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MAINE COMPREHENSIVE CANCER CONTROL PROGRAM

A REPORT ON EVALUATION FISCAL YEAR 2010-2011

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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I. ACRONYMS

ACoS	**American College of Surgeons**
ACS	**American Cancer Society**
AMT	**Activity Monitoring Tool**
BRFSS	**Behavioral Risk Factor Surveillance System**
CCC	**Comprehensive Cancer Control**
CCPH	**Center for Community and Public Health**
CDC	**U.S. Centers for Disease Control and Prevention**
CME	**Continuing Medical Education**
F/U	**Follow-up**
HMP	**Healthy Maine Partnership**
HPV	**Human Papillomavirus**
IRB	**Institutional Review Board**
MAB	**Medical Advisory Board**
MBCHP	**Maine Breast and Cervical Health Program**
MBOH	**Maine Bureau of Health (Now ME-CDC, see below)**
MCCCP	**Maine Comprehensive Cancer Control Program**
MCD	**Medical Care Development**
MCRCCP	**Maine Colorectal Cancer Control Program**
MCS	**Maine Cancer Society**
ME-CDC	**Maine Center for Disease Control and Prevention**
MYRBS	**Maine Youth Risk Behavior Survey**
PCP	**Primary Care Physician**
PRAMS	**Pregnancy Risk Assessment Monitoring System**
RDC	**Resource Development Centers**
STD	**Sexually Transmitted Disease**
YRBS	**Youth Risk Behavior Survey**
UV	**Ultraviolet**

II. EXECUTIVE SUMMARY

BACKGROUND

The Maine Center for Disease Control and Prevention, Department of Health and Human Services, contracted with the Center for Community and Public Health (CCPH) at the University of New England (UNE) 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. Maine's 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 cumulative five-year implementation of the 2006-2010 Cancer Plan;
- the development and writing of the 2011-2015 Cancer Plan;
- the effectiveness of the Maine Cancer Consortium partnership in relation to the restructuring of the Consortium;
- key MCCCP-related program activities and accomplishments;
- key MCCCP program initiatives; and
- population outcomes for core cancer indicators.

Among the MCCCP specific initiatives evaluated and included in this report are:

1. *Sun Blocks* Childcare Sun Safety Program
2. Colorectal Cancer Awareness Mini-grants: Healthy Maine Partnerships
3. Maine Colorectal Cancer Control Program

PURPOSE OF THE REPORT

This 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 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 2006-2010 Maine Comprehensive Cancer Control Plan (Cancer Plan). The *Activity-Monitoring Tool* was used to track progress in reference to successful implementation for all strategies listed in the Cancer Plan. For the overall five years of implementation, the results suggest that 200 of the 254 (79%) of the strategies were achieved either partially or completely. The new five-year plan (2011-2015) will also track plan progress on an annual basis through a process being developed during the summer of 2011. The first status review for the new Cancer Plan will be completed in the fall of 2011, just after the year one anniversary of the 2011-2015 Cancer Plan's introduction.

2011-2015 Cancer Plan Development and Introduction

Two thousand ten marked the completion of the second five-year Cancer Plan for the state of Maine. In May of 2009, the Maine Comprehensive Cancer Control Program (MCCCP) and the Consortium embarked on a year-long process of developing the third Maine Cancer Plan. The 2011-2015 Cancer Plan Development section of this report briefly reviews this year-long project and stakeholder satisfaction with the overall planning and Cancer Plan development process. 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 and stakeholders. The survey results from the October 21, 2010 Cancer Plan Kick-Off Meeting reflect that the meeting was successful in realizing its goals, and was an appropriate and motivational vehicle for introducing the new plan to community partners and stakeholders who will bring the plan to life.

Maine Cancer Consortium

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 brief summary of the data collected through both the survey and the interviews. The partnership findings were a critical element in the discussions and decision to restructure the Consortium during the timeframe covered by this evaluation report. The new structure, in addition to the pursuit of 501c3 status, will increase the Consortium's ability to garner and enhance resources for Maine, ensure the work of the Consortium's membership aligns with the 2011-2015 Cancer Plan goals and objectives, and most effectively and efficiently utilizes the energy of the partnership.

2010-2011 MCCCP Accomplishments

Maine's Comprehensive Cancer Control Program completed the fourth year of its second five-year program implementation grant from the U.S. Centers for Disease Control and Prevention (CDC). In July of 2010, the MCCCP sponsored a site visit from the CDC that garnered excellent marks for the superior work being done by the program. Since MCCCP's inception there have been a number of notable achievements and this section of the report highlights some of the 2010-2011 accomplishments.

Childcare Sun Safety Program

The third year of the *Sun Blocks* Childcare Sun Safety Program implementation began in August, 2010. 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. A baseline evaluation survey was administered in August 2010, with follow-up conducted in April 2011.

A total of 32 childcare providers attended the August training. Of these, 23 were recipients of mini-grant funding. Quantitative findings suggest that providers receiving Sun Blocks funding have been successful in implementing sun protection-related policy and program-related changes among funded providers. The same providers have had less success in enforcing strict requirements relating to use of hats, sunglasses, and sun-protective clothing among children. However, qualitative responses generally indicate that providers have been doing more to encourage the use of these items. Funding for training and educational materials is likely to have played an important role in this. Overall, providers expressed great gratitude for the funds and training, and were able to use them to raise awareness in communities and improve their own capacity for reducing childhood exposure to ultraviolet radiation.

Colorectal Cancer Awareness Mini-Grants: Healthy Maine Partnerships

In 2010, the MCCCP announced the availability of Colorectal Cancer Awareness Mini-Grants to support the Healthy Maine Partnerships in their efforts to promote colorectal cancer prevention and early detection within their communities. The collaborative mini-grants were awarded to all eight Public Health Districts in Maine. The evaluation results presented in this report reflect that individual HMPs worked collaboratively within their districts to achieve objectives. This year's mini-grant also enhanced coordination and collaboration between HMP district-wide work and the statewide MCRCCP media and education efforts.

Maine Colorectal Cancer Control Program Media Campaign

The Maine Comprehensive Cancer Control Program (MCCCP) undertakes multimedia efforts to promote colorectal cancer (CRC) screening and raise awareness of the Maine Colorectal Cancer Control Program (MCRCCP). These efforts exist in the form of a website, phone hotline, radio and television public service announcements (PSAs), social media, and earned media strategies. Materials were created to align with key messages of the Center for Disease Control and Prevention's (CDC) national *Screen for Life* campaign.

A paid media campaign took place in November and December of 2010. This included TV and radio ads which aired throughout the state, and exposed the majority of Mainers in the target age range to CRC messaging. Additional media attention to CRC took place in March of 2011, which Maine's Governor LaPage proclaimed as Colon Cancer Awareness Month. During these two periods, ads and news stories focused on CRC coincided with considerable increases in visits to the Screen Me website. In March, a spike in call volume to the CRC hotline was also observed, along with an increasing number of program-funded CRC screenings. The available data suggests a correlation between media coverage, website and hotline use, and screening rates. This conforms to the pattern we would expect to result from successful efforts to leverage both paid and earned media to increase knowledge and awareness of CRC issues.

Outcome Findings

Outcome findings from several state-level disease surveillance sources are included in this report in the section titled Results Part III. Trend data is also provided when available. The findings show that the rate for tobacco use among adults reduced towards the desired program goal, while the rate for tobacco use among 9-12th graders increased. For both Youth and Adults the rates for various indicators of Cancer Risk Factors (obese, overweight, fruits and vegetable consumption) showed negative growth, while physical activity rates showed positive growth for both groups. Last, cancer screening rates showed positive growth as well.

Evaluation Recommendations

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

1. Continue to utilize evaluation results to adapt, enhance and/or expand program initiatives and Consortium team activities to ensure activities are evidence-based.
2. Embed continuous program evaluation, wherever appropriate and possible, to glean data/evidence on the effectiveness of new and emerging strategies in cancer control.
3. Ensure continued coordination between state-wide and local-level colorectal cancer awareness efforts to maximize program impact and reach.
4. Clarify the role of evaluation within the new Consortium structure to ensure that it reflects the needs of both the Consortium and the MCCCP.
5. Create a time-limited data workgroup to assess effectiveness of current data sources and the feasibility of incorporating new data sources for tracking cancer indicators.
6. Develop a comprehensive five-year evaluation plan for the next five-year request for CDC Comprehensive Cancer funding.

III. BACKGROUND

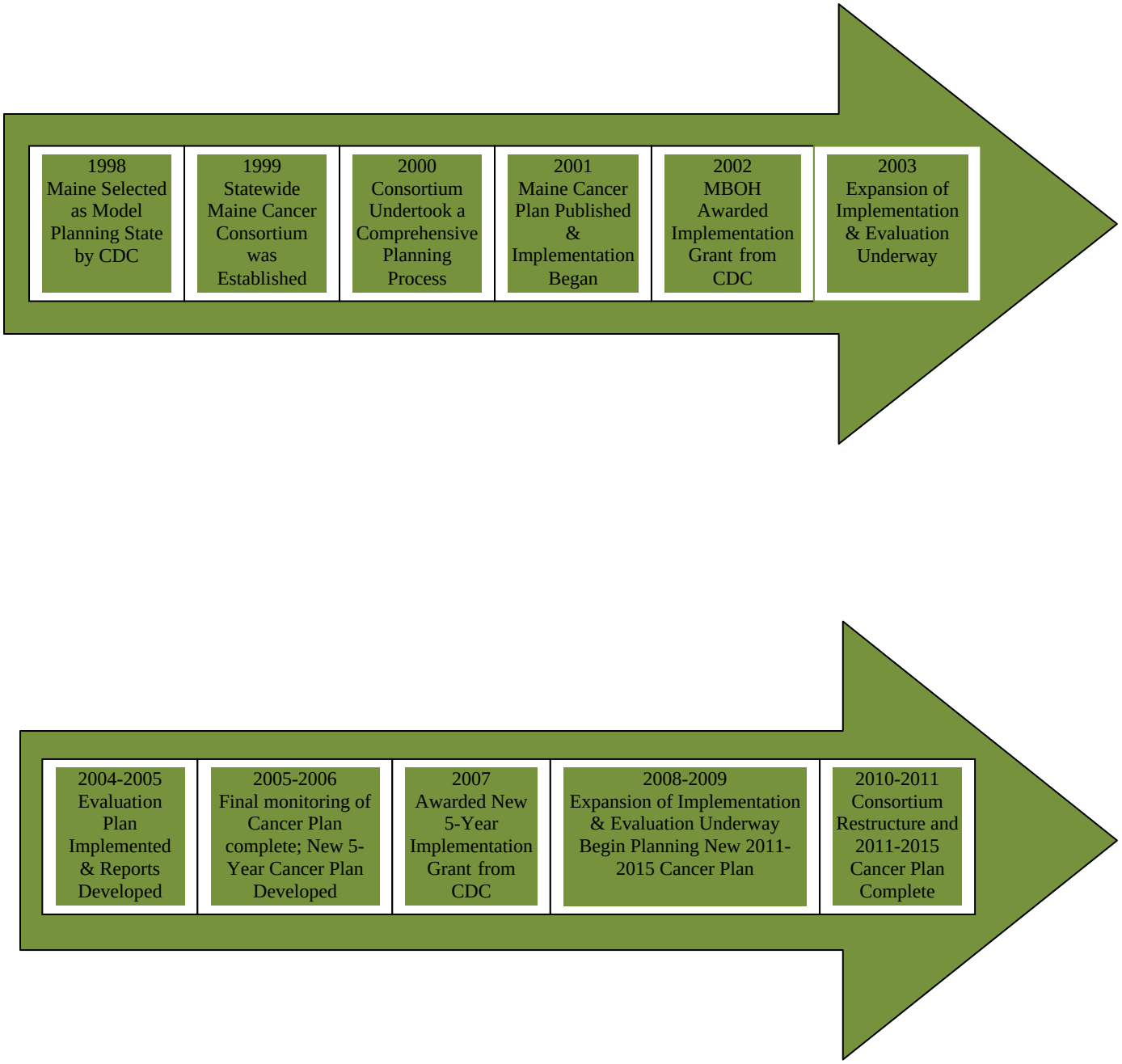
The Maine Center for Disease Control and Prevention (ME-CDC) contracted with the Center for Community and Public Health (CCPH) at the University of New England (UNE) to evaluate the statewide comprehensive cancer control initiative. This report provides information on three major areas of the program that have similar goals and objectives. They include the:

1. Maine Cancer Consortium (Consortium)
2. Maine's Comprehensive Cancer Control Plan (Cancer Plan)
3. Maine Comprehensive Cancer Control Program (MCCCP) Activities and Initiatives

As depicted in MCCCP Timeline below (Figure 1), Maine's Comprehensive Cancer Program first received CDC funding in 1998, the Consortium was established in 1999, and 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 an October 2010 rollout. A comprehensive evaluation plan was developed in 2007 and was designed to address the process, outcomes and contextual factors related to the MCCCP.

This annual report attempts to capture activities, successes, and challenges that have occurred during the previous year (July 2010 – June 2011) of implementation of the Maine comprehensive cancer control 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 (3) the Maine Comprehensive Cancer Control Plan (completion of the 2006-2010 Cancer Plan and the development and introduction of the 2011-2015 Cancer Plan). These three areas complement one another and share many activities, successes and challenges. As is true for the implementation of these three components, this evaluation report reflects the integration of the components and their shared goal of reducing Maine's cancer burden.

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



MAINE COMPREHENSIVE CANCER CONTROL PROGRAM

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

The programmatic objectives of MCCCP are:

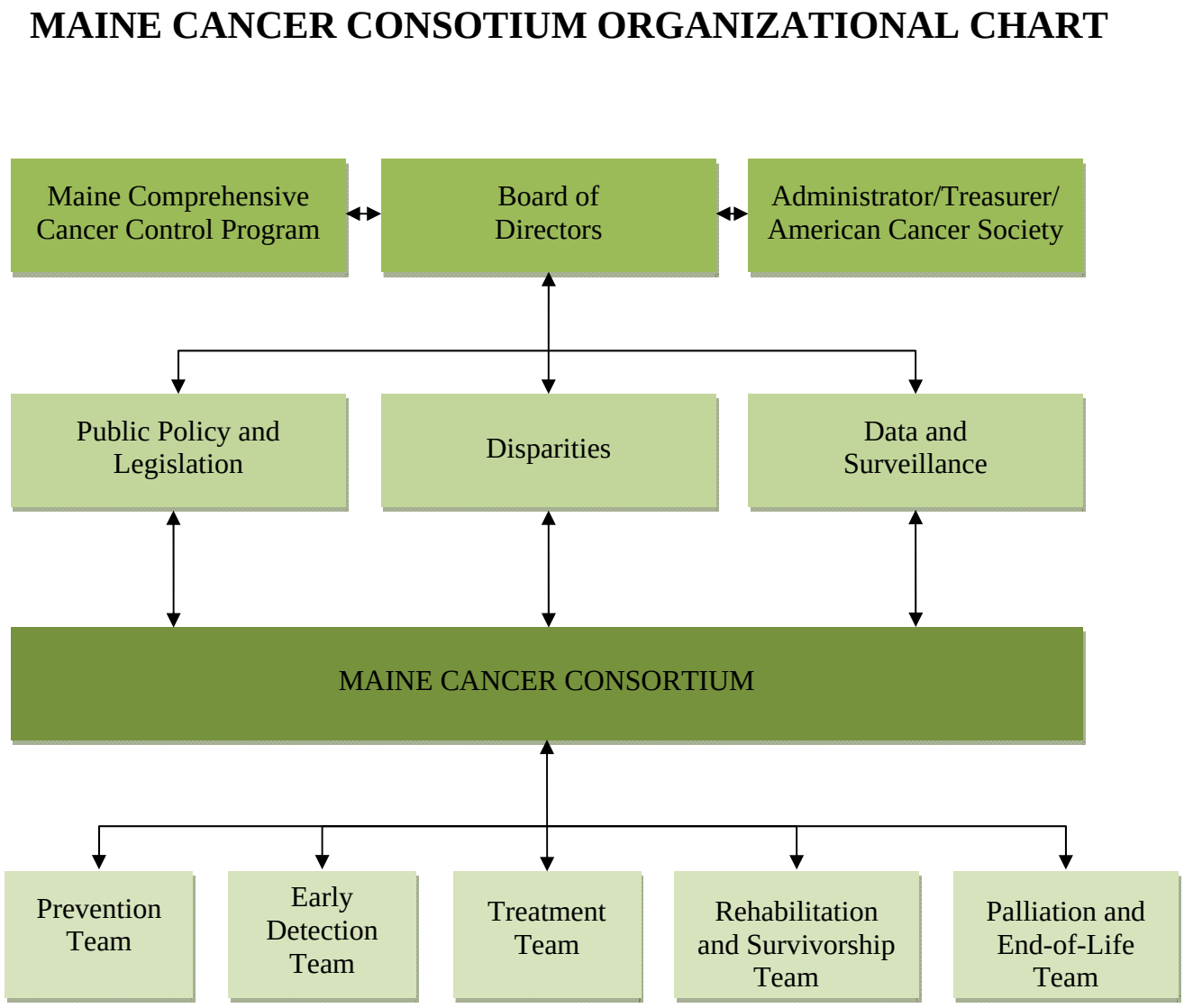
- Improve and expand the collaborative efforts already in place through the Consortium among stakeholders working on cancer control in Maine.
- Increase the use of the Cancer Plan as the statewide document directing collaborative cancer control efforts.
- Provide technical assistance to organizations 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.

In July 2011, the MCCCP will enter the final year of their second five-year implementation grant from the CDC. The program's strong performance will serve as the springboard for applying to the CDC for continuation of funding for cancer priorities in the future. Within the 2011-2012 fiscal year, a comprehensive evaluation plan will be developed to accompany future grant applications for cancer-related programs and initiatives in Maine.

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. In 2010, as a result of a number of influences (including both the Consortium Partnership Survey and interviews conducted in the spring of 2010, as well as the Cancer Plan development process) highlighted the need to revisit, and ultimately redesign, the Consortium's organizational structure. This evolution does not suggest failure of past structure, but rather growth and support for emerging needs of the organization. Moving forward into the 2011-2015 Cancer Plan, the organizational structure for the Consortium is now 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. An organizational chart for the new structure of the Consortium is provided on the next page in Figure 2 (See Appendix A for Consortium membership as June 2011).

Figure 2: Maine Cancer Consortium Organizational Chart



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

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

MAINE CANCER PLAN

The Consortium and MCCCP worked collaboratively to create the Maine Comprehensive Cancer Control Plan, published first in 2000. The third edition of this plan was introduced in October 2010 at the Cancer Plan Stakeholders Meeting. The purpose of the Cancer Plan is to provide a template for what should be done to provide statewide coordination of cancer control efforts in Maine. As with the previous two plans, the 2011-2015 Cancer Plan is designed to be a guide for the work being undertaken by many organizations and people to reduce Maine's cancer burden. The report is structured in alignment with the Consortium's new structure and sets out goals and objectives for overarching cancer issues (such as legislation, disparities, funding, etc.) as well as for each of the team content areas (such as prevention, early detection, treatment, etc.).

This report provides details on the evaluation of the full five-years of the 2006-2010 Cancer Plan that was completed in 2010. Also included is the evaluation of the 2010-2015 Cancer Plan development process along with its introduction in October of 2010 at the Stakeholders Meeting (see Results Part I section of this report).

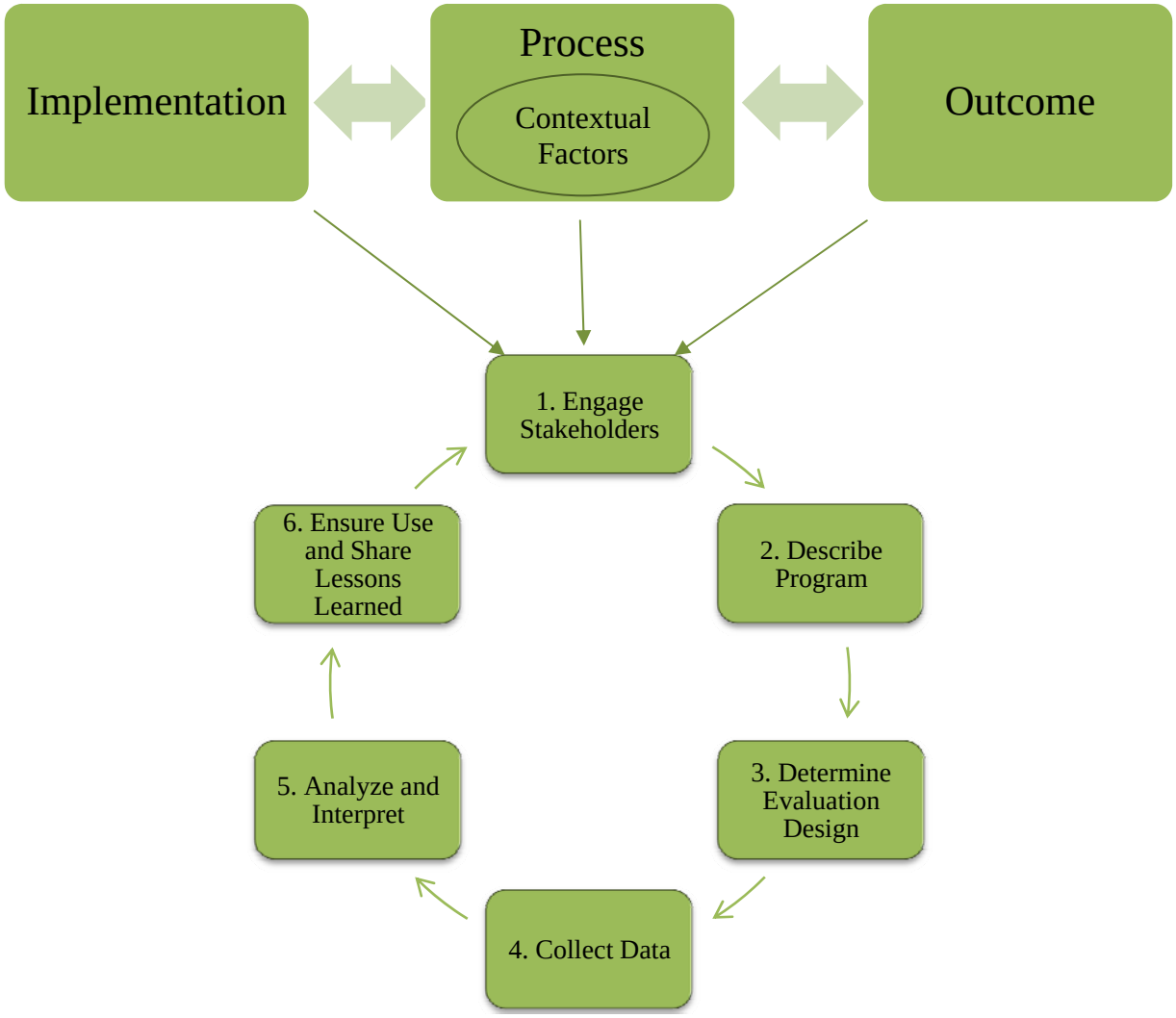
The Maine Comprehensive Cancer Control Plan 2011-2015 (current Cancer Plan) can be read in its entirety at www.cancerplanme.pbworks.com.

IV. EVALUATION DESIGN

EVALUATION FRAMEWORK

As seen in Figure 3, 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 3: 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 2010-2011 project year. All tools developed by the independent evaluator were done so using a collaborative process with the MCCCP staff and its partners.

Table 1: Data Sources

Evaluation Component	Source
Process Evaluation	
❖ **Modified Activity Monitoring Tool** - Both electronic tool and paper /pencil tracking tool used by independent evaluator with stakeholders	• Developed by Independent Evaluator
❖ **Cancer Plan Stakeholders Meeting** - Paper/pencil survey administered in October 2010	• Developed by Independent Evaluator
❖ **Cancer Consortium Annual Meeting** - Paper/pencil surveys administered in May 2011	• Developed by Independent Evaluator
Program-Sponsored Initiatives: Formative Evaluation	
❖ **Program Accomplishments** - Email, program accomplishments updates - Interviews with staff	• Developed by CCPH evaluator and MCCCP
❖ ***Sun Blocks* Childcare Sun Safety Program** - Post Training paper/pencil surveys (August '10) - Follow up electronic survey - May 2011	• Developed by CCPH evaluator and MCCCP
❖ **Colorectal Cancer Awareness Mini-Grants to Healthy Maine Partnerships** - Electronic Grant Survey administered in June 2011 - Review/analysis of standard grant reports/documentation	• Developed by CCPH evaluator and MCCCP
❖ **Maine Colorectal Cancer Control Program Media Campaign** - Secondary data from marketing reports, administrative records, and reports from HMPs - Google Analytics	• Developed by CCPH evaluator
Outcome Evaluation	
❖ **Maine Cancer Registry, CDC Wonder** - Secondary data (incidence and mortality)	• Maine-CDC • CDC
❖ **Maine Youth Risk Behavioral Survey** - Secondary data (behaviors)	• Maine-CDC • CDC
❖ **Behavioral Risk Factor Surveillance System** - Secondary data (behaviors)	• Maine-CDC • CDC
❖ **Maine Pregnancy Risk Assessment Monitoring System** - Secondary data (behaviors)	• Maine-CDC • CDC
❖ **Maine Integrated Youth Health Survey**	• Maine-CDC

V. 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. Since 2010 is the last year of the Cancer Plan, the results here also represent the cumulative success of the full five years of the 2006-2010 Maine Cancer Plan, which often served as the baseline for developing the 2011-2015 Cancer Plan.

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. With the implementation of the new 2011-2015 Cancer Plan, on-going tracking of the plan's goals and objectives will be the responsibility of the Consortium Teams. The MCCCP independent evaluators will work with the teams during the summer and fall of 2011 to establish a tracking system that can be responsive and viable for the life of the plan, as well as allowing for the annual status review of the plan's goals and objectives by the Center for Community and Public Health evaluation team.

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. Beginning in 2009 the addition of an 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. Finally, the data reflected in this report includes all activities undertaken through the fall of 2010 (when the new 2011-2015 Cancer Plan was introduced) that affected any of the goals, objectives, and or strategies as the 2006-2010 Cancer Plan over the life of the plan's implementation.

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 intervention.

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 stage of life. 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 2010 is the final year of the Cancer 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 Cancer Plan. Additionally, activities undertaken during the remainder of 2010 were collected and integrated into the spring results. At the Cancer Plan Kick-Off Meeting in October 2010, all AMT results were compiled to provide a complete picture of the overall success with implementing the 2006-2010 Cancer Plan.

Chart 1 illustrates the overall combined status of strategies (N=130) for all workgroups and task forces completing the Activity-Monitoring Tool in 2009 or 2010: Early Detection, Colorectal Cancer, Palliative and End-of-Life Care, 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 2010. 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).

Chart 1: Completion of Strategies for All Workgroups (51% of all Plan Strategies)

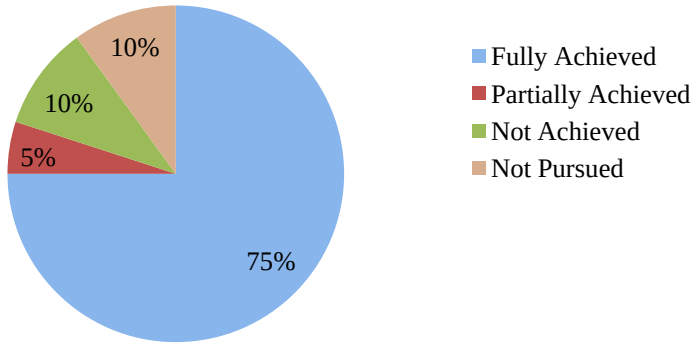
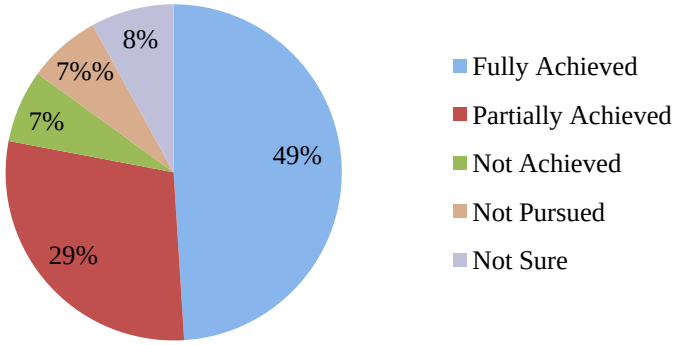


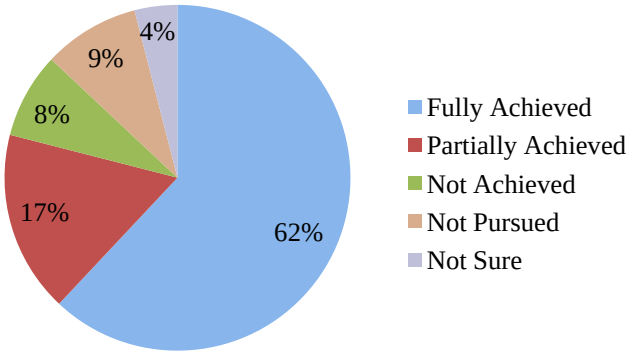
Chart 2 illustrates the overall combined status of all other strategies (N=124) that were also measured via an AMT activity. For this 49% of Cancer Plan strategies, almost half (49%) were reported as fully achieved and 29% were partially achieved. Combined 78% of non-Workgroup-tracked strategies were 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.

Chart 2: Completion of Strategies tracked by Individual Stakeholders and Partners (49% of total strategies)



Finally, Chart 3 represents overlaying Charts 1 and 2, i.e. status of all strategies tracked in 2009 or 2010 (both workgroup and individual stakeholders and partners). As the figure reflects the 2010 plan implementation goal of 79% of strategies being either achieved or partially achieved. While only 79% of the 2010 Cancer Plan Strategies were achieved or partially achieved as of April 2010 when AMT data gathering took place, another 1% was achieved by the October 2010 meeting.

Chart 3: Completion of Strategies Reported by All Sources (100% of strategies)



The overall 254 strategies tracked through the AMT efforts in 2010 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 & End-of-Life 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 & End-of-Life 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.

Additionally, Appendix B provides an 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.

Conclusions

The Consortium and the MCCCP set a high standard of achievement for the 2006-2010 Cancer Plan of realizing 80% of Cancer Plan's strategies as either achieved or partially achieved. It is commendable that the goal was almost reached. In the process of reaching 79% of the goal it is worth noting that three goal areas in the plan exceeded the 80% goal target. Implementation realized 92% of strategies, and Skin Cancer and Evaluation both realized 100% of strategies.

The new Consortium structure's integration with the 2011-2015 Cancer Plan will provide the opportunity to redesign the Cancer Plan tracking/monitoring process. It is commendable that during the development of the new Cancer Plan a great deal of work was expended to ensure that the objectives for the plan were concrete and measurable so that annual progress on the plan can be clearly recorded. The new monitoring process being developed will be crucial for re-energizing the work of stakeholders over the next five years. It will be important that the new process include mechanisms for guiding course corrections to the plan as the environment in which cancer work is being done changes over the life of the plan.

2011-2015 MAINE CANCER PLAN DEVELOPMENT

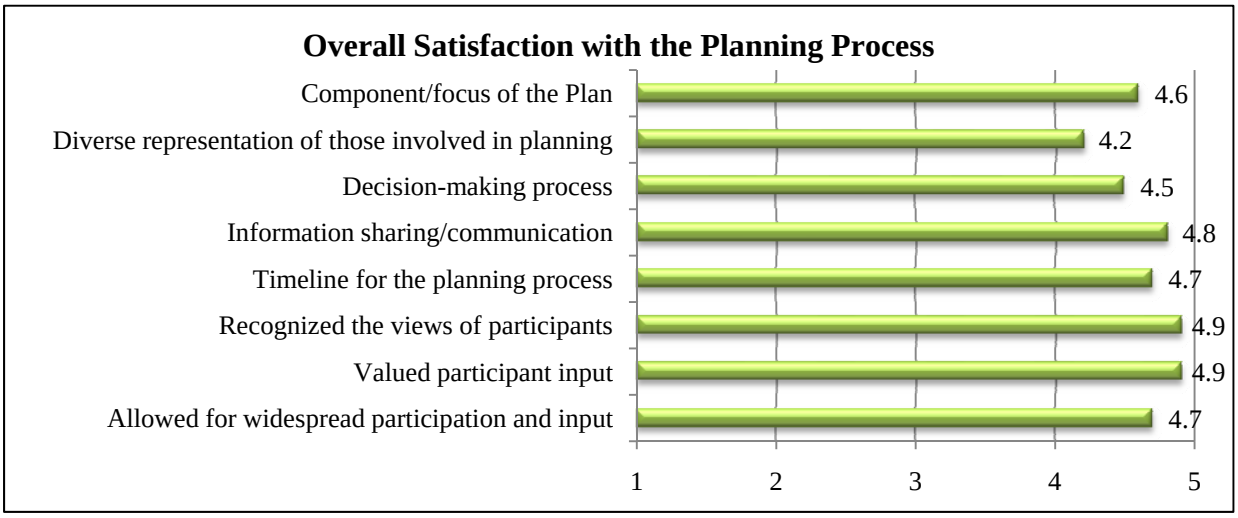
As noted earlier, 2010 marks the completion of the second five-year Cancer Plan for Maine. Beginning in May of 2009 with a Planning Meeting, MCCCP and the Consortium embarked on an 18 month process of developing the third Maine Cancer Plan (2011-2015). Thus, one of the priority program initiatives for 2009-2010 became the development and writing of this strategic plan. MCCCP scheduled two meetings for developing the plan, and in an effort to secure optimal input, the MCCCP also utilized an online collaboration tool—a Wiki—which allowed for input, ideas, comments, etc., from not only the Consortium but also from additional community members and stakeholders. This new approach to seeking and receiving input and feedback worked well both in expanding collaborative contribution and in allowing revisions and refinements to the plan at a level not previously accomplished.

Four major vehicles provided the context for evaluating the Cancer Plan development process: (1) the Planning Meeting in May 2009; (2) the Consortium's Annual Meeting in October 2009; (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); and (4) Key informant interviews done in the spring of 2010 (interview questions included ones concerning their feelings about and involvement with the planning process, and whether or not the plan reflects their cancer priorities). A synopsis of each event follows.

- **Planning Meeting for 2011-2015 Cancer Plan: May 14, 2009:** 60 participants attended and 52% completed evaluation survey with an average score of 4.5 (on a five point scale) in response to the usefulness of the meeting for planning how to develop the new plan. Example of comments included: "Good communication, help and involvement." 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 ensure that everyone has maximum opportunity for involvement and responsibility in bringing the plan to reality.

- **2009 Maine Cancer Consortium Annual Meeting: October 29, 2009:** The 2009 Annual Meeting was structured around getting input, ideas and direction for the 2011-2015 Cancer Plan. There was a 65% response rate for the evaluation survey distributed at the meeting. All respondents identified that the meeting was a good use of their time and expertise and very relevant to their work. For example, when asked if the meeting provided an opportunity to participate in creating the 2011-2015 Cancer Plan the average rating was 4.7 (on a five point scale), and when asked if the meeting gave the opportunity to provide feedback on plan development the average rating was 4.8. The following chart reflects some of the most significant evaluation findings from the meeting in relation to participant's satisfaction with their involvement in the Cancer Plan development process.

Chart 4: Overall Annual Meeting Satisfaction Rating and Respondent Comments



- **Consortium Partnership Survey Cancer Plan Participation Questions:** 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 (73%). In terms of the partners' comfort with the way decisions were made concerning what goals, objectives and strategies were included in the final plan, 85% of respondents were either somewhat, very, or extremely comfortable with the decision-making process. The positive responses 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. In reference to overall satisfaction with the plan development process, 88% were either somewhat (27%), mostly (45%) or completely (15%) satisfied with the overall process. In concert with the 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.

- **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 "Well 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."

Comments on Cancer Plan Development Process

All of the data collected reflects that the entire Cancer Plan development process was much improved over the previous processes utilized for developing the two earlier plans. The majority of contributors indicated they felt the ability to provide feedback electronically expanded access and input to the process and the plan. A majority of Cancer Plan development participants (73%) 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 Cancer 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.

Through the evaluation of the development process, it was identified that it would be good to use some 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 plans. This effort could go far in promoting and supporting the overall Cancer Plan priorities, objectives, and strategies in a way that could minimize duplication and maximize collaborative efforts across the Consortium within its new structure and the new Cancer Plan's framework.

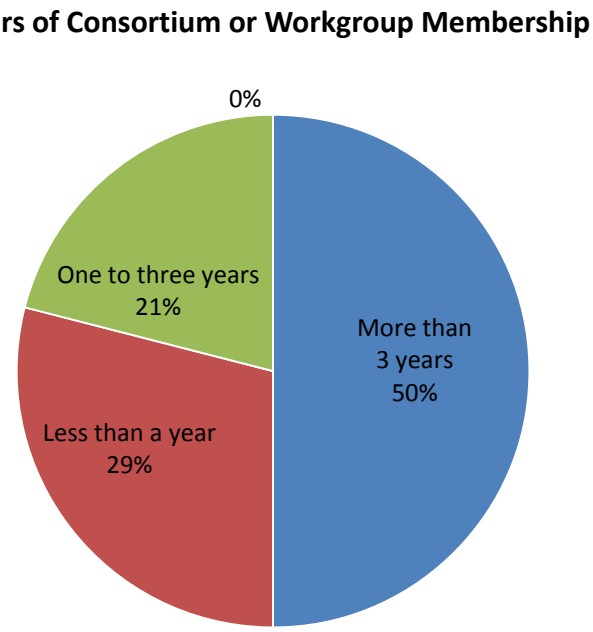
MAINE CANCER PLAN STAKEHOLDERS MEETING: OCTOBER 21, 2010

Composition of Meeting Attendees

On October 21, 2010 the Maine Cancer Consortium sponsored a day-long Cancer Plan Stakeholder's meeting to introduce and distribute the *Maine Comprehensive Cancer Control Plan: 2011-2015* to parties involved in developing and implementing the new plan. This meeting was attended by 54 stakeholders from Maine's cancer community and other interested parties , including community-based organizations such as the Healthy Maine Partnerships. Thirty-four participants returned the evaluation survey for a response rate of 63%.

The majority (85%) of attendees who completed the evaluation survey were members of the Maine Cancer Consortium or one of its workgroups, with the remaining 15% of respondents representing four (12%) non-members and one (3%) "Not sure" who indicated "off and on" membership. Of the Consortium members, fourteen (50%) have been members for over three years. Another six (21%) have been Consortium members for one to three years, and the final eight (29%) have been members for less than a year, three of which indicated that this event was their first meeting as a Consortium member. Chart 5 delineates the years of Consortium membership for survey respondents.

Chart 5: Years of Consortium/Workgroup for Respondents (n= 28)



As the above figure indicates, the Stakeholder's Meeting garnered good representation from the cancer community. Additionally, the meeting attracted those involved with developing the plan as more than half (55%) of the survey respondents indicated that they had participated in the development of the 2011-2015 Cancer Plan. All of the non-members indicated they had not been involved in development of the plan and the "not sure" attendee indicated "partial" involvement with plan development.

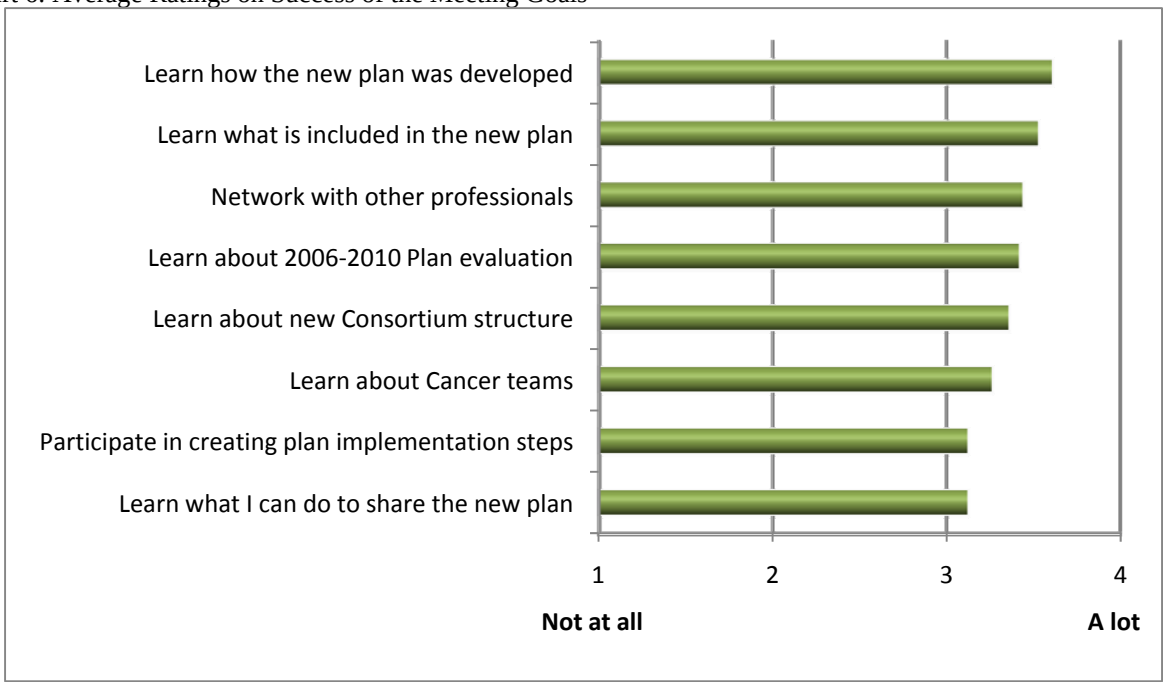
Meeting Goals

The evaluation survey asked eight questions concerning whether the meeting realized its goals of: (i) professional networking, (ii) information sharing on the success of the previous plan, how the new plan was developed, and what the new Consortium structure looks like, and (iii) strategizing on the dissemination/sharing and implementation of the new plan. All eight questions utilized a four-point scale with 1 indicating "Not at all" and 4 indicating "A lot." For six of the eight questions, all 34 respondents completed the question and for the remaining two questions, 33 respondents answered them.

The meeting did an excellent job of realizing its goals with an average of 3.36 on the 4-point scale for the eight questions in total. Learning about how the new plan was developed got the highest average rating at 3.61 and learning what is included in the plan was next highest with an average rating of 3.53. Having an opportunity to network with other professionals received an average rating of 3.44 and the evaluation presentation of the successes and challenges the 2006-2010 Cancer Plan received a 3.42 average rating. Learning about the new Consortium

organizational structure and its teams were rated at 3.36 and 3.26 respectively. Rounding out the eight questions were two questions on whether the meeting provided an opportunity to strategize about sharing the new plan and creating implementation steps for the new plan, both of which received an average rating of 3.12. Thus, of the three meeting goals, strategizing for moving forward with the plan was the least realized, however, 3.12 on a 4-point scale is still a very strong success indicator. Chart 6 delineates the ratings for the eight questions on the meeting's success at realizing its goals.

Chart 6: Average Ratings on Success of the Meeting Goals



Guest Speaker

The second section of the evaluation survey posed six questions concerning the session conducted by the guest speaker Cathy Kidman. The six questions were aligned with the learning objectives for the keynote speech and group work facilitated by the guest speaker. Based on the respondent's answers the objectives of the afternoon session were met very successfully. All 34 survey respondents answered all six questions on a four-point scale with 1 being "Not at all" to 4 being "A lot," with an average score of 3.46 across all six questions.

Attendees were asked if the session increased their knowledge of the importance of collaboration and partnerships to implementing the statewide plan, which received the highest average score of 3.62. An increase in their knowledge about the importance of adapting in times of change and challenge received an average rating of 3.54. An increase in their understanding of the importance of participation in the Consortium's efforts to bring the plan to fruition received an average score of 3.47, and an increase in their understanding of the importance of their role in motivating others to embrace the plan received a 3.46 average scoring. An increase in their understanding of their organization's role in implementing the plan and what is needed to do so

received 3.37 and 3.31 average ratings respectively. Chart 7 reflects the above noted success of the afternoon session orchestrated by Cathy Kidman.

Chart 7: Average Ratings for the Guest Speaker Session

The session increased my:

Additionally there were many comments about the guest speaker presentation and the work session she facilitated. The following is a sampling of those comments: "*Cathy Kidman was extraordinary and brought it all together,*" "*Enjoyed Cathy – very inspirational and enjoyable,*" "*Cathy Kidman was a wonderful choice – very up lifting,*" and "*☺terrific.*"

Usefulness of the Meeting

The final section of the survey consisted of three Yes/No questions (with room for comments), one scaled question (the same four-point scale as used previously), and three open-ended questions. The first four questions attended to the usefulness of the overall meeting and the final three questions addressed expanding implementation of the plan. In reference to the usefulness of the meeting, when asked how relevant the meeting was to their work, the 34 respondents provided a very good average rating of 3.69 on the four-point scale. Comments shared included:

> "*Framework for various teams is particularly helpful in accomplishing the* [plan] *objectives, and being an effective avenue for commitment*;" and
>
> "*Learned about programs that I can pass on to community members.*"

When queried about whether the meeting was a good use of their time and expertise 94% of respondents to this question answered a resounding "Yes," with 6% (2) answering "No." Comments from "yes" answers about the useful of the meeting included:

> "*A great chance to network with others doing work around the state and find ways to partner,"* and
>
> *"Presentation activities were important to note."*

Comments from the "No" answers included:

> "*I have attended numerous times and never found this useful – the plan does not reach the correct groups."*

Attendees were asked if the meeting provided them with the information and tools they need to share the 2011-2015 Cancer Plan with those who can work on it, to which 33 of 33 (100%) respondents answered in the affirmative. Comments to this question included:

> "*The information from the panel presentation was quite valuable and worth sharing,"* and
>
> "*Is there the possibility of a summary powerpoint or handout to disseminate the most important facts of the plan?"*

Additionally, attendees were asked if the meeting helped them to be a strong advocate for the goals, objectives, and strategies of the plan, to which 32 respondents provided an answer. Only two (6%) of respondents indicated "No" and the remaining 94% answered "Yes." Among the half dozen comments to this question were:

> "*Plan to present at the December [*committee title*] Committee meeting,"* and
>
> *"Networking opportunity was an effective component of this meeting."*

Finally, the three open-ended questions gave an opportunity for survey respondents to provide feedback to the Consortium on: (i) additional ways to utilize respondent's expertise when implementing the plan, (ii) suggested next steps for expanding knowledge/interest/action around the plan, and (iii) any others comments they had about the plan or the meeting. In terms of additional ways to utilize expertise, comments included:

> "*Collaboration with hospitals and worksite wellness programs,"* and
>
> *"Team participation, especially in a cross-cutting teams, such as Data."*

There were numerous answers to the question asking for suggestions for next steps the Consortium (and its members) can take to expand the knowledge, interest, and actions around the 2011-2015 Cancer Plan. Among those suggestions were the following:

> "*HMPs can bring Cancer Plan to their boards for discussion and dissemination to community in general;"*
>
> *"Update Consortium website with each team's status/progress;"*
>
> *"Encourage members (and send reminders) to make comments about the Cancer Plan on the Wiki site;"*
>
> *"Too little about some cancers, i.e. ovarian, testicular, prostate, it seems only women and children's cancers are important; need involvement of men and medical professionals (physicians), researchers from labs and teaching hospitals;"* and
>
> "*I think the focus on partnerships and collaborations is critical moving forward, and has me considering new relationships that my organization can develop."*

The final survey question provides the opportunity for respondents to comment on anything they would like to tell the Consortium about the 2011-2015 Cancer Plan process or about the meeting. Respondents provided the following comments:

> *"Today's meeting was great;"*
>
> *"I really enjoyed the lunch panel and learned a lot about their example initiatives;"*
>
> *"Excellent, stimulating, motivational;"*
>
> *"Very comprehensive! Good meeting – learned a lot about what is going on throughout Maine. Great lunch! Will attend more meetings."*

Evaluation Discussion and Conclusions

As the above data results reflect, based on those who completed the evaluation survey, the Stakeholders meeting was very successful at realizing the goals it set for introducing the 2011-2015 Cancer Plan. Based on the survey data, the agenda and content of the meeting provided participants with what they needed to understand how the plan was developed and what their role can be in seeing the plan successfully implemented over the next five years. The data also indicates that an important subliminal goal of the meeting, to get attendees excited and motivated to do the work of the new plan, was also successfully met.

The strength of the scaled responses concerning whether the meeting goals were met and whether the evaluation presentation and plan introduction presentations were engaging reflect that all were well received. The panel and the guest speaker received high marks as well. The bulk of the written comments provided on the surveys were very positive and indicate that

meeting participants are excited about the new plan and energized to implement their portions of it.

As noted above, the areas where respondents reflected room for improvement was around the creation of concrete implementation steps for meeting the plan goals and how best to share the plan in a range of appropriate venues. This finding may reflect that only 55% of survey respondents were involved in developing the plan and thus, and the other nearly half (45%) of the attendees were seeing it for the first time at the meeting. However, there is clearly an openness and willingness expressed by respondents in their comments to take on the work that lies ahead with implementing this challenging new plan. It would be advantageous for the Consortium to embrace the comments provided by ensuring that the implementation work done to move the plan forward gets shared, recorded, and rewarded so that it continues throughout the next five years.

MAINE CANCER CONSORTIUM

Two thousand and ten was a year of change for the Maine Cancer Consortium. As noted earlier, in 2010 a number of influences (including the Consortium Partnership Survey, interviews conducted in the spring of 2010, and the evaluation of the Cancer Plan development process) highlighted the need to revisit, and ultimately redesign, the Maine Cancer Consortium's organizational structure. This evolution does not suggest failure of past structure, but rather reflects growth and support for emerging needs and changing functions of the organization. Thus, as reported in depth in last year's evaluation document, the Consortium completed a major organizational restructuring in 2010. Beginning in October 2010, a new organizational chart was adopted and the Consortium began the necessary steps to becoming an independent nonprofit organization.

The new organizational structure for the Consortium is aligned around cancer teams which reflect the cancer continuum and overarching areas critical to the advancement of cancer control and care. The Maine Cancer Consortium Annual Meeting on May 19, 2011 was designed to showcase and reflect this new structure. In presenting the new structure at the annual meeting, the Consortium Board of Directors hoped to expand the opportunities for involvement in the Consortium to a wider segment of Maine's cancer community. Creating an environment for engaging both new and existing members was an anticipated outcome for both the Consortium re-structuring and the annual meeting presentations. As the following evaluation results from the annual meeting reflect, that outcome was successfully realized.

2011 MAINE CANCER CONSORTIUM ANNUAL MEETING: MAY 19, 2011

As has been the case for a number of years, the Maine Cancer Consortium Annual Meeting was well received and quite successful at realizing the goals the Board of Directors had identified for the meeting. Of the 65 attendees, 42 (65%) completed the evaluation survey tool provided at the meeting. Overwhelmingly, respondents identified that the meeting was a good use of their time and expertise, that it was relevant to their work, and that the presentations were informative.

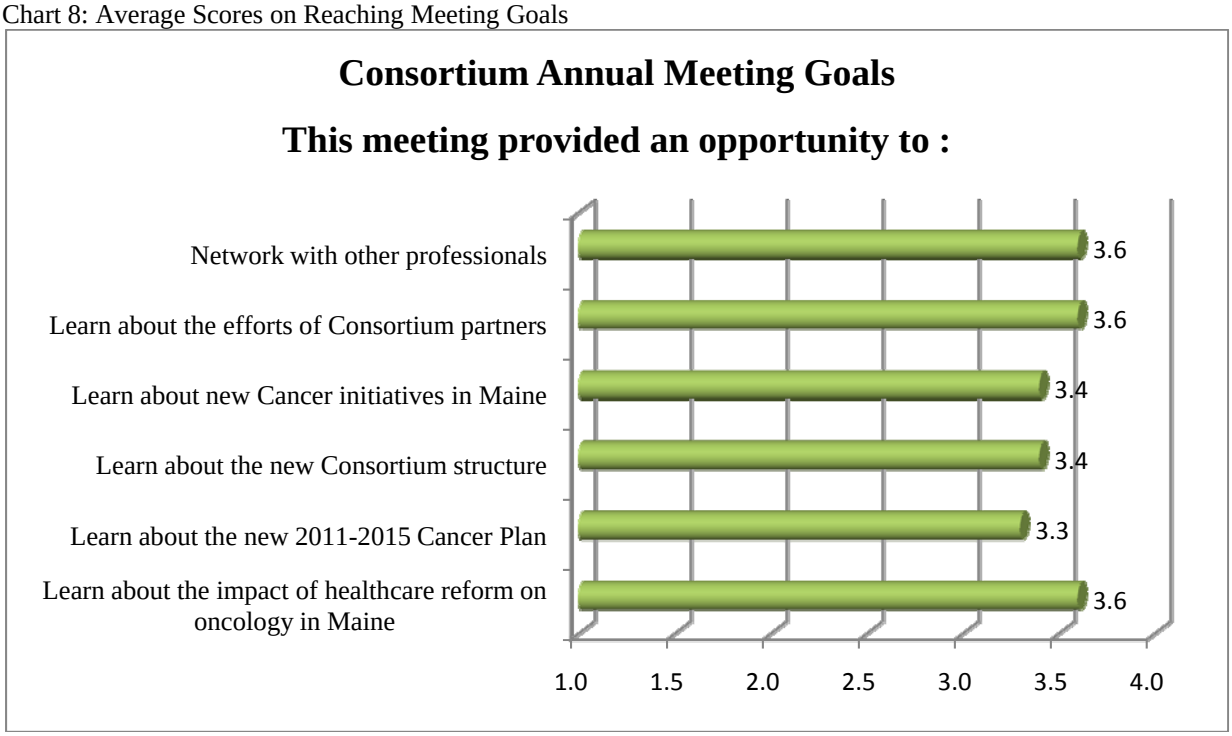
The evaluation survey tool was divided into five sections: (1) meeting goals, (2) keynote speaker, (3) overall program, (4) demographics of attendees, and (5) other information/comments. The results and findings are delineated here by survey section.

Section 1: Meeting Goals

There were six questions in this survey section which sought to determine if the meeting agenda and activities provided an opportunity for attendees to learn about key areas which the Board of Directors had targeted as goals for the day. Attendees were asked to rate the six areas of opportunity on a scale of one to four on which one represented "poor" and four represented "excellent." The average ratings for the six identified areas ranged from 3.3 to 3.6, reflecting that the activities and presentations were very effective for realizing the meeting goals. Half of the goal areas garnered a 3.6 average response and for all six goals, the bulk of responses were three's and four's.

The three opportunities offered by the meeting that received a 3.6 average ranking were: (1) Networking with other professionals; (2) Learning about efforts of Consortium partners; and (3) Learning about the impact of healthcare reform. Learning about the new Consortium structure and new cancer initiatives in Maine each received an average of 3.4, and learning about the new Cancer Plan received a 3.3 average rating. Chart 8 provides a breakdown of the average score for each goal area identified in the first section and reflects strong success of goal attainment.

Chart 8: Average Scores on Reaching Meeting Goals



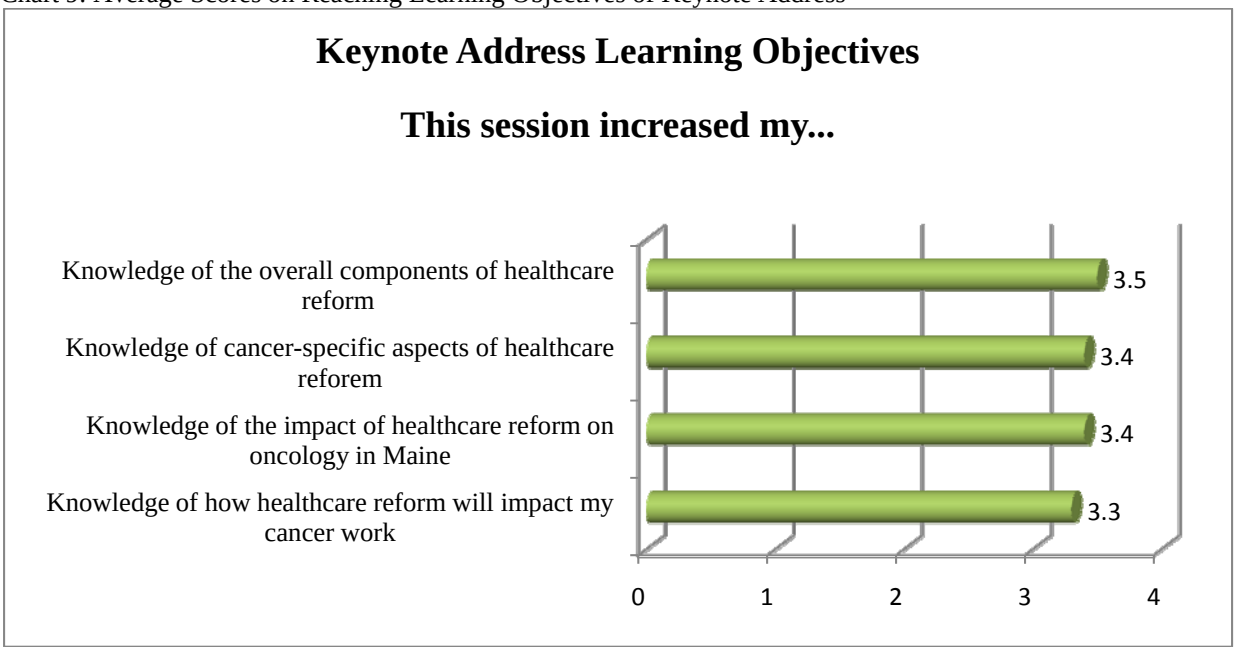
Section 2: Keynote Speaker

The keynote address for the 2011 annual meeting was given by Dr. Daniel M. Hayes who spoke on the Impact of Healthcare Reform on Oncology in Maine. The second section of the survey tool included four questions regarding whether the keynote address met its learning objectives of

increasing attendees' knowledge in four key areas. Meeting participants were asked to utilize a four point scale for increased knowledge on which one represented "none" and four represented "greatly." The average ratings for the four questions ranged between 3.3 and 3.5 with the highest ranking (3.5) attributed to an increase in knowledge of the overall components of healthcare reform. The 3.3 average ranking referenced an increase in knowledge of how healthcare reform will impact the attendee's work. Due to the diverse nature of work engaged in by attendees (such as community-based education and prevention activities) it may have been harder for participants to see how their work will be directly impacted by healthcare reform. Chart 9 provides a breakdown of the average rating for each of the four learning objectives identified for the keynote address. Additionally, there were some written comments concerning the keynote speaker which are best exemplified by this one:

"Dr Hayes is an excellent, thoughtful speaker."

Chart 9: Average Scores on Reaching Learning Objectives of Keynote Address



Section 3: Overall Program for the Day

The six questions in this section of the survey asked attendees to rate the extent to which they found the additional meeting presentations (other than the keynote address) informative or useful. Respondents were asked to utilize a four point scale on which one represented "not informative" and four represented "very informative." There was also space provided for respondents to enter comments about each presentation, an opportunity many respondents chose to take. The average ratings for these six presentations ranged from 3.4 to 3.8, which again indicates that the substantive agenda items resonated with the meeting attendees.

The legislative update was useful to the attendees who responded to the evaluation survey as this presentation received an average of 3.8 on the four-point scale and garnered 33 ratings of 4. Additionally, the legislative presentation collected 11 written comments exemplified by the following sampling of those comments:

> "*The most comprehensive presentation of Maine cancer legislation I have heard in many years. Spectacular. Very helpful. Please post to Consortium website asap;"*
>
> *"Excellent presentation even for those not aware of legislative issues;"*
>
> *"Very helpful in explaining a confusing bunch of legislation;" and*
>
> *"Excellent – easy to understand."*

The presentations on Maine General's Accountable Care contract and the HMP Prevention Initiatives both received an average rating of 3.7 and a few comments. Maine General's presentation comments are reflected in the comments below:

> "*very interesting – hopeful*;" and
> "*excellent – would have liked to hear more."*

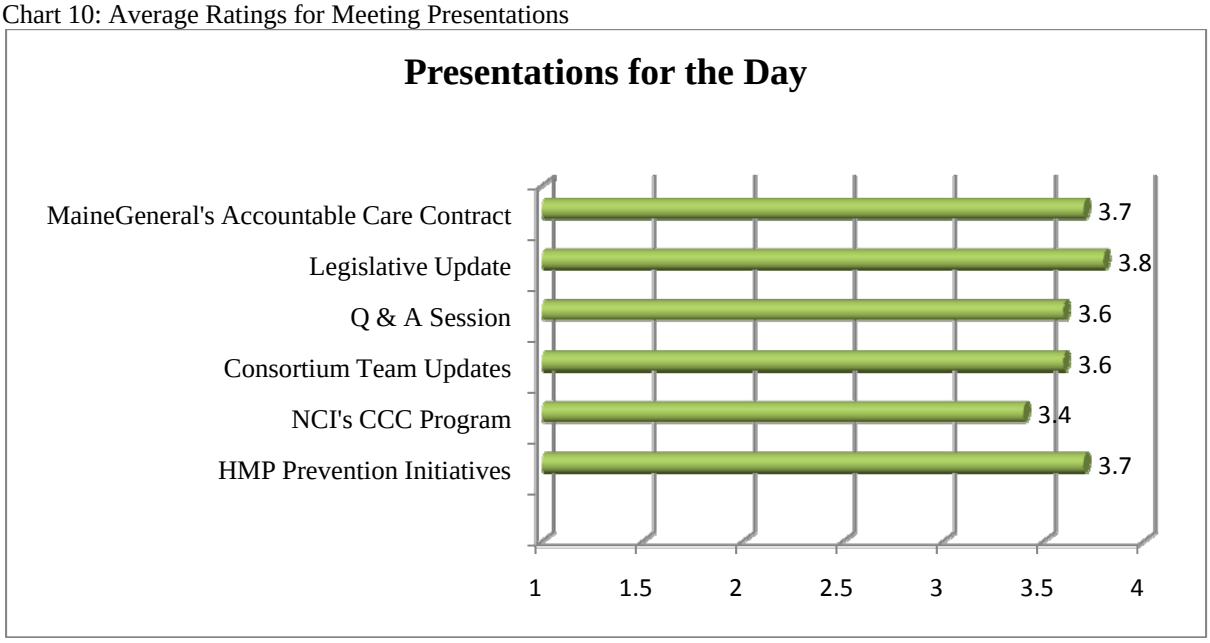
The Question and Answer Session and the Consortium Team Updates both received an average rating of 3.6 along with comments such as, "*outstanding panel,*" and, "*wish there was more time."* The NCI's Community Care Centers Program presentation received an average rating of 3.4.

Some comments in this section of the survey may be reviewed when planning next year's annual meeting program agenda. One was a comment about language used in a presentation that made it hard for the respondent to understand what was being discussed. The respondent stated *"…I'm just not familiar with some of the jargon."*

The second area for review was reflected in a few comments around the length of some panel updates. The responses suggest an expectation of presenters staying within their allocated time, and included, *"some updates too long,"* and, *"people need to keep within time limit."* Finally, a couple of comments reflected a perceived omission of credit for work done, which included, *"…likes to use other group's work…without acknowledging their sources,"* and *"…some important contributors were inadvertently excluded."*

Chart 10 provides a breakdown of the average rating for each of the six presentations that comprised the bulk of the meeting's agenda. In total, the table reflects that the Consortium chose issues that are important to those working in the cancer community across Maine.

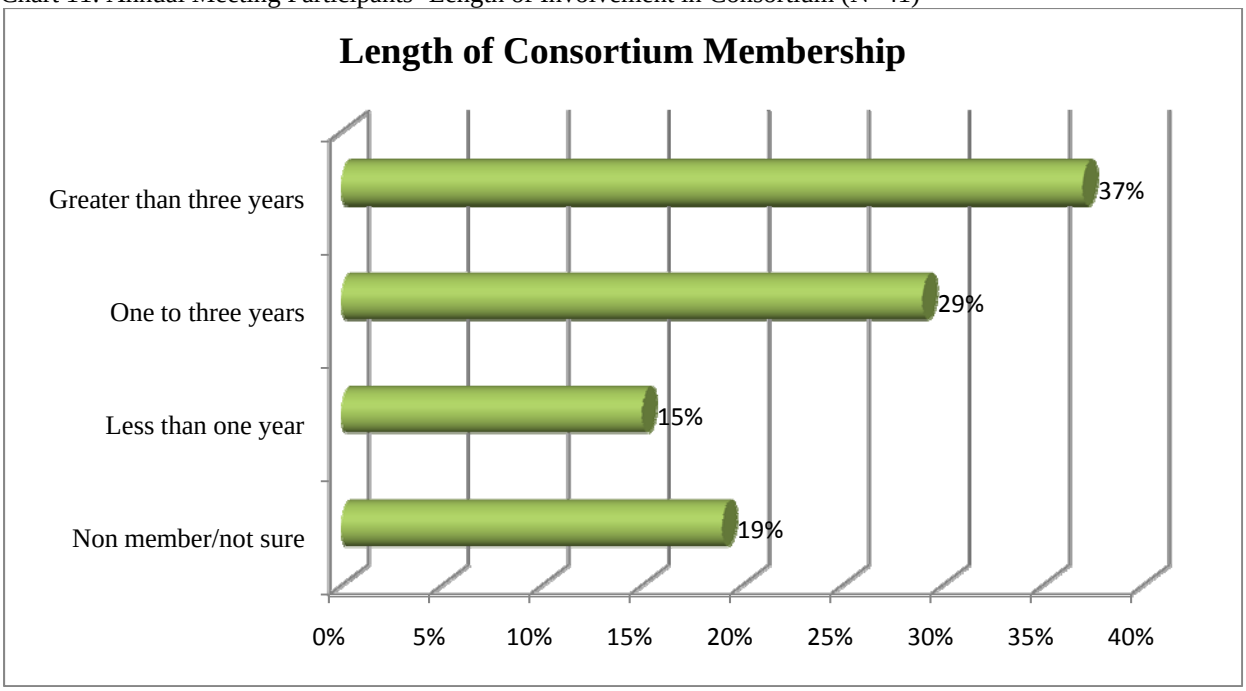
Chart 10: Average Ratings for Meeting Presentations



Section 4: Group Demographics

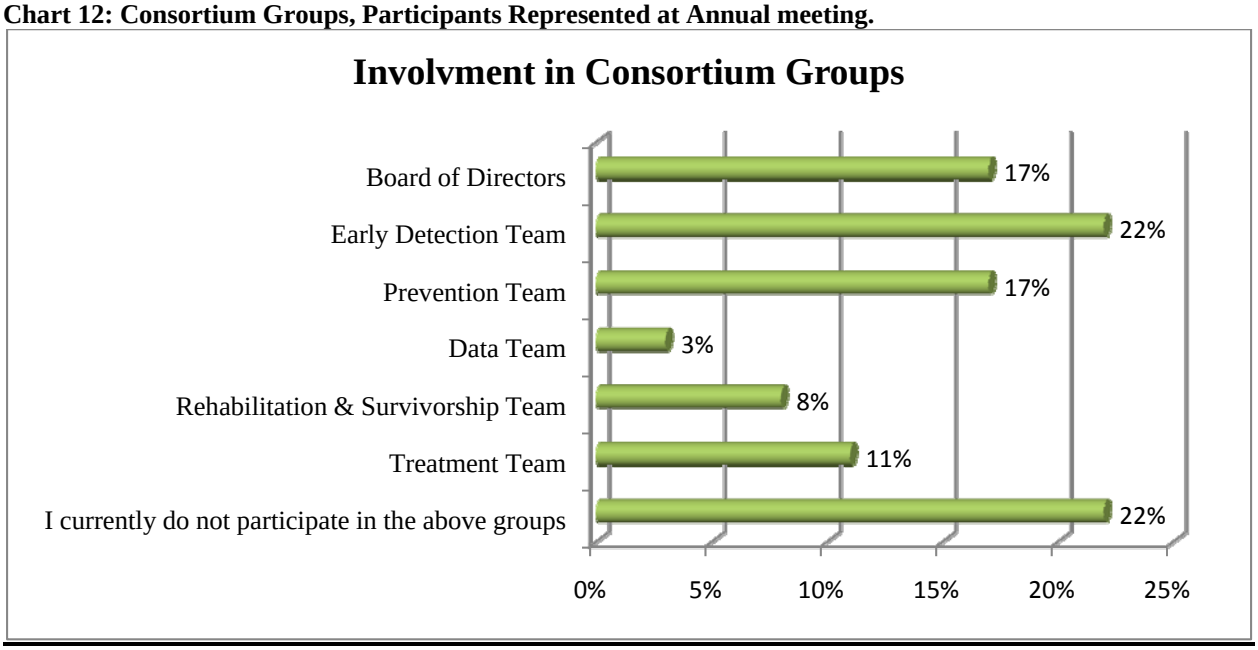
This section of the evaluation survey sought to define the demographic characteristics of annual meeting participants. Respondents were asked to identify length of Consortium membership, type of Consortium membership within the new structure, and how they participate in Consortium activities. It terms of length of membership 15 (37%) respondents, have been Consortium members for more than three years, 12 (29%) have been Consortium members for one to three years, and six (15%) have been members for less than one year. Eight (19%) respondents were either not members (12%) or not sure (7%). Chart 11 provides a breakdown of meeting participants in reference to their self-reported Consortium membership status

Chart 11: Annual Meeting Participants' Length of Involvement in Consortium (N=41)



Within the restructuring of the Consortium there are a number of vehicles for participation. The new structure includes five cancer teams (Prevention, Early Detection, Treatment, Rehabilitation & Survivorship, and Palliation & End-of-Life Care), three overarching areas (Public Policy & Legislation, Disparities, and Data & Surveillance). Six of these groups were represented through 78% (28) of the survey respondents. The remaining 22% (8) of survey respondents reported not participating in any of the groups. Chart 12 delineates which Consortium groups were represented at this year's annual meeting.

Chart 12: Consortium Groups, Participants Represented at Annual meeting.



The last question in this section of the evaluation survey asked respondents about how they have participated in Consortium activities (excluding attendance at today's meeting). For the 40 respondents to this question, 73% (29) answered that they participate in other Consortium activities, and 27% (11) answered that they did not. The most frequent reasons provided for not being involved in other Consortium activities were, "*…availability of time*," and, "*new to group"* or "*new to my job, will be more involved now*."

Section 5: Other Information and Comments

The final section of evaluation survey provided attendees an opportunity to share the relevance of the meeting to their work and to share with the Consortium anything else they may have to say about the meeting. In terms of the meeting's relevance, respondents were asked to use a four point scale (one representing "not at all" and four representing "very") to identify how relevant the meeting was to their work. The 3.6 average rating received for this question reflects that the annual meeting planning committee did a good job of targeting the issues attendees find relevant in their daily work. Additionally, 100% of survey respondents answered "yes" to the Yes/No question of whether the meeting was a good use of their time and expertise.

In reference to "additional comments" about the meeting there were nine responses that fell into three broad groups. The first were about time as represented by this statement, *"Need to honor timeline – 30 minutes over is unacceptable."* Also, in this group was a suggestion for shorter, more frequent meetings: *"Consider a half-day meeting – a lot to absorb and hard to be away all day…"*

The second group of comments complimented the structure of the meeting, and the final group of comments addressed the overall success of the day as exemplified by the following comments:

"*Excellent format, informative, appropriate topic,"*

"Excellent as always," and

"Thank you for inviting me to attend."

Discussion and Conclusions

From the strong response rate (65%) and excellent ratings for all questions on the survey, the 2011 Maine Cancer Consortium's Annual Meeting successfully met its goals, learning objectives, and the needs of its attendees/members. Based on responses, the meeting attendees were predominantly Consortium members (81%) and four of the five cancer teams were represented. The only team not represented in the survey responses was Palliation & End-of-Life Care. This may reflect the composition of that team, i.e. it has more community members not associated with a specific cancer organization that is a member of the Consortium, or it may reflect that the program content for the day did not resonate with that team's membership. For subsequent meetings the Board of Directors may want to survey the needs of all its teams to assure that the program for the day meets their needs.

That said, the program content for the day was regarded as pertinent. Healthcare reform and legislative issues were salient topics for participants and the strong ratings of both presentations support that. As noted earlier, in total, the program content of the day appears to have hit its mark in terms of engaging the audience and providing new and/or valuable information to those working within the cancer community in Maine. As one attendee commented, *"Best meeting yet! Good presenters. Informative. Good engagement with audience."*

In terms of planning for future annual meetings, there are three areas that may warrant review by the meeting planning committee. First, as mentioned above, it may be worth reviewing who attended or did not attend this meeting, and whether the program content is engaging for all the cancer teams and Consortium members. While it is never realistic to think everyone's needs can be met by the meeting agenda, there may be content areas that could draw a broader group of Consortium members. If a goal of the new structure is to increase participation in Consortium activities and events by community members, the annual meeting should pique the interest of this new population.

Second, as identified earlier, there may still be some confusion around how people fit into the new Consortium structure, particularly if they are not directly connected to a Consortium member organization. Moving forward it would be good for the Consortium to clearly identify the various vehicles for Consortium involvement, (i.e. team participation, expertise area, Board of Directors, etc.) for the populations the Consortium wants to engage on a consistent basis. Among the 42 survey respondents there were eight who said they did not participate in a Consortium group and three who were not sure if they are a Consortium member, and who may

fall into the easy to recruit category for Consortium membership since attending the annual meeting itself indicates an interest in engagement with the Consortium.

Finally, as with any event there are a couple of logistical points that should be reviewed for future planning. The first is timing. It should be expected and enforced for program presenters to stay within the time frames identified. The second is language. It can't be expected that presenters can change the content-specific language of the field, however, it might be well to remind or request of presenters to be respectful that not all in the audience are enmeshed in cancer-related language. The goal should not be just to use less "jargon," but rather to appreciate that jargon creates a barrier to understanding for those who aren't familiar with it.

VI. RESULTS PART II: IMPLEMENTATION

2010-2011 PROGRAM ACCOMPLISHMENTS

Two thousand ten marked the beginning of the fourth year of a five-year CDC implementation grant awarded to the Maine Comprehensive Cancer Control Program (MCCCP). In 2002, and then again in 2007, MCCCP 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 $87,531 in in-kind contributions from Maine Cancer Consortium members and staff during 20010-2011fiscal year.
- Provided significant staff support to the Maine Cancer Consortium, individual workgroups, and the Board of Directors.
- Sponsored and/organized the Maine Cancer Consortium's Annual Meetings, and Annual Board of Director's Retreats
- Established and supported infrastructure for the Maine Colorectal Cancer Control Program (MCRCCP).
- Initiated and managed statewide ScreenME campaign for Colorectal Cancer prevention and detection awareness, including "Turn Maine Blue" initiatives in March of 2011.
- Initiated and facilitated the process for developing and introducing the Maine Comprehensive Cancer Control Plan: 2011-2015.
- Awarded mini-grants totaling $160,000 to the Healthy Maine Partnerships to advance colorectal cancer public education and awareness efforts.
- Provided mini-grants totaling $40,000 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 nearly 50 childcare providers through implementation of the *Sun Blocks Childcare Sun Safety Program*.
- Provided technical assistance to Care Model efforts by the Healthy Maine Partnerships.

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 2010-2011 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 TRAINING EVALUATION: AUGUST 2010

SunBlocks: Building a Foundation for Healthy Skin

I. Background

The 2010 *SunBlocks* Program training for childcare providers and resource development centers from across the state was held in Augusta in August 2010. Thirty-three people attended the training and all 33 trainees completed the evaluation surveys, thus providing an excellent response rate of 100%. Four (12%) of the 33 survey respondents indicated they had attended an earlier *SunBlocks* training. As was the case in the previous two years in which the *SunBlocks* training was provided, participants overwhelmingly rated the training as excellent, engaging, and very useful to their work with children, parents, and staff. Illustrative of the strong success of the training are the reasons given be those four attendees for whom this was a repeat performance:

"I learn more every year! I love this program!";

"New ideas are always useful, new staff training material";

"Updated information, reinforces information.";

"This is wonderful and I truly feel that we need to get the RDC's to help promote it."

II Organization of Training

The evaluation survey tool was divided into four sections with three sections using a rating scale and the fourth providing opportunities for participants to write their responses. Sections 1, 2, and 3 utilized a five point scale on which 1 indicated "Very Poor" and 5 indicated "Excellent."

Section 1 posed three questions concerning how well the training was organized. As Table 3 below reflects, survey participants provided strongly positive responses to the organizational aspects of the training (questions 1 to 3) with 75% giving them a 5 rating and another 24% giving them a 4 rating – only 1 (1%) trainee used the 3 point of the scale. Chart 1 depicts the descriptive statistics (count, frequency, mean, and median) for each question in Section 1, all of which are overwhelmingly favorable.

Table 3**:** Survey Section 1 - Organization of the Training (n=33)

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 0.0%	0 0.0%	0 0.0%	6 18.2%	27 81.8%
2. How would you rate the length of the training in relation to the amount of information covered? (Mean= 4.6; Median=5.0)	0 0.0%	0 0.0%	1 3.0%	11 33.3%	21 63.7%
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 0.0%	0 0.0%	0 0.0%	7 21.2%	26 78.8%

III. Training Objectives

Section 2 of the evaluation survey posed seven questions concerning whether the training met its stated objectives. Table 4 below depicts the descriptive statistics (count, frequency, mean, and median) for each question in Section 2, and reflects another set of overwhelmingly favorable responses. Taking all seven questions in total, 58% of respondents marked the 5 rating ("Excellent"), with another 40% marking the 4 rating on the scale. The 3 rating was utilized only 6 times (2%) for the seven questions. The question that received the bulk of those 3 ratings (4 of the 6) was the question that asked participants to rate their knowledge of the training objectives, which may speak to a need to more clearly identify and reinforce the training objectives throughout the training day.

Table 4**:** Survey Section 2 - Objectives of the Training (n=33)

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=4.2; Median=4.0)	0 0.0%	0 0.0%	4 12.1%	17 51.5%	12 36.4%
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=4.3; Median=4.0)	0 0.0%	0 0.0%	1 3.0%	17 51.5%	15 45.5%
6. Describe the importance of routinely practicing proper sun safety with children attending childcare centers. (Mean=4.8; Median=5.0)	0 0.0%	0 0.0%	0 0.0%	6 18.2%	27 81.8%
7. Discuss the components of the proposed sun safety policy. (Mean=4.5; Median=5.0)	0 0.0%	0 0.0%	0 0.0%	15 45.5%	18 54.5%
8. Assess the UV index and identify appropriate sun protection measures. (Mean=4.7; Median=5.0)	0 0.0%	0 0.0%	0 0.0%	11 33.3%	22 66.7%
9. Implement the childhood sun safety seasonal teaching plans. (Mean=4.6; Median=5.0)	0 0.0%	0 0.0%	1 3.0%	12 36.4%	20 60.6%
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 0.0%	0 0.0%	0 0.0%	14 42.5%	19 57.5%

IV. Training Presentation

The last section of rated responses, Section 3, queried participants on the presentation of the training. The bulk of the survey respondents indicated the training presentation was balanced in reference to learning styles and presentation styles, and was of high quality. Fifty-nine percent (59%) of survey respondents provided an “Excellent” (5 on the scale) rating to the three questions in this section. Another 40% provided a 4 rating and only one (1%) of survey respondents used the 3 on the scale for one question. Table 5 depicts the descriptive statistics (count, frequency, mean, and median) for each question in Section 3.

Table 5**:** Survey Section 3 - Presentation of the Training (n=33)

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=4.5; Median=5.0)	0 0.0%	0 0.0%	0 0.0%	16 48.5%	17 51.5%
12. How would you rate the balance of presentation styles? (Mean=4.5; Median=5.0)	0 0.0%	0 0.0%	1 3.0%	14 42.5%	18 54.5%
13. How would you rate the overall quality of the presentation? (Mean=4.7; Median=5.0)	0 0.0%	0 0.0%	0 0.0%	10 30.3%	23 69.7%

V. Open-ended Questions on Overall Training

The final section of the training evaluation survey consisted of seven open-ended questions that provided participants the opportunity to write their responses and comments. Many participants took the time to compose an answer to all of the open-ended questions, which from an evaluation perspective indicates high levels of satisfaction and excitement among participants at the end of the training day. By way of example, 32 or the 33 survey respondents (an excellent response rate to an open-ended question) chose to answer the question, "*What was most useful part of today's training for you?*" The responses to that question fell into four broad categories, (i) training content (overall education and specific activities); (i) resources and handouts; (iii) networking opportunities; and (iv) policy implications/development. A sampling of the comments in each of the categories includes the following:

(i) Usefulness of training content

> *"I think the information in the beginning of the training about sun screen, UV rays and skin cancer was very useful. It has forever changed my thinking of sun damage and prevention,"* and
>
> *"The sunblocker babes, the activities and different ideas to involve the kids."*

(ii) Usefulness of resources and handouts

> *"The USB and notebook of materials to aid in implementing this information,"* and
>
> "*Training materials and networking with others for ideas as to how to implement policy."*

(iii) Usefulness of networking opportunities

> *"Networking, getting materials to provide to parents and use with staff and children,"* and "*Lots of networking w/ great ideas from past participants."*

(iv) Usefulness for policy development

> *"The discussion with other providers and ideas for our safety. The materials are excellent and will be very helpful in making my policy,"* and
>
> *"The information, just myself becoming more informed, I feel with the information I can confidently address a policy for our center."*

Participants were asked if they received training materials, and were those materials in a format that is useful to them. Twenty-two survey respondents answered this question with over a third (37%) mentioning the flash drive as especially useful. All responses indicated that the materials were "*extremely helpful*" and that training participants are anxious to use them at their centers. A representative sampling of the answers to this question includes:

> *"I think the USB flash drives are a fabulous idea. They make it really easy to access and print out materials. The flash drives make the resources very accessible!"*
>
> *"Can't wait to get them home to share with rest of staff and parents!"*
>
> *"I will plan on using these references to develop our policy," and*
>
> *"This is the best part, wonderful training materials… flash drive. Contacts for other professionals and easy to use materials."*

Participants were queried about what, if any, additional information or skills they might need to feel confident to implement the childhood sun safety teaching plans. Seventeen survey respondents provided an answer to this question. Most respondents indicated that they had gotten what they needed from the training other than the "*practice*" they need to actually do back at their centers. They feel they need to put to use what they have learned at the training or as a couple of respondents stated:

> *"Practice and more ideas for older kids, 5th and 6th graders…"*and
>
> *"I think it will all come together with experience in implementing it in my childcare [center]."*

Participants were also asked about what, if any, additional information or skills they might need to establish a sun safety policy at their center. Thirteen respondents provided an answer to this

question. Again, the written responses indicate that trainees felt they got what they needed at the training:

> "*This training did a wonderful job of giving me the information I need to create and implement a sun safety policy in my childcare [center]*."

A couple of respondents asked for additional information, as these two comments reflect:

> "*We need more information on shady places and what we could do to get more shade. Like building ideas,*" and
>
> *"Refresher class later in the year."*

Participants were also asked about how important the availability of scholarship funds (if received) was to their attendance at training today? Twenty-five respondents chose to provide an answer to this question with "*very*," "key," "*high*," and "*very important*" being phrases frequently included in those responses. A representative sampling of the 25 responses includes the following:

> "*Funding is so important in this economy! I am so grateful for it!!"*
>
> *"The scholarship fund was very useful to pay for someone to take my place;"*
>
> *"Very important. Being from Northern Maine required hiring a staff and traveling. Being a new center funds are limited and this grant will be greatly appreciated and put to good use!"*
>
> *"I would have attended anyway, but am so excited to have received the grant;"* and
>
> *"Extremely Important."*

Finally, the survey asked if there is anything they would suggest that be changed or done differently in a future training. Of the seventeen respondents who answered this question, almost half (47%) suggested no change is needed with comments ranging from, "*Not really*" to "*No, good time length, good information. Thanks."* Among the suggestions offered by the other nine respondents are the following:

> *"More activities for older school age children;"*
>
> *"Have people introduce themselves and where they are from (to assist with networking);"*
>
> *"More ideas for shade solutions for the grant"* and
>
> *"Pose questions that providers (or situations) have encountered (opposition) to help us be prepared."*

There was a space at the end of the survey for respondents to provide any additional comments and fourteen participants chose to respond in this section. Along with a multitude of "*thank you,*" all of comments were positive remarks about the setting, the materials, the trainers, the food, etc. A representative sampling of those fourteen responses includes:

> *"Setting was great. Other attendees gave great information and the materials were very clear & helpful;"*
>
> *"This training was well worth the traveling! I have walked away with so much wonderful information that will definitely change the way I implement sun care in my childcare facility;"*
>
> *"This was the best class I've ever attended! So professional and organized. Everyone was so nice, good food, also answers everyone's questions the best they can;"*
>
> "*Excellent training! Well worth the time and I traveled 3 hrs to get here;"* and
>
> "*Terrific job, ladies! Impressive!"*

VI. Evaluation Discussion and Conclusions

The extremely strong scaled and open-ended responses on the evaluation survey clearly suggest that there is not much that needs to change in this training curriculum and presentation. Overall, participants were very pleased with the training and identified little that could make it better. That said, there were a few suggestions that warrant review as the 2011 training is designed. From an evaluation perspective it seems useful to revisit how the training objectives are initially framed (and continuously reinforced) within the training as some respondents were not clear about them.

Additionally, there were some concrete needs for additional information that the trainers may want to incorporate (such as suggestions for shade area resources), or be clearer about what is not part of the training (such as activities for older children). There were also some operational suggestions about changes to the training which may warrant review as the 2011 training is developed, for example, introductions and clear designation of the grantees from current and past years. However, for the third year in a row, the *SunBlocks* training curriculum and trainers got rave reviews, thus one would be hesitant to change any components of the training very dramatically, or as the training participants so eloquently said about changing the training:

> "*Nothing. Everything was perfect and so professional;"*
>
> *"Nothing, this is my second training and it was awesome… see you next year;"* and
>
> *"This was wonderful, a beautiful space! The information was so worth the training. Thank you for bringing awareness to 3-5 year olds!"*

SUN BLOCKS CHILDCARE SUN SAFETY PROGRAM

Introduction

Skin cancer is one of the contributors to cancer incidence in Maine.[1] Exposure to harmful levels of ultraviolet (UV) radiation during childhood and adolescence increases the risk of developing basal and squamous cell carcinomas, as well as melanoma, as adults.[2,3] 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 healthy, 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.

The third year of the *Sun Blocks* Childcare Sun Safety Program implementation began in August, 2010. The Maine Comprehensive Cancer Control Program (MCCCP) provided mini-grants of up to $1,000 to childcare providers 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 provider, regardless of the level of skin cancer prevention and sun safety activities at the time of application. Funded providers were required to attend a training event in August to learn about implementing sun protection practices and policies. Providers that did not receive funding were also welcome to attend the training.

A total of 32 childcare providers attended the August training. [The training was evaluated in the previous section of this report.] These providers completed a baseline survey. Twenty-three childcare providers were the recipients of mini-grant funding. Of these, all but two had not previously received funding through the *Sun Blocks* program. These providers received a total of $20,000 in funds, which was distributed in $1,000 and $500 mini-grants. Additionally, several non-funded childcare providers, and a select group of Healthy Maine Partnerships (HMPs) and Resource Development Centers (RDCs), participated in the August training session. 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. This report reviews findings from baseline and follow-up surveys to assess the implementation and reach of the 2010-2011 Sun Blocks mini-grant program.

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[1] 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.

[2] 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.

[3] 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.

Findings

In conformance with the analyses from previous years, baseline survey responses were grouped into three categories based on type of childcare provider. Group A consists of funded providers, Group B, non-funded, and Group C, HMPs and RDCs. The number of providers in these groups is as follows:

Number of baseline survey responses by group:

Group A	**Group B**	**Group C**
23	5	4

The follow-up survey was distributed via email on May 2, 2011. In the prior week an email was sent to all participants to notify them that they would be receiving the survey. Participants were given two weeks to respond. For funded recipients, response to the survey was a required component of the mini-grant. This requirement resulted in a 100% response rate from those participants. Responses from providers in groups B and C were much lower, with only one response from each group.

F/U survey response information

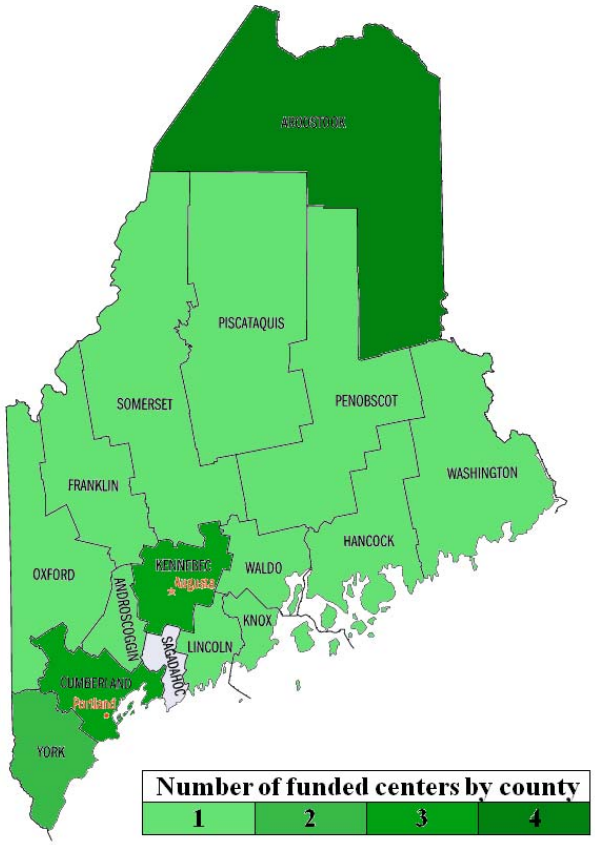
Group A			**Group B**			**Group C**		
Completed	Total	Response Rate	Completed	Total	Response Rate	Completed	Total	Response Rate
23	23	100%	1	5	20%	1	4	25%

Since response rates from participants in groups B and C were small for both baseline and follow-up surveys, this analysis will focus on the mini-grant-funded providers (group A).

Demographic Information

Mini-grants were distributed to childcare providers located throughout Maine. Of Maine's 16 counties, all but one (Sagadahoc) are home to at least one mini-grant recipient. This is an increase from last year, when 4 counties were not represented.

Figure 4: Number of Funded Providers by County



Respondents were asked to identify their facility as a childcare providers, Head Start or Early Head Start, nursery or preschool, Family Child Care Home, RDC, or HMP. Details on how facilities self-identified in baseline and follow-up surveys are provided in Table 6. Note that several participants self-identified as more than one type of facility.

Table 6: Self-identified type of provider among funded providers in baseline and follow-up surveys

Provider Type	**Baseline**	**Follow-up**
Childcare center	14	15
Head Start or Early Head Start	7	7
Nursery or preschool	5	3
Family Child Care Home	4	4
RDC	0	0
HMP	0	1

Differences in self-reported provider type are likely due to the fact that different staff members may have filled out the baseline and follow-up surveys. However, responses are similar enough that they provide a sense of the distribution of mini-grant funding based on provider type.

As part of the follow-up survey, funded providers reported the following details:

Chart 13: Number of Children

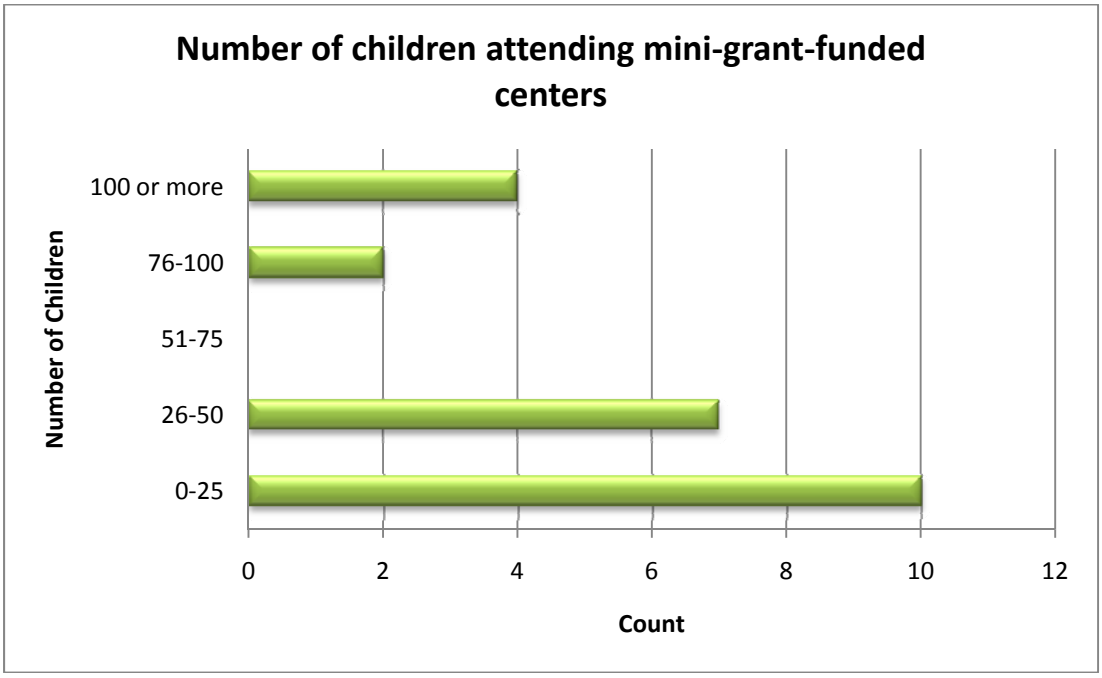
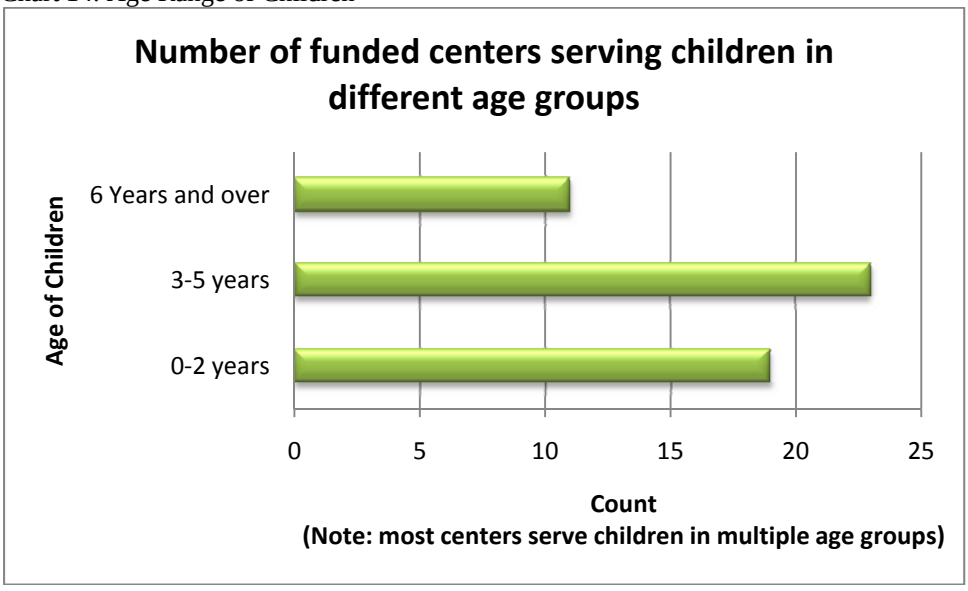


Chart 14: Age Range of Children



Note that two providers reported that they had previously received Sun Blocks funding; one in year one and another in year two of the program.

Sun Protection Practices: Comparative Findings from Baseline and Follow-Up Surveys

Table 7: Baseline and Follow-Up Responses to Sun Protection Practices Questions (number and percent of all responding)

Question text	**Number responding "Yes"**	
Do you, or the caregivers in your center…	**Baseline n (%)**	**Follow-Up n (%)**
apply sunscreen to children before they participate in outdoor activities?	23 (100)	22 (100)
require children to wear hats when they participate in outdoor activities?	9 (40.9)	9 (40.9)
require children to wear sunglasses when they participate in outdoor activities?	5 (22.7)	5 (22.7)
require children to wear sun-protective clothing when they participate in outdoor activities?	2 (9.5)	1 (4.5)
schedule outdoor activities and events for children between 10:00 a.m. and 4:00 p.m.?	21 (100)	22 (100)

Most providers reported that sunscreen is typically applied twice a day, between 15 and 30 minutes before children play outside. Two respondents stated that they ask parents to apply sunscreen in the morning before children are dropped off.

Most providers reported that they recommend that children wear hats, but do not require it. Several stated that they purchased hats with mini-grant money. Typical barriers relating to use of hats and sunglasses include these items being removed or lost by children, or simply not fitting correctly.

Very few providers reported requiring children to wear sun-protective clothing, citing that it is too costly to provide or require parents to purchase. Ultimately, use of hats, sunglasses, and sun-protective clothing is typically being left to the parents' discretion. Interestingly, the two providers that responded "yes" at baseline to the question regarding clothing, responded "no" at follow-up. In the related open-ended question, these providers indicated that the decision is left to the parents. Overall, responses suggest that cost and time constraints make it difficult for providers to require children to have and wear protective clothing. The one follow-up "yes" response came from a provider that had answered "no" at baseline.

While all providers schedule outdoor activities during peak sun hours, many reported in the follow-up survey that they are mindful about leading activities in shaded areas. One provider reported checking UV conditions before planning outdoor activities. In general, the determining factor in whether children played outside on a given day is temperature more so than UV conditions.

Responses to open-ended follow-up questions are informative. They suggest that, while providers are not strictly requiring the use of certain items as a result of the mini-grant awards, they are becoming increasingly aware of their importance, and are actively encouraging

use. In several instances, providers reported that mini-grant funds have helped make these items more readily available to children. Selected comments relating to these questions are provided below.

Table 8: Responses to questions relating to use of sunscreen, sunglasses, hats, clothing, and shaded play areas

Please describe when and how often sunscreen is applied to children while at the center or any barriers faced in doing so.
• *"Sunscreen is applied to all children at least 1/2 an hour before going outside, and it is applied twice a day. One barrier we face is the time it takes to apply it to all of the children. For instance, in a classroom of 24 children it can take up to half an hour."* • *"We ask parents to apply before drop-off each morning to cover our early morning outside time. Then we re-apply each time we go out after that."*
Please describe when and how often children at the center wear hats or any barriers faced in doing so.
• *"Children are asked to wear hats at all times outside. However, obstruction occurs when they are on the playground equipment. Hats are too large even though they are children's sizes and come off frequently."* • *"As part of our new policy it is a recommendation, not a requirement. Staff provide hats for children to use and encourage them to use them outside. Some kids take them off and won't wear them."* • *"The children are offered and encouraged to wear the hats, but it's difficult to "make" them wear hats, especially infants and young toddlers. They tend to want to take them off once on."* • *"Bucket hats were purchased with the mini-grant and offered to each child for outdoor activities."*
Please describe when and how often children at the center wear sunglasses or any barriers faced in doing so.
• *"We do not require that the children wear sunglasses outside, although we do encourage it. Our biggest barrier with this is that the children lose or misplace them."* • *"Only occasionally. This seems to be a "catch 22" topic. I feel that, along with the benefits of wearing eye protection, there is also a risk of eye injury when young children wear them during active play. We are discussing this further as a staff."* • *"We do not require but recently purchased the sunglasses and we will be recommending and reinforcing for the children to keep their sunglasses on."*
Please describe when and how often children at the center wear sun-protective clothing or any barriers faced in doing so.
• *"We can't ask parents to provide sun-protective clothing because of extra expense. However, we ask them to bring long sleeved shirts and pants."* • *"No, it is recommended but not required. It is up to parents and they are encouraged to provide children with appropriate clothing."* • *"Only a few of the children wear sun protective clothing. It is not cost effective for the families to purchase this type of clothing."*
Please describe any successes and/or challenges involved [in scheduling outdoor activities and events for children between 10:00 a.m. and 4:00 p.m.]?
• *"During the summer we often find shaded spaces for picnic lunches however, will play outside at 9 and 4."* • *"We go on three field trips a week and their (sic) are times when there is no shading around, but with our new canopies that can travel we can make that happen for them."* • *"We get the UV ray warnings, so when it is really high, we go out earlier."* • *"The children often play under the newly added shade structures, even when not required to do so."*

When asked about specific precautions taken for children playing outdoors during peak sun hours, responses included the following:

- *"We would provide plenty of water, inside breaks in the A/C, hats and water play."*
- *"We make sure that they rotate between sun and shade regularly and we also make sure all children have a drink outside during these times. We make them wear sunscreen, hats if they have them, and sunglasses."*
- *"We only stay outside for a limited time and break up the visits outside. We use sunscreen and hats and I encourage sunglasses."*

Sun Protection Policy and Programming: Comparative Findings from Baseline and Follow-Up Surveys

Follow-up responses relating to sun protection policies and programming indicate that the Sun Blocks mini-grants have had a positive impact on providers in terms of their capacity to educate parents and children on issues relating to sun protection, and also to provide shades spaces in which children can play.

Table 9: Follow-Up Responses to Sun Protection Policy and Programming Questions

Question text	**Number responding "Yes"**	
	Baseline n (%)	**Follow-Up n (%)**
Does your center have a formal policy regarding sun protection?	6 (28.6)	21 (95.5)
Does your center distribute sun protection information to parents?	9 (42.9)	22 (100)
Does your center provide educational lessons to the children that attend your center?	21 (95.5)	21 (95.5)
Does your center currently have an adequately-shaded play area?	6 (31.6)	16 (72.7)

Nineteen providers (86% of those responding to the question) reported having completed development of sun protection guidelines. All responding providers reported having provided sun protection training to staff, children, and parents as well. The number of individuals trained with mini-grant funds is summarized below.

Table 10: Estimated number of staff, parents, and children who received skin cancer prevention training, education and/or materials.

Trained/Educated Population	**Average Per Provider**	**Total Statewide**
Childcare Center Staff	15	332
Parents	42.3	931
Children	47.8	1051

Sun Protection Mini-Grant Activities:

As of May 2011, 14 of the funded providers reported that they have completed the mini-grant requirements. Those that had not completed the grant requirements are in the process of doing so. Reasons for not having completed the requirements included:

- *"We just received our check this month (May). Apparently the original got lost in the mail, and was just reissued."*
- *"We have done the training with materials. I have repaired the shade structure from last year. I am waiting on the hats, sun glasses."*
- *"We have purchased 90% of what we said we were going to."*
- *"We are in the process of completing the renovations to our playground, adding much needed shade structures."*

The most commonly-reported use of funds was for the creation of shaded play areas. Photographs of a selection of these structures are included in this report. Other providers reported using a portion of the funds for staff and parent trainings, updating policies, purchasing sun protection educational materials, and purchasing hats and sunglasses, shirts, and school supplies for sun-safety activities. Nine providers reported that they were able to leverage additional funds or in-kind contributions to support their sun protection activities.

When providers were asked which aspects of the program they found most useful, responses included the following:

- *"Of course receiving the funding was the most important. Other important items: Parent and children's activities and sun policy examples. Great."*
- *"I love the thumb drive with all the information. Very useful and easy to use."*
- *"The seasonal teaching plans, the parent materials, and the sun safety policy that we are working on for our center."*
- *"All of the materials and training was very useful and educating."*

Comments in response to the question of what was least helpful included:

- *"We needed to supplement the teaching plans for our infant and toddler classrooms."*
- *"The parent materials, only because I'm not sure if they actually looked at/used the materials."*
- *"The only negative I could see is the process of getting the funds distributed - we reside in northern Aroostook County and by the time we received our funds it was impossible to do outside work and it has made it a time crunch to get the work done."*

Discussion and Recommendations

This report focused primarily on responses among funded providers. This is because follow-up response rate from non-funded participants was too low to provide any meaningful information. This could be due in part to the fact that this is the third year of Sun Blocks funding. With each year of funding, there are fewer participants involved in the program that have not been funded.

Quantitative findings suggest that providers receiving Sun Blocks funding have been successful in implementing sun protection-related policy and program-related changes. The same providers have had less success in enforcing strict requirements relating to use of hats, sunglasses, and sun-protective clothing among children. However, qualitative responses generally indicate that providers have been doing more to encourage the use of these items. Funding for training and educational materials is likely to have played an important role in this.

The bulk of the mini-grant awards were used to increase shaded play areas. In the future, shifting the focus from building shade structures to purchasing hats, sunglasses, and sun-protective clothing may help increase use of these protective items among children. Also, only one provider reported considering UV conditions before planning outdoor activities. While the survey did not explicitly ask this question, responses suggest that this is not a major consideration for providers. Training activities did include a review of options for obtaining daily UV condition information and using that information for planning purposes. However, more emphasis on this in future trainings may help embed it in providers' routines.

It is should be noted that that providers were able to make good use of any funds that remained after they met core program requirements. Among other things, these remaining funds allowed providers to provide sun protection education and training to a fairly large number of people, including over a thousand parents statewide. This indicates that these childcare providers are well-positioned in their communities to help raise awareness around public health issues, particularly those with implications for young children.

COLORECTAL CANCER INITIATIVES

Colorectal cancer is the second leading cause of death among cancers that affect both 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 FY 2009-2010, two specific colorectal cancer programs were implemented through the Maine Comprehensive Cancer Control Program (MCCCP). First, the Healthy Maine Partnerships (HMPs), in eight Public Health Districts, were awarded Colorectal Cancer Awareness Mini-Grants to promote district-wide awareness and screening for colorectal cancer. Second, the MCCCP successfully secured a five-year CDC grant to increase colorectal screening rates in Maine. Among the activities implemented in year two for the Maine Colorectal Cancer Control Program (MCRCCP) was the initiation of a statewide media campaign, *Screen ME*, which pulled the work of the HMPs and MCRCCP together and offered an integrated colorectal cancer prevention and early detection effort. This section of the report presents the evaluation results for these two colorectal cancer initiatives: the HMP mini-grants and the MCRCCP media campaign.

COLORECTAL CANCER AWARENESS MINI-GRANTS TO HEALTHY MAINE PARTNERSHIPS

Background

In early 2007 the MCCCP announced the availability of funds to support the Healthy Maine Partnerships (HMPs) in colorectal cancer prevention and awareness activities. The purpose of the Colorectal Cancer Awareness Mini-Grants was to develop community-based projects to increase awareness of the importance of screening for colorectal cancer, especially among adults age 50 and older. Successful HMPs across the eight public health districts were awarded 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 screening barriers. Building on the success of that three-year mini-grant initiative, in FY 2010-2011 the MCCCP awarded collaborative HMP Colorectal Cancer Prevention Mini-Grant funds to the eight Public Health Districts to continue their work directed at increasing awareness of the need for early screening for the age 50 and over population. The stated purpose of the mini-grant funds *"is to enhance statewide public education and outreach initiatives aimed at increasing awareness of the importance of screening for colorectal cancer through the reduction of structural barriers, the development of partnerships, and initiation of local and community awareness activities."*

This year's HMP mini-grants were allocated by Public Health District rather than to individual community coalitions/partnerships as was done in the previous three years. The intent in doing district-wide grants was to encourage the HMP coalitions to work together across their district in colorectal cancer awareness efforts. The district-wide grants were also designed to promote coordination between the districts' colorectal cancer education efforts and the MCRCCP, most specifically the statewide media campaign and Colon Cancer Awareness Month activities.

Each district identified a lead coalition to facilitate mini-grant efforts. The lead HMP then worked with their counterparts in the district to design and implement a district-wide workplan and coordinate colorectal cancer awareness and screening efforts across the district. Additionally, each district designated a representative to the MCRCCP's Public Education and Outreach Advisory Group. This group met quarterly and served as the venue to bring together and coordinate stakeholders from both the HMP awareness efforts and MCRCCP.

Design, Methodology& Data Collection

The evaluation of the 2010-2011 HMP mini-grants utilized an electronic survey completed by the HMPs in June of 2011. The MCCCP evaluators created the survey based on the explicit purpose, objectives, and requirements of the grant program. The survey sought to collect data on: (1) the activities implemented within each district; (2) the coordination of colorectal cancer awareness efforts across districts; and (3) the coordination between districts and the statewide MCRCCP initiatives, focused on the media campaign and the provision of screening services. Additionally, the evaluators reviewed the mid-year progress reports submitted by each district to enhance the data collected via the electronic survey. Final narrative reports were not yet available at the time of this evaluation report, but were collected by MCCCP in July 2011.

The electronic survey was administered using Survey Monkey and was sent to each district's lead HMP with a request to distribute the survey further to their HMP partner colleagues if appropriate. The intent from the evaluation perspective was to gather as much information on specific activities being undertaken not only district-wide but also at the individual community coalition level where possible. Since the district lead HMP was responsible for the reporting requirements for the mini-grant, it was deemed appropriate to leave the decision up to the lead HMP as to whether further distribution of the survey was necessary or desired.

For half of the districts (50%), only the lead HMP completed the electronic survey. For the other half, all of the district's participating HMPs responded to the survey. The evaluation results delineated below encompass all 19 responses to the electronic survey. For the questions concerning statewide requirements, such as the Public Education and Outreach Advisory Group participation, the HMPs who were not the district representative indicated they were not and, for the most part, did not answer questions relating to this aspect of the mini-grant work.

Evaluation Results

As noted above, this year's mini-grants sought to enhance coordination and collaboration on two fronts: (1) between the HMP districts and the MCRCCP, and (2) with each public health district. Evaluation results will be discussed in four discrete sections, reflecting these two fronts. The first two sections reflect the coordination/collaboration objectives of the grant program. The third section highlights the specific work done by HMP under the grant for all the districts. The final section addresses the overall goal of the grants to increase awareness of and eliminate barriers to preventative screening for colorectal cancer by looking at the impact of the grant activities and status of barriers.

A. District and Statewide Coordination/Collaboration

Among the requirements of the 2010-2011 HMP mini-grants was attendance at Maine Colorectal Cancer Control Program's Stakeholder Meeting held in September 2010. Fifteen survey respondents answered the question asking if they attended this meeting, and all 15 answered in the positive, reflecting 100% attendance at the meeting among HMP public health districts.

Another requirement of the mini-grant award was that each public health district must designate a representative to sit on the MCRCCP's Public Education and Outreach Advisory Group—a group comprised of stakeholders from MCCCP, MCRCCP, HMPs, and other key public health education and cancer partners. The Public Education and Outreach Advisory Group met (via phone and in person) three times during the grant year, and the survey asked if the HMP representative attended those meetings. While attendance started strong with 100% attendance at the August meeting, it waned over the fiscal year. The December meeting garnered 87% HMP attendance and the May meeting was attended by only 60% of the HMP representatives.

HMP were asked how effective the advisory group meetings were in terms of facilitating collaboration and communication between statewide and local media efforts around colorectal cancer education and screening. Of the 12 survey respondents who rated the effectiveness of the meetings on a scale from 1 (very ineffective) to 4 (very effective), 83% rated effectiveness at a 3 and 17% rated it at a 4, for an average rating of 3.2. Thus, for those who attended the meetings they were seen as useful, or as one respondent indicated, *"They are a good chance to hear about "the whole" of the CRC prevention effort, within which our project fits."*

Additionally, the survey posed an open-ended question that sought to identify enhanced coordination between state and local activities around the media campaign. Respondents were asked to share examples of how their local media campaign enhanced and/or expanded the statewide media campaign. Eight respondents provided written comments to this question. The bulk of respondents extended the reach of the statewide *Screen ME* television and radio spots by partnering with local radio/TV program shows (such as "HealthBeat" and "Public Health and You") to talk about the importance of colorectal cancer screening. Most HMPs indicated they "localized" the spots and spread them to other local and social venues such as movie screens, Facebook, and one site played the radio spot on the "hold" line of the local hospital. Print media ads were also utilized and extended through local venues beyond where the central statewide campaign could reach.

B. District-wide Coordination

Through these mini-grants, each public health district was to develop and implement a district-wide workplan for increasing awareness of colorectal cancer and screening within the whole district. The survey asked (yes or no) if such a workplan was developed and 100% of respondents answered "yes." A follow-up question asked: *"Were you able to collaborate with other HMPs within your PH district in raising awareness of colorectal cancer?"* The question received 11 responses with 73% (8) yes and 27% (3) no. However, due to a typographical error in the survey – the question said HMSs not HMPs – it can be surmised that two of the "NO" responses came from the respondents who said, "*What's a HMS*" and "*Unsure of what HMSs are.*" The other "no" answer did state, "*No joint efforts were done.*" Factoring in these comments the "yes" response rate increases to 91%.

Seven HMPs indicated good coordination across their districts including logistics, such as regular e-mail and phone contact and monthly meetings of all district HMP directors. A number of HMP also said they coordinated across the district on specific activities such as doing the worksite wellness portion of the mini-grant and participating in health fairs and providers' forums together.

The HMPs were also asked if they coordinated colorectal cancer awareness activities across their district to coincide with Colon Cancer Awareness Month (March). Eleven respondents answered this question with 9 (82%) saying "yes" and 2 (18%) saying "no." When asked to explain either how or why not, ten respondents provided comments. The "no" responses included, "*We did CRC activities within our county but didn't have enough time to coordinate a district-wide effort,"* and, *"No correspondence about this."*

The eight "yes" responses indicate that most districts coordinated their March activities across their districts and kept each other informed throughout the month. One respondent stated,"*[We] sent out emails and made phones calls to district partners throughout the month of March to coordinate activities."* The district-wide coordination of efforts can be captured by a sampling of the other comments provided:

> *"Worksite presentations done by HMP staff in their respective service areas;"*
>
> *"Dissemination of materials throughout the region as well as a press event for the Turning City Hall Blue event;"* and
>
> *"Through Maine General Prevention Center."*

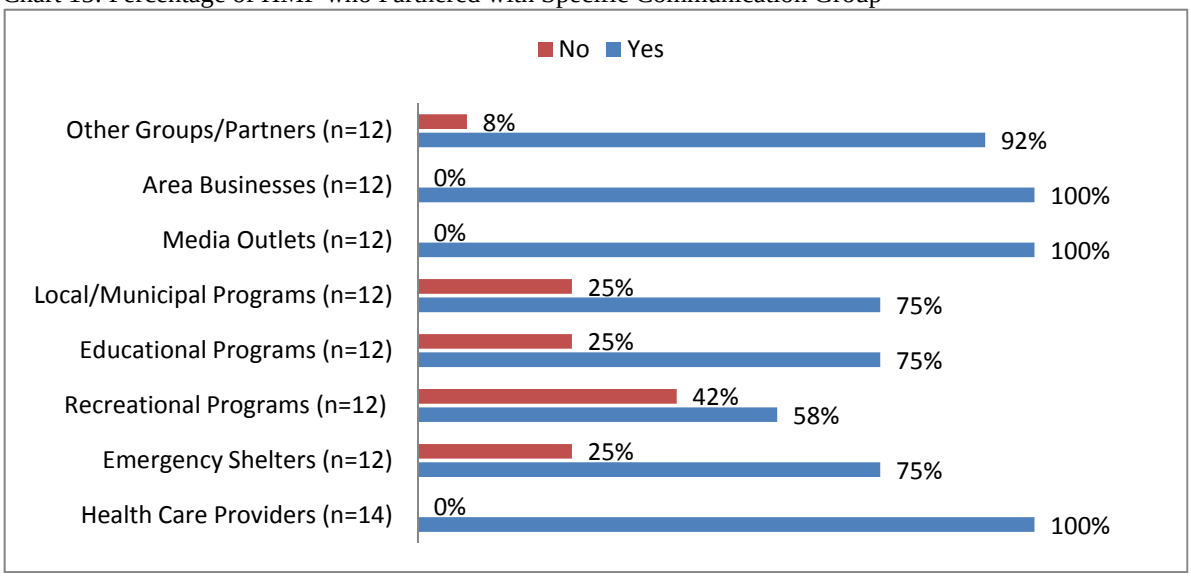
C. HMP Colorectal Cancer Prevention Activities

The majority of the survey was designed to capture the specifics of the work being done within public health districts to promote the importance of being screened for colorectal cancer, especially for those 50 or over. Working with partners is critical to the success of community-based colorectal cancer awareness efforts; therefore, the survey identified eight broad categories of partners HMP might engage in their efforts. For each partner category respondents were asked: (1) if they had collaborated with, been in communication with, or distributed materials to these partners as part of the mini-grant; (2) if so, who and in what ways; and (3) what types of materials were shared with the partners. The categories of partners included:

- Healthcare Providers
- Emergency Shelters (homeless, DV, etc.)
- Recreational Programs (rec centers, parks, gyms, etc)
- Educational Programs (schools, libraries, academic institutions, etc.)
- Local/Municipal Programs (local gov., clubs, civic groups, community centers, etc.)
- Media Outlets (newspapers, radio, websites, etc.)
- Area Businesses
- Other Groups/Partners

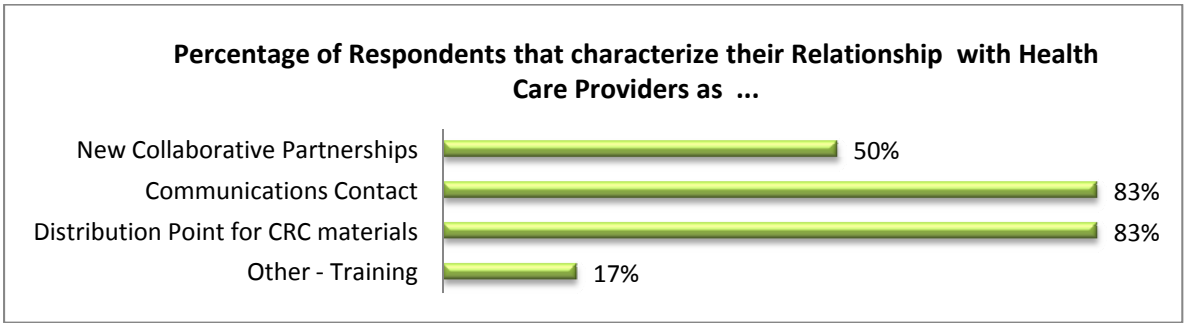
Chart 15 reflects the responses to this aspect of the survey.

Chart 15: Percentage of HMP who Partnered with Specific Communication Group



The range of partners engaged by HMP was broad and extensive. As would be expected, Healthcare Providers provided the longest list of partners and included primary care practices, FQHCs, rural, local and community clinics/ health centers, hospitals, hospital clinics and practices, family medicine practices, endoscopy departments, and individual doctors across all public health districts. In most districts, over the past three years the HMPs have established solid relationships with healthcare providers. Thus, when asked about the nature of their relationship with this category of partners, for many of the respondents it was one of maintenance rather than starting a new collaboration or partnership. Chart 16 delineates how the survey respondents characterize their relationships with health care providers as a result of their MCCCP mini-grant work.

Chart 16: Health Care Providers

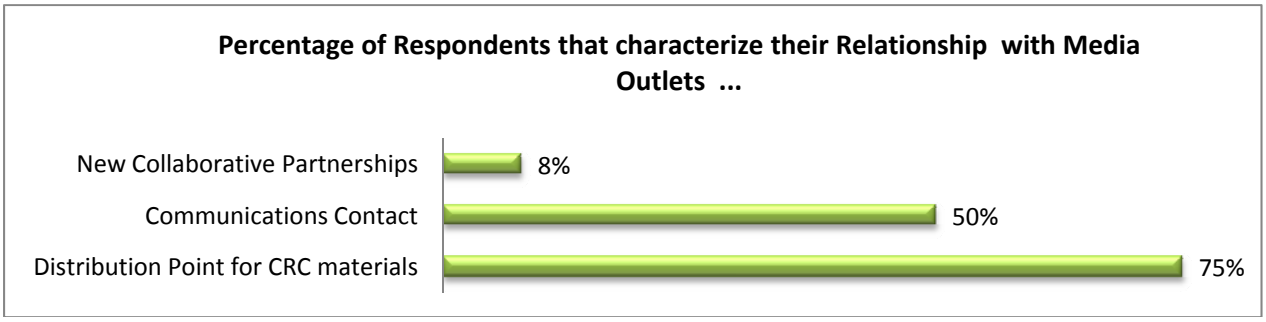


As Chart 16 above indicates, 83% of respondents see healthcare providers as a key distribution point for colorectal cancer materials. For the 12 respondents who distributed materials to healthcare providers, 100% distributed bookmarks, 92% distributed posters, and 50% distributed e-mails and fliers. An additional 67% provided a presentation or training to healthcare partners. Pamphlets (42%) and personal letters (33%) were also distributed.

As could be anticipated with this year's focus on the *Screen ME* media campaign, collaborations/communications with media partners was a strong focus of the awareness work done by HMP districts this year. Of the 12 respondents who answered questions about work with media outlets, 100% collaborated/communicated with one or more media partners. Ten of the 12 indicated they had worked with print media, four districts mentioned working with radio, and three indicated work with electronic media. A number of districts indicated they had engaged unusual media outlets such as billboards, phone line messaging, theaters, metro buses, and organization/event program guides.

As was true for the Healthcare Providers category, for most of the 12 respondents their relationships with media outlets were already established so the work under this year's mini-grant can be characterized as reaffirming existing communication and distribution paths. The most common types of materials distributed to media included TV/radio spots, newspaper ads, newspaper articles/letters to the editor, and press releases. Chart 17 reflects how survey respondents characterize their relationships with media outlets as a result of their MCCCP mini-grant work.

Chart 17: Media Outlets



Partnerships with Area Businesses also received a 100% response rate among respondents. Twelve respondents answered the questions about working with Area Businesses. A couple of responses exemplify what many said: *"Greater than 35 businesses,"* and *"Information about the program included in annual worksite mailing to 150 businesses."*

What stands out in the responses this year is the large number of respondents who worked with their local Chambers of Commerce as a venue to extend their reach into the business community. While most of the HMPs have been working with the business community over the past three years, almost half indicate that they are continuing to forge new collaborative partnerships. Chart 18 depicts how survey respondents characterized their relationships with Area Businesses as a result of their MCCCP mini-grant work.

Chart 18: Area Businesses

As Chart 18 reflects, businesses are an excellent distribution point for colorectal cancer prevention materials, and 92% of respondents partner with businesses to raise the awareness around colorectal cancer screening. Of the 12 survey respondents, 83% distributed bookmarks, 67% distributed posters, and 33% distributed fliers. Pamphlets and e-mails were also distributed (16% each) and a third (33%) of respondents indicated they had done presentations at area businesses. In one district, the HMP offered mini-grants to business to do colorectal screening education during the month of March, and another HMP utilized the business e-newsletter to distribute colorectal cancer prevention information.

Educational Programs and Local/Municipal Programs both received positive response rates of 75% (9 respondents). In the Educational Programs category, of the 9 respondents who explicated their work with educational programs,78% indicated they partnered with community libraries. Adult education and school programs (including school heath newsletter), senior education centers, and worksite wellness events/newsletter were also identified in this category. As Chart 19 reflects, 100% of respondents strongly characterized their relationship with educational programs as being an excellent distribution point for cancer materials. Bookmarks and posters were distributed to their identified educational programs by 100% of respondents, and pamphlets and fliers were distributed by a third (33%) of the HMPs who responded.

In the Local/Municipal Programs category, 9 respondents identified their relationships as building on what they had established in previous years and thus requiring ongoing communication contacts. Local/municipal programs are also seen as an excellent distribution point for colorectal cancer materials and 100% of respondents capitalized on those distribution points. Over three quarters of respondents (78%) indicated that they are collaborating with town/city offices/government. Local senior centers were also noted, as were housing authorities and local soup kitchens and food pantries. The types of materials distributed included posters (89%), bookmarks (78%), pamphlets (44%), fliers (33%), and for one program, their HMP newsletter.

Charts 19 and 20 also depict how the survey respondents characterized their relationships with Educational and Local/Municipal programs as a result of their MCCCP mini-grant work.

Chart 19: Educational Programs

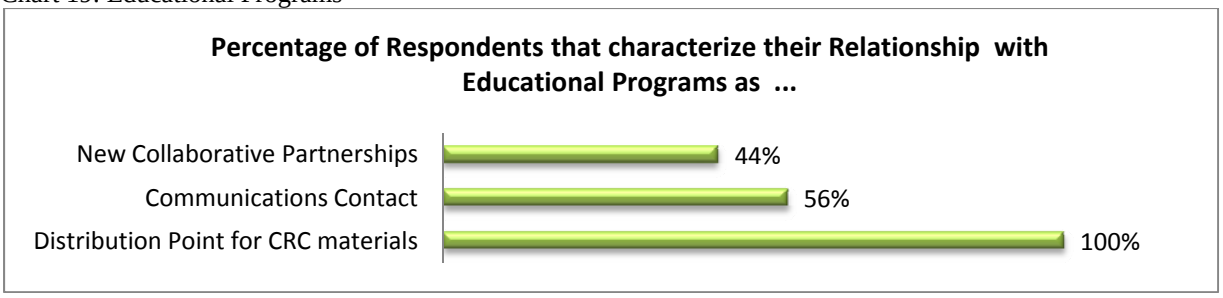
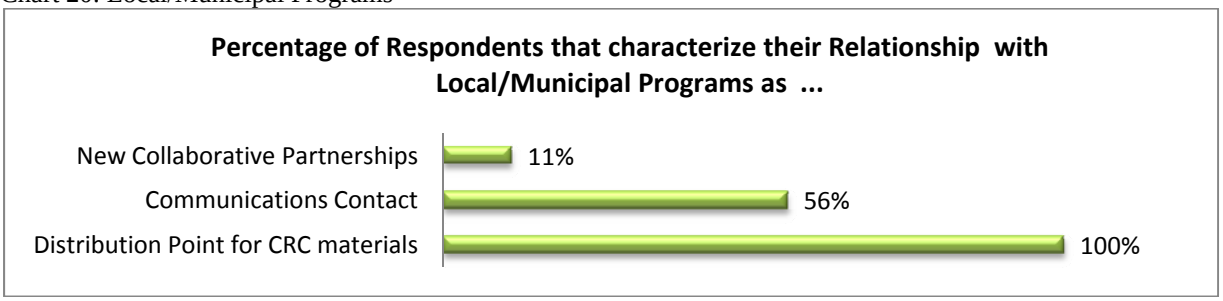


Chart 20: Local/Municipal Programs



Collaborating with Recreational Programs received a "yes" response from just over half (58%) of the 12 survey respondents. Of the seven respondents who answered, 100% characterized their relationships with these programs as points of distribution for colorectal cancer materials. Also, 71% identified the need for continued communication contacts as part of an ongoing relationship built in previous years. The types of materials distributed to recreational programs included posters (86%), bookmarks (71%), pamphlets (43%), and e-mail (29%). The types of recreational programs HMP are collaborating with include: YMCA (71%), local recreation/parks departments (57%), community centers, and one with a local camp.

Collaborating with Emergency Shelters received a "yes" response from three (25%) of the 12 survey respondents. For those three respondents, two work with the homeless shelters in their district and one works with the domestic violence projects in their catchment area. One respondent sees emergency shelters as a new collaborative opportunity, two see them as ongoing partnerships, and all three see shelters as a point of distribution for colorectal cancer materials. Posters and bookmarks were distributed by 100% of respondents and other types of materials distributed included pamphlets (67%) and fliers (33%). Charts 21 and 22 depict how survey respondents characterize their relationships with recreational programs and emergency shelters as a result of their MCCCP mini-grant work.

Chart 21: Recreational Programs

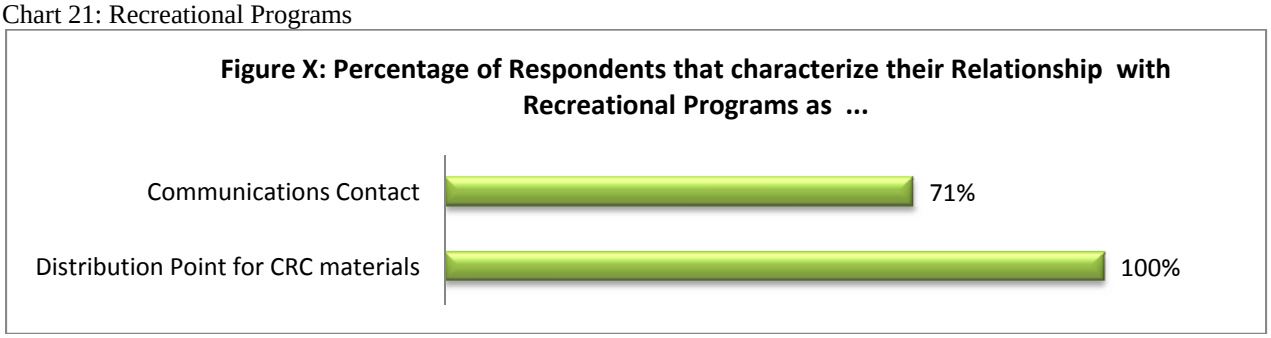
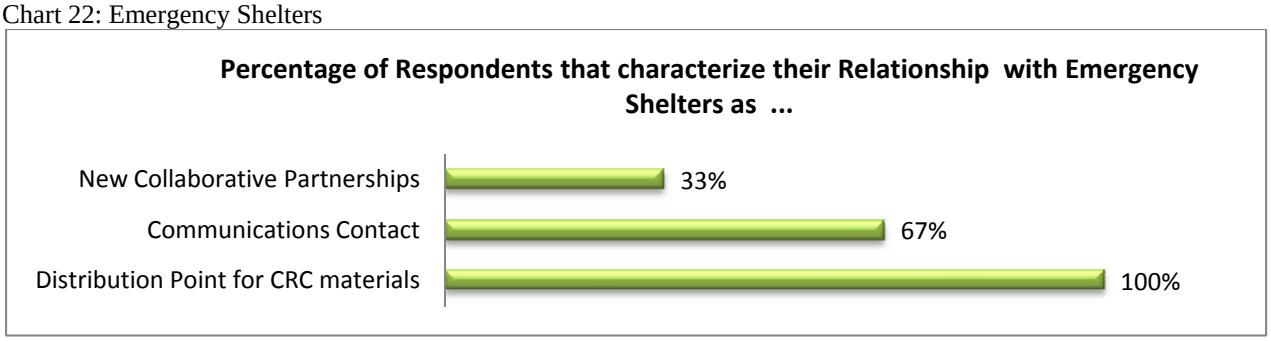
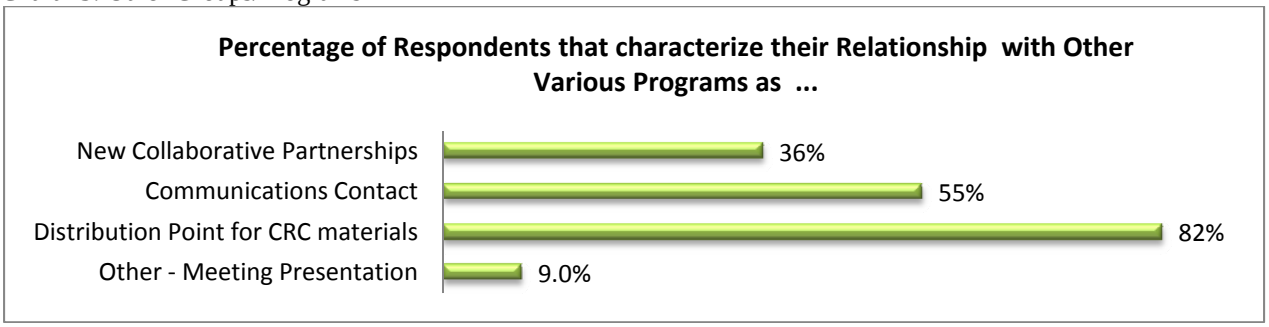


Chart 22: Emergency Shelters



After the questions pertaining to the identified partner categories, the survey provided the opportunity for respondents to identify "Other Groups" they had collaborated/communicated with or distributed materials to as part of their MCCCP mini-grant. Eleven of the 12 respondents (92%) answered "yes" that they had worked with other groups. Among the groups identified were public health district councils and collaboratives, churches and faith-based organizations, Meals on Wheels, food pantries, health events and fairs, boards of health, senior groups (such as Senior Plus, Senior Generations, etc.), public health departments, and local service clubs (Lion's, Rotary, etc.). Eighty-two percent of respondents characterized their relationships with these various groups as providing a distribution point for colorectal cancer materials, 55% saw the relationships as an opportunity for communication contacts, and 36% identified these groups as new collaborative partnerships. The two major types of materials distributed were bookmarks and posters, with both being distributed by 82% of respondents. Pamphlets and fliers were each distributed by 27% of respondents, and e-mail and presentations were each utilized by 18% of respondents. Chart 23 depicts how the survey respondents characterize their relationships with these myriad Other Groups/Programs as a result of their MCCCP mini-grant work.

Chart 23: Other Groups/Programs



Finally, MCCCP sought to determine if the HMP mini-grants had an impact on worksite wellness initiatives. The survey included a question asking if the HMP participated in any worksite wellness initiatives, and if so, which ones. Eleven respondents answered this question, and of those, 82% (9) replied in the affirmative. Most of the respondents to this question identified their worksite wellness work as educational and materials distribution. Many provided worksite events such as a wellness breakfast, lunch & learns, a wellness forum, and a March awareness health fair. Distribution of materials was identified and in one district the HMP linked colorectal MCRCCP screening providers with businesses to provide presentations and referrals to the screening program when appropriate.

D. Impact of Colorectal Cancer Prevention Mini-Grants

The survey included two questions aimed at determining the reach and impact of the mini-grants. The questions asked respondents to identify: (1) whether the funds extended the reach of their colorectal cancer programs, and (2) what they see as the greatest impact of the mini-grant program in their community. Eleven respondents answered each of the two questions.

The first question asked, "Did your HMP use MCCCP grant funds to create new activities, expand existing ones, or both?" "Create new activities" and "expand existing activities" each received a response rate of 27%, and almost half the respondents (46%) answered "both." When asked to explain, the written responses indicated that new and expanded activities often targeted worksite wellness and media activities. As one representative respondent stated: *"We had done some educational presentations at worksites in a prior grant cycle, so we expanded our worksite contacts in this cycle."*

For media activities, the mini-grant funds also provided an opportunity to both build on previous work – *"Organized radio and movie ads conducted the year before"* – and to develop new activities – "*Did local cable show and resolution with local board of health."* Other expansions noted were expanding activities such HealthFests and adding to CRC materials to already existing networks. Among the new activities cited were an initiative with physician practices and a colorectal screening awareness open house with a hospital partner.

The second question was open-ended and asked respondents to share what they thought was the greatest impact the MCCCP mini-grant funds had in their community. Almost a third of the responses (73%) mentioned raising awareness about the importance of screening as the greatest impact and having the ability to, *"extend the reach of the statewide Screen ME campaign"* to access more people who need, but can't afford, screening. This respondent's remarks probably best capture the essence of the others in this group:

> *"The grant funds have played a big role in increasing the community's awareness about colorectal cancer screening. Through the outreach done we were able to let people know about different resources available to them (i.e. the MCRCCP screening grant)."*

The second most frequently mentioned impact of the work done under the grant funds was increasing comfort around the topic of colorectal cancer. These two quotes represent those respondents who identified the greatest impact of the program as:

> *"It is allowing the community to be able to speak openly about colorectal cancer;"* and *"An ability to now discuss more freely the importance of having screenings and a better understanding of prevention."*

Other impacts identified by individual respondents included:

> "*One-on-one education with seniors about the importance of being screened;"* and *"By having a district-wide coordinated approach to working with employers we reached more people in the target population of 50+ years old."*

Influencing the impact of any initiative are the structural barriers that attempt to impede implementation. The survey asked respondents two questions pertaining to structural barriers. First, they were asked a scaled question about how effective the mini-grant funding has been in reducing structural barriers to enhancing public education and outreach concerning the importance of colorectal cancer screening in their community. On a four-point scale where 1 represents "very ineffective" and 4 represents "very effective" the average rating was 2.93 (n=15). Thirteen of the 15 respondents (87%) rated the effectiveness of the program at a 3 (effective). Thus, a clear majority of the respondents see this funding as having been effective in reducing structural barriers.

The second question was open-ended and asked respondents to identify and explain any remaining structural barriers to providing information about or increasing screening rates for colorectal cancer in their community. Each of the 15 respondents provided a response to this question. A number of responses referenced access to screening services and the travel distance/time to go out of their region to get screened. Access as a barrier was also identified in reference to the funding available through MCRCCP to provide no-cost screening to uninsured populations. One respondent put it succinctly by writing, *"travel for the procedure, cost, lack of insurance."* Another stated that, *"over 35% of our citizens do not have a regular medical home,"* and finally, one respondent crafted the barrier this way:

> *"There remain individuals who cannot pay for screening and are not eligible for low or no cost screening. Also, uninsured individuals who do not see primary care providers regularly are unlikely to be screened."*

The other structural barrier that was identified was the ability to engage primary care providers in developing reminder systems. The following quote touches on the critical issues of competing priorities and free/reduced care:

> *"Difficult to get primary care providers to discuss their procedures for patient reminder systems and work to improve them. They have so many competing priorities. Some providers of screening did not want to promote their guidelines for free or reduced care because they already have increased rates of free and reduced care."*

Evaluation Discussion & Recommendations

The final question on the survey tool provides the opportunity for respondents to share, "anything else about the MCCCP grants that you'd like to tell us." While a few of the answers raised some concerns/questions (such as a difference of opinions among physicians about the need for full colonoscopy for screenings, travel and timing for Advisory Group meeting, and a request to know the number of free screenings done in one region), the majority of the eight written responses provided strong support for the mini-grants and the work it is allowing HMPs to undertake. A sampling of those responses speak for themselves and identifies the successful coordination the grant program is seeking to achieve:

> "*It has been wonderful to have prevention funds around the importance of colorectal screening. This project was successful in accomplishing increased awareness and screenings;*"
>
> "*It is exciting to have the resources to work to educate our residents about the dangers of this silent killer;*"
>
> "*Great program!*" *and*
>
> "*It's been extremely helpful to have both the outreach and the screening grants – they go so well together and really help educate the community AND offer free screenings for those who qualify. The collaboration has been crucial in increasing awareness.*"

One clear finding of this year's evaluation is that the HMPs are continuing to build on the strong relationships they established with some of the key partner categories that have extensive reach into the priority population for colorectal cancer screening. From an evaluation lens, there were no major issues raised in terms of program implementation or administration in this year's evaluation of the mini-grants. There were some district specific concerns that surfaced through the evaluation survey instrument, and those have been forwarded on to the MCCCP staff to address on an individual level. While the structural issues identified may be beyond the realm of the mini-grants, they should not be dismissed lightly. The issues raised can serve as excellent benchmarks when crafting the priorities of the program in the upcoming year.

The improvement recommendation that emerges from the evaluation process is the need to strengthen and support inter-district coordination of activities. Promoting collaboration is always a challenge as authentic collaboration must be organic. That said, role modeling and incentives can provide a context for engaging in collaboration when individual entities may feel they do not have the time/resources to do so. Thus, the MCCCP may want to review the structure of future mini-grants to build in or more strongly encourage additional possibilities for, and benefits from, integrated district-wide activities.

MAINE COLORECTAL CANCER CONTROL PROGRAM: MEDIA CAMPAIGN

Introduction

The Maine Comprehensive Cancer Control Program (MCCCP) undertakes multimedia efforts to promote colorectal cancer (CRC) screening and raise awareness of the Maine Colorectal Cancer Control Program (MCRCCP). These efforts exist in the form of a website, phone hotline, radio and television public service announcements (PSAs), social media, and earned media strategies. Materials were created to align with key messages of the Center for Disease Control and Prevention's (CDC) national *Screen for Life* campaign. These are as follows:

- Screening for colorectal cancer saves lives.
- Of cancers affecting both men and women, colorectal cancer is the second leading cancer killer in the United States.
- If you're 50 or older, see your doctor and get screened for colorectal cancer.
- If you think you may be at increased risk for colorectal cancer, talk to your doctor about when to begin and how often to be screened.
- Because precancerous polyps or cancer in the colon or rectum don't always cause symptoms, it is important to be screened regularly for colorectal cancer.
- Colorectal cancer screening helps prevent colorectal cancer by finding precancerous polyps so they can be removed **before** they turn into cancer. Screening also helps find colorectal cancer early, when treatment can be very effective.
- Many insurance plans, including Medicare, help pay for colorectal cancer screening.

Most recently, a large earned media push took place in March of 2011, coinciding with broader media attention as part of Colon Cancer Awareness Month.[4] Utilization numbers for web and phone based sources of information peaked during this time, but have declined since.

Information presented in this section has been collected through multiple sources, including Google Analytics, marketing reports, administrative records, and reports from HMPs who distributed fliers and other materials. In this section we use this information to better understand the reach and impact of the overall media campaigns over the course of the past year. Print and broadcast media directed individuals to the CRC website and hotline. Therefore, utilization numbers from those services provide some insight on how well increased attention on CRC awareness in March motivated individuals to seek out more information on screening.

Website

MCRCCP established the colonscreenme.org website as part of the *Screen ME* campaign.[5] This site provides general information on CRC, tips for prevention, survivor stories, and other informational resources. The site also directs visitors to the Colon Screening Hotline to schedule a screening. Google Analytics was used to gather website utilization data, which provided information for the following review of the site's utilization.

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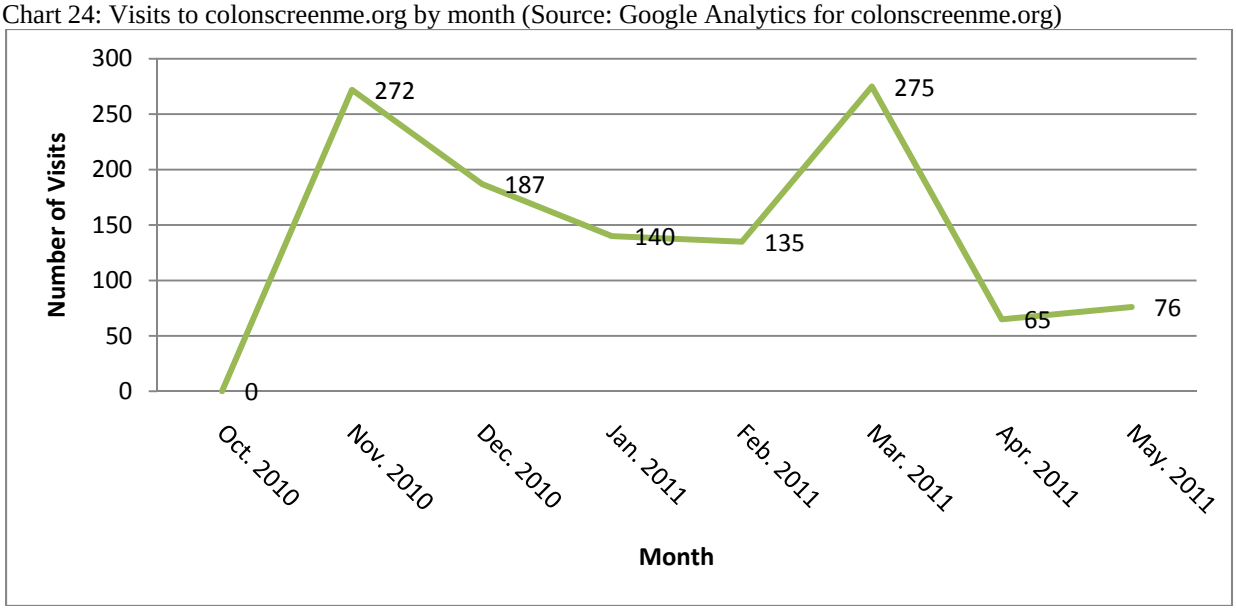
[4] State of Maine. Office of Gov. Paul LaPage. *Governor Paul LePage Declares March Colon Cancer Awareness Month*. Maine.gov, 3 Mar. 2011. Web. <http://www.maine.gov/tools/whatsnew/index.php?topic=Gov+News&id=205496&v=article2011>.

[5] Screen ME - Comprehensive Cancer Control - CDC; DHHS Maine." *Maine.gov* |. Web. 18 July 2011. <http://www.maine.gov/dhhs/boh/ccc/screen-me.shtml>.

Figure 5: One of the banner images from colonscreenme.org (Source: Google Analytics for colonscreenme.org)

As of June 1, 2011, the site has been visited a total of 1150 times since its launch in November 2010. Seven hundred and fifty three (65.48%) of these have been from unique visitors. The average time that each visitor spends on the site is 2 minutes, 27 seconds.

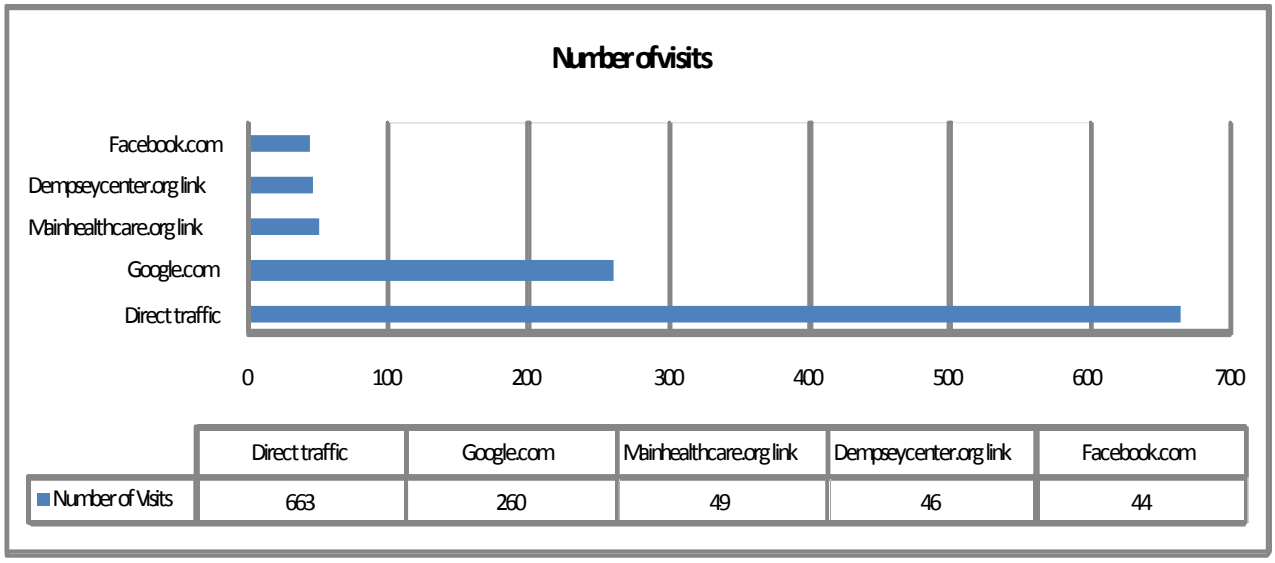
Chart 24: Visits to colonscreenme.org by month (Source: Google Analytics for colonscreenme.org)



Visits to the site peaked during the initial launch in November 2010, and again March 2011. Because March is Colon Cancer Awareness Month, much media attention was devoted to the issue in that month. For that reason, a spike in traffic in March followed by a drop-off in April is not surprising. This pattern is also observable in the hotline call volume numbers. However, the decrease in visits to the website in April is much greater (decreased by 76.4%) than calls to the hotline (decreased by 12.1%).

The number of visits from primary sources of traffic is summarized in the table below. It is worth noting that people are mainly coming to the site directly or by searching Google, rather than by clicking on links posted on other websites. This suggests that people are learning about the site primarily through non-web-based promotional activities and/or word of mouth.

Chart 25: Number of visits by top sources of traffic. (Source: Google Analytics for colonscreenme.org)



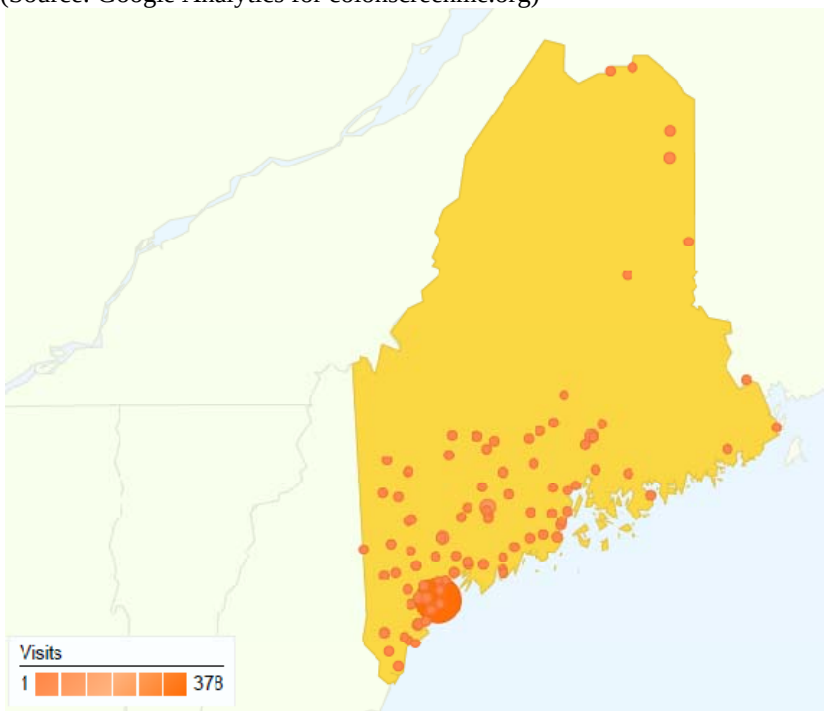
	Direct traffic	Google.com	Mainhealthcare.org link	Dempseycenter.org link	Facebook.com
Number of Visits	663	260	49	46	44

In terms of geographic reach, the majority (871 or 75.7%) of the site's 1150 visits have come from viewers in Maine. In addition, viewers in 35 states and 17 countries have visited the site. In general, the origins of visits to the site coincide with Maine's population centers. However, there appears to be a slightly disproportionate concentration of visitors from central and southern counties. This is likely due to the greater frequency of radio and television ads for the website and hotline in these areas during March 2011. The top ten cities of origin for site visits are as follows:

Table 11: Website visits by city. Percentages in the far left column assume a best-case scenario in which all visitors are in the target age group (50+) (Source: Google Analytics for colonscreenme.org)

City	Total population	Population in the target age range (50+)	Total website visits	Website visits as a percent of the target population
Portland	66,194	20,662	378	1.83%
Augusta	18,560	7,608	64	0.84%
Lewiston	36,592	11,344	42	0.37%
Bangor	35,473	4,759	40	0.84%
Brunswick	15,175	2,522	19	0.75%
Presque Isle	9,692	1,601	18	1.12%
Biddeford	21,277	3,306	14	0.42%
Auburn	22,883	3,638	14	0.38%
Waterville	15,968	2,361	13	0.55%
Gorham	6,882	882	12	1.36%

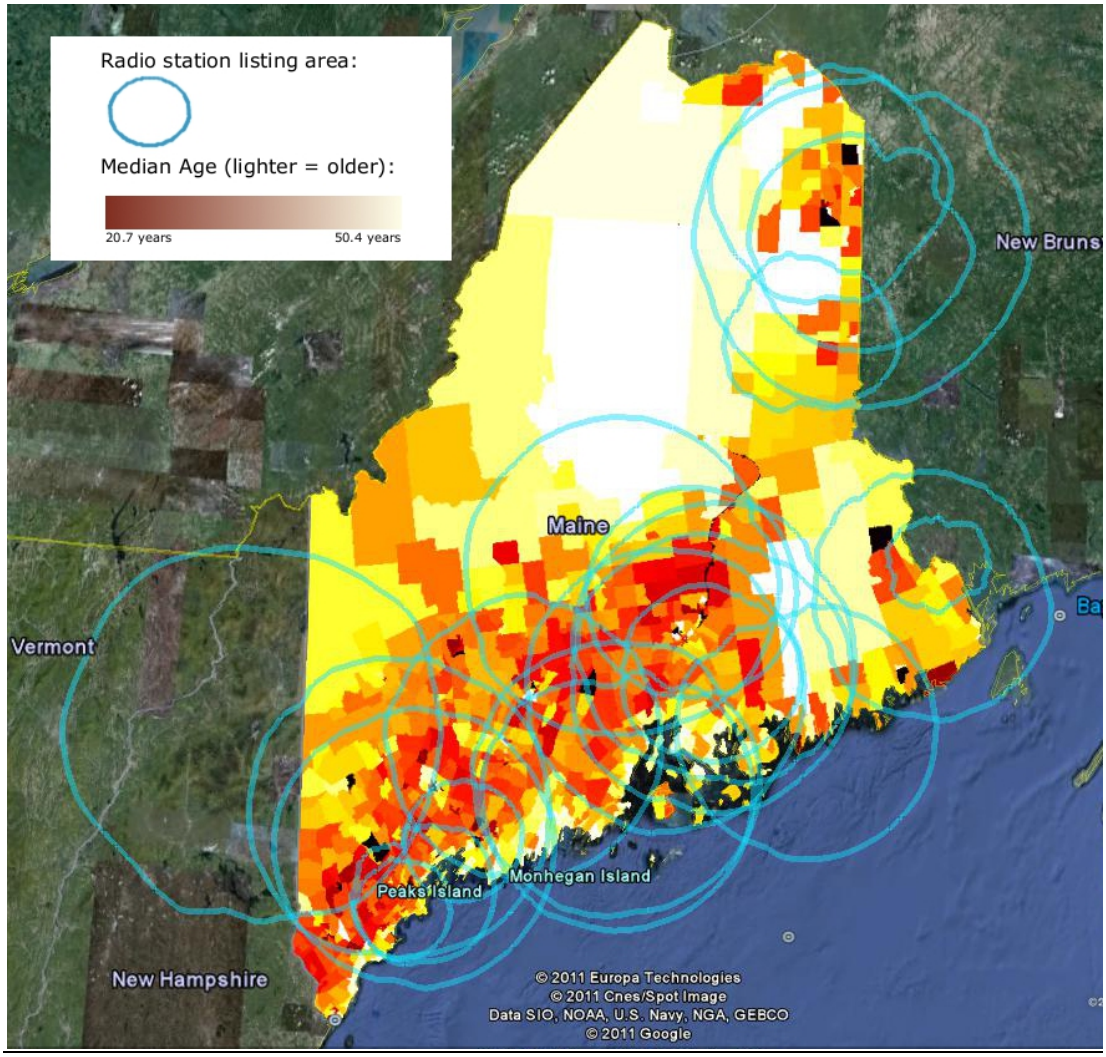
Figure 6: Visits to colonscreenme.org by geography. Larger circles represent higher concentrations of visitors. (Source: Google Analytics for colonscreenme.org)



Radio Campaign

In March 2011, radio ads ran on stations throughout the state. While not all stations provided information on the number of times these ads aired, we know that they played at least 224 times on stations in Cumberland County, at least 126 times in Aroostook County, and at least 293 times in stations throughout central Maine.

Figure 7: Reach of FM radio ads based on listening area of stations airing ads, compared to median age by Maine census tract.[6][7][8]



Note: Map does not include 3 AM stations broadcasting out of Portland and Waterville (WGAN, WZAN, and WTVL). While these stations likely cover areas also covered by the FM stations, they may have extended the reach of messaging.

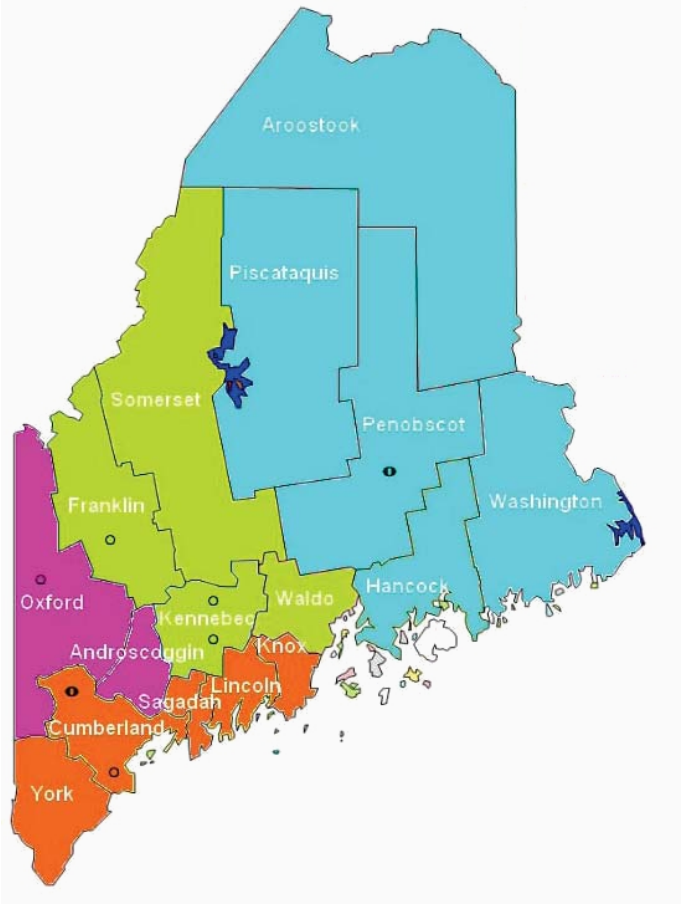
This map, combined with Figure 6 - *Visits to colonscreenme.org by geography* above, suggest that the radio campaign did not reach the remote northeastern regions of the state along the Canadian border. While these areas are sparsely populated,[9] residents tend to be older than the general population, and are therefore more likely to be among the program's target audience. These maps also indicate that people living in and around Millinocket in Penobscot county may not have been exposed to radio messaging.

[6] "Census Data in Google Earth – Juice Analytics." *Juice Analytics - Your Data Is Meant for Action.* Web. 21 June 2011. <http://www.juiceanalytics.com/writing/census-data-in-google-earth/>.
[7] "FM Query -- FM Radio Technical Information -- Audio Division (FCC) USA." *Federal Communications Commission (FCC) Home Page*. Web. 21 June 2011. <http://transition.fcc.gov/mb/audio/fmq.html>.
[8] "Google Earth." *Google*. Web. 21 June 2011. <http://www.google.com/earth/index.html>.
[9] "Maine 2000: Summary of Population and Housing Characteristics." *US Census Bureau*. Web. 21 June 2011. <http://www.census.gov/prod/cen2000/phc-1-21.pdf>.

CRC Screening Hotline

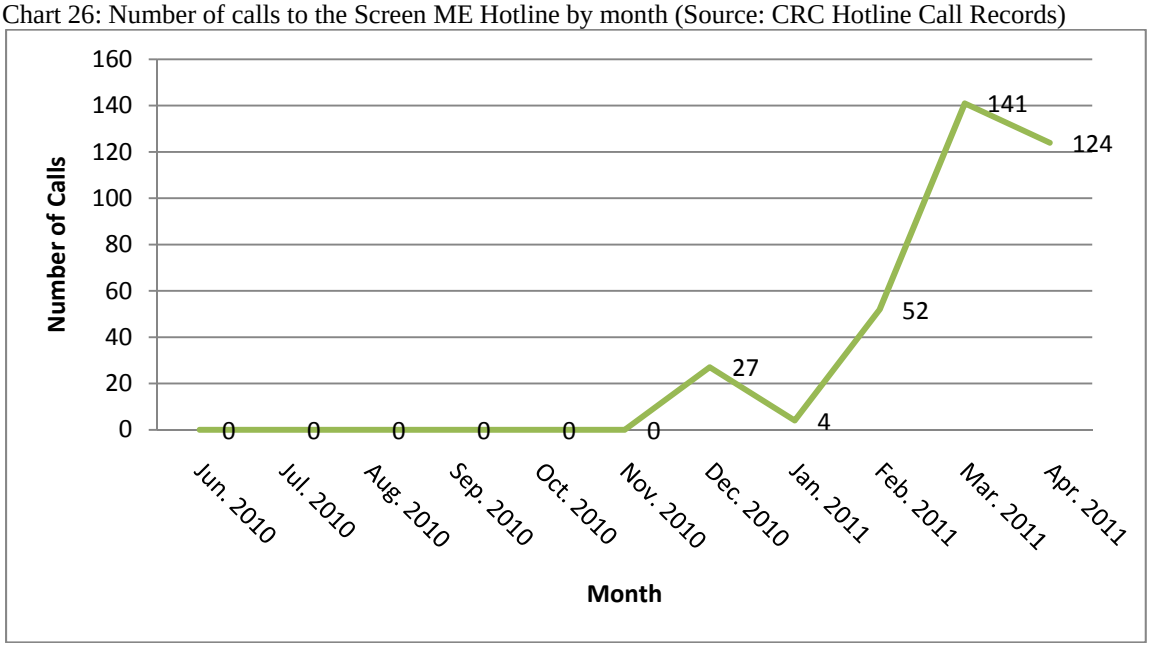
MCCCP-sponsored media directs individuals to the *Screen ME* Hotline. The hotline assists callers in scheduling colon screenings. Callers hear a brief message about the importance of CRC screening followed by a list of Maine counties to choose from. Calls are then triaged to a local provider for program enrollment and scheduling.

Figure 8: MCRCCP Hotline triage and service areas – January 2010 (Source: MCRCCP)



This hotline has been in service for several years, but lacked the promotional component necessary to create awareness. This is reflected in the call volume numbers, which show that for June 2010 to April 2011, the hotline did not receive any calls prior to December 2010. Call volume peaked in March 2011, coinciding with the large media attention that CRC awareness received that month.

Chart 26: Number of calls to the Screen ME Hotline by month (Source: CRC Hotline Call Records)



A total of 348 calls have been made to the hotline since December 2010. The average call length is 2 minutes, 17 seconds. The recorded message is approximately 1 minute and 20 seconds in length, so this call time suggests that most people are staying on the line long enough to be redirected to a local provider.

Television Campaign

A television campaign designed to raise awareness of CRC ran in November and December of 2010. Reports from the media firm contracted to execute this campaigns revealed that a series of MCRCCP-funded television ads aired in markets throughout Maine on four days over the course of four weeks in November and December of 2010. Specifically these spots ran on 11/15/2010, 11/22/2010, 11/29/2010, and 12/6/2010. Thirty-second spots were broadcast on network affiliate stations based in Portland, Bangor, and Presque Isle. They aired a total of 717 times, reaching an estimated 99% of the target audience – viewers who are 50 years or older. On average, these viewers were exposed to the ads between 16.6 and 17.9 times.

Table 12: Summary of MCRCCP CRC media campaign. (Source: MCRCCP Media Campaign Reports)

Area	Estimated Reach (%)	Estimated Frequency	Number of Spots
Portland	99	17.9	333
Bangor	99	17.3	260
Presque Isle	99	16.6	124
TOTAL	**99**	**16.6 - 17.9**	**717**

Note: Reach refers to the percent of the target audience (viewers 50 years and over) who viewed the ads at least one time. Frequency is the number of times the average viewer in the target audience viewed the ads.

Earned Media

Earned media refers to non-paid media coverage. Examples include editorials in local print and broadcast media, and web-based coverage that references or links to MCRCCP resources.[10] The Governor's announcement declaring March as Colon Cancer Awareness Month sparked a flurry of earned media for MCRCCP's efforts to promote screenings through the MCRCCP *Screen ME* program. These included television and print media news stories, blog articles, and discussion and dissemination of information on the social networking sites Facebook and Twitter. Among these, there were a total of 22 references of links to the MCRCCP hotline and colonscreenme.org site. The following table summarizes this earned media.

Table 13: Summary of earned media during March Colon Cancer Awareness Month (Source: Burgess Advertising and Marketing report)

Source	Number of Pieces	Potential Viewers	Number of References to MCRCCP Hotline or Website
Local News (TV/Web)	9	117,500	5
Print Media	3	82,500	1
Facebook.com	6	4,705	1
Twitter.com	15	8,436	9
Blogs	4	unknown	6
TOTAL	**37**	**213,141**	**22**

Several individuals on social media sites were active in posting links to Colon Cancer Awareness Month stories. While people on these social media platforms tend to be younger than the target population,[11] it is quite possible that these specific individuals posting CRC resource information have many "friends" and "followers" within the target age group.

Media and MCRCCP CRC Screening Rates

MCRCCP screening records over the course of four months were reviewed to determine whether the increase in call volume during March was reflected in the actual number of screenings provided. While individuals may receive screenings through the MCRCCP program without calling the hotline, and these numbers do not capture screenings paid for by private insurance companies, it is worth noting that the records do indicate an increasing trend in the number of screenings provided by MCRCCP.

[10] "CDC - An Effective Tobacco Counter-Marketing Campaign - Smoking & Tobacco Use." *Centers for Disease Control and Prevention*. Web. 21 June 2011. <http://www.cdc.gov/tobacco/stateandcommunity/counter_marketing/manual/index.htm>.

[11] "2011 Facebook Demographics and Statistics – Including Federal Employees and Gays in the Military | IStrategyLabs - A Social Experiential Agency." *IStrategyLabs = Social Media Marketing, Experiential Marketing, Innovation Design, Content Creation*. Web. 21 June 2011. <http://www.istrategylabs.com/2011/01/2011-facebook-demographics-and-statistics-including-federal-employees-and-gays-in-the-military/>.

Chart 27: MCRCCP screening numbers over the course of 4 months (Source: " Activity Report, All Health Systems, Maine Colorectal Cancer Control Program")

Discussion and Recommendations

The available data does not allow for a causal relationship between CRC-related media and screenings among the target population to be established. However, one can expect to see a correlation between greater media attention to CRC issues and increases in hotline call volume, website visits, and screenings provided through the MCRCCP program. Increased media coverage occurred during November of 2010 and March of 2011. During these months one can see increased volume, visits, and screenings. It is important to note that a wide range of factors could have an influence on these numbers (ie. other messaging in national media, changes in physician referral patterns, seasonal variations in screening rates, etc.); however, they do follow the general pattern that we would expect to result from successful efforts to leverage both paid and earned media to increase knowledge and awareness of a specific health issue within a given population.

The available data also provides some key take away messages that can help continue to raise awareness of CRC and the importance of screenings. These are summarized in the following points.

- Distribution of media coverage reached the major population centers. However, the geography of visitors to the website, suggests that media message strategies were less effective in reaching the target population in some areas of the state, including populations in the vicinity of Lewiston-Auburn, Millinocket, and Bangor. When planning future campaigns, increased concentration of outreach activities, and increased activity among community partners in these areas, could result in more individuals within the target population being exposed to CRC messaging.

- The origins of visits to the site suggest that people who visited primarily learned about the site from offline sources, such as print media, radio, TV, and word-of-mouth.

Continued emphasis on these avenues for distributing CRC awareness information is recommended.

- While individuals on social media sites (Facebook, Twitter) posted links to Colon Cancer Awareness Month articles, information may not have been present on web pages more commonly visited by individuals in the target population. An environmental scan to understand which websites are most often used by people in the target age range, combined with a coordinated earned media effort to get links to MCRCCP resources on these sites, may be effective in driving more people to the website and hotline, and ultimately increasing screening rates.

- However, it is expected that as time goes by more and more individuals in the 50 and older age group will be regular users of social media services. In fact, data from Facebook.com suggests that the number of accounts owned by people 55 and over is increasing at nearly 60% each year – the second fastest growing group of Facebook users after 18-24-year-olds.[12] This fact, combined with the low-cost of using social media as a messaging platform, means MCRCCP should not abandon social media outreach strategies.

- Call volume was negligible prior to the focused media attention in November and March. Although we would expect some degree of volume to be sustained now that the word is out, the numbers do suggest that monthly call volume is very much driven by the amount of media attention to the issue of CRC screening. This fact should be considered when planning and coordinating future media efforts and hotline services.

[12] "2011 Facebook Demographics and Statistics – Including Federal Employees and Gays in the Military | IStrategyLabs - A Social Experiential Agency." *IStrategyLabs = Social Media Marketing, Experiential Marketing, Innovation Design, Content Creation*. Web. 21 June 2011. <http://www.istrategylabs.com/2011/01/2011-facebook-demographics-and-statistics-including-federal-employees-and-gays-in-the-military/>.

VII. RESULTS PART III: OUTCOMES

Outcome evaluation is an important component of any comprehensive evaluation plan. In the previous two sections of this 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 section, the evaluation focus is on quantitative data to assess the effectiveness of those activities and strategies, i.e., the results (outcomes) of program implementation. Additionally, outcome data can highlight the anticipated and unanticipated changes brought about by the Cancer Plan. Outcome evaluation plays a valuable role and serves many purposes throughout the program.

The information provided below is based on outcome data for select objectives linked to specific goals outlined in the 2006–2010 Maine Comprehensive Cancer Control Plan. All objectives (with baseline data) included in this evaluation are listed below. Outcome data is also provided for CDC core indicators for comprehensive cancer programs. Results should be interpreted with caution. While the program theory originally set forth suggests that the accomplishments of the outlined strategies will lead to achieving objectives and ultimately, goals, there are additional factors that may 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.

More detailed outcome information on all cancers is accessible through *The Maine Cancer Surveillance Report 2009* published in the fall of 2009. Additionally, the cancer incidence and mortality findings can be accessed through the Maine Cancer Registry's *Maine Annual Cancer Report* on 2008 Cancer Incidence and 2007 Cancer Mortality located at the Maine Cancer Registry website http://www.maine.gov/dhhs/bohdcfh/mcr/.

INTERMEDIATE OUTCOMES

As noted earlier within the cancer plan monitoring section, not all the goals and objectives of the Cancer Plan are specifically 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 Integrated Youth Health Survey (MIYHS) 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. Third, 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. Fourth, 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 14 provides data for tobacco use among youth 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 14*:* 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] * tobacco products includes smokeless tobacco products. **CDC Performance Measure for CCCP/CRCCP Adult current smokers – Maine	23.6%	20.8%	20.9%	20.2%	18.2%	17.2% 22%	NA
Reduce cigarette smoking among pregnant and postpartum women to 15% by 2010.[3]							
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] (*tobacco use includes smokeless tobacco products). **CDC Performance Measure for CCCP/CRCCP	--	16.2%	--	14.0%	--	18.1%	--
Reduce tobacco use of 6 -8th graders to 5.5% by 2010. 2009 current smoking rate is 7.2	--	7.5%	--	5.5%	--	NA	--
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]	56.5	NA
Reduce involuntary exposure to secondhand smoke for all Maine residents[6]							
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]	81.3[7]	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 Monitoring 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 2009,2008and 2007 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 2011.

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 MIYHS 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 19.7%. 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, and 7.2% in 2009. Finally, the data suggest that since 2000 progress has been made in terms of exposure to secondhand smoke, with 83.3% of adults banning smoking in their homes in 2009, 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 15 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 15: 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%	37.8%	NA
Reduce the proportion of adults that are obese to 20% by 2010. **CDC Performance Measure for CCCP/CRCCP	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 combined (64.1%) are comparable to national rates (63.1%), Maine has the highest adult obesity rate (26.4%) in New England. While 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 16 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 16: 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%	--	14.9%	--
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. Note: 2009 definition used: doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey	--	62.3%	--	59.7%	--	63.2	--
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 17 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 17*:* 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 18 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 18: 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.[13] 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.

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

Intermediate Outcomes: Detection

This section provides screening data for select cancers collected through the Maine Behavioral Risk Factor Surveillance System, and presented in Table 19. 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 19: 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] **CDC Performance Measure for CCCP/CRCCP	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 2 years for women over 50.[4] **CDC Performance Measure for CCCP/CRCCP	84.7%[5]		84.3%[5]		85.1%[5]	--	NA
Increase the proportion of Maine women with a	97.0%	95.2%[2]	97.0%	--	95.6%	--	NA

uterine cervix who have ever received a Pap test to 98% by 2010.							
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. **CDC Performance Measure for CCCP/CRCCP	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. **CDC Performance Measure for CCCP/CRCCP	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 and cervical cancer screening rates both remained stable during 2006-2010. Screening rates for colorectal cancer through sigmoidoscopy/colonoscopy have increased by 34.8% 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 campaigns, in and of themselves, have raised awareness, and that subsequent colorectal 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.[14] Although overall cancer mortality is declining due to improvements in prevention, detection and treatment, 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 20 and 21 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]

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

Table 20*:* Age-Adjusted Cancer Incidence Rates in Maine by Site and Sex.

Objectives	**2002 Baseline**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
All sites	500.8	490.7	504.5	517.7	536.1	515.0	499.6
Male	589.9	571.0	587.6	593.2	620.6	598.4	568.6
Female	439.2	433.7	441.6	464.9	475.7	454.8	449.7
Lung & Bronchus	75.9	75.9	77.2	78.0	80.2	77.8	75.7
Male	96.0	96.2	96.7	95.1	98.3	94.7	89.9
Female	60.7	60.7	63.0	65.3	67.5	65.1	65.1
Colon & Rectum	61.2	55.3	55.2	54.4	50.3	49.0	44.4
Male	74.3	67.3	61.6	63.1	57	53.6	49.8
Female	51.8	46.4	49.0	47.0	45.2	45.2	39.9
Melanoma of the Skin	20.7	21.8	22.0	23.1	21.3	22.4	19.7
Male	24.1	27.6	27.0	27.3	24.9	24.6	22.9
Female	18.6	17.4	18.4	20.2	18.5	21.0	17.3
Breast (Female)	126.3	126.3	122.1	130	129.1	128.7	124.8
Cervix Uteri (Female)	7.1	8.0	8.9	6.3	NA	NA	5.8
Prostate (Male)	162.2	156.7	165.4	151.1	NA	NA	147.8
Oral Cavity & Pharynx	12.4	12.1	12.1	10.1	12.3	11.9	10.9
Male	19.5	17.7	19.6	15.4	19.8	17.4	15.3
Female	6.5	7.0	5.6	5.7	5.8	7.2	6.8
Urinary Bladder	27.1	30.5	27.7	26.6	30.3	29.0	25.8
Male	46.7	54.7	46.5	43.7	51.3	48.5	45.5
Female	12.2	12.4	13.0	14.0	14.3	14.4	11.1

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

Objectives	2002 Baseline	2003	2004	2005	2006	2007
All sites	213.9	204.1	205.8	204.7	194.3	191.9
Male	267.9	243.8	252.0	253.7	240.7	235.8
Female	177.3	178.1	173.7	171.2	162.9	163.3
Lung & Bronchus	63.2	62.3	61.1	60.2	61.5	56.3
Male	81.4	79.5	78.2	77.5	77.6	70.4
Female	49.8	49.9	48.9	47.6	49.9	56.5
Colon & Rectum	21.7	19.2	17.6	17.6	17.1	19.0
Male	27.6	21.7	17.6	21.0	21.0	21.8
Female	17	17.2	17.5	15.1	14.1	17.0
Melanoma of the Skin	3.5	2.5	2.9	2.6	3.3	2.8
Male	5.9	3.6	4.1	3.6	4.7	4.1
Female	1.7	1.7	1.8	1.9	2.3	1.8
Breast (Female)	23.9	27.3	21.3	22.4	21.4	20.3
Cervix Uteri (Female)	2.1	1.8	2.0	1.9	1.7	2.2
Prostate (Male)	26.4	27.6	26.9	25.9	23.9	22.5
Oral Cavity & Pharynx	2.8	2.7	3.3	2.4	2.4	2.4
Male	4.2	4.0	5.0	4.3	2.9	3.7
Female	1.6	1.5	1.8	0.9	2.0	1.3
Urinary Bladder	5.1	5.0	6.0	5.4	6.1	6.7
Male	8.4	7.4	11.7	9.9	9.5	11.0
Female	2.7	3.2	3.0	2.2	3.9	3.6

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 Cancer Registry's Maine Annual Cancer Report published in July, 2011 provides detailed data on 2008 Cancer Incidence and 2007 Cancer Mortality Rates

At the time the 2006–2010 Maine Comprehensive Cancer Control Plan was developed limited cancer indicators were available to be included in the overall program evaluation. Over the years various agencies have increased the collection of cancer data and the calculation of cancer indicators. For example, in 2010 a Statewide Community Health Needs Assessment (CHNA) was completed by the OneMaine Collaborative. This report was created to identify the most important health issues in the state of Maine, and by county, using scientifically valid health indicators and comparative information. The assessment also identifies priority health issues where better integration of public health and healthcare can improve access, quality, and cost effectiveness of services to residents of Maine. Cancer health is one of the core components of the CHNA, and is broken down by into the following sections: cancer risk factors, cancer prevalence rates, cancer management and patient care, and the quality and effectiveness of cancer care, see Table 22. Future quantitative evaluation of cancer activities within the MCCCP will greatly benefit from increased access to cancer data sources as it will strengthen the qualitative evaluation findings.

Table 22: Cancer Health – OneMaine CHNA.

		Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penobscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York	Maine	US	Maine Counties Source
CANCER HEALTH																				
Risk Factors	% Current Smokers (Age 18+)	20%	27%	16%	20%	19%	24%	18%	19%	25%	23%	21%	20%	26%	21%	31%	25%	22%	18%	2010 Household Survey
	% Sedentary Lifestyle	20%	25%	16%	18%	20%	20%	19%	20%	24%	23%	26%	20%	26%	25%	25%	20%	21%	24%	2010 Household Survey
	% Former smokers (Age 18+)	32%	30%	31%	36%	30%	33%	30%	43%	30%	29%	38%	35%	32%	28%	30%	31%	31%	26%	2010 Household Survey
	% Overweight (Age 18+)	39%	38%	36%	38%	38%	34%	38%	34%	36%	34%	38%	39%	40%	36%	39%	37%	37%	36%	2010 Household Survey
	% Obesity (Age 18+)	31%	31%	24%	31%	22%	31%	25%	25%	33%	35%	33%	23%	28%	27%	33%	23%	28%	27%	2010 Household Survey
Disease Prevelance	% Diagnosed Cancer (Age 18+)	5.8%	8.2%	6.1%	8.0%	9.4%	8.4%	9.6%	9.9%	9.3%	6.2%	8.0%	8.1%	9.8%	8.8%	8.4%	7.4%	7.5%	6.1%	2010 Household Survey
	All Cancers, Incidence Rate	585	669	580	609	744	609	690	715	684	638	779	582	629	661	787	605	629	476	ME CDC Cancer Reg
	Bladder, Incident Rate	35	32	34	41	37	29	31	45	40	35	45	25	34	24	43	38	35	22	ME CDC Cancer Reg
	Female Breast Cancer, Incidence Rate	141	151	159	156	198	166	196	203	178	145	232	145	161	171	142	163	162	132	ME CDC Cancer Reg
	Female Cervix Uteri, Incidence Rate	7.9	4.5	7.5	8.7	8.6	8.0	6.4	3.8	3.5	7.0	3.9	3.6	7.7	20.5	8.0	6.8	7.3	8.5	ME CDC Cancer Reg
	Colorectal, Incidence Rate	57	84	52	72	66	55	59	60	69	69	77	54	64	70	95	58	62	52	ME CDC Cancer Reg
	Lung and Bronchus Cancer, Incidence Rate	93	121	79	83	129	92	100	94	107	104	118	79	122	97	148	80	95	70	ME CDC Cancer Reg
	Melanoma, Incidence Rate	25	13	32	15	27	22	39	31	24	19	16	38	15	25	18	29	26	18	ME CDC Cancer Reg
	Male Prostate, Incidence Rate	169	149	179	176	231	193	190	228	184	175	243	212	178	199	261	191	187	142	ME CDC Cancer Reg
Management / Patient Care	% Reported Mammogram past year (40+)	69%	73%	69%	74%	68%	72%	66%	71%	70%	67%	69%	65%	60%	68%	68%	68%	69%	76%	2010 Household Survey
	% Stage Female Breast, Local	68%	62%	67%	71%	67%	65%	66%	65%	67%	63%	72%	67%	63%	64%	69%	63%	66%	61%	ME CDC Cancer Reg
	% Stage Female Breast, Distant	4.3%	3.6%	2.9%	9.7%	3.7%	2.6%	5.7%	2.8%	3.2%	2.4%	5.0%	7.4%	3.2%	6.0%	4.2%	4.7%	3.8%	4.8%	ME CDC Cancer Reg
	% Reported Pap Smear past 2 years	67%	72%	70%	72%	72%	77%	69%	72%	68%	68%	75%	72%	64%	73%	69%	70%	70%	85%	2010 Household Survey
	% Stage Cervix Uteri Female, Local	46%	20%	59%	25%	43%	33%	50%	50%	100%	56%	100%	50%	0%	42%	100%	71%	52%	48%	ME CDC Cancer Reg
	% Stage Cervix Uteri Female, Distant	15%	0%	3%	25%	29%	27%	25%	0%	0%	19%	0%	50%	17%	17%	0%	9.5%	14%	11%	ME CDC Cancer Reg
	% Reported Blood Stool Test Past Year (Age 50+)	23%	15%	17%	25%	25%	20%	23%	20%	27%	22%	23%	19%	21%	20%	22%	18%	20%	21%	BRFSS 2006/2008
	% Reported Having Sigmoid/Colonoscopy Past 5 Yrs (Age	67%	57%	69%	59%	56%	68%	60%	63%	61%	59%	58%	67%	51%	56%	58%	66%	63%		2010 Household Survey
	% Stage Colorectal, Local	47%	52%	43%	41%	48%	46%	50%	41%	28%	51%	42%	41%	45%	41%	54%	45%	47%	38	ME CDC Cancer Reg
	% Stage Colorectal, Distant	18%	14%	19%	14%	13%	19%	17%	22%	36%	18%	20%	15%	15%	22%	15%	16%	17%	19	ME CDC Cancer Reg
	% Stage Lung and Brunchus Male, Local	17%	20%	14%	15%	30%	13%	12%	5.0%	16%	22%	21%	8%	17%	24%	12%	9%	16%	15%	ME CDC Cancer Reg
	% Stage Lung and Brunchus Male, Distant	55%	48%	51%	51%	40%	48%	53%	57%	51%	48%	42%	50%	48%	32%	54%	58%	50%	54%	ME CDC Cancer Reg
	% Stage Lung and Brunchus Female, Local	20%	20%	18%	30%	28%	18%	23%	11%	18%	22%	19%	24%	26%	19%	20%	21%	21%	18%	ME CDC Cancer Reg
	% Stage Lung and Brunchus Female, Distant	50%	46%	42%	52%	37%	54%	47%	50%	58%	44%	52%	43%	43%	50%	49%	49%	47%	51%	ME CDC Cancer Reg
	% Reported Prostate Exam (PSA test) past 2 yrs (males Age 50+)	65%	68%	75%	60%	64%	77%	68%	65%	72%	62%	63%	69%	55%	68%	65%	75%	69%	*	2010 Household Survey
	% Reported Digital Rectal Exam past 2 years (males Age 50+)	71%	65%	73%	57%	71%	67%	63%	75%	66%	63%	65%	69%	53%	68%	65%	69%	68%		Household Survey
	% Stage Prostate, Local	84%	78%	73%	74%	79%	75%	81%	77%	84%	68%	61%	78%	78%	85%	77%	79%	76%	80%	ME CDC Cancer Reg
	% Stage Prostate, Distant	4.5%	3.8%	3.6%	1.3%	5.5%	6.2%	4.3%	3.4%	1.3%	3.4%	4.9%	4.4%	3.7%	2.7%	4.0%	3.0%	3.8%	4.2%	ME CDC Cancer Reg
Quality/Effectiveness	All Cancers, Mortality Rate	216	285	205	251	256	244	244	267	277	227	296	209	251	243	307	217	234	190	ODRVS Mortality
	Bladder, Mortality Rate	10	6.0	6.7	1.1	10	6.9	9.8	12	9.4	6.7	14	5.5	5.2	3.5	8.2	8.3	7.5	4.4	ODRVS Mortality
	Female Breast Cancer, Mortality Rate	24	40	26	20	31	33	35	21	38	26	23	30	24	27	34	27	28	28	ODRVS Mortality
	Female Cervix Uteri, Mortality Rate	2.4	2.7	2.3	2.2	1.2	3.2	1.6	1.9	2.3	3.5	0.0	0.0	8.9	5.1	4.0	0.6	2.5	2.6	ODRVS Mortality
	Colorectal, Mortality Rate	17	30	18	26	19	22	19	27	24	20	27	16	27	21	16	19	21	19	ODRVS Mortality
	Lung, Mortality Rate	66	91	59	86	74	69	64	76	80	77	69	72	72	67	101	60	69	54	ODRVS Mortality
	Melanoma, Mortality Rate	4.0	2.8	2.9	1.1	8.1	5.0	4.1	5.8	1.8	2.5	3.9	2.7	0.7	4.4	3.1	4.8	3.6	2.7	ODRVS Mortality
	Male Prostate, Mortality Rate	20	18	22	25	38	28	33	29	17	21	24	28	21	23	32	19	23	20	ODRVS Mortality

All rates are per 100,000 population (based on US Census estimates 2008) unless otherwise noted

VIII. OVERALL EVALUATION RECOMMENDATIONS: MCCCP, MRCCP, CANCER PLAN, AND CONSORTIUM

Throughout this report there have been evaluation recommendations posed for specific initiatives or programs which can be utilized to enhance or improve implementation of those individual programs. Taken in total the findings and recommendations of the report speak to some overarching evaluation recommendations for the work of MCCCP as a whole. As stated earlier, these evaluation recommendations are intended to inform program staff and stakeholders about areas for growth and should be viewed as an opportunity to strengthen and inform the work of MCCCP and its partners.

Changes in structure, such as with the Consortium, and changes in environment, such as new data sources, suggest that enhanced evaluation can be a goal for the program as it seeks another five-years of program funding. For example, before developing the future outcome indicators for MCCCP, the program should conduct an assessment of available data sources and indicators. A thorough understanding of the feasibility of available cancer data sources will increase the Consortium's ability to align program goals and objectives with available data sources. This will allow for continued qualitative and quantitative program evaluations which will greatly benefit the efforts of the program.

The following overarching program evaluation recommendations for the MCCCP are as follows:

1. Continue to utilize evaluation results to adapt, enhance and/or expand program initiatives and Consortium team activities to ensure activities are evidence-based.
2. Embed continuous program evaluation, wherever appropriate and possible, to glean data/evidence on the effectiveness of new and emerging strategies in cancer control.
3. Ensure continued coordination between state-wide and local-level colorectal cancer awareness efforts to maximize program impact and reach.
4. Clarify the role of evaluation within the new Consortium structure to ensure that it reflects the needs of both the Consortium and the MCCCP.
5. Create a time-limited data workgroup to assess effectiveness of current data sources and the feasibility of incorporating new data sources for tracking cancer indicators.
6. Develop a comprehensive five-year evaluation plan for the next five-year request for CDC Comprehensive Cancer funding.

IX. APPENDICES

APPENDIX A: MAINE CANCER CONSORTIUM MEMBER ORGANIZATIONS 2011

2-1-1 Maine
ACCESS Health
American Cancer Society
Androscoggin Home Care and Hospice
Bennett Breast Care Center
Beth C Wright Cancer Center
Burgess Advertising & Marketing
Calais Regional Hospital
Cancer Care Center at Penobscot Bay Medical Center
Cancer Care Center of York County
Cancer Community Center
CancerCare of Maine
Cape Elizabeth High School
Central Maine Medical Center
City of Portland, Public Health Division
CLEAN: Maine
Coalition Against Tobacco
Coastal Healthy Communities Coalition
Communities Promoting Health
Community Health Promotion Program
Coordinated Care Services
Dermatology Associates
Eastern Maine Medical Center
Family Planning Association of Maine
Franklin Memorial Hospital
Genentech
Goodall Hospital
Harold Alfond Center for Cancer Care
HealthReach HomeCare and Hospice
Healthy Acadia
Healthy Aroostook
Healthy Communities of the Capital Region
Healthy Community Coalition of Greater Franklin County
Healthy Living Project
Healthy Maine Partnerships
Healthy Peninsula Project
Healthy Waldo County
Kelly Middle School
Kennebec Pharmacy & Home Care
Knox County Community Health Coalition
Lung Cancer Alliance
Maine Academy of Family Physicians
Maine Association of Mental Health Services
Maine Breast and Cervical Health Program
Maine Cancer Foundation
Maine Cancer Registry
Maine Center for Cancer Medicine
Maine Center for Disease Control and Prevention
Maine Center for Disease Control, Physical Activity, Nutrition, and Healthy Weight Program
Maine Center for Public Health
Maine Coalition to Fight Prostate Cancer
Maine Colorectal Cancer Control Program
Maine Comprehensive Cancer Control Program
Maine Dartmouth Family Practice
Maine Department of Education
Maine Department of Environmental Protection
Maine Department of Health and Human Services, Division of Health Engineering
Maine Department of Health and Human Services, Office of Minority Health
Maine Department of Health and Human Services, Public Health Nursing
Maine Employees Health Trust
Maine Hospice Council
Maine Hospital Association
Maine Medical Center
Maine Medical Center Cancer Institute
Maine Municipal Association
Maine Office of Data, Research, and Vital information, BRFSS Program
Maine Primary Care Association
MaineGeneral Medical Center
MaineHealth
MaineHealth Learning Resource Centers
Mayo Regional Hospital
Melanoma Foundation of New England
Mercy Hospital
Mid Coast Hospital
Millinocket Regional Hospital
Molly Ockett Middle School
Muskie School of Public Service
Northern New England Clinical Oncology Society
Novartis
Partnership for a Healthy Community
Partnership for a Healthy Penobscot
Partnership for Tobacco-Free Maine
Penobscot Bay Medical Center
Penquis Health Services
Piscataquis Public Health Council
Pleasant Point Health Center
Portland Gastroenterology Center
Redington-Fairview General Hospital
River Valley Healthy Communities
Sheepscot Valley Health Center
Somerset Heart Health
Southern Maine Medical Center
SPRINT for Life
St John Valley Partnership
St Mary's Regional Medical Center
Stephens Memorial Hospital
The Aroostook Medical Center
The Patrick Dempsey Center for Cancer Care
Togus Veterans Administration Medical Center
Town of Fairfield
United Way of Greater Portland
United Way of Mid Maine
University of Maine at Augusta
University of Maine at Orono
University of New England
University of New England Coastal Healthy Communities Coalition
University of Southern Maine
Waldo County General Hospital
Washington County: One Community
Waterville Public Schools
Yarmouth Elementary School
York Hospital

APPENDIX B: 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 (such as, cancer clinical trials, publications, etc.). 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

- Maine Breast Care Nurse Network
- 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

- Full-day melanoma conference for PCPs.
- Annual Continuing Education Program for mammography technicians attended by 115 in May 2010.
- ACS Living with Cancer Conference.
- 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.
- ACoS Annual Meeting (2009)
- Annual Mammogram Tech Conference attracted 125 registrants (2009).
- Changing Horizons in Breast Care training (2008)
- 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.
- Training in state-of-the-art breast cancer techniques with health care professionals.

APPENDIX C: CANCER PLAN STAKEHOLDER MEETING (10/21/10) SURVEY TOOL

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…

	Not at All			*A lot*
1. Network with other professionals	1	2	3	4
2. Learn about the successes/challenges of the 2006-2010 Cancer Plan	1	2	3	4
3. Learn about the process used to develop the 2011-2015 Cancer Plan	1	2	3	4
4. Learn what is included in the 2011-2015 Cancer Plan	1	2	3	4
5. Participate in creating implementation steps for meeting the goals set in the 2011-2015 Cancer Plan	1	2	3	4
6. Learn about the new Cancer Consortium organizational structure & its impact on 2011-2015 Cancer Plan implementation	1	2	3	4
7. Learn about the Cancer teams & where/how my cancer work fits best	1	2	3	4
8. Learn what I can do to share the 2011-2015 Cancer Plan in a variety of venues to assure its goals are met over the next 5 years	1	2	3	4

Section #2: Keynote Speaker: Cathy Kidman

Please rate the presentation based on the following learning objectives. This session increased my…

	Not at all			*A lot*
9. Understanding of the importance of participating in the Consortium's efforts to realize the goals of the 2011-2015 Cancer Plan	1	2	3	4
10. Knowledge about the importance of adapting during times of change and challenge	1	2	3	4
11. Understanding of my role in motivating others to embrace the 2011-2015 Cancer Plan goals, objectives and strategies	1	2	3	4
12. Understanding of my organization's role in making the 2011-2015 Cancer Plan a success	1	2	3	4
13. Understanding of what I (and my organization) need to make the implementation of the 2011-2015 plan a success	1	2	3	4
14. Knowledge about the importance of collaboration and Partnerships when implementing a statewide plan	1	2	3	4

Section #3: About You

15. How long have you been a member of the Consortium and or its workgroups?

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

16. Please describe your level of participation in the Consortium and its activities during this time.

_____

17. Did you participate in the development the 2011-2015 Cancer Plan? Yes_____ No _____

Section #4: Other Information

18. Has today's meeting helped you to be a strong advocate for the goals, objectives, and strategies of the 2011-2015 Cancer Plan? Yes_____ No_____

Comments: _____

19. Has today's meeting provided you with the information and tools you need to share the 2011-2015 Cancer Plan with those who can work on it? Yes_____ No_____

If no, what additional information or tools would be helpful to you?

_____

20. How relevant was today's meeting to your work? ***Not at all*** 1 2 3 4 ***Very***

Comments:

_____

21. Was today's meeting a good use of your time and expertise? Yes_____ No _____

Comments:

_____

22. Are there other ways we might utilize your expertise as we implement the 2011-2015 Cancer Plan?

_____

23. Do you have suggestions for next steps the Consortium and its members can take to expand the knowledge about, interest in, and or actions involving the 2011-2015 Cancer Plan?

_____

24. 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 D: CONSORTIUM ANNUAL MEETING (5/19/11) SURVEY TOOL

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…

	Poor			Excellent
1. Network with other professionals	1	2	3	4
2. Learn about the efforts of Consortium partners (ex: HMPs)	1	2	3	4
3. Learn about new Cancer initiatives in Maine	1	2	3	4
4. Learn about the new Cancer Consortium structure	1	2	3	4
5. Learn about the new 2011-2015 Maine Cancer Plan	1	2	3	4
6. Learn about the impact of healthcare reform on oncology in Maine	1	2	3	4

Section #2: Keynote Speaker: Dr. Daniel M. Hayes

Please rate the presentation based on the following learning objectives. This session increased my…

	None			Greatly
7. Knowledge of the overall components of healthcare reform	1	2	3	4
Comments: _____				
8. Knowledge of cancer-specific aspects of healthcare reform	1	2	3	4
Comments: _____				
9. Knowledge of the impact of healthcare reform on oncology in Maine	1	2	3	4
Comments: _____				
10. Knowledge of how healthcare reform will impact my cancer work	1	2	3	4
Comments: _____				

Section #3: Overall Program for the Day

Please indicate the extent to which you found the meeting presentations informative or useful.

	Not Informative			Very Informative	Not Applicable
11. Maine General's state contract - Barbara Crowley	1	2	3	4	NA
Comments: _____					
12. Legislative Update – Hilary Schneider	1	2	3	4	NA
Comments: _____					

	Not Informative			Very Informative	Not Applicable
13. Q & A Session - Moderator	1	2	3	4	NA
Comments: _____					
14. Consortium Team Updates – Team Chairs	1	2	3	4	NA
Comments: _____					
15. NCI/NCCCP Contract – Barbara Grillo	1	2	3	4	NA
Comments: _____					
16. HMP Prevention Initiatives – Marice ReyesTran & others	1	2	3	4	NA
Comments: _____					

Section #4: 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
____ Prevention Team
____ Early Detection Team
____ Data Team
____ Disparities Team
____ I currently do not participate in the above groups.
___ Rehabilitation & Survivorship Team
___ Palliation & End-of-Life Care Team
___ Public Policy & Legislation Team
___Treatment Team
___Other - Please specify: _____

19. Outside of today's meeting, have you participated in Consortium activities, such as designing the new structure, working on the new Cancer plan, etc.? Yes_____ No _____ Why not?_____

Section #5: Other Information

	Not at all			Very
20. How relevant was today's meeting to your work?	1	2	3	4

Please explain your answer:
_____

21. Was today's meeting a good use of your time and expertise? Yes_____ No _____
If No, why not? _____

22. Are there other ways the Consortium might utilize your expertise?
_____

23. What else, if anything, would you like to tell us about today's meeting?
_____

Thank You

APPENDIX E: SUN BLOCKS TRAINING 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 2010

SUNBLOCKS SUNBLOCKS

August 2010

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

START

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	☐ Oxford
☐ Aroostook	☐ Penobscot
☐ Cumberland	☐ Piscataquis
☐ Franklin	☐ Sagadahoc
☐ Hancock	☐ Somerset
☐ Kennebec	☐ Waldo
☐ Knox	☐ Washington
☐ Lincoln	☐ 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: _____

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 adequately shaded play area?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

7. Has your center received a Childcare Skin Cancer Prevention Mini-Grant? (Select all that apply)

- ☐ Yes, received for 2008-2009
- ☐ Yes, received for 2009-2010
- ☐ Yes, received for 2010-2011
- ☐ 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: _____

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? ☐ Yes ☐ No ☐ I do not know	d. Are parents asked to apply sunscreen before their child arrives at the center? ☐ Yes ☐ No ☐ I do not know
b. Are parents asked to provide sunscreen for their child? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ I do not know	
c. Please describe when and how often children at the center wear hats:	

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? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ I do not know	
c. Please describe when and how often children at the center wear sun protective clothing:	

13. Do you, or the caregivers in your center, encourage 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? ☐ Yes ☐ No 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

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

APPENDIX F: SUN BLOCKS EVALUATION SURVEY

Sun Blocks Survey – 2011

1.

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

*** 2. 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

Other (please specify)

Page 1

Sun Blocks Survey – 2011

2.

*** 3. What county is your childcare center or organization located?**

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

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

- ○ 0-25
- ○ 26-50
- ○ 51-75
- ○ 76-100
- ○ 101+
- ○ N/A

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

- ☐ 0-2 years
- ☐ 3-5 years
- ☐ 6 years and older
- ☐ N/A

Page 2

Sun Blocks Survey – 2011

3. Sun Blocks program

*** 6. Did your center attend the Sun Blocks program training in October, 2010?**

- ○ Yes
- ○ No

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

- ☐ Yes, received for 2008-2009
- ☐ Yes, received for 2009-2010
- ☐ Yes, received for 2010-2011
- ☐ No

Page 3

Sun Blocks Survey – 2011

4. Mini-grant activities

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

  - Yes
  - No

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

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

  - Yes
  - No

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

  - Yes
  - No

* **12. 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

Page 4

Sun Blocks Survey – 2011

5. Policies & information

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

- ○ Yes
- ○ No
- ○ I don't know

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

- ○ Yes
- ○ No
- ○ I don't know

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

- ○ Yes
- ○ No
- ○ I don't know

Page 5

Sun Blocks Survey - 2011

6. Shade

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

- Yes
- No
- I don't know

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

- Yes
- No

*** 18. Please discribe any successes and/or challenges involved.**

Page 6

Sun Blocks Survey - 2011

7. Sunscreen

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

- ○ Yes
- ○ No

Page 7

Sun Blocks Survey - 2011

8.

*** 20. 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 don't know

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

Page 8

Sun Blocks Survey - 2011

9. Hats & sunglasses

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

- ○ Yes
- ○ No

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Sun Blocks Survey - 2011

10.

*** 23. 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.

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

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

- ○ Yes
- ○ No

Page 10

Sun Blocks Survey - 2011

11.

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

- ☐ Childcare center provides sunglasses for all children served.
- ☐ Parents asked to provide sunglasses for their children.
- ☐ I don't know.

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

Page 11

Sun Blocks Survey - 2011

12. Clothing

* **28. 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

Page 12

Sun Blocks Survey - 2011

13.

*** 29. 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 don't know.

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

Page 13

Sun Blocks Survey - 2011

14. Playtime policies

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

  - Yes
  - No

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

* **33. 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

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

  - Yes
  - No

* **35. Please describe any successes and/or challenges involved.**

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

Page 14

Sun Blocks Survey - 2011

15. Additional comments

* **37. 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?**

* **38. 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?**

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

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APPENDIX G: HEALTHY MAINE PARTNERSHIPS COLORECTAL CANCER GRANT SURVEY

MCCCP - 2011 HMP Survey

Thank you for taking a few minutes to respond to this survey about the Maine Comprehensive Cancer Control Program (MCCCP) mini-grants. Through these grants, MCCCP hopes to raise awareness across Maine about the importance of getting screened for colorectal cancer (CRC).

This survey is a chance for you to share what HMPs are doing at the local level. We designed it to gather information that will help build a stronger program while being as simple to fill out as possible. All responses are anonymous.

This survey is being conducted by the Center for Community and Public Health (CCPH) at the University of New England. CCPH is the external evaluator for MCCCP. If you have any questions or problems about taking the survey please contact RuthAnne Spence at rspencephd@une.edu or at 221- 4573.

1. Which of Maine's 8 Public Health Districts does this HMP operate in?

- ◯ District 1 - York
- ◯ District 2 - Cumberland
- ◯ District 3 - Western Maine
- ◯ District 4 - Mid Coast
- ◯ District 5 - Central Maine
- ◯ District 6 - Penquis
- ◯ District 7 - Downeast
- ◯ District 8 - Aroostook

MAIN OBJECTIVES

These questions focus on how HMPs are meeting the core objectives of the MCCCP grants.

2. Did the grantee attend the statewide colorectal cancer stakeholder meeting on September 15, 2010 in Augusta?

- ◯ Yes
- ◯ No

3. Did the grantee prepare and implement a district-wide evidence-based workplan for increasing awareness of colorectal cancer and screening within your district?

- ◯ Yes
- ◯ No

Page 1

MCCCP - 2011 HMP Survey

4. Did your Public Health District's designated representative to the MCCCP's Public Education and Outreach Advisory Group attend the following meetings?

	Yes	No
Monday Aug. 2, 2010	○	○
Thursday Dec. 16, 2010	○	○
Tuesday May 10, 2011	○	○

5. In your opinion, how effective were these meetings in building collaboration and communication between state-wide and local media efforts around CRC?

	Very ineffective	Ineffective	Effective	Very effective	N/A
Meeting effectiveness	○	○	○	○	○

Please comment

REDUCING BARRIERS

These questions relate to efforts to reduce barriers to CRC screening through use of MCCCP grant funds.

6. Please identify and briefly explain any remaining structural barriers to providing information about or increasing screening rates for CRC in your community.

7. In your estimate, how effective has this funding been in reducing structural barriers to enhancing public education and outreach concerning the importance of CRC screening in your community?

	Very ineffective	Ineffective	Effective	Very effective
Effectiveness of funding	○	○	○	○

Now we're going to ask a series of questions about which kinds of organizations you've worked with to raise awareness about the importance of CRC screening.

If you have worked with a particular group, you will be given an opportunity to elaborate. You must provide an answer to each question in this section in order to move forward.

HEALTH CARE PROVIDERS

Page 2

MCCCP - 2011 HMP Survey

8. Has your HMP either collaborated with, been in communication with, or distributed materials to HEALTH CARE PROVIDERS as part of the MCCCP grant?

(This includes clinics, hospitals, health centers, primary care centers, mental health centers, etc.)

- ◯ Yes
- ◯ No

HEALTH CARE PROVIDERS

9. Please list the specific HEALTH CARE PROVIDERS you have worked with.

10. Which of the following characterize the nature of the relationships you have built with HEALTH CARE PROVIDERS as a result of the MCCCP grant? (check all that apply)

- ☐ New collaborative partnerships
- ☐ Communication contacts
- ☐ Distribution points for CRC materials
- ☐ Other (please specify)

11. Please indicate the type of materials distributed to HEALTH CARE PROVIDERS. (check all that apply)

- ☐ Bookmarks
- ☐ Emails
- ☐ Fliers
- ☐ Mailed Letters
- ☐ Pamphlets
- ☐ Postcards
- ☐ Other (please specify)
- ☐ Posters
- ☐ Presentations
- ☐ PSAs (Radio)
- ☐ PSAs (Television)
- ☐ Signs (billboards, etc.)

EMERGENCY SHELTERS

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12. Has your HMP either collaborated with, been in communication with, or distributed materials to EMERGENCY SHELTERS as part of the MCCCP grant?

(This includes homeless shelters, domestic violence shelters, etc.)

- ◯ Yes
- ◯ No

EMERGENCY SHELTERS

13. Please list the specific EMERGENCY SHELTERS you have worked with.

14. Which of the following characterize the nature of the relationships you have built with EMERGENCY SHELTERS as a result of the MCCCP grant? (check all that apply)

- ☐ New collaborative partnerships
- ☐ Communication contacts
- ☐ Distribution points for CRC materials
- ☐ Other (please specify)

15. Please indicate the type of materials distributed to EMERGENCY SHELTERS. (check all that apply)

- ☐ Bookmarks
- ☐ Emails
- ☐ Fliers
- ☐ Mailed Letters
- ☐ Pamphlets
- ☐ Postcards
- ☐ Other (please specify)
- ☐ Posters
- ☐ Presentations
- ☐ PSAs (Radio)
- ☐ PSAs (Television)
- ☐ Signs (billboards, etc.)

RECREATIONAL PROGRAMS

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16. Has your HMP either collaborated with, been in communication with, or distributed materials to RECREATIONAL PROGRAMS as part of the MCCCP grant?

(This includes recreation centers, gyms, parks, etc.)

- ◯ Yes
- ◯ No

RECREATIONAL PROGRAMS

17. Please list the specific RECREATIONAL PROGRAMS you have worked with.

18. Which of the following characterize the nature of the relationships you have built with RECREATIONAL PROGRAMS as a result of the MCCCP grant? (check all that apply)

- ☐ New collaborative partnerships
- ☐ Communication contacts
- ☐ Distribution points for CRC materials
- ☐ Other (please specify)

19. Please indicate the type of materials distributed to RECREATIONAL PROGRAMS. (check all that apply)

- ☐ Bookmarks
- ☐ Emails
- ☐ Fliers
- ☐ Mailed Letters
- ☐ Pamphlets
- ☐ Postcards
- ☐ Other (please specify)
- ☐ Posters
- ☐ Presentations
- ☐ PSAs (Radio)
- ☐ PSAs (Television)
- ☐ Signs (billboards, etc.)

EDUCATIONAL PROGRAMS

Page 5

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20. Has your HMP either collaborated with, been in communication with, or distributed materials to EDUCATIONAL PROGRAMS as part of the MCCCP grant?

(This includes schools, libraries, academic institutions, etc.)

- ◯ Yes
- ◯ No

EDUCATIONAL PROGRAMS

21. Please list the specific EDUCATIONAL PROGRAMS you have worked with.

22. Which of the following characterize the nature of the relationships you have built with EDUCATIONAL PROGRAMS as a result of the MCCCP grant? (check all that apply)

- ☐ New collaborative partnerships
- ☐ Communication contacts
- ☐ Distribution points for CRC materials
- ☐ Other (please specify)

23. Please indicate the type of materials distributed to EDUCATIONAL PROGRAMS. (check all that apply)

- ☐ Bookmarks
- ☐ Emails
- ☐ Fliers
- ☐ Mailed Letters
- ☐ Pamphlets
- ☐ Postcards
- ☐ Other (please specify)
- ☐ Posters
- ☐ Presentations
- ☐ PSAs (Radio)
- ☐ PSAs (Television)
- ☐ Signs (billboards, etc.)

LOCAL/MUNICIPAL PROGRAMS

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24. Has your HMP either collaborated with, been in communication with, or distributed materials to LOCAL/MUNICIPAL PROGRAMS as part of the MCCCP grant?

(This includes local government, clubs, groups, community centers, etc.)

- ◯ Yes
- ◯ No

LOCAL/MUNICIPAL PROGRAMS

25. Please list the specific LOCAL/MUNICIPAL PROGRAMS you have worked with.

26. Which of the following characterize the nature of the relationships you have built with LOCAL/MUNICIPAL PROGRAMS as a result of the MCCCP grant? (check all that apply)

- ☐ New collaborative partnerships
- ☐ Communication contacts
- ☐ Distribution points for CRC materials
- ☐ Other (please specify)

27. Please indicate the type of materials distributed to LOCAL/MUNICIPAL PROGRAMS. (check all that apply)

- ☐ Bookmarks
- ☐ Emails
- ☐ Fliers
- ☐ Mailed Letters
- ☐ Pamphlets
- ☐ Postcards
- ☐ Other (please specify)
- ☐ Posters
- ☐ Presentations
- ☐ PSAs (Radio)
- ☐ PSAs (Television)
- ☐ Signs (billboards, etc.)

MEDIA OUTLETS

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28. Has your HMP either collaborated with, been in communication with, or distributed materials to MEDIA OUTLETS as part of the MCCCP grant?

(This includes newspapers, radio stations, websites, etc.)

- ◯ Yes
- ◯ No

MEDIA OUTLETS

29. Please list the specific MEDIA OUTLETS you have worked with.

30. Which of the following characterize the nature of the relationships you have built with MEDIA OUTLETS as a result of the MCCCP grant? (check all that apply)

- ☐ New collaborative partnerships
- ☐ Communication contacts
- ☐ Distribution points for CRC materials
- ☐ Other (please specify)

31. Please indicate the type of materials distributed to MEDIA OUTLETS. (check all that apply)

- ☐ Bookmarks
- ☐ Emails
- ☐ Fliers
- ☐ Mailed Letters
- ☐ Pamphlets
- ☐ Postcards
- ☐ Other (please specify)
- ☐ Posters
- ☐ Presentations
- ☐ PSAs (Radio)
- ☐ PSAs (Television)
- ☐ Signs (billboards, etc.)

AREA BUSINESSES

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32. Has your HMP either collaborated with, been in communication with, or distributed materials to AREA BUSINESSES as part of the MCCCP grant?

- ◯ Yes
- ◯ No

AREA BUSINESSES

33. Please list the specific AREA BUSINESSES you have worked with.

34. Which of the following characterize the nature of the relationships you have built with AREA BUSINESSES as a result of the MCCCP grant? (check all that apply)

- ☐ New collaborative partnerships
- ☐ Communication contacts
- ☐ Distribution points for CRC materials
- ☐ Other (please specify)

35. Please indicate the type of materials distributed to AREA BUSINESSES. (check all that apply)

- ☐ Bookmarks
- ☐ Emails
- ☐ Fliers
- ☐ Mailed Letters
- ☐ Pamphlets
- ☐ Postcards
- ☐ Other (please specify)
- ☐ Posters
- ☐ Presentations
- ☐ PSAs (Radio)
- ☐ PSAs (Television)
- ☐ Signs (billboards, etc.)

OTHER

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36. Has your HMP either collaborated with, been in communication with, or distributed materials to any OTHER groups as part of the MCCCP grant?

(This includes community events, other types of organizations, groups, programs, etc.)

- ◯ Yes
- ◯ No

OTHER

37. Please list the specific OTHER groups you have worked with.

38. Which of the following characterize the nature of the relationships you have built with OTHER groups as a result of the MCCCP grant? (check all that apply)

- ☐ New collaborative partnerships
- ☐ Communication contacts
- ☐ Distribution points for CRC materials
- ☐ Other (please specify)

39. Please indicate the type materials distributed to OTHER groups. (check all that apply)

- ☐ Bookmarks
- ☐ Emails
- ☐ Fliers
- ☐ Mailed Letters
- ☐ Pamphlets
- ☐ Postcards
- ☐ Other (please specify)
- ☐ Posters
- ☐ Presentations
- ☐ PSAs (Radio)
- ☐ PSAs (Television)
- ☐ Signs (billboards, etc.)

GRANT IMPLEMENTATION

This final section asks a few specific questions relating to grant implementation. Your comments are appreciated.

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40. Were you able to collaborate with other HMSs within your Public Health District in raising awareness of CRC?

- ◯ Yes
- ◯ No

Please explain how or why not.

41. Did you coordinate CRC awareness activities across the public health district to coincide with Colorectal Awareness Month (March)?

- ◯ Yes
- ◯ No

Please explain how or why not.

42. Did your HMP participate in any work site wellness initiatives?

- ◯ Yes
- ◯ No

If so, which ones?

43. Did your HMP use MCCCP grant funds to create new activities, expand existing ones, or both?

- ◯ Create new activities
- ◯ Expand existing activities
- ◯ Both

Please explain.

GRANT IMPLEMENTATION

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44. Please share what you think is the greatest impact the MCCCP grant funds have had in your community.

45. In the space below, please share an example of how your local media campaign enhances and/or expanded the statewide media campaign.

46. Is there anything else about the MCCCP grants that you'd like to tell us?

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