?

**From your perspective, what were facilitators in the MCRCCP start-up phase?**
Can you give me an example?
Can you explain that further?
What was successfully developed/implemented (ex. procedures/algorithms/protocols)? Why?

**From your perspective, what were challenges in the MCRCCP start-up phase?**
Can you give me an example?
Can you explain that further?
What was not implemented? In brief, how and why?
What has been done, but has not worked?

**Overall, what were the "lessons learned" as part of the MAB process?**
Can you think of successes that you can build upon moving forward?

Can you think of challenges that you will need to address moving forward?

**Is there any question that I should have asked?**
And your response to that question would be…?

**Do you have anything you would like to add to complete the interview?**

Thank you for your time, and I appreciate your willingness to share your perspective.

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