Comprehensive Cancer Control

Evaluation Report:

Maine Comprehensive Cancer Control Program
Maine Cancer Consortium
Maine Cancer Plan

September 2007
Final Report

Prepared for:

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Executive Summary

Background

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

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

In relation to these areas, this report provides an overview of findings related to the implementation of the 2006-2010 Cancer Plan, the effectiveness of the Maine Cancer Consortium partnership and Program-related activities and accomplishments.

Moreover, the report includes evaluation data from the following initiatives implemented by the MCCCP along with the Skin Cancer Workgroup and Colon Cancer Task Force of the Cancer Consortium:

1) *Screen ME!* Colon Cancer Social Marketing Campaign
2) *Sun Safety Kits* for Elementary Schools

Purpose of the Report

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

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

Results: At-a-Glance

Cancer Consortium, Partnership Self-Assessment

The web-based *Partnership Self-Assessment Tool* was administered as part of a larger web-based survey to a total of 106 members of the Maine Cancer Consortium during the fall of 2006. The overall results, calculated based on the mean of all items, suggest an overall synergy score of 3.6 up from 2.8 from the previous 2005 survey. This score can be interpreted to fall within the “work zone” thus, indicating more effort is still needed to maximize the Consortium’s full potential. Specific areas of strength include but are not limited to leadership, use of financial and in-kind resources, evaluating the initiative, organizing Consortium activities, management of grants, and use of non-financial resources (e.g., use of members’ expertise). The

findings suggest that providing orientation to new members, coordinating communication with those outside the Consortium, and increased funding are areas most in need for improvement. Finally, overall the results suggest that, of those who completed the survey, approximately 85% believed that the benefits exceeded or greatly exceeded the drawbacks.

Comprehensive Cancer Control Program Results

During the 2006 cycle, the Maine Comprehensive Cancer Control Program (MCCCP) and Maine Cancer Consortium completed the final wave of its Colon Cancer Social Marketing Campaign. According to the recent evaluation survey results, since the initial Pre-Wave and the Follow-Up surveys in 2005, there has been a sustained 12% increase in the number of respondents claiming to have been screened. This suggests that the continued media campaign by the MCCCP and others has served to maintain the increased base rate in screening behavior. Additional MCCCP accomplishments can be found in *Results Part II.*

2006-2010 Maine Cancer Plan Implementation Findings

This evaluation report provides information on select goals, objectives, and strategies delineated in the Maine Cancer Plan. The *Activity-Monitoring Tool* was used to track progress, to date, with regard to implementation for all strategies listed in the 2006-2010 Maine Cancer Plan. Overall, for the first year of implementation the results suggest that some progress has been achieved for approximately 72% of the strategies assessed.

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

Recommendations

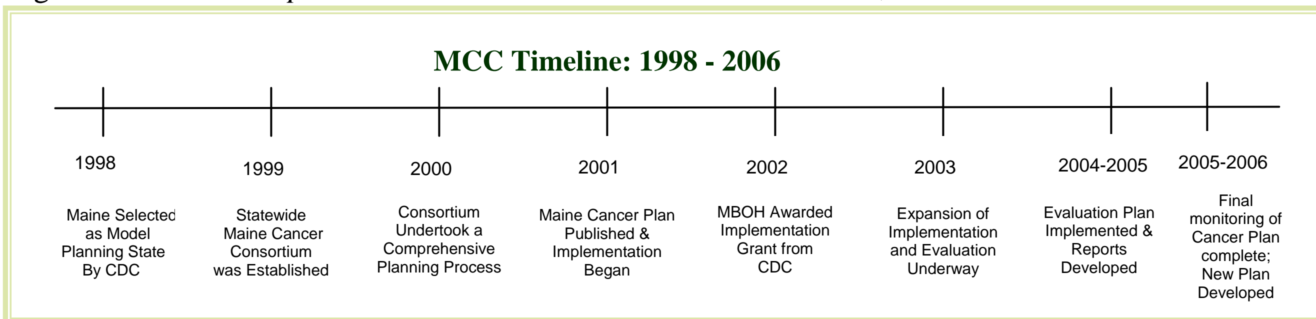
The following recommendations have been provided.

1. Enhance Communication of Consortium Activities and Message
2. Enhance the Consortium’s membership and participation.
3. Enhance Outcome Evaluation

Background

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

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



As depicted in the figure above, the actual implementation of the Maine Cancer Plan has been underway since 2001. The newest version of the 5-year Cancer Plan was announced May 18, 2006 with implementation beginning in the fall of 2006. This report attempts to capture activities, successes, and challenges that have occurred, since the launch of the new cancer plan, related to three major areas of the initiative. They include: 1) the Maine Comprehensive Cancer Control Program housed within the ME-CDC; 2) the Maine Cancer Consortium and related Workgroups or Task Forces; and 3) the Maine Cancer Plan. These three areas complement one another and many of the activities overlap.

Maine Comprehensive Cancer Control Program

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

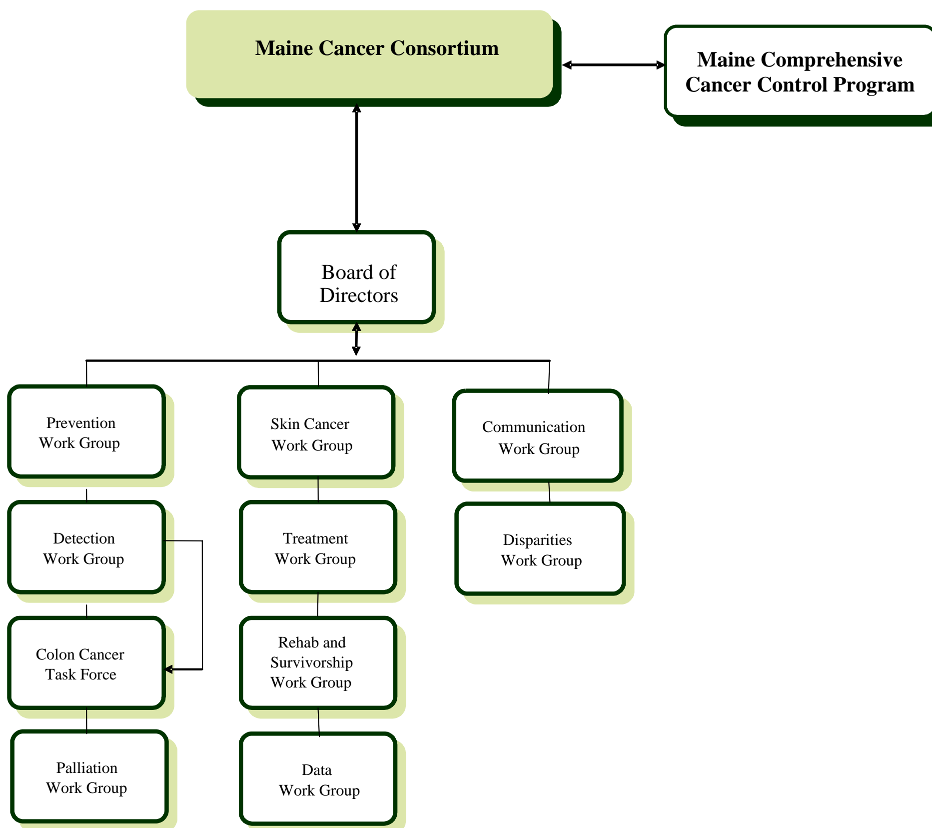
- Improve and expand the collaborative efforts already in place through the Maine Cancer Consortium among stakeholders working on cancer control in Maine.
- Increase the use of the Maine Cancer Plan as the statewide document directing cancer control efforts.
- Provide technical assistance to organizations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

- Evaluate the efforts and impact of the Consortium and CCC Program.

Maine Cancer Consortium

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

Figure 2. *Maine Cancer Consortium Organizational Chart*



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

- Increase statewide integration, coordination, and provision of quality prevention, treatment, palliative, and end of life care services in Maine.
- Increase access to high quality cancer prevention, treatment, palliative, and end of life care information and services for all Maine residents regardless of geographic, financial, and other demographic factors.
- Increase the proportion of residents who appropriately utilize screening, follow-up, treatment, rehabilitation, survivorship, hospice, and palliative care services.

- Improve the quality and coordination of cancer surveillance and other data systems and the extent to which these and other evaluation data are used for comprehensive cancer control programming and management.
- Increase support from policy and grant makers for comprehensive cancer control in Maine.

Maine Cancer Plan

The Consortium and CCC Program worked collaboratively to create the *Maine Cancer Plan*, published in 2006. The purpose of the Plan was to provide a template for what should be done to provide statewide coordination of cancer control efforts in Maine through 2005. The eight components of the Maine Cancer Plan are depicted below in Figure 3.

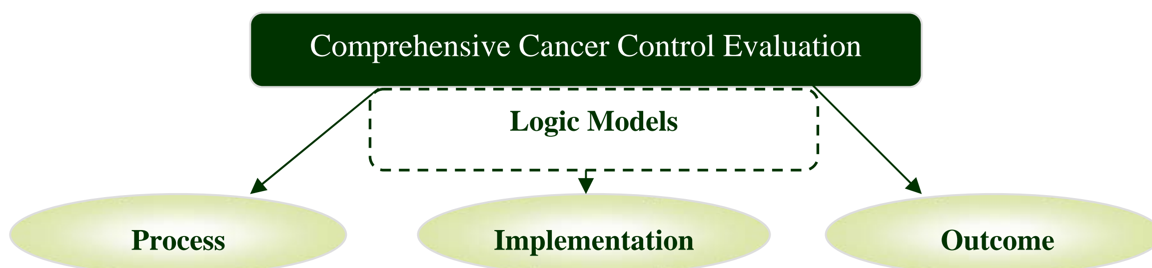
Figure 3. *Maine Cancer Plan Components, Goals, Objectives: 2006-2010*

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

Evaluation Design

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

Figure 4. *Comprehensive Cancer Control Evaluation Design*



Data Collection Methodology

Quantitative and qualitative information were collected as part of this evaluation. Table 1 depicts the data sources for each component of the evaluation during the 2006-2007 cycle year. All tools developed by the Maine Center for Public Health were done so using a collaborative process with the Maine CCC program.

Table 1. *Data Sources*

Evaluation Component	Source
Process Evaluation	
• **Consortium Partnership Self-Assessment** - On-line	• Developed by the Center for the Advancement of Collaborative Strategies in Health, modified by the Maine Center for Public Health
Implementation Evaluation	
• **Modified Activity Monitoring Tool** - Paper and pencil tracking tool	• Developed by the Maine Center for Public Health
• **Interviews with Staff** - In person, program accomplishments updates	• Developed by the Maine Center for Public Health
• **Sun Safety Kit evaluation survey** - Paper/pencil distributed to elementary schools	• Developed by the Maine Center for Public Health & MCCCP
• **Social marketing surveys** • Maine residents, 50 & older: Telephone, Pre/Post (30 items)	• Developed by Digital Research, Inc.
Outcome Evaluation	

• **Maine Cancer Registry, CDC Wonder** - Secondary data (incidence and mortality)	• Maine-CDC • CDC
• **Youth/Behavioral Risk Factor Surveillance System** - Secondary data (behaviors)	• Maine-CDC • CDC

RESULTS PART I: PROCESS

Understanding the contextual factors (e.g., environmental, organizational, human, etc.) that either hinder or facilitate a program's success provides important information that can be used for program replication and decision-making.

Cancer Consortium Findings

Partnership Self-Assessment

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

In response to such changes in the collaborative process and armed with the motivation to examine potential improvements in partnership functioning, the Consortium participated in another *Partnership Self-Assessment* during October and November of 2006.

2006 Assessment
The web-based *Partnership Self-Assessment Tool* was administered as part of a larger web-based survey to a total of 106 members of the Maine Cancer Consortium during the fall of 2006. Members were selected to participate in this survey if they met the following two criteria: 1) were a member of a Workgroup or Board of Directors, 2) had an e-mail address.

The survey included a series of 73 questions. The majority of questions were based on the *Partnership Self-Assessment Tool* developed and tested by the Center for the Advancement of Collaborative Strategies in Health at The New York Academy of Medicine. Questions pertaining to the partnership tool were used to assess how well the Consortium's collaborative process was working and to identify specific areas for improvement. Additional questions provided information about a participant's involvement in the Consortium, including the length of time involved and the level of involvement.

Response Rate and Participant Characteristics
A total of 47 members completed the survey during the two week timeframe for a response rate of 47%. Over 60% of respondents indicated that they had been involved in the Consortium for one year or more. Approximately 55% classified themselves as "involved," or "very involved" and one-third (32%) self-classified as "somewhat involved" and the remaining 13% classified themselves as "rarely" or "not at all involved" when asked about their involvement in the Consortium.

Table 2 provides a summary of responses. As planned, the results suggest that only current members (except for one participant) participated in the survey. The responses also reflect a mix of views from members at varying levels of involvement. In terms of work group and Board participation, the majority (89%) were involved in work groups with the Colon Cancer Task Force (30%) having the most representation.

Table 2. *Involvement in Consortium (n =47)*

Involvement in Consortium	Percent
Length of Time Involved in Consortium	
• Not a member	2%
• Less than one year	26%
• One to three years	23%
• Greater than three years	43%
• Other	6%
Level of Involvement	
• Not at all involved	2%
• Rarely involved	11%
• Somewhat involved	32%
• Involved	34%
• Very involved	21%
Currently a Work Group Member	
• Yes	89%
• No	9%
• Used to be	2%
Work Group Membership	
• Prevention	23%
• Skin Cancer Task Force	18%
• Early Detection	13%
• Colon Cancer	30%
• Treatment	10%
• Rehabilitation/Survivorship	23%
• Palliative Care	15%
• Data	18%
• Disparities	5%
• Communication	8%
Length of Time Involved in Work Group	
• Not a member	5%
• Less than one year	32%
• One to three years	37%
• Greater than three years	28%

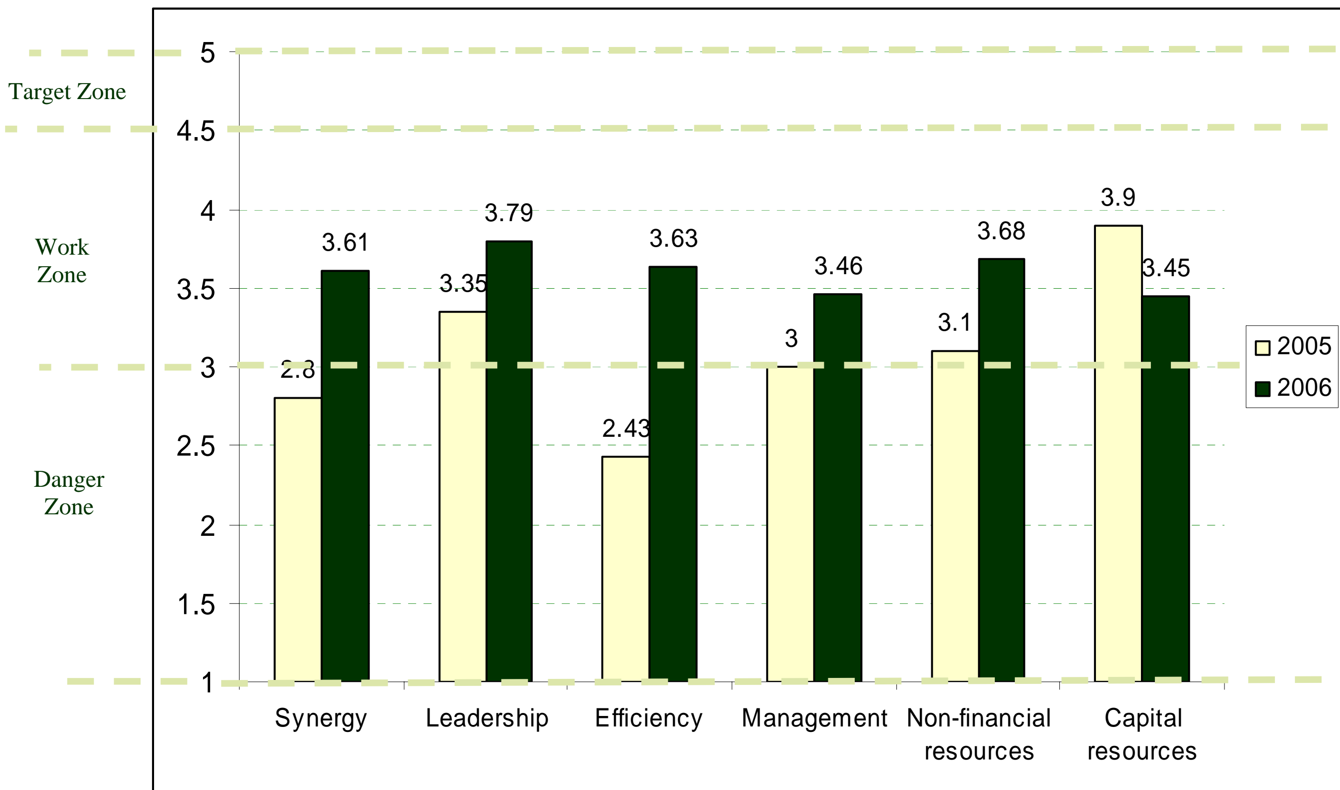
Overall Partnership Tool Results: Synergy

The self-assessment tool focuses primarily on a construct known as *partnership synergy*. This construct is used to determine how well a collaborative process is working. A key indicator of a successful collaborative process, synergy refers to a partnership's ability to accomplish more collectively compared to what could be achieved by individual members.

The overall results of the *Partnership Self-Assessment Tool* are illustrated below in Figure 5. The findings indicate that the Consortium scored within the second or "work" zone for all of the six domains identified. The results suggest that more effort is needed in all areas in order to maximize the partnership's collaborative potential and in order to achieve scores within the "target zone" (optimal performance).

Finally, all mean scores except for "capital resources" have increased since the previous administration of the survey. These increases can be interpreted as improvements in the Consortium's work. Moreover, it should be noted that the difference in numbers reflects the change in the administration of the survey (i.e., majority were members and those at least somewhat involved in Consortium).

Figure 5. *Partnership Self-Assessment Overall Results, by Survey Year*



Despite scoring in zone two, the Consortium has several noteworthy strengths and accomplishments. The following tables highlight these strengths as well as the weaknesses in each area. This information is intended to be used to celebrate successes and to strengthen the partnership.

Partnership Synergy Results

Each item listed below in Table 3 represents one attribute of synergy, as operationalized by this instrument. The overall results, calculated based on the mean of all items, suggest an overall synergy score of 3.6 up from 2.8 from the previous 2005 survey. This score can be interpreted to fall within the "work zone" thus, indicating more effort is still needed to maximize the Consortium's full potential. The mean scores depicted below indicate that the Partnership is doing "well" with regard to the items listed in Table 3.

Table 3. *Partnership Synergy Results*

Synergy Items	Mean 1 = Not well at all 5 = Extremely well
By working together, how well the Consortium members are able to:	
Identify new and creative ways to solve problems	3.8
Develop goals that are widely understood and supported among partners	3.9
Identify how different services and programs in the community relate to select problems	3.7
Respond to the needs of the community	3.6
Implement strategies that are likely to work in the community	3.6
Obtain support from those who can block the Partnership's plans	3.5
Carry out comprehensive activities	3.6
Clearly communicate to people how the Partnership will address problems	3.2

Leadership Results

Table 4 highlights the results of specific leadership attributes that are linked to high levels of synergy. Overall, the findings suggest several strengths including but not limited to: taking responsibility for the partnership, fostering respect, trust, and inclusiveness, inspiring people to be involved, communicating the vision of the partnership, and combining the perspectives, skills and resources of partners. Only one area, creating an environment where differences of opinion can be voiced, had a mean rating of below 3.5. Thus, the results are indicative of strong leadership effectiveness in the partnership.

Table 4. *Leadership Results*

Leadership Effectiveness Items	**Mean** **1 = Poor 5 = Excellent**
Leadership attributes:	
Taking responsibility for the partnership	4.1
Inspiring or motivating people involved in the partnership	3.8
Empowering people involved in the partnership	3.7
Communicating the vision of the partnership	3.8
Working to develop a common language within the partnership	3.6
Fostering respect, trust, inclusiveness and openness	4.0
Creating an environment where differences of opinion can be voiced	3.4
Resolving conflict among partners	3.7

Combining the perspectives, resources and skills of partners	3.8
Helping the partnership be creative and look at things differently	3.7
Recruiting diverse people and organizations into the partnership	3.6

Efficiency Results

Table 5 depicts the results of how well the Consortium optimizes the involvement of its members. According to the *Center for the Advancement of Collaborative Strategies in Health*, efficient partnerships keep members engaged by matching the roles and responsibilities of members based on interests and skills; and making good use of members' time, experience, financial, and in-kind resources. Based on the scores below, the Maine Cancer Consortium does a "good" job using its members' in-kind resources, and drawing on the financial resources and time of the members.

Table 5. *Efficiency Results*

Efficiency Items	Mean 1 = Poor 5 = Excellent
How well the partnership uses its partners':	
Financial resources	3.6
In-kind resources	3.7
Time	3.6

Administration and Management Results

The administration and management of a partnership attempting to achieve a high level of synergy is typically one that provides an orientation to new members, minimizes the barriers for involvement, facilitates timely communication, coordinates meetings and other activities, applies for and manages funds, and provides analytic support. As seen in Table 6, the Consortium's "management team" has been successful at securing funding, organizing partnership activities and evaluating the initiative. Moreover, two areas that needed improvement from the last survey, coordinating communication among the Consortium and performing secretarial duties are now considered to be "good." The scores suggest that providing orientation to new members and coordinating communication with those outside the Consortium are areas most in need for improvement. It should be noted, however, both of these areas are being addressed by the newly active Communications Workgroup.

Table 6. *Administration and Management Results*

Administration and Management Items	Mean 1 = Poor 5 = Excellent
Consortium administration and management activities:	
Coordinating communication among partners	3.5
Coordinating communication outside of partnership	2.8
Organizing partnership activities, including meetings and projects	3.8
Applying for and managing grants and funds	3.8
Preparing materials that inform partners and timely decisions	3.5
Performing secretarial duties	3.6
Providing orientation to new partners	2.9
Evaluating the progress and impact of the partnership	3.7
Minimizing barriers for participation in meetings and activities	3.5

Non-Financial Resources Results

The Consortium's ability to secure sufficient non-financial resources from its members is an important dimension of Partnership synergy. The six types of non-financial resources included in the survey are listed in Table 7. Overall, the Consortium has "most of what it needs" in terms of skills and expertise, legitimacy and credibility, the ability to bring people together for meetings, and data and information. The Consortium also has "some to most of what it needs" in terms of political connections, connections to people affected by cancer.

Table 7. *Sufficiency of Non-Financial Resources Results*

Non-Financial Resources Items	Mean 1 = None 5 = All of what it needs
Kinds of non-financial resources:	
Skills and expertise	4.0
Data and information	3.7
Connections to target populations	3.5
Connections to political decision-makers, government, and others	3.3
Legitimacy and credibility	3.9
Influence and ability to bring people together for meetings, activities	3.7

Financial Resources Results

Although the relationship of financial resources to a partnership's level of synergy may be indirect, financial and capital resources are essential to carry out the management of activities. Table 8 highlights the three items used to assess the sufficiency of money, space, equipment, and goods. The results suggest that the Consortium has "most of what it needs" in terms of equipment, goods, and space and "some of what it needs" in the area of money. These results are not surprising in light of the effort to secure funding for the implementation of the new Cancer Plan.

Table 8. *Sufficiency of Financial Resources Results*

Financial and Other Capital Resources Items	Mean 1 = None 5 = All of what it needs
Kinds of financial resources:	
Money	2.9
Space	3.7
Equipment and goods	3.7

Decision-Making Process and Satisfaction Results

As seen in Table 9, the results suggest that the majority (68%) of the members of the Consortium are very to extremely comfortable with the way decisions are made. Moreover, most (69%) rarely felt left out of the decision-making process.

In terms of overall satisfaction, members of the Consortium indicated high levels. While the majority of respondents were "completely" or "mostly" satisfied with the way the partners work together, their influence and role, and the planning and implementation process, there is room for improvement, particularly since satisfaction impacts involvement and commitment levels.

Table 9. *Decision-Making and Satisfaction with Participation*

Items	Scale				
Decision-Making:	Not at all Comfortable	A Little Comfortable	Somewhat Comfortable	Very Comfortable	Extremely Comfortable
Comfort with the way decisions are made	0%	2%	30%	58%	10%
Decision-Making:	None of the Time	Almost None of the Time	Some of the Time	Most of the Time	All of the Time
How often partnership's decisions supported	0%	0%	10%	75%	15%
How often left out of decision-making	17%	52%	28%	0%	2%
Satisfaction with Partnership	Not at All Satisfied	A Little Satisfied	Somewhat Satisfied	Mostly Satisfied	Completely Satisfied
The way partners work together	0%	0%	16%	58%	26%
Influence in partnership	0%	8%	18%	42%	32%
Role in partnership	0%	13%	13%	42%	32%
Partnership's plans for achieving its goals	0%	0%	18%	63%	18%
Implementation of the plan	0%	0%	16%	63%	21%

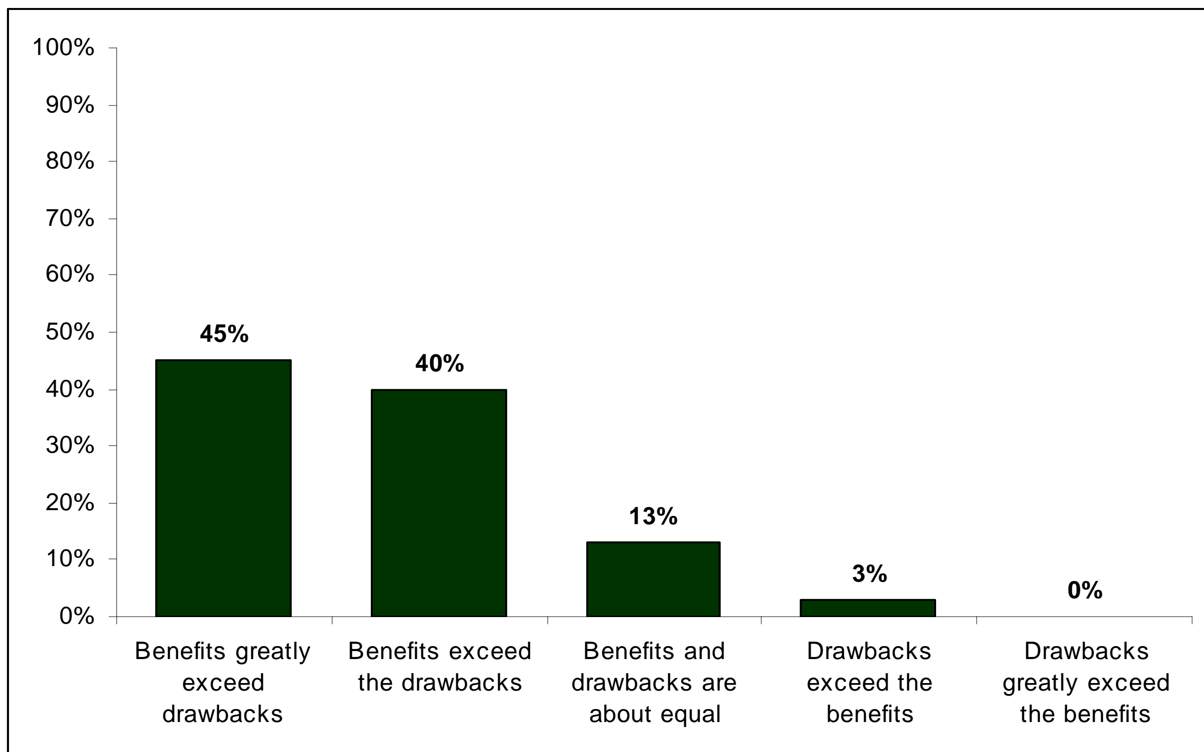
Benefits versus Drawbacks Results

The perceived benefits and drawbacks of a partnership are perhaps two of the most important factors that influence participation. The literature suggests that those who tend to receive substantial benefits from participation tend to be more active[1]. In addition, minimizing specific drawbacks that are associated with involvement in a collaborative effort may be just as important as providing additional benefits.

Respondents of the *Partnership Self-Assessment Tool* were asked to compare the benefits and drawbacks they were experiencing as a result of their involvement in the Consortium. Figure 6 depicts the findings. Overall the results suggest that, of those who completed the survey, approximately 85% believed that the benefits exceeded or greatly exceeded the drawbacks.

[1] Lasker, R. D., Weiss, E. S., & Miller, R. (2001). Partnership synergy: A practical framework for studying and strengthening the collaborative advantage. *The Milbank Quarterly, 79*(2), 179-205.

Figure 6. *Drawbacks and Benefits of Participation*

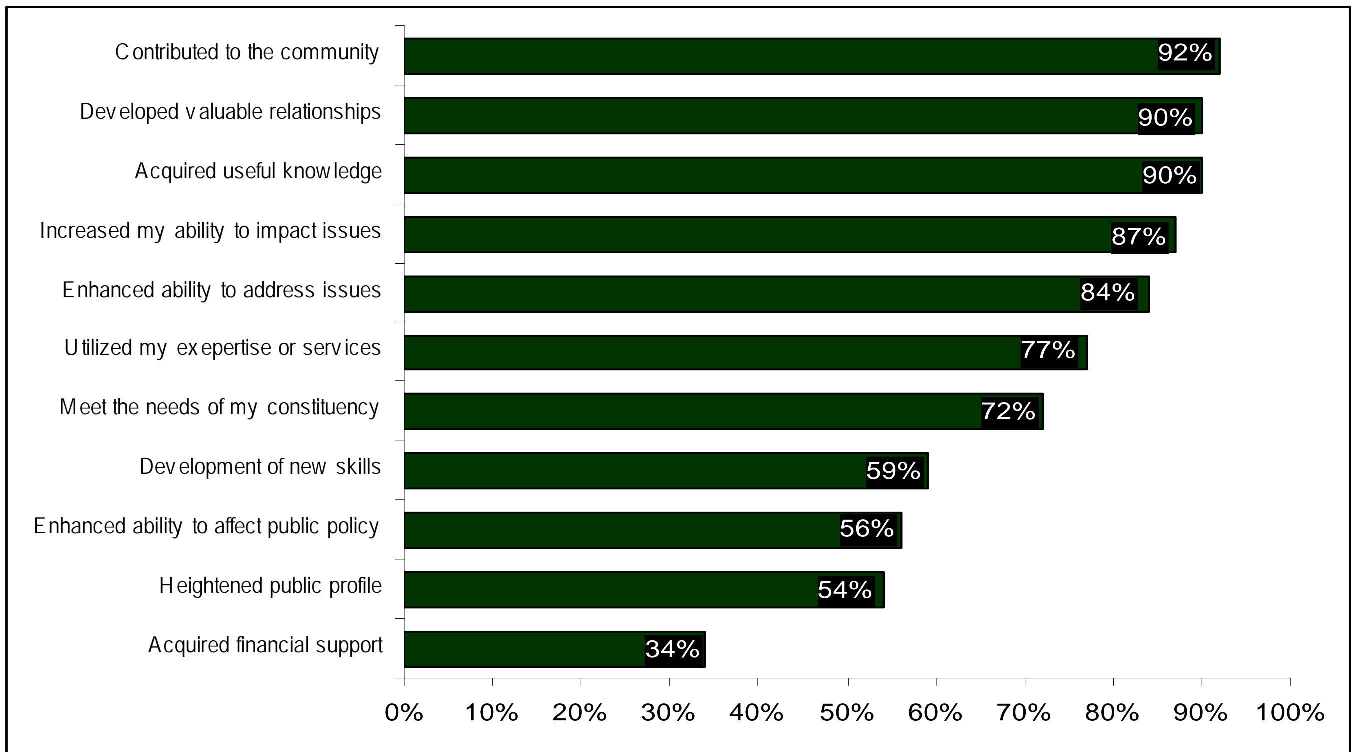


Specific Benefits Results

Respondents were asked to identify whether or not they received 11 specific benefits as a result of their participation in the Consortium. Figure 7 highlights the findings for each area. Overall, the results suggest that members who responded are receiving substantial benefit.

Most (87%) of those who completed the survey indicated that the Consortium enhanced their ability to address cancer. Additionally, over three-quarters of respondents also indicated that their participation led to: 1) contribution to the community, 2) the development of valuable relationships, 3) an enhanced ability to impact the issue of cancer, and 4) opportunities for acquiring useful knowledge. Of the listed benefits, acquisition of additional funding support ranked the lowest.

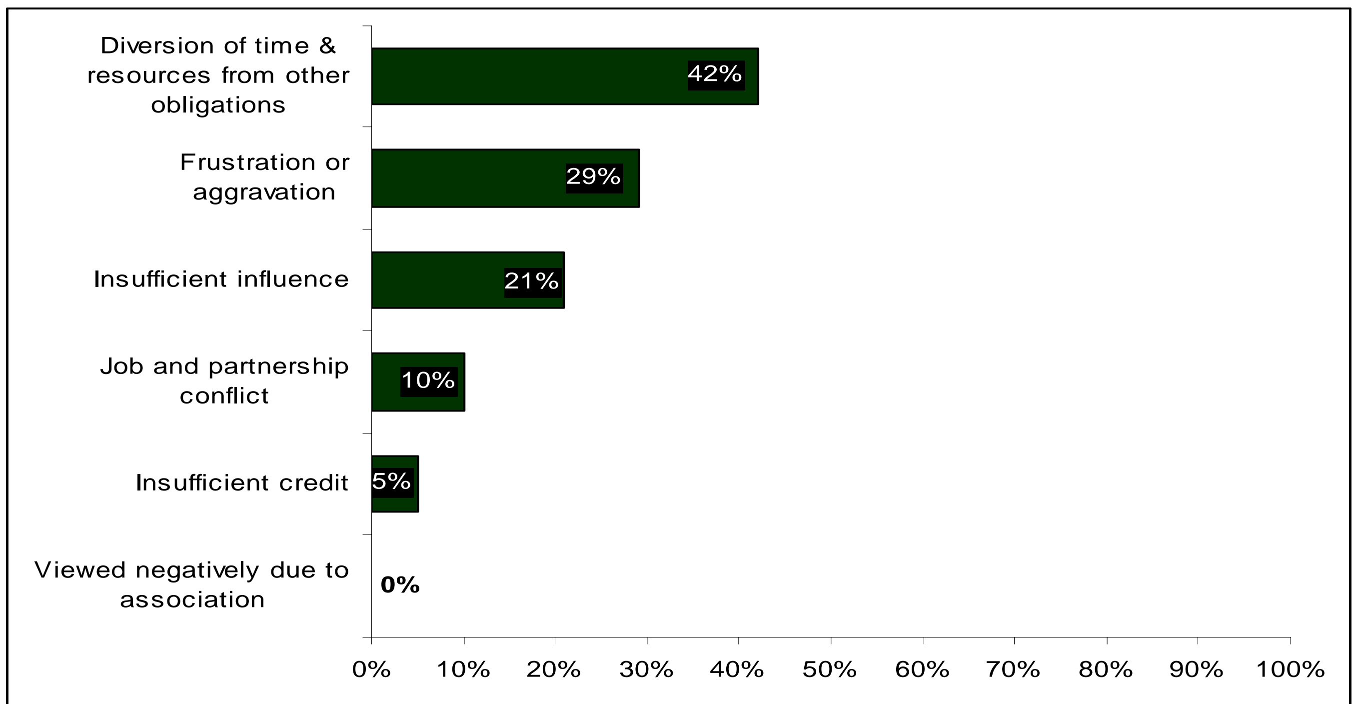
Figure 7. *Specific Benefits Identified by Respondents*



Specific Drawbacks Results

Respondents were also asked to identify whether or not they experienced six specific drawbacks as a result of their participation in the Consortium. Figure 8 highlights the findings for each area. Overall, the results suggest that members who responded are experiencing few drawbacks. The most commonly experienced drawback by approximately 40% of respondents was the diversion of time and resources from other obligations. This finding has been corroborated by previous evaluation findings and should not be surprising for a volunteer organization.

Figure 8. *Specific Drawbacks Identified by Respondents*



Qualitative Comments

Participants were invited to make additional comments regarding the survey or Consortium. The two most common comments relate to the members' lack of time to contribute to the Consortium and the need for increased public relations.

Limitations

The results of the *Partnership Self-Assessment Tool* are intended to be used to identify strengths and weaknesses of the Maine Cancer Consortium. The findings provide a springboard for discussion on what is working and those areas that may require additional effort, as resources permit, in order to maximize the Consortium's potential.

Given the intended use of this information, it is important to keep in mind that there are several limitations that warrant attention. They include:

- The information provides a snapshot approach of the partnership and its members at a given point in time. The Consortium is a large dynamic partnership. Membership and level of involvement are subject to change.
- Of the 105 members in the sample, only 47 (45%) completed the computer-based survey. This group of participants may not adequately reflect the views of all Consortium members.
- Comparisons to the results of the 2005 survey should be reviewed with caution as the sampling and administration of the survey are not equivalent.

Additional Consortium Findings

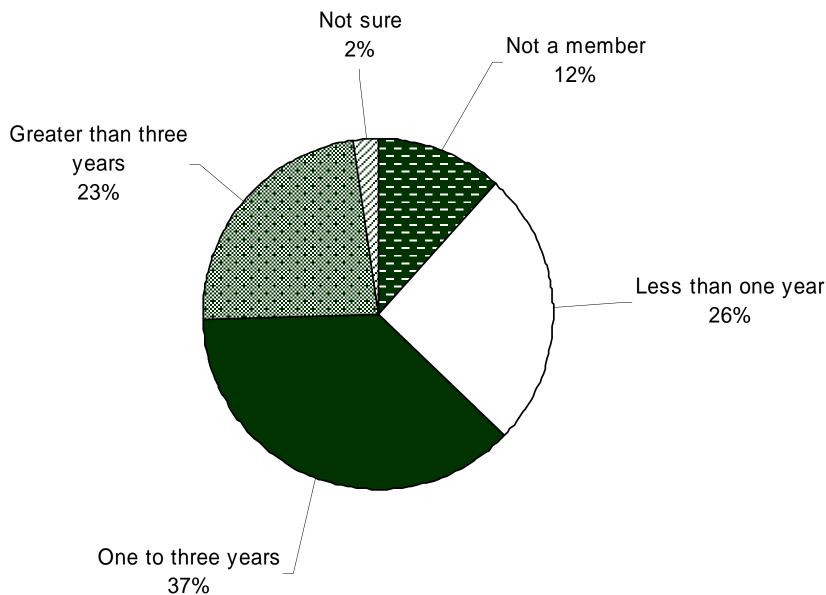
Annual Meeting Evaluation Results

The Maine Cancer Consortium held its annual meeting October 18, 2006 with the primary purpose of discussing the implementation and funding for the new 2006 Cancer Plan. Sixty-eight people attended. Of these, 43 people returned evaluation surveys for a 63% response rate. The purpose of the survey was to capture attendees' feedback regarding the meeting goals, keynote address and to find out more those people who attended the meeting. The findings are summarized below.

Participant Characteristics

A total of 43 people returned evaluation surveys. Most of the participants (88%) were members of the Consortium and many (60%) had been involved in the Consortium for a year or more. Participants' length of involvement in the Consortium is presented in the following figure.

Figure 9 . *Annual Meeting Participants' Length of Involvement in Consortium*



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

Table 10. *Annual Meeting Participants' Involvement in Work Groups*

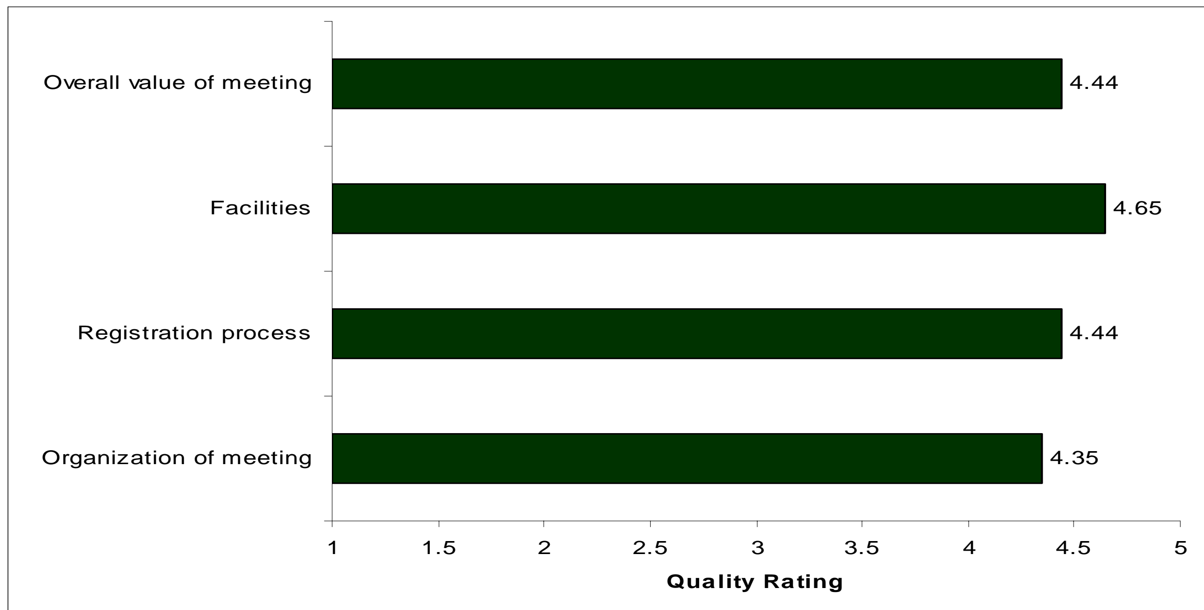
Consortium Group	Percent Involved
Board of Directors	14%
Primary Prevention Workgroup	9.3%
Skin Cancer Task Force	14%

Early Detection Workgroup	11.6%
Rehabilitation & Survivorship Workgroup	18.6%
Hospice & Palliation Workgroup	11.6%
Colon Cancer Task Force	21%
Data Workgroup	4.7%
Communication Workgroup	2.3%
Treatment Workgroup	9.3%
No involvement in groups	11.6%

Feedback on Meeting Organization and Goals

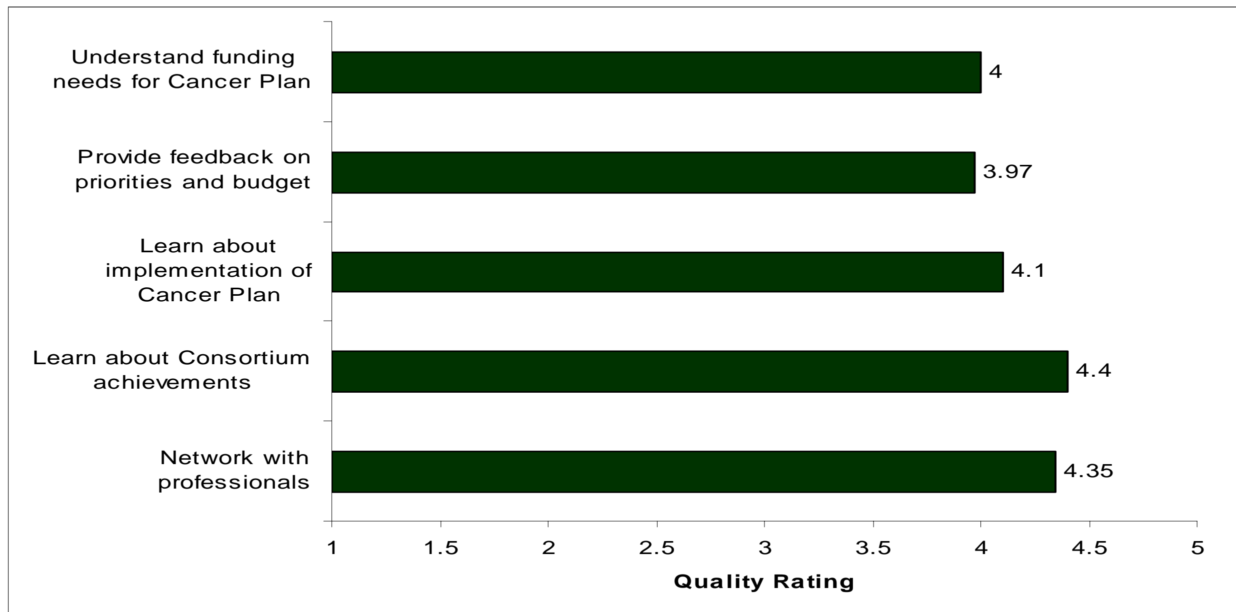
Using a 5-point scale, (1 = very poor; 5 = excellent) participants rated how well the meeting was organized. The average ratings for the organization, registration, facilities and value of meeting ranged from 4.35 to 4.65. A summary of these findings are summarized in the following figure.

Figure 10. *Average Rating of the Organization of the Meeting*



Participants also rated how well the meeting goals were achieved. All of the goals were rated relatively high with average ratings ranging from 3.97 to 4.35. As shown in the following figure, participants rated the opportunity to learn about the Consortium's achievements and to network the highest. This finding is congruent with the open-ended responses provided on the evaluation forms. Issues related to the priorities, budget, funding and implementation of the Cancer Plan were rated slightly lower. These findings, in addition to qualitative comments on the evaluation forms suggest a need for clarification of such discussions. The average participant ratings of the meeting goals are summarized in Figure 11.

Figure 11. *Average Ratings of Annual Meeting Goals*



Breakout Planning Sessions

One of the primary goals of the Annual Meeting was to solicit input on the Legislative Ask budget. This was accomplished through breakout sessions with Work groups. It is important to note that budget allocations presented in the breakout sessions were based on previous discussions in work groups. Thus, the participants' in the Annual Meeting may not have been present at the initial discussions.

Participants were asked to break out into groups based on work group and discuss priorities and budget allocation based on their group's section of the Cancer Plan. Of the respondents to the evaluation survey, 23% (n = 10) attended the Prevention Group, 23% attended the Rehabilitation/Survivorship Group, 21% (n = 9) attended the Early Detection, 10% (n = 4) attended the Data/Surveillance Group, 7% attended the Treatment Group and the remaining 5% (n = 2) of the respondents attended the Disparities Group.

Using a 5-point scale (1 = very dissatisfied, 5 = very satisfied) participants were asked to rate their satisfaction with the planning sessions in terms of the selected priorities and budget allocations. Participants were generally satisfied with the selected priorities (*mean* = 4.14) that came out of their breakout session. Participants were slightly less satisfied (*mean* = 3.82) with budgeting for these priorities. The few comments regarding the budget allocations included:

> *"All over the place, X-mas wishes!"*
>
> *"Hard to budget for the priorities – very vague."*
>
> *"We needed more information."*

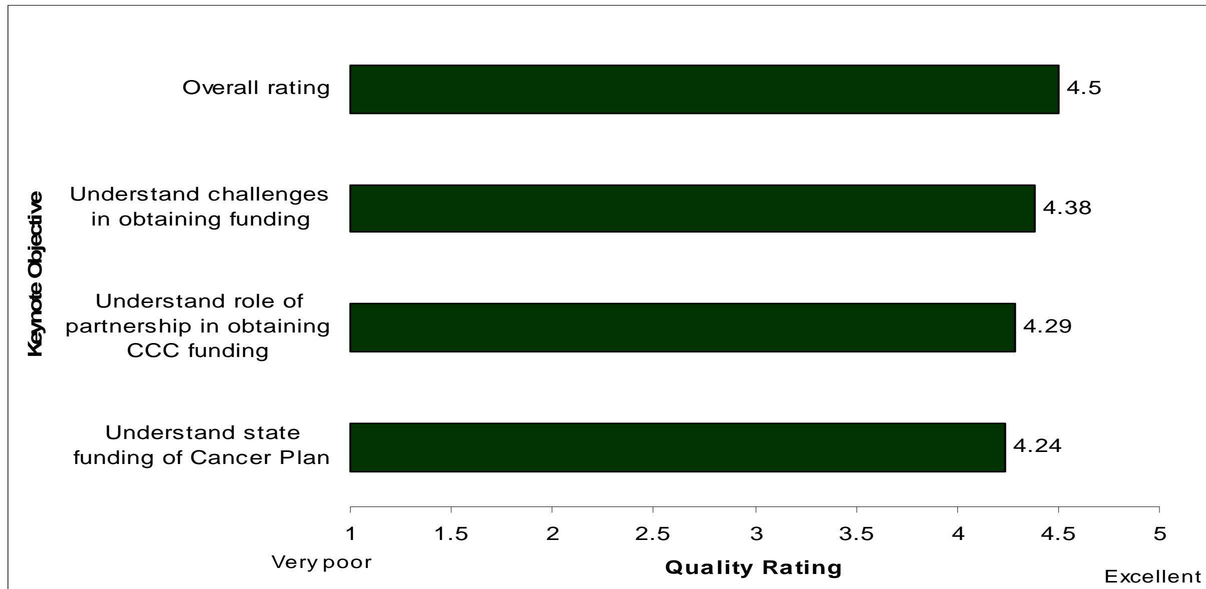
Again, the feedback on the budgeting process may reflect some of the participants' absence at the previous budget discussions. Finally, while there was some noted confusion over the

content of the planning session, based on a five-point scale, participants felt strongly that the breakout sessions valued participant input (*mean* = 4.49).

Keynote Speaker

The keynote address was given by Dr. Andrew Salner of the Connecticut Comprehensive Cancer Control Program. Dr. Salner spoke about Connecticut's success in obtaining state funding for their cancer plan and provided tips for Maine in doing the same. Using a 5-point scale (1 = very poor; 5 = excellent) respondents rated the presentation in terms of its learning objective to increase participants' knowledge of obtaining state funding for comprehensive cancer control. All of the objectives were given an average rating of over 4.2 indicating the session's success. The following chart summarizes these findings.

Figure 12. *Average Ratings of Annual Meeting Keynote Speaker*



Qualitative Responses

Respondents were asked to list the most useful aspect of the meeting. The most common responses of those who commented (n = 28) included networking, learning about the Consortium goals, objectives and Work groups, and the keynote address, as illustrated in the following quotes:

"Networking and learning about the various aspects to funding/budget and approaching the legislature!"

"Understanding how the overall plan was put together and plans for implementation."

"Gaining a more comprehensive awareness of what the Consortium is all about and its goals."

A small number of respondents (n = 15) listed what they believe to be the least useful aspect of the meeting. The most often cited was the breakout sessions as illustrated in the following quotes:

> *"Breakout session needed more structure and a designated facilitator in advance."*
>
> *"Budget discussions seemed unrealistic…"*

Maine Cancer Consortium Mini-Grants

The Maine Comprehensive Cancer Control Program, working in partnership with the American Cancer Society made funds available to support the Consortium Work Groups with implementing activities to achieve their goals and objectives. Applicants were allowed to request up to $4,000. The funding period was between January to June 2006.

All Maine Cancer Consortium Work Groups that had received a mini-grant were asked to complete a brief survey. (See Attachment A for a copy of the survey.) The purpose of the evaluation was to find out how work groups felt about the application, implementation and administration processes of the mini-grants and to gather suggestions for improving the process for next year.

The work groups that received mini-grants include: Early Detection, Skin Cancer, Colon Cancer, Data and Surveillance, Communications, Rehabilitation and Survivorship, Palliation and End-of-Life Care, and Prevention. All but the Prevention Work Group completed the survey. The survey was administered to three of the work groups by the public health educator, to three different work groups by the evaluation contractor, and to one work group via email. The surveys were completed between May and June 2007.

Results

Useful in Achieving Goals, Objectives and Strategies
All work groups that completed the survey responded that the mini-grant funding helped the work group to work toward their goals. All but one work group reported that the mini-grants helped the work group to achieve its objectives and to implement strategies (Table 11).

Table 11. *Mini-Grant Funding and Workgroup Goals, Objectives and Strategies*

Funding helped work groups to:	Missing	No	Somewhat	Yes
Work toward goals	1 (14%)	0 (0%)	0 (0%)	6 (86%)
Achieve objectives	1 (14%)	0 (0%)	1 (14%)	5 (71%)
Implement strategies	1 (14%)	0 (0%)	1 (14%)	5 (71%)

Satisfaction with Processes
Work groups were asked to rate their satisfaction with the application process, the process for identifying projects, and the on-going administration process for the mini-grants (on a scale of 1 - 5, 1 = poor and 5 = excellent). Work groups' average rating was 4.2 for the application process, 4.1 for the process for identifying projects, and 4.3 for the on-going administration process. This indicates that work groups were very satisfied overall with the mini-grants.

Table 12. *Average Satisfaction Ratings for Mini-Grant Processes*

Process	Mean response
Application process	4.2
Process for identifying projects	4.1
On-going administration process	4.3

Suggestions for Improving Processes

Application Process
The most common suggestions work groups gave for improving the application process was to provide notification of potential funding further in advance. Another widespread suggestion was to make the guidelines and restrictions for applying clearer. Other suggestions include:

- Provide a longer grant period or a quicker turnaround time from application to funding.
- Require a lead agency or clarify as to whether it is the work groups' responsibility or the fiscal agents'/lead agency's responsibility.
- The budget was difficult for our work group as we had a lot of unknown costs and we had to guesstimate.
- Allow for the possibility of work groups to combine mini-grants for a larger project, a larger amount of funding and combined efforts would result in larger impact.
- Explore the possibility of rotating funding to different work groups so that more money is given and there is possibly a longer time-frame for completion of projects. For example, in Year 1 fund three work groups at $6,000 each and give them a year or longer to complete the project. In Year 2, fund three other work groups.
- With the new request for funding under the Legislative Ask, it raises the questions as to whether the mini-grant funds are duplicative.

Identifying Projects
Work groups were asked if they had any suggestions for improving the process for identifying projects for the mini-grants. The most common suggestion was to have the Consortium leadership be clearer about what projects they expect, what is appropriate and what is not. One work group had a difficult time figuring out what to do with the funding. They were overwhelmed by the multiple types of cancers addressed in their work group and spent several meetings trying to determine a project. Another had to first figure out what the work group's objectives and strategies would be for the year. Thus, they had to clarify the work group's purpose before they could determine a mini-grant project. Another work group felt it was hard to do a project for such a small amount of funding. Finally, contrary to most comments, one work group described having creative members and felt they had an easy time finding projects.

Another frequent suggestion was to give work groups more time to identify projects. Other suggestions and comments include:

- State "rules" or guidelines for acceptable projects upfront. Some of it is semantics as different work groups speak different languages.

- Connect the projects with goals, objectives and purpose of work group.
- Have Consortium Board involved from the beginning. Communication needs to be strengthened both ways [Board and work groups].
- There was some uncertainty as to who could do the project.
- Another suggestion for collaboration and implementing strategies and projects in general, not just for the mini-grants, is to have the Consortium build some relationships with other resources such as universities so they are more aware of projects that students and interns could be doing for Consortium.

Ongoing Administration
Work groups were asked if they had any suggestions for improving the ongoing administration process for the mini-grants. Many work groups were unclear about this process. Part of this seems to be due to the fact that the administration of the mini-grants was very simple. All work groups were pleased that the reporting requirements were simple, minimal and manageable. Other suggestions were to continue to keep the administration process simple, grant extensions for submitting the final report and have a clearly written expectation of the role of the fiscal agent.

General comments and suggestions regarding the Consortium work groups in general include decreased time and energy among the all volunteer membership. Thus, some work groups indicated the need for more members. One work group stated a need for a clear description of the chair's roles and responsibility and that the chair should receive some sort of compensation.

RESULTS PART II: IMPLEMENTATION

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

Activity-Monitoring Tool Results

An Activity Monitoring Tool (AMT) was developed in 2004. This tool was then modified in 2005 to meet the changing needs of the Consortium. The AMT tracks progress towards achievement of the stated measure and reports feedback on accomplishments, strengths, and challenges.

In response to previous evaluation findings, the Consortium members were committed to making all objectives within the 2006-2010 Maine Cancer Plan measurable. Thus, the AMT and this report focus on all objectives and related strategies as outlined in the Cancer Plan. This report also focuses solely on those strategies for which there was an active Workgroup or Task Force. Finally, it is important to note that this report does not include Maine Comprehensive Cancer Control Program-specific strategies due to their exclusion in the new tracking tool.

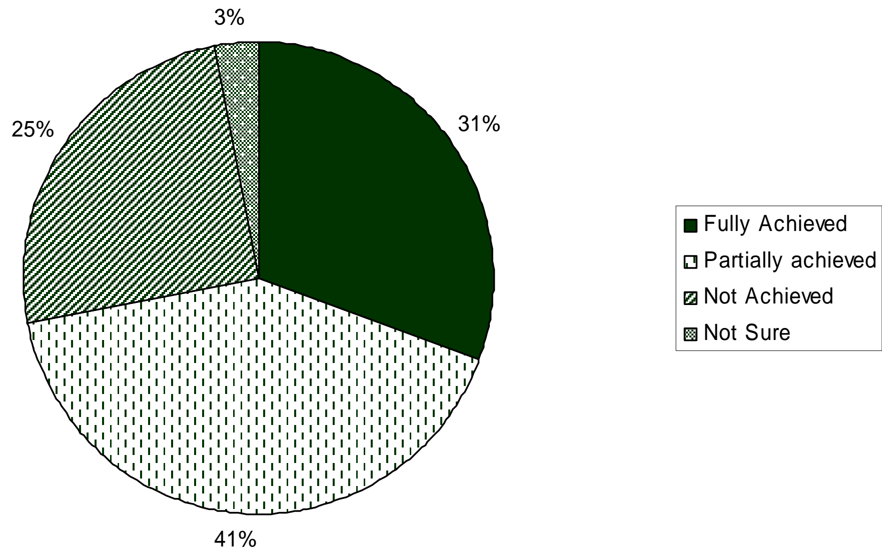
Considerations for the Interpretation of Tracking Information

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

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

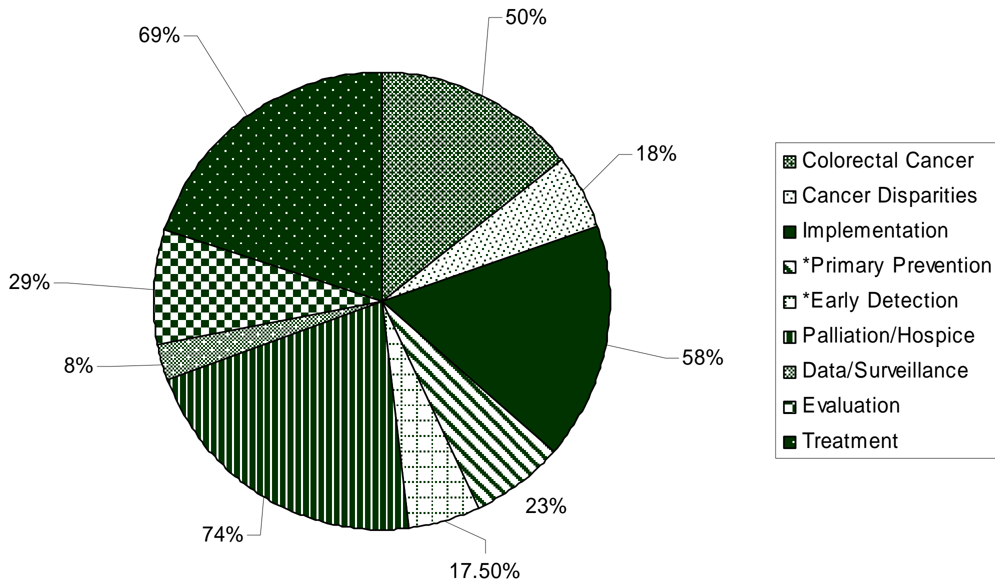
Figure 13 illustrates the overall combined status of strategies (*N*= 262) for all active work groups. A little over 30% of strategies were fully achieved and 41% were partially achieved. Given this is the end of Year 1 of a five year plan, it is expected that fewer strategies would be fully achieved. Many of the strategies listed as "partially achieved" or “not achieved” were on-going strategies that will be worked on over the course of the next four years. In fact, 92% of all strategies are on-going.

Figure 13. *Progress of Strategies, All Active Work Groups*



On average, work groups have achieved an average of approximately 40% of strategies. As shown in Figure 14 and Table 13, the number of fully achieved strategies varied greatly among specific work groups. Due to the diversity among work group functions and roles, this information should be interpreted with caution and should not be used for comparison purposes.

Figure 14. *Fully Achieved Strategies by Active Work Group*



Note. *Colorectal and Skin Cancer results not included.

Table 13. *Summary of Strategy Status for All Active Work Groups*

Work Groups & Goals	Total Strategies	Progress			
		Fully Achieved	Partially Achieved	Not Achieved	Not Sure
Cancer Disparities	**17**	**3 (18%)**	**6 (35%)**	**7 (41%)**	**1 (6%)**
Primary Prevention	**104**	**24 (23%)**	**50 (48%)**	**26 (25%)**	**4 (4%)**
Tobacco Use	28	5	18	4	1
Overweight/PAN	15	5	7	3	0
Oral Health	5	0	4	1	0
Skin Cancer	23	8	5	10	0
Sexual Health	13	0	10	3	0
Environmental Health	20	6	6	5	3
Early Detection	**40**	**7 (17.5%)**	**24 (60%)**	**9 (22.5%)**	**0 (0%)**
Early Detection*	29	3	19	7	0
Breast Cancer	11	2	7	2	0
Cervical Cancer	11	1	7	3	0
Colorectal Cancer	6	3	2	1	0
Prostate Cancer	4	0	3	1	0
Skin Cancer	5	1	3	1	0
Genetics	3	0	2	1	0
Skin Cancer (Prevention & Early Detection)	28	9	8	11	0
Treatment	**16**	**11 (69%)**	**5 (31%)**	**0 (0%)**	**0 (0%)**
Rehabilitation & Survivorship	**19**	**0 (0%)**	**10 (53%)**	**9 (47%)**	**0 (0%)**
Palliative and Hospice Care	**34**	**25 (74%)**	**3 (9%)**	**6 (18%)**	**0 (0%)**
Data and Surveillance	**13**	**1 (8%)**	**5 (38%)**	**3 (23%)**	**4 (30%)**
Implementation	**12**	**7 (58%)**	**3 (25%)**	**2 (17%)**	**0 (0%)**
Evaluation	**7**	**2 (28.5%)**	**2 (28.5%)**	**3 (43%)**	**0 (0%)**
Total	**262**	**80 (30.5%)**	**108 (41%)**	**65 (25%)**	**9 (3%)**

Note. *Colorectal and Skin Cancer results not included.

Cancer Plan Implementation Strengths, Opportunities and Challenges

As part of the AMT, work groups were asked to identify the strengths, opportunities, and challenges of implementing strategies. A review of strengths for all strategies combined revealed several consistent themes. The most commonly noted strength was the dedicated and knowledgeable work group members. Most work groups mentioned collaborations with organizations represented on the work groups as a significant strength, e.g., the American Cancer Society, the Maine Hospice Council, the Maine Breast and Cervical Health Program, and the Healthy Maine Partnerships. For example, for the Prevention Work Group a partnership with the Minority Health Program has assisted with the implementation of disparity- related strategies.

Additional select **strengths** include:

- Highly-engaged, committed work group members.
  - Partnerships with organizations represented on the work groups and partnerships members have with organizations outside the work group.
  - Diversity of employment and experience.
  - Strong networking.

- Dedicated support of administrative assistant.
- Availability of funding, grants and mini-grants.
- Existing resources such as the Maine Comprehensive Cancer Control Program and staff, an intern from the University of Maine at Orono to work on Work Group strategies, End-of-life care conferences, a recording mechanism (MDEs for breast and cervical health), and a cancer registry.
- Existing policy to support cancer control.
    - The Treatment Act (as of 2001 every woman with a breast or cervical cancer diagnosis who is uninsured is put on the Treatment Act and her health care is paid for).
    - Through member organizations the Consortium, has a strong advocacy staff and these strategies are in their work plan.
    - Accessibility of Maine legislators.

Opportunities

Work groups listed several opportunities that occurred over the past year that contributed to the successful implementation of Cancer Plan strategies. The most common opportunity included collaborative partnerships with new offices, programs or members representing new organizations. For example, members' efforts with the Office of Minority Health have provided increased energy to solve disparity issues in both the Prevention and Data and Surveillance Work Groups. Representation from the Maine Melanoma Foundation has brought more visibility to the Skin Cancer Task Force. Other current and future opportunities include new screening opportunities from additional funding for the Maine Breast and Cervical Health Program (MBCHP) and a pilot project with Portland Public Health and the MBCHP to provide colorectal screening to MBCHP clients. Finally, a public and community education mini-grant to the Healthy Maine Partnerships was provided through collaboration with the American Cancer Society and the Maine Cancer Foundation.

Challenges

For strategies that have not been achieved or in some cases pursued, there are a variety of challenges that have prevented the completion of certain strategies. The most common challenge includes the limited time members can devote to the implementation of the Cancer Plan as work groups consist of volunteer members. Other more general challenges include having quantifiable objectives, lack of available and timely data, limited funding, and geographical barriers in Maine.

Some challenges faced by the Work groups are specific to their unique objectives. For example, survivorship is subjective and this work group felt it is hard to make some of their strategies inclusive. Other unique challenges include inconsistent messages regarding most effective prevention and/or detection activities (i.e., screening methods).

Additional select **challenges** include:

- Some work groups have limited staff and lack of volunteer and professional support.
- Shifting focus within work group.
- Screening barriers.
    - Mixed messages regarding which way to screen, multiple options recommended for screening.

    - Recommendations for screening geared to older audience.
    - Financial barriers for screening.
- Data and Surveillance barriers for race and ethnicity.
    - Over-sampling is complicated.
- Lack of communication. Need more communication and integration with various state programs.
- Economic barriers for many Mainers. (i.e., Treatment is still an issue for women with a high deductible as part of their health insurance.)
- Educational barriers for some Mainers. (e.g., some women think that if they had one Pap test they are done for life - need to educate that need a PAP every 1-3 years.)

Program Accomplishments

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

Overall Implementation

- Recognized as a state program.
- Successfully re-competed for Comprehensive Cancer Control Program Implementation funds.
- Received 5-year federal funding for Program Implementation from the Centers for Disease Control and Prevention for 2007-2012.
  Amount: Approximately $1,275,000 for five years.
- Received 5-year federal funding for both Colorectal and Skin Cancer prevention projects.
    - Amount: Approximately $1,175,000 over five years.
- Recognized as a model program and state throughout the country.
    - Existing staff serve as a resource for other states.
- The Maine Cancer Consortium updated the Maine Cancer Plan to reflect emerging needs and new issues in cancer prevention, detection, and care (*Maine Cancer Plan, 2006- 2010*).
- Provided significant staff support to the Maine Cancer Consortium, individual work groups, and the Board of Directors.
- Sponsored and organized Maine Cancer Consortium annual meetings.
- Successful in advocating for the integration of cancer into Healthy Maine Partnership.
- Established educational seminars for Consortium members and others interested in comprehensive cancer control.

- Awarded $24,000 in mini-grants to the Prevention, Early Detection, Skin Cancer, Palliation, Rehabilitation and Survivorship Work Groups and Colon Task Force to assist with implementations of their work plan.

Colorectal Cancer Prevention Activities

- Completed the three-year *Screen Me!* Colorectal Social Marketing Campaign.
  - Results demonstrate an increase in overall colorectal cancer screening rate in Maine.
- As part of the Campaign, materials (Fact sheets, Posters, Bookmarks and Community Action Kit) were created and distributed to Maine's communities.
  - Fact sheets to Shaw's Grocery Stores and Libraries in Maine.
  - Developed and distributed Community Resource Guide to 50 Healthy Community Coalitions statewide.
  - The Colossal Colon was hosted at Portland and Bangor malls in March 2007 with over 20,000 individuals touring the Colon.
- Collaborated with the American Cancer Society, and the Maine Cancer Foundation to provide 10 mini-grants to Healthy Maine Partnerships to implement activities to raise colorectal cancer screening awareness.
- Included colon cancer question on the 2006 *Behavioral Risk Factor Surveillance System* (BRFSS) in Maine.

Skin Cancer Prevention Activities

Mini-grants

- Working in collaboration with the Department of Education, awarded 50 $500 mini-grants to public elementary schools across Maine to support skin cancer prevention in elementary schools.
- Distributed 18,000 UV Bead Bracelets to schools in Maine.
- Included skin cancer questions on 2006 BRFSS and the Youth Risk Behavior Survey in Maine.
- Participated in various statewide discussions and conferences regarding sun safety.
- Held an annual 2007 *Protect the Skin You're In Day* on July 15th at the Portland Sea Dog's baseball game. Provided over 3,500 packets of sunscreen to people attending the baseball game.
- Middle School Safety Kits, 7th grade edition were distributed to all public middle schools (236) in Maine with a 7th grade classroom.
- Launched the *BU-BUV Safe Campaign*, in which 18,000 UV Bead Bracelets were distributed to every 7th grade student in public schools in Maine.
- Con-SUN-tration games were developed to teach sun safety to non-reading aged children. They were distributed to local W.I.C. agencies in May 2006 for Skin Cancer Awareness Month.
- Participated in a poster session for the CDC Cancer Conference in Atlanta for the *BU-BUV Safe Campaign* in 2007.
- Developed a Maine specific skin cancer awareness brochure, poster and bookmarks.

Evaluation

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

Program-Sponsored Initiatives: Evaluation Results

Screen Me! Colon Cancer Social Marketing Campaign[2]

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

Campaign Description
Against this backdrop, the Maine Comprehensive Cancer Control Program (MCCCP) began working with Burgess Advertising and Associates in December 2004 to develop and implement a three-year social marketing campaign to increase awareness and screening of colon cancer prevention in Maine. While the campaign has been evaluated at several time points, the findings presented in this report represent the results of Wave IV of an ongoing effort to measure the effectiveness of the final year of a targeted 3-year advertising campaign for Maine's Comprehensive Cancer Control Program (MCCCP). The Wave IV survey, conducted in March and April of 2007, is the latest in a series of studies which began with an initial Pre-Wave conducted in January of 2005, followed by a second wave conducted in May of 2005 and Wave III in February of 2006.

Summary of Methods
The following report provides a brief overview of findings from the most recent telephone survey among Maine residents, aged 50 years or older regarding colon cancer and early detection. For a copy of the full report please contact the CCC program.

The Wave IV study began with a survey of 300 members of the general population of Maine residents, aged 50 years or older, with no personal history of colon disease. In order to analyze Maine's unscreened resident population more thoroughly in 2007, data was collected from an additional sample of 99 residents who say that they have not been screened for colon cancer.

A decision was made in 2007 to exclude from the study respondents who have previously been diagnosed with colon polyps, in addition to colon cancer or other related conditions. For consistency of comparison, results from previous waves have been re-tabulated, removing respondents who have previously been diagnosed with colon polyps.

The Wave IV evaluation of the general population was conducted between March 26, 2007 and April 4, 2007. Interviewing for the augment sample, comprised of residents who reported that they had not been screened for colon cancer, began on April 5, 2007 and concluded on April 19, 2007.

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[2] This section provided by Digital Research Inc.

The primary objective of the Wave IV study was to measure the level of awareness, attitudes, and behavior toward colon cancer early detection and to assess whether any shifts in these levels have occurred since the time of the Pre-Wave, Follow-Up and Wave III surveys.

Participant Characteristics

Telephone interviews conducted with 399 Maine residents, aged 50 years or older, with no personal history of colon disease which was operationalized to mean:

- No colon polyps
- No colon cancer
- No inflammatory bowel disease
- No ulcerative colitis
- No Crohn's disease

Two methodological enhancements have been introduced in the current wave to better understand the behavior and attitudes toward colon cancer early detection.

1. In prior waves, respondents diagnosed with colon polyps were included in the survey. To remove any chance of data distortion by including this group, those diagnosed with colon polyps were excluded from this year's evaluation. By excluding this segment, the results more accurately reflect the behavior and attitudes of those who do not have a relevant condition that could potentially influence their attitudes and behavior toward colon cancer screening. In order to preserve comparability across waves, all prior data was re-tabulated to exclude respondents with colon polyps (approximately 10% of respondents were removed from each prior wave). As a result, the data in this report has been updated to reflect these changes.

2. Because the number of unscreened respondents is generally small in the general population (approximately 22%), it can be difficult to gain a true representation of this groups' attitudes and behavior. In order to gain a more detailed look of this group, an augment of 99 unscreened respondents were interviewed separately and included in our overall analysis of the unscreened population.

Table 14. *Summary of Survey Samples*

	Evaluations			
	2005 Pre-Wave (Benchmark)	**2005 Follow-up**	**2006 Wave III**	**2007 Wave IV**
Dates	Jan. 2005	May 2005	Feb. 2006	March 2007
Sample Size	*N*=453	*N*=263	*N*=359	*N*=399 (300 general + 99 Augment)

Respondent Demographic Profile

A number of questions were asked in order to create a demographic profile of the respondents. Respondents participating in the Wave IV study are generally:

- Between the ages of 50 and 65 years;
- More likely to be female (67% female);
- Have a higher education level (42% completing grade 12 and 57% having completed 4 years of college or more);
- Predominantly White or Caucasian (97%);
- Retired (49%); and
- Have a mean income of $41,537.

A comparison of respondents' demographics of the Pre-Wave to Wave IV studies is shown in the following table.

Table 15. *Respondents' Demographic Profile, Multi-Sample Comparison*

Respondent Demographics	Waves			
	Pre-Wave (N=453)	Follow-Up (N=263)	Wave III (N=359)	Wave IV (N=300)
	%	%	%	%
	(a)	(b)	(c)	(d)
Age				
50-55	21	27	23	21
56-60	16	19	16	16
61-65	13	14	15	12
66-70	12	14	13	15
71-75	14	10	10	10
76 and older	22b	16	21	24b
Gender				
Male	32	37c	28	33
Female	68	63	72b	67
Marital status				
Married	56	65ac	55	62
Single	11	7	11	11
Partnered	1	2	0	0
Divorced/Separated	12	10	12d	7
Widowed	18	16	21	18
Education Level				
Grades 1 through 8 (elementary school)	4	3	4	4
Grades 9 through 11 (some high school)	8b	2	4	5b
Grade 12 or GED (high school graduate)	34	38	41	34
Some college	24	22	19	26
College graduate	17	19	17	17
Some postgraduate work	3	5	3	2
Post graduate degree	8	9	9	12
Employment				
Employed for wages	23	32a	37ad	30a
Self-employed	9	8	7	6
Out of work for more than 1 year	1	1	1	2
Out of work for less than 1 year	2	1	1	1

	Waves			
	Pre-Wave (N=453)	Follow-Up (N=263)	Wave III (N=359)	Wave IV (N=300)
A homemaker	5	7	6	6
A student	0	0	0	1
Retired	49	43	44	49
Unable to work	8	6	4	4
Race, ethnicity				
White/Caucasian	96	96	97	97
Black, African American	0	0	1	0
Hispanic, Latino	0	1	1	0
Native American or Alaska Native	1	0	0	1
Asian	0	0	1	0
Annual Household Income				
Less than $15,000	19b	12	16	18
$15,000 to $24,999	15	18	13	12
$25,000 to $49,999	26	22	24	25
$50,000 to $74,999	13	18	15	13
$75,000 to $99,999	4	8ac	3	7c
$100,00 or more	4	2	6b	5
Refused	19	20	23	20
Mean income	$38,156	$41,940	$41,807	$41,537

Summary Findings

Congruent with previous surveys, the primary objective of the current Wave IV survey was to measure the level of awareness of recently aired advertising campaigns and to see if any movement has occurred in attitudes or behavior regarding colon cancer over time.

Effectiveness of the recent media campaigns has been determined by:

- Evaluating the extent of advertising recall for the recent media campaigns sponsored by the Maine Comprehensive Cancer Control Program (along with the CDC and the American Cancer Society);

- Assessing the current attitudes and practices of Maine adults regarding early cancer detection; and

- Determining the current levels of awareness of existing colon cancer screening methods.

In order to accomplish the above goals, this report will consider several analytic components:

- A detailed analysis that includes all respondents;

- Where appropriate, a comparison between two respondent segments: screened vs. not screened.

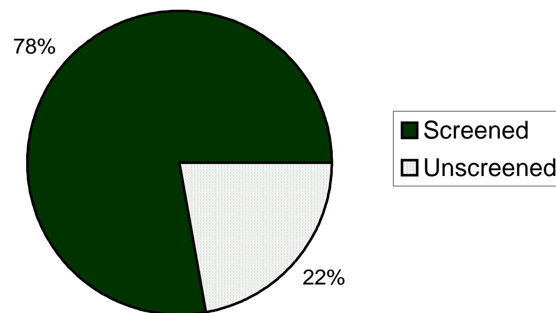
- When appropriate, regional comparisons will be supplied. The *Southern Maine region* includes Cumberland, York, and Sagadahoc Counties. The *Mid-Maine region* includes Androscoggin, Hancock, Kennebec, Knox, Lincoln, Penobscot, and Waldo Counties. The

North/Downeast region includes Aroostook, Franklin, Oxford, Piscataquis, Somerset, and Washington Counties. These regions were defined by MCCCP representatives.

- When relevant, comparisons across the Pre-Wave, Follow-Up Wave, Wave III and the current wave (Wave IV) will be included in order to directly assess changes following the media campaigns.

Screened versus Unscreened Respondents
In this wave of the research, 78% of respondents have been screened for colon cancer (either by blood stool test or sigmoidoscopy/colonoscopy); while 22% have not been screened[3].

Figure 15. *Screened versus Unscreened Respondents*



In the Pre-Wave, it was found that 65% of respondents were screened and 35% were not screened. In the Follow-Up wave this percentage increased to 77% of respondents screened and 23% not screened, marking a significant and very encouraging change from the Pre-Wave results. Since the follow-up the proportion of screened and unscreened respondents has remained virtually unchanged.

Table 16. *Screening Status by Survey Wave*

	Screening Status	
	Screened %	Unscreened %
2007 Wave IV	78	22
2006 Wave III	77	23
2005 Follow-Up	77	23
2005 Pre-Wave	65	35

[3] For the purposes of determining the proportion of screened vs. unscreened respondents in the general population over time, the proportion reported here does not include the augment of additional unscreened respondents. However, throughout the remainder of the report, comparisons of screened and unscreened respondents will include the augment sample in order to gain a richer understanding of the unscreened population.

From an analysis across Maine regions, an insightful pattern of findings emerge. There is evidence demonstrating an increase in colorectal screenings since the time of the Pre-Wave. This finding suggests that the advertising campaign has had a positive effect on screening behavior in the North/Downeast and Mid-Maine regions.

In the North/Downeast and Mid-Maine regions we see an increase in screening from the Pre-Wave to the Follow-Up, which in turn is followed by stabilization in the screening rates from the Follow-Up to Wave IV. This stabilization indicates that a plateau may have been reached in terms of awareness building activities alone. The data suggests that advertising activities are, at a minimum, necessary to sustain the increased base rates in screening, but that more needs to be done to identify and understand potential barriers to obtaining additional colorectal screenings in these regions of Maine.

Table 17. *Screening Status by Region*

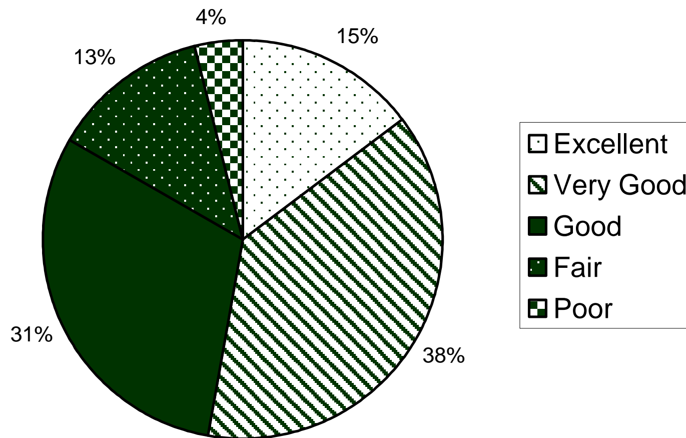
	Southern Maine			
	2005 Pre-Wave n=145	2005 Follow-Up n=74	2006 Wave III n=112	2007 Wave IV n=95
	%	%	%	%
	(a)	(b)	(c)	(d)
Screened	72	72	83a	80
Unscreened	28c	28c	17	20
	North/Downeast Maine			
	2005 Pre-Wave n=105	2005 Follow-Up n=61	2006 Wave III n=89	2007 Wave IV n=63
	%	%	%	%
	(a)	(b)	(c)	(d)
Screened	57	77a	70a	73a
Unscreened	43bcd	23	30	27
	Mid-Maine			
	2005 Pre-Wave n=180	2005 Follow-Up n=106	2006 Wave III n=156	2007 Wave IV n=141
	%	%	%	%
	(a)	(b)	(c)	(d)
Screened	68	82a	76	78a
Unscreened	32bd	18	24	22

Note: Shaded percentages are significantly greater than a, b, and/or c at the 95% confidence level.

Respondent Health Profile

All survey respondents were aged 50 or older, with no personal history of colon disease. A health profile of these respondents in the Wave IV survey indicates that the survey population is generally comprised of Maine adults in reasonable health, with sufficient access to health care, and engaged in the health care system.

Figure 16. *Wave IV Respondents' Health Profile*



Concern with Cancers
Respondents were asked a series of questions regarding their concern with being personally diagnosed with various forms of cancer and their perceptions of how widespread a problem each cancer is to the State of Maine.

Findings indicate that unscreened respondents are generally less concerned with a personal diagnosis of cancer and believe it to be a less widespread problem in the State of Maine.

Table 18. *Respondents' Cancer Concern by Screening Status*

	Not at all concerned with being diagnosed with…		Not at all widespread in Maine	
	Screened	Unscreened	Screened	Unscreened
	%	%	%	%
Type of Cancer	(a)	(b)	(c)	(d)
Lung cancer	53	66a	5	13c
Breast cancer	34	52a	5	16c
Prostate cancer	37	40	7	21c
Colon cancer	46	57a	6	20c
Skin cancer	43	48	9	17c

Except in Wave III, the prewave and subsequent waves do not differ statistically from each other suggesting no change in concern with a personal diagnosis of colon cancer. Additionally, there has been no change in the relative ranking of colon cancer with regard to its seriousness (versus other cancers).

Colon Cancer Screening: Awareness and Usage
Respondents were asked a series of questions regarding their awareness of and use of colon cancer screening tests.

- Three quarters of the respondents (72%) have heard of the blood stool home test kit. Of those who have heard of the blood stool home test, approximately two-thirds (69%) have used this test kit.

- Seven out of ten respondents (72%) have heard of both sigmoidoscopies and colonoscopies. Of those who have heard of sigmoidoscopies and colonoscopies, only one in five (21%) has taken both of these exams, but more respondents have had colonoscopies rather than sigmoidoscopies (42% vs. 4%).

Table 19. *Awareness of Screening Methods by Survey Wave*

Method	Awareness of Screening Methods			
	Pre-Wave (N=453) %	Follow-up (N=263) %	Wave III (N=359) %	Wave IV (N=300) %
	(a)	(b)	(c)	(d)
Both:	72	77	69	72
Colonoscopy	15	17	23a	22a
Sigmoidoscopy	1	1	1	0
Blood Stool Test	71	75	73	72

An analysis across subgroups revealed the following with regard to awareness and usage of screening methods:

- Female respondents are more likely to have heard of a blood stool home test kit than males (79% vs. 59%);

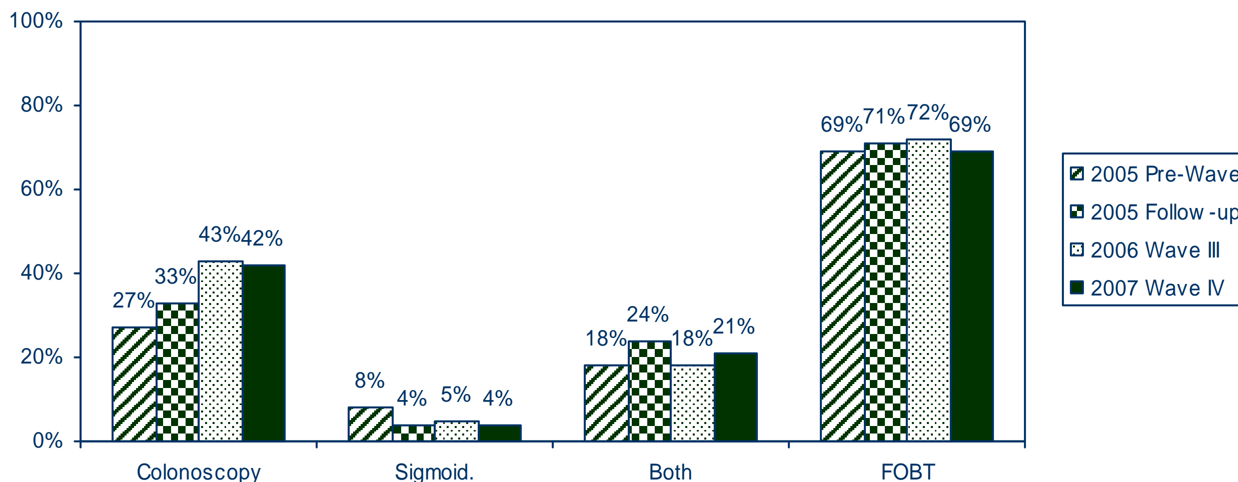
- Female respondents are also more likely than males to have heard of both colonoscopy and sigmoidoscopy (77% vs. 62%). However, males are more likely than females to have heard only of colonoscopies (31% vs. 18%);

- Those respondents with incomes of $50K or greater are more likely to have heard of both colonoscopies and sigmoidoscopies than those who earn less (85% vs. 67%); and

- Not surprisingly, unscreened respondents were less likely to report being aware of screening methods**.**

Usage. Looking at the Wave IV data, we find a significant increase in the percentage of respondents who say that they have had a colonoscopy since the Follow-Up: 42% of those who have heard of either exam in the Wave IV study report that they have had a colonoscopy, up from 33% in the Follow-Up study.

Figure 17. *Respondents' Reported Usage of Colon Cancer Screening Methods*



Converging evidence. A review of the data from the 2002, 2004, and 2006 BRFSS, illustrates a sizeable shift in the percentage of Maine residents who claim to have never been screened for colorectal cancer by having a colonoscopy or sigmoidoscopy. Since 2002, there has been a 17% decrease.

Those age 50+ who have never had a colonoscopy/sigmoidoscopy

2002 BRFSS	2004 BRFSS	2006 BRFSS	Total % Change
53%	41%	36%	17%

Although the timing of the two studies is somewhat different, our data corresponds with the trends observed in the BRFSS. When comparing the MCCCP surveys to the 2002 and 2006 BRFSS, we see a similar magnitude of shift. Since the Pre-Wave in 2005, there has been a 15% decrease in the number of Maine residents claiming to have never been screened for colon cancer by getting a colonoscopy or sigmoidoscopy. The converging data from the BRFSS and the MCCCP is very encouraging and indicates that awareness building activities likely play an important role in stimulating and stabilizing changes in screening behavior.

Those age 50+ who have never had a colonoscopy/sigmoidoscopy

2005 Pre-Wave n=453	2005 Follow-Up n=263	2006 Wave III n=359	2007 Wave IV n=300	Total % Change
%	%	%	%	
(a)	(b)	(c)	(d)	
51bcd	40cd	36	36	15%

Note: Shaded percentages are significantly greater than a, b, and/or c at the 95% confidence level.

Intent to Screen

Respondents were also asked about their intent to be screened for colon cancer in the future. Overall, the majority of respondents (77%) say they will screen for colon cancer by home stool test kit or by sigmoidoscopy/colonoscopy either within the next six months or at some time in the future, but not within the next six months.

Since the Pre-Wave, there has been a 10% increase in the number of respondents stating that they will screen for colon cancer (from 67% to 77%). However, unscreened respondents are more likely than screened respondents to state they do not intend to get screened in the future.

Table 20. *Intent to Screen by Screening Status and Survey Wave*

	Screened				Not Screened			
	Pre-Wave (N=296)	Follow-Up (N=203)	Wave III (N=275)	Wave IV (N=233)	Pre-Wave (N=157)	Follow-Up (N=60)	Wave III (N=84)	Wave IV (N=166)
Intent to be Screened	% (a)	% (b)	% (c)	% (d)	% (e)	% (f)	% (g)	(h)
Total Yes	79e	80f	80g	85h	42	51	56eh	45
Yes, within the next six months	30e	30f	25	27	22	23	23	22
Yes, but not within the next six months	49e	50f	55g	58ah	20	28	33eh	23
No	14	15	13	12	47ag	37b	35c	46d
Not Sure	7	5	7	4	11	10	10	8

Media Campaign: Ad Recall and Reach

Respondents were asked several questions about their memory for any colon cancer commercials or ads that they have seen or heard in the past several months. These were unaided recall-type questions that tap the respondents' explicit memory for these advertisements.

Background on Advertisements. At the same time the MCCCP released its media campaign in 2005, after which the Follow-Up study was conducted, the CDC and the American Cancer Society (ACS) aired ad campaigns with similar subject matter. This presented a confounding variable in terms of obtaining a true measure to evaluate the MCCCP ad. However, with the Follow-Up study this did provide a unique opportunity to determine whether the clutter of colon cancer ads, in general, resulted in any changes in attitudes, awareness and behavior, and which ads were particularly memorable.

In 2006, the MCCCP media campaign was presented in an environment independent of the campaigns conducted by the CDC and the ACS, allowing an opportunity to evaluate the impact of the MCCCP media campaign alone. This was accomplished by releasing the MCCCP ads in February, ahead of the campaigns conducted by the CDC and the ACS in March of 2006, which were aired in conjunction with colon cancer awareness month. Ad recall was therefore measured at the end of February, prior to the other ads being aired.

Similar to the Follow-Up survey in 2005, the MCCCP ads of 2007 were aired in conjunction with those from the CDC and the ACS. Therefore, the ad recall measure reported for 2007 reflects the same confound described earlier. This should be kept in mind when interpreting the impact of the MCCCP ads.

Ad Recall. Overall, more than two-thirds of the respondents (69%) recalled having seen, heard, or read a colon cancer early warning commercial or an advertisement during the past several months. This percentage of recall is a positive finding and is up from both the Follow-up Wave and Wave III (58% and 60%). As mentioned previously, it is difficult to attribute this increase solely to the MCCCP since the ads were presented with ads from both the CDS and ACS. Also, as this effort behind driving colon cancer awareness has been done with some continuity over these years, we may be seeing some residual effects of this ongoing effort.

Table 21. *Ad Recall by Survey Wave*

	2005 Follow-Up (n=263)	2006 Wave III (n=359)	2007 Wave IV (n=300)
Ad Recall	**% (a)**	**% (b)**	**% (c)**
Yes	58	60	69ab
No	41c	38c	28

Note: Shaded percentages are significantly greater than a, b, and/or c at the 95% confidence level.

Additional findings include:

- In 2007, we found that screened respondents are more likely to recall colorectal screening advertisements.
- Those in North/Downeast and Mid-Maine regions are less likely to recall ads than those in Southern Maine.

Table 22. *Ad Recall by Screening Status and Region*

	Screening Status		Region		
Ad Recall	**Screened n=233**	**Unscreened n=166**	**Mid-Maine n=141**	**North/Downeast n=63**	**Southern n=95**
	% (a)	% (b)	% (c)	% (d)	% (e)
Yes	72b	52	68	67	73
No	26	40a	31e	30e	20
Don't Know	2	2	1	0	7c

Note: Shaded percentages are significantly greater than a, b, and/or c at the 95% confidence level.

Medium. As expected, television is the most recalled medium for advertising colon cancer screening. Since the Follow-Up in 2005, there has been an increase in the number of unscreened respondents who report having seen colon cancer screening advertisements, suggesting that this target audience is being reached.

Table 23. *Ad Medium Recall by Survey Wave and Screening Status*

Of those who remember seeing, hearing, reading an ad	2005 Follow-Up		2006 Wave III		2007 Wave IV	
	Screened n=122	Unscreened n=31	Screened n=176	Unscreened n=41	Screened n=233	Unscreened n=166
	%	%	%	%	%	%
	(a)	(b)	(c)	(d)	(e)	(f)
T.V.	83	71	83	93bc	90	91b
Magazine	22	29df	22d	7	21	12

Note: Shaded percentages are significantly greater than a, b, and/or c at the 95% confidence level.

TV Advertisement Recall. Respondents who recalled the TV campaigns were asked if they recalled the sponsor of the ad.

- Nine out of ten respondents (95%) could not recall the sponsor, while only 5% could.
  - In the previous wave (2006) the findings illustrated that those residing in Mid-Maine or North/Downeast counties were more likely than those in Southern Maine counties to say that they recall the sponsor of the ads (12-16% vs. 4%). However, in the current wave no differences emerge across regions.
- Of those 5% of respondents who said that they were able to recall the sponsor of the advertising, typical responses included *the State of Maine* or *the American Cancer Society.*
- Respondents most readily recall the main message as being "Get tested/screened if you're over fifty."

Table 24. *Message Recall*

Specific Message Recall	Among Those Seeing an Ad (N=192) %
Get tested/screened if you're over fifty	54
Colonoscopies are important	20
Getting tested can find colon cancer in an early stage when it is treatable	18
Colon cancer is preventable with early detection	14
Talk to your doctor	10
Getting tested can find colon polyps that can be removed	8
Colon cancer is treatable	4
Colonoscopies might not be pleasant	4
The most common symptom is no symptom	3
Stick around for the show by getting screened	3
Colon cancer affects both men and women	3
Colon polyps can turn into cancer if untreated	1
Colon cancer is a leading killer of both men and women	1
Medicare will help pay for testing	0
Don't Know/Not sure	8

The results above appear to be similar across the three regions of Maine and across age, education and income groups.

TV Campaign Influence on Intended Behavior
An important goal of the MCCCP media campaign is to increase awareness of colon cancer early detection and eventually to influence behavior. In evaluating the behavior component, respondents were asked if seeing these ads changed the likelihood that they would be screened for colon cancer in the future.

- One in four respondents (28%) claim that they are much more likely to be screened;
- Another one in five (20%) state that they are somewhat more likely to be screened;
- Almost half (49%) state that the ad did not change their opinion about colon cancer screening.

A comparison of screening intent across waves does not provide evidence that intended behavior has changed since the launch of this campaign.

Table 25. *Likelihood of Screening by Survey Wave*

Likelihood of screening (of those who recall seeing the TV ad)	2005 Follow-Up n=123 % (a)	2006 Wave III n=184 % (b)	2007 Wave IV N=192 % (c)
More likely (NET):	**52**	**44**	**48**
Much more likely	37b	20	28
Somewhat more likely	15	24a	20
Less likely (NET):	**3**	**5**	**1**
Somewhat less likely	1	4	1
Much less likely	2	1	0
Ads did not change my opinion	**43**	**51**	**49**

An analysis comparing screened and unscreened respondents did not show any differences with regard to future intent to screen for colon cancer because of the advertisements.

Conclusions and Recommendations

- Overall, the findings from this survey are encouraging. Since the initial Pre-Wave and the Follow-Up in 2005, there has been a sustained 12% increase in the number of respondents claiming to have been screened. This suggests that the continued media campaign by the MCCCP and others has served to maintain the increased base rate in screening behavior.
- This year marks the first time we have seen an increase in the number of respondents who have seen or heard colon cancer screening advertisements. Perhaps the onslaught of ads from the MCCCP and other organizations, along with the repetition of MCCCP ads from prior years solidified recall of these campaigns.

- MCCCP ads are memorable. This research shows that Mainers recalled more elements from the MCCCP ads than other sponsored television advertisements.

- Advertisements alone will not spur additional changes in screening intent. While advertising plays an important role in increasing awareness and providing information, there are other barriers that prevent screening behavior (i.e., cost, lack of insurance coverage, access to testing facilities, etc.).

Recommendations

- Unscreened respondents still are not as concerned about some cancers or feel that any cancer is a widespread problem. Work needs to be done to continue to change the perception of these cancers within this population;

- There is evidence that advertising, particularly via television, is building awareness for colon cancer and early detection, but after an initial spike its message may not necessarily be prompting additional behavioral changes. However, intentions to screen have increased. These findings suggest that while ads certainly build awareness, they cannot alone influence action. Other barriers to screening need to be addressed to further increase screening rates; and

- This research indicates that those who have lower incomes are less likely to screen for colon cancer. This suggests that the cost to receive medical care or to be properly insured is a likely barrier to screening. More needs to be done to make these screening tests affordable and accessible.

Elementary-School Sun Safety Mini-Grants

Project Description

The MCCCP provided funding to the Maine Department of Education for public elementary schools to submit an application for the amount of $500 to support skin cancer prevention. Based on the Centers for Disease Control and Prevention's School Recommendations for Skin Cancer Prevention, grantees were asked to focus on educating students, faculty, and staff on sun protection behavior, including wearing protective clothing (pants, long-sleeve shirts, hats, sunglasses), applying sunscreen with an SPF of 15 or higher, and seeking shade when outdoors. Activities could include special event days, incorporating skin cancer prevention education into comprehensive school health education, developing educational materials, purchasing and building shade structures (trees, awnings, etc) to the school campus, and/or providing faculty and staff training. Additionally, grantees were expected to develop school-wide sun protection guidelines, based on the CDC's Recommendations.

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

Objective 1: To increase the number of Maine elementary school students, faculty, and staff who have received skin cancer prevention education before June 15, 2007.

Objective 2: To increase the number of elementary schools in Maine that have developed school-wide sun protection guidelines before June 15, 2007.

Methods

Mini-grant recipients were asked to complete a narrative final report detailing their activities, use of funds, barriers to implementation, accomplishments, and whether or not they achieved their anticipated impact of their efforts.

Response Rate and Participant Characteristics

During the first round of mini-grants, 49 schools were funded to complete sun safety activities. To date, 75% (n = 37) have returned final reports.

Respondents represented schools from around the state representing the following 14 counties: Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York.

Key Findings

Thirty schools (83%) had completed all activities at the time of the report. The remaining 17% are to complete activities between Summer and Fall 2007. The following summary includes 32 schools unless otherwise noted.

Activities Completed

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

Table 26 provides a summary of responses and examples of the four categories of activities are provided below.

Educational activities/program for students, faculty, staff:

- Distribution and demonstration of sun safety products
    - Sunscreen
    - UV beads
    - Hats
    - Sunglasses
- Classroom education
    - Sun safety curriculum
    - Sunscreen application
    - Making UV beads
    - Watched videos
    - Class discussions
- Development or use of educational materials/outreach
    - Parent education (pamphlets)
    - Bulletin/display boards
    - Newsletters
    - Brochures
    - Videos
    - Books
    - PowerPoint presentations
    - UV meters

School-wide special event:

- Health fairs, etc.
- Assembly
- Guest Speakers
- Sun safety event for whole school
    - Slip, Slap, Slop (American Cancer Society)
    - Distribution of sun safety products

Sun structures:

- Shade trees
- Sun Shelters (e.g., gazebo)
    - Including area to play and/or eat (e.g., picnic tables with umbrellas)

Sun Safety Policies[4]*:*

Respondents were asked if their school currently had or were developing sun protection guidelines. Twenty schools (61%) reported having sun protection guidelines completed or in progress. Nineteen of these schools (95%) developed (or are developing) the guidelines as a result of receiving the mini-grant. Policies range from including the use of sun safety products at school to implementing annual education about sun safety and skin cancer. These findings

[4] 33 schools responded to this question

suggest that the mini-grants did help to achieve the grant's objective to increase the number of schools with sun safety guidelines.

Table 26. *Schools' Reported Activities*

Activity	Frequency	Example
Educational activities	23 *(72%)*	*"Developed sun safe guide for parents- sent home with all 400+ students. 2. In classroom 20 min information/ discussion, educating students about dangers of sun and practicing sun safe practices."* *Grades K-2- Skit done involving children and how to protect themselves against the sun. Showed what happens with a sunburn in the skit. Passed out bracelets (UV sensitive beads) and sunscreen towelettes with UVA/UVB protection to each kid. Grade 3-5 taught sun safety materials- Gave each kid a bracelet and 100% UV protection sunglasses. Grade 6-8 watched the video "The dark side of the Sun".*
Development of sun safety policy and/or committee to develop[5]	19 *(58%)*	*"Sun safety Policy Committee initiated including: principal, school nurse, Health education coordinator, parent, and teacher."*
School-wide event	18 *(56%)*	*"We had a "Beach Day" at the elementary school. Teacher taught 'sun safety' to students."* *"We had 2 school-wide events. Assembly- April 12, 2007 with sun safety tip and facts. May 23- Tree planting event- all students assisted"*
Development of a shade structure	18 *(56%)* (4 to be completed)	*We purchased shade structures for many outdoor events that take place at out school.* *"The activity yet to be completed will consist of the planting of a large Red Maple shade tree."*

Use of Funds

Recipients were required to report the percentage of funds allocated to various areas. The most common uses of funds included the purchase of shade structures and education materials. These findings are summarized below.

The average reported percentages are as follows:

- Purchase of shade structures:
  - 72% of schools (n = 23) reported using funds for shade structures.
  - Average percent of funds spent: 54%

[5] This number represents those schools who responded to the specific question regarding the development of guidelines as most schools did not list this as an activity in their narrative.

- Purchase of sun safety education program materials:
    - 69% of schools (*n* = 22) reported using funds for purchasing program materials.
    - Average percent of funds spent: 28%
- Sponsor special event day(s):
    - 19% of schools (*n* = 6) reported using funds for a special event.
    - Average percent of funds spent: 20%
- Develop educational materials for students, faculty, staff:
    - 34% of schools (*n* = 11) reported using funds to develop educational materials.
    - Average percent of funds spent: 6%

In-kind support. Twenty-four schools reported receiving in-kind or additional support. Including volunteer time, additional grant money, and donations from retailers.

Barriers

Respondents were asked to identify any barriers they encountered while implementing this grant. The most commonly noted barrier was related to financial aspects of the mini-grant such as timing of the release of funds and expense of materials. A summary of these findings is located in Table 27.

Table 27. *Barriers to Implementation of Sun Safety Grant*

Barrier	Frequency	Example
Financial - Expense of sun structure - Timing of funds	12 *(37.5%)*	*"If I had more funding I would have given stipends to alumnae and presenters who staffed the sessions."* *"I had many ideas to promote this project but financially ran out of money."* *"Shade structures are more expensive than anticipated."* *"The money was received late in the year which delayed the purchase of the trees and held up the implementation of the activities until very late in the school year."*
No barriers	12 *(37.5%)*	*"None. The health teacher and myself paired up and taught the classes together. The teachers were very cooperative with changes in their schedule to teach these kids about sun safety."*
Time constraints - Timing in school year	6 *(19%)*	*"It has been a time challenge to communicate and prepare site using volunteers."* *"The largest problem was working late in the school year. It is difficult to teach this topic when there is still snow on the ground. Because of the many end of the year activities, it was difficult to get into the classrooms…"*

Administrative	6 *(19%)*	*"I was unable to attend a parent organization meeting for education, but plan to in the future."* *"Any teachers [who] are ed. specialists are not required to be at teacher meeting when educations done."*

Accomplishments

Schools were asked to describe their accomplishments as a result of the mini-grant. All schools noted the increase in awareness of sun safety issues among students, faculty, staff and parents; thus, suggesting the mini-grant achieved this objective.

Table 28. *Accomplishments as a Result of Sun Safety Mini-Grant*

Accomplishment	Frequency	Example
Promoting and increasing awareness of sun safety issues among students, faculty, staff, parents (people "talking about" sun safety) - community outreach and awareness/building relationships	32 *(100%)*	*Promoted sun safety and encourage sun safe behaviors. Community awareness of skin cancer prevention.* *High level of interest and involvement with students…* *I am thrilled to report that as a result of this grant I was able to reach approximately 600 people in our community (including students and staff) regarding sun safety.*
Creation of or groundwork formed for sun safety policy	9 *(28%)*	*Guidelines on sun safety implemented.* *Adding sun safety statement to wellness policy.* *A policy could follow more easily now.*
Creation of shade structure - positive environmental change	7 *(22%)*	*Adding shaded area to student play area.* *Positive environmental impact. Development of shade structures. 3 trees will eventually provide fruit.*

Anticipated Impact
Common themes included increasing awareness about sun safety and skin cancer, improved sun safety practices, and providing shade on school grounds. Select verbatim descriptions are provided below.

- We anticipated that awareness about the need for sun safety measures would result in increase in practice. We also sought to provide a sun-safe environment at school.
- Teachers would plan outdoor activities using best sun safety practice. Students would ask to seek shade, water, and tell their parents how important sunscreen is. Parents would become more aware of sun safety through educational materials sent home and child's sharing.
- To raise awareness about skin cancer. To educate children, parents, and staff regarding sun protection. To increase sun safety measures used by target audience. To provide shade structures on school grounds.
- Children will recognize the benefits and potential risks associated with sun overexposure.
- As school, community leaders, we need to model best practice with "sun safety". Students and families notice our practices and then follow suit. When the space is completed we anticipate even more practical prevention happening.
- Raise awareness that would promote sun safety behaviors. Teacher will add sun safety to their classroom health curriculum. Develop policy on sun safety.
- To encourage students and staff to get excited about sun safety and encourage institution of safe practices into their lives.
- Practicing safe sun activities that will last their lifetime.
- It was my hope to educate and create a greater public awareness regarding sun safety. I also hoped to create and implement sun safety guidelines for our wellness team.
- To bring more awareness to parents/ students on importance of sun protection. Also, to have areas available for students to seek shade when outside.
- Increasing awareness of the importance of sun safety in elementary age children. Build good habits and positive attitudes toward sun safety and skin cancer prevention.
- To raise awareness of sun related cancer issues and safety issues for children and our school community, as well as get district guidelines started.
- I anticipated raising awareness ~ and having children think about sun safety. This project far exceeded all expectations! Grade 1 made small posters; grade 3 used UV meters and posted results. All grades received hats or beads! All grades received hats or beads! The entire student body saw sun safe videos!
- Improved awareness and sun safety practices by students and staff. Include sun safety into health curriculum. Establish school policy or guidelines.
- Students would practice sun safety!

Thirty-one (97%) schools reported they had "partially" or fully achieved their anticipated impact of their efforts. Participants measured impact by feedback and observed behaviors among parents, students and staff. As shown in the following quotes:

> *"The funding combined with the interest and enthusiasm of students, staff, and community members maximized the impact of this process led to achieving our goals."*

> *"Students brought home info verbally and written and I received feedback from these parents. Students started coming to PE with sunblock, hats, and sunglasses on."*
>
> *"It has been a good starting point for our schools. We hope to see even more results as our project progresses."*

For those few schools (*n* = 8; 25%) who noted they had only partially achieved their impact they noted the ongoing and long-term process of making change. As one respondent explained,

> *Building a change in attitudes needs to be accomplished over time. However, parents are taking increased responsibility for applying sunscreen and sending hats in with students.*

Conclusions and Recommendations

The findings from the final reports suggest the following grant objectives were reached:

Objective 1: To increase the number of Maine elementary school students, faculty, and staff who have received skin cancer prevention education before June 15, 2007.

Objective 2: To increase the number of elementary schools in Maine that have developed school-wide sun protection guidelines before June 15, 2007.

Recommendations:

- In order to increase the schools' ability to complete all activities, consider revising the grant timeline.
- Many schools noted the unanticipated expense of a sun shade structure. Provide resources for sun shade development to help inform schools' planning for use of funds in this way.
- Consider providing information regarding sun safety in winter.
- Create an on-line reporting form to increase the return rate, ease the burden of school representatives and enhance data analysis.

RESULTS PART III: OUTCOMES

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

The information provided below is based on outcome data for select objectives as they are linked to specific goals outlined in the 2006 - 2010 Comprehensive Cancer Plan. All objectives (with baseline data) that are included in this evaluation are listed below. Once again, the results should be interpreted with caution. While the program theory delineated in the original logic models suggests that the accomplishments of specific strategies will lead to achieving objectives and ultimately, goals, there are a series of additional factors that clearly can impact program replication (e.g., funding of initiatives). Until these factors are better understood, generalizations about changes in the data should be made with caution.

Additional outcome information will be included in a comprehensive surveillance document currently being developed by the Maine Cancer Consortium Data Workgroup. Once completed, this document will be included in subsequent evaluation reports.

Intermediate Outcomes

Intermediate outcomes often focus on behavior and systems change. The Maine Comprehensive Cancer Control Program's intermediate outcomes can be categorized into risk factors and screening behaviors. Tables 29 - 33 provide data from the Behavioral Risk Factor Surveillance System (BRFSS) in Maine[6]. These data are collected annually through a random digit dial telephone survey of Maine adults. Data pertaining to youth are collected utilizing the Maine Youth Risk Behavior Surveillance System (MYRBS). This school-based survey is administered to 9th – 12th grade students every two years. Citations are provided for data reported from additional sources.

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

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

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 29. *Intermediate Outcomes: Tobacco Use*

Measurable Objectives	Previous Plan [1]				New Plan
	2002	2003	2004	2005	2006
Tobacco Use: Adults and Youth					
• Reduce proportion of Maine adults aged 18 and older who use tobacco products to 18% by 2010[2]	23.6%	23.6%	*21%	20.8%	20.9%
• Reduce cigarette smoking among pregnant and postpartum women to 15% by 2010[3] o Pregnant women who smoked during last 3 months of pregnancy	16%	*16%	20%	17.5%	NA
o Postpartum women who smoked after pregnancy	NA	*21%	24.5%	23.4%	NA
• Reduce tobacco use of 9-12th graders to 15% by 2010[4]	--	20.5%	--	*16.2%	--
• Reduce tobacco use of 6 -8th graders to 5.5% by 2010[4]	--	8.7%	--	*7.5%	--
• To increase the proportion of adults who receive advice to quit smoking from a health care professional by 2010	78.1[5]	--	74.9%[6]	--	NA
• Reduce involuntary exposure to secondhand smoke for all Maine residents[6] o Proportion of Maine adults who report no exposure to secondhand smoke at their workplace	--	--	75.4%	NA	NA
o Proportion Maine workplaces that do not allow smoking in any work areas	87.5%[5]		89.4%	NA	NA
o Proportion of Maine adults who do not allow smoking in their homes	63.3%[5]	--	71.6%	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] Results based on current cigarette smokers [have smoked 100 cigarettes in their lifetime and smoke now]
[3] Maine Pregnancy Risk Assessment System (PRAMS)
[4] Results based on current cigarette smokers, MYRBS [smoked in the last 30 days]
[5] Results based on 2000 Adult Tobacco Survey, 2002 data not collected. Baseline reported in the Cancer Plan from BRFSS and is not comparable to current data, thus it is not reported in this report.
[6] 2004 results based on Maine Adult Tobacco Survey, questions may vary in sampling and wording from BRFSS 2000, 2002 baseline listed in Cancer Plan.
* = Baseline as listed in 2006-2010 Cancer Plan
- - = Data not collected (MYRBS survey administered on odd years only)

The tobacco use results suggest that the rate of current adult smokers has remained relatively stable over the past several years. However, youth smoking rates have decreased according to trend analyses conducted using the Maine Youth Risk Behavior Survey. Results from the MYRBS suggest that the percentage of high school students who smoked cigarettes during the past 30 days decreased from 20.5% in 2003 to 16.2% in 2005. Moreover, according to the MYRBS the percentage of middle-school students who smoked cigarettes in the past 30 days

decreased from 8.7% in 2001 to 7.5% in 2005. It remains to be seen if the youth smoking rates continue to decline as more recent numbers are not available. Thus, any change in this objective since baseline is unknown. Finally, the data suggests that since 2000 progress has been made in terms of exposure to secondhand smoke, with approximately 72% of adults banning smoking in their homes, up from 63% in 2000. Data being collected for 2007 will help elucidate further changes in tobacco-related behavior.

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

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

Table 30. *Intermediate Outcomes: Physical Activity and Nutrition, Overweight/Obesity*

Measurable Objectives	Previous Plan				New Plan
	2002	2003	2004	2005	2006
Physical Activity and Nutrition, Overweight/Obesity: Adults					
• Increase to 30% the proportion of adults who consume five or more servings of fruits and vegetables every day by 2010	29.4%	*27%	- -	28.7%	NA
• Reduce the proportion of adults that are overweight[2] to 35% by 2010	38%	38.3%	*37.6%	36.9%	36.6%
• Reduce the proportion of adults that are obese to 20% by 2010[3]	20.7%	19.9%	*23.4%	22.7%	23.1%
• Increase to 80% the proportion of adults who participate in any physical activities in the past month[4]	74.2%	79.4%	*78.5%	77.7%	79.1%
• Increase to 55% the proportion of adults who participate in 30 minutes of moderate physical activity five or more days per week OR vigorous physical activity 20+ minutes for three or more days per week	--	*53.1%	--	54.1%	NA
Physical Activity and Nutrition, Overweight/Obesity: Youth					
• Increase to 35% the proportion of youth who consume five or more servings of fruits and vegetables per day by 2010[5].	--	*22.6%	--	18.9%	--
• Reduce the proportion of youth who are overweight to 5% or at risk for being overweight to 10% by 2010					
o High School overweight	--	*13%	--	10.9%	--
o High School at risk	--	*15%	--	14.4%	--
o Middle School overweight	--	*13%	--	12.2%	--
o Middle School at risk	--	*18%	--	15%	--
• Reduce the proportion of kindergarten students who are overweight to 5% or at risk for being overweight to 10% by 2010[6]					
o Overweight	15.2%		*15%	NA	--
o At risk	21.3%		*18%	NA	--

• Increase to 80% the proportion of youth who engage in vigorous physical activity three or more days per week for 20 minutes or more each time by 2010					
o High School	--	*61%	--	62.3%	--
o Middle School	--	*72%	--	74.7%	--

Notes:
[1] Plan objectives have changed since the previous 2001-2005 Cancer Plan, thus the purpose of these numbers is to provide a 5-year snapshot of the current objective.
[2] Overweight based on Body Mass Index of 25 – 29.9
[3] Obese based on Body Mass Index of $\geq$ 30
[4] BRFSS, 2003 -2005. Question wording may differ from previous versions. "Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week"
[5] High School students, MYRBS
[6] Maine Child Health Survey
* = Baseline as listed in 2006-2010 Cancer Plan
NA = Data not available/not yet provided
- - = Data not collected (YRBS survey administered on odd years only, select BRFSS questions not included annually)

The results in Table 30 suggest that adults continue to increase fruit and vegetable consumption over the past several years, nearly achieving the objective. However, since 2001 where the percentage was 25% (*not shown)* high school students' consumption of fruits and vegetables appears to be on a downward trend with less than 25% of students eating five or more servings daily, as reported in 2003 and 2005.

Reported levels of physical activity among youth also appear to be increasing slightly since baseline. While the numbers have fluctuated over the past 5 years, BRFSS data for adult physical activity also suggests an upward trend, showing slight increases since baseline.

Finally, according to the 2006 BRFSS, while Maine's rates of overweight and obese adults (59%) are comparable to national rates (61%), Maine has the highest adult obesity rate in New England. The data suggest a slight decrease since baseline in the rate of Maine adults who are overweight. The rates of obesity for those 18 and older, however, suggest little change since the 2004 baseline.

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

Table 31. *Intermediate Outcomes: Sun Safety*

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

Notes:
* Baseline data as reported in the Maine Cancer Plan.

Questions pertaining to sun safety were not included in past versions of the MYRBS and the latest available data is from 2005. Thus, more data is needed to identify a trend in sunscreen use among Maine youth.

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

Table 32. *Intermediate Outcomes: Sexual Health Behaviors, Youth*

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

* Baseline data as reported in the Maine Cancer Plan.

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 33. *Intermediate Outcomes: Screening Behavior*

Measurable Objectives	Previous Plan				New Plan
	2002	2003	2004	2005	2006
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%	--	*72.7%	76.0%[2]	72.0%
• Increase the proportion of Maine women aged 50 and older who have received both a mammogram and a clinical breast exam within the preceding year to 70% by 2010.	62.6%	--	*61.6%	60.1%[2]	61.5%
Screening Behavior: Cervical Cancer[1]					
• Increase the proportion of Maine women with a uterine cervix who have ever received a Pap test to 98% by 2010	97.0%	--	*97.0%	95.2%[2]	97.0%
• Increase the proportion of Maine women aged 18 and older with a uterine cervix that received a Pap test within the preceding 1 to 3 years to 92% by 2010	92.1%	--	*88.7%	87.9%[2]	89.1%
Screening Behavior: Colorectal Cancer					

• Increase the proportion of people aged 50 and older who have ever received a screening colonoscopy or sigmoidoscopy to 75% by 2010.	47.3%	NA	*59.1%	NA	64.2%

Notes:

[1] Data Source: University of Southern Maine reports generated from Maine BRFSS data and collected by Maine Breast and Cervical Health Program
[2] This data was collected by Maine BRFSS by special request of MBHCP even though Women's Health Module not included in Core Survey. National data is not available for this year.
* Baseline data as reported in the Maine Cancer Plan.
NA = Data not available/not yet provided
- - = Data not collected as part of Maine BRFSS. Women's Health Module only asked in even years since 2000.

Based on the results provided, breast and cervical cancer screening behavior appears to have remained unchanged since the 2004 baseline with slight changes occurring in 2005 only. Screening rates for colorectal cancer appear to be on rise. As noted in the previous section on the social marketing campaign, there has been a 17% increase in sigmoidoscopy/colonoscopy screenings since 2002, and this trend appears to be continuing since the 2004 baseline.

Long-Term Outcomes

Cancer is the leading cause of death in Maine with one in four deaths due to cancer. The overall cancer death rate, however, is declining due to improvements in prevention, detection and treatment of many types of cancer.[7] Despite the declines, Maine continues to have overall cancer incidence and mortality rates higher than the national rates. Moreover, Maine has the highest cancer mortality rate in New England. Within this context, the MCCCP's long-term outcomes refer to reducing both incidence and mortality for all types of cancer.

Table 34 provides data from the Maine Cancer Registry on incidence and data from CDC Wonder on mortality rates for those cancers specifically addressed in the Maine Comprehensive Cancer Control Plan. A shown in this table, the latest available data is from 2004. The baseline as noted in the MCCC plan is from 2002.

Additional information on all cancers will be tracked within the MCCCP's surveillance plan to be included in subsequent annual evaluation reports.

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

Table 34. *Incidence and Mortality Rates for Select Cancers*

Objectives	Baseline[1] 2002	2003	2004	2005	2006
Incidence[2]					
• All cancers	500.8	490.7	504.5	NA	NA
Men	589.9	571.0	587.6	NA	NA
Women	439.2	433.7	441.6	NA	NA
• Lung cancer	75.9	75.9	77.2	NA	NA
Men	96.0	96.2	96.7	NA	NA
Women	60.7	60.7	63.0	NA	NA
• Colorectal cancer	61.2	55.3	55.2	NA	NA
Men	74.3	67.3	61.6	NA	NA
Women	51.8	46.4	49.0	NA	NA
• Melanoma	20.7	21.8	22.0	NA	NA
Men	24.1	27.6	27.0	NA	NA
Women	18.6	17.4	18.4	NA	NA
• Breast cancer[3]	126.3	126.3	122.1	NA	NA
• Cervical cancer	7.1	8.0	8.9	NA	NA
• Prostate cancer	162.2	156.7	165.4	NA	NA
• Oropharyngeal cancer	12.4	12.1	12.1	NA	NA
Men	19.5	17.7	19.6	NA	NA
Women	6.5	7.0	5.6	NA	NA
• Bladder cancer	27.1	30.5	27.7	NA	NA
Men	46.7	54.7	46.5	NA	NA
Women	12.2	12.4	13.0	NA	NA
Mortality[2]					
• All cancers	213.9	204.1	205.8	NA	NA
Men	267.9	243.8	252.0	NA	NA
Women	177.3	178.1	173.7	NA	NA
• Lung cancer	63.2	62.3	61.1	NA	NA
Men	81.4	79.5	78.2	NA	NA
Women	49.8	49.9	48.9	NA	NA
• Colorectal cancer	21.7	19.2	17.6	NA	NA
Men	27.6	21.7	17.6	NA	NA
Women	17	17.2	17.5	NA	NA
• Melanoma	3.5	2.5	2.9	NA	NA
Men	5.9	3.6	4.1	NA	NA
Women	1.7	1.7	1.8	NA	NA
• Breast cancer[3]	23.9	27.3	21.3	NA	NA
• Cervical cancer	2.1	1.8	2.0	NA	NA
• Prostate cancer	26.4	27.6		NA	NA
• Oropharyngeal cancer	2.8	2.7	3.3	NA	NA
Men	4.2	4.0	5.0	NA	NA
Women	1.6	1.5	1.8	NA	NA

• Bladder cancer	5.1	5.0	6.0	NA	NA
Men	8.4	7.4	11.7	NA	NA
Women	2.7	3.2	3.0	NA	NA

Notes:
[1] Baseline rates included in the Maine Cancer Plan
[2] All data are calculated per 100,000 and age-adjusted to the 2000 U.S. Standard Population
[3] Females only
NA = Data are not yet available

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

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 MCCC initiative and the current MCCC plan, additional years of data will be necessary.

Recommendations: MCCP and Consortium Overall

1. **Enhance Communication of Consortium Activities and Message**
   - Develop, implement, and evaluate routine mechanisms for communicating with members. Specifically, continue to build and activate the Communications Workgroup
   - Provide orientation to new members including consortium vision, activities, goals and objectives.
   - Enhance public relations effort. Showcase, celebrate, and publicize accomplishments among Consortium members and others through newsletters, press releases and other venues.

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

3. **Enhance Outcome Evaluation**
   - Continue to align evaluation with surveillance activities, specifically in the tracking of outcomes.
   - Develop outcome evaluation of select workgroup activity each year. Work with evaluator to identify appropriate intervention and design evaluation.
   - Discuss revising the process of activity-monitoring with Consortium Work Groups. Consider tracking progress of work groups regularly to enhance data.

Appendix A:

Maine Cancer Consortium Workgroup Mini-Grant Evaluation Survey

Maine Cancer Consortium
Work Group Mini-Grant Evaluation

Please discuss and answer the following questions with the entire Work Group and email your responses to Ruth Dufresne at dufresne@maine.rr.com. Thank you.

Name of Work Group: ____
Date: ______________________

1. Did the mini-grant funding help the Work Group to:

Work toward goals?	___ No	___ Somewhat	___ Yes
Achieve objectives?	___ No	___ Somewhat	___ Yes
Implement strategies?	___ No	___ Somewhat	___ Yes

Please respond to the questions below based on a scale of one to five with "1" being "poor" and "5" being "excellent."

2. How would you rate the application process for the mini-grants?

Poor				Excellent
___ 1	___ 2	___3	___4	___5

3. How would you rate the process for identifying projects for the mini-grants?

Poor				Excellent
___ 1	___ 2	___3	___4	___5

4. How would you rate the on-going administration process for the mini-grants?

Poor				Excellent
___ 1	___ 2	___3	___4	___5

5. Does the Work Group have any suggestions for improving the application process?

____

____

____

6. Does the Work Group have any suggestions for improving the process for identifying

projects for the mini-grants?

____

7. Does the Work Group have any suggestions for improving the ongoing administration process for the mini-grants?

Thank you.

Appendix B

Screen ME! Social Marketing Campaign: MCCCP Telephone Survey 2007

Digital Research, Inc. Project # 1131
201 Lafayette Center
Kennebunk, ME 04043

MCCCP Telephone Survey 2007 (Wave IV)

Hello. I'm _____________ from Digital Research, a local Maine marketing research firm. Today we're conducting a survey on behalf of Maine's Bureau of Health to gather health information from Maine residents. Your telephone number has been selected randomly and any information we obtain from you will remain confidential. Is there a person in your household who is 50 years of age or older? (If yes) May I please speak to that person? (REPEAT INTRODUCTION IF PHONE HANDED TO ANOTHER PERSON)

IF NOT AVAILABLE OR NOT A GOOD TIME, ASK FOR A CONVENIENT TIME TO CALL BACK.

First _____________________ (Date/Time)
Second ____________________ (Date/Time)
Third _____________________ (Date/Time)

1. Thank you for speaking with me today. Let me just confirm once more, are you at least 50 years of age or older?

Yes [ ] – **Continue** No [ ] – **May I please speak with a person in your household who is 50 years of age or older?**

2. Do you have any kind of health care coverage, including health insurance, private insurance such as HMOs, or government plans such as Medicare or Mainecare?

( ) Yes
( ) No
( ) Don't know
( ) Refused

3. Have you personally been diagnosed with any of the following conditions? [**Read list, check all that apply]**

( ) Colon polyps→ terminate
( ) Colon cancer → terminate
( ) Inflammatory bowel disease → terminate
( ) Ulcerative colitis → terminate
( ) Crohn's disease → terminate
( ) None (do not read)
( ) Refused → terminate

[Must answer "None" to continue with survey; terminate all others.]

4. Has anyone in your immediate family or anyone close to you had a diagnosis of colon cancer?

   ( ) Yes
   ( ) No
   ( ) Don't know/not sure
   ( ) Refused

5. How would you describe your general level of health? (Read choices)

   ( ) Excellent
   ( ) Very good
   ( ) Good
   ( ) Fair
   ( ) Poor

6. When was the last time that you had a complete physical exam from a doctor or health care provider?

   ( ) Within the past year (anytime less than 12 months ago)
   ( ) Within the past 2 years (1 year but less then 2 years ago)
   ( ) Within the past 5 years (2 years but less than 5 years ago)
   ( ) 5 or more years ago
   ( ) Never had one
   ( ) Don't know/Not sure
   ( ) Refused

7. Have you ever been diagnosed with any form of cancer?

   ( ) Yes
   ( ) No → Skip to Q9
   ( ) Refused → Skip to Q9

8. **[If yes to Q7]** What form of cancer have you been diagnosed with? (do not read list)

( ) Bladder → Ask all parts of Q9 (a,b,c,d,e)
( ) Breast → Ask all parts of Q9 except Q9a
( ) Prostate → Ask all parts of Q9 except Q9b
( ) Skin → Ask all parts of Q9 except Q9c
( ) Lung → Ask all parts of Q9 except Q9d
( ) Ovarian → Ask all parts of Q9
( ) Leukemia → Ask all parts of Q9
( ) Lymphoma → Ask all parts of Q9
( ) Other [Note: ______________________] → Ask all parts of Q9

9. Now I am going to read a list of different types of cancers. How concerned are you that you may personally be diagnosed with that type of cancer, extremely concerned, very concerned, somewhat concerned, slightly concerned or not at all concerned?

[Rotate list randomly]	Extremely concerned	Very concerned	Somewhat concerned	Slightly concerned	Not at all concerned
a. Breast cancer (ask only of women)	( )	( )	( )	( )	( )
b. Prostate cancer (ask only of men)	( )	( )	( )	( )	( )
c. Skin cancer	( )	( )	( )	( )	( )
d. Lung cancer	( )	( )	( )	( )	( )
e. Colon Cancer	( )	( )	( )	( )	( )

10. I am once again going to read a list of different types of cancers. How widespread a problem would you say each cancer is to the population of Maine? Read choices

[Rotate list randomly]	Extremely widespread	Very widespread	Somewhat widespread	Slightly widespread	Not at all widespread
Breast cancer	( )	( )	( )	( )	( )
Prostate cancer	( )	( )	( )	( )	( )
Skin cancer	( )	( )	( )	( )	( )
Lung cancer	( )	( )	( )	( )	( )
Colon Cancer	( )	( )	( )	( )	( )

11. A blood stool home test kit is a special kit used at home to determine whether the stool contains any blood. Have you ever heard of such a home test kit?

( ) Yes
( ) No →SKIP TO Q13
( ) Don't know/Not sure → SKIP TO Q13
( ) Refused → SKIP TO Q13

12. Have you ever used a blood stool home test kit?

( ) Yes
( ) No
( ) Don't know/Not sure
( ) Refused

13. Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever heard of either of these exams?

( ) Yes, both
( ) Yes, sigmoidoscopy
( ) Yes, colonoscopy
( ) No -> SKIP TO Q15
( ) Don't know → SKIP TO Q15
( ) Refused → SKIP TO Q15

14. Have you ever had any of these exams?

( ) Yes, both
( ) Yes, sigmoidoscopy
( ) Yes, colonoscopy
( ) No
( ) Don't know
( ) Refused

15. Do you intend to be screened in the future for colon cancer either by a home stool test kit or by a sigmoidoscopy/colonoscopy?

( ) Yes, within the next six months
( ) Yes, but not within the next six months
( ) No, I do not intend to be screened for colon cancer
( ) I'm not sure (do not read)
( ) Refused (do not read)

16. In the past several months, have you seen, heard, or read any colon cancer early warning commercials or ads? (do not read)

( ) Yes
( ) No → Skip to Q23
( ) Don't Know
( ) Refused

17. Where did you see, hear, or read the commercials or ads? (Do not read; Multiple response).

( ) TV
( ) Radio
( ) Newspaper
( ) Magazine
( ) Internet

( ) Other

(If "TV" not checked, skip to Q23)

18. Thinking about the TV ad for colon cancer than you saw, do you recall the sponsor of the ad?

( ) Yes
( ) No → SKIP TO Q20
( ) Unsure

19. Who was the sponsor?

---

20. Please tell me anything you can remember about the TV ad for colon cancer (Unaided, Do not read)(Multiple Responses)

MCCCP Ads:

Joan Benoit
[ ] Joan Benoit
[ ] Marathon runner
[ ] Screening is a jog in the park

Tim Sample
[ ] Tim Sample
[ ] Humorist/Cartoonist/Writer
[ ] Colonoscopy is like a Maine winter – not the most pleasant thing but you'll survive

American Cancer Society Ads:

[ ] Man at the diner/restaurant talking to the women
[ ] Shows how a colonoscopy works using his mash potatoes and peas

CDC Ads

[ ] Jimmy Smits (actor)
[ ] A movie/show screening is not real life – do the real screening test
[ ] Stick around and enjoy the show

More General
[ ] If you are 50 years or older get tested/screened
[ ] Medicare helps pay
[ ] Colorectal cancer is the 2nd leading cancer killer of men and women
[ ] Screening can help find and prevent colon cancer

[ ] Other mentions

---

21. What was the main message of the ad and/or what did it ask you to do? (Probe for details. Prompt: Did the main message say anything else?) (Unaided) (Multiple Responses)

    [ ] Getting tested can find colon polyps that can be removed
    [ ] Colon polyps can turn into colon cancer if untreated
    [ ] Colon cancer is preventable with early detection
    [ ] Colon cancer is a leading killer/leading killer of both men and women
    [ ] Get tested/screened if you're over fifty
    [ ] Getting tested can find colon cancer in an early stage when it is treatable.
    [ ] Colon cancer is treatable
    [ ] The most common symptom of colon cancer is no symptom
    [ ] Medicare will help pay for testing
    [ ] Talk to your doctor
    [ ] Colon cancer affects both men and women
    [ ] Colonoscopies are important
    [ ] Colonoscopies might not be pleasant
    [ ] Stick around for the show by getting screened
    [ ] Other____
    [ ] Don't know/not sure
    [ ] Refused

22. After seeing these ads, how does it change your likelihood to be screened for colon cancer in the future? Would you say that…(read choices):

    ( ) I am much more likely to be screened
    ( ) I am somewhat more likely to be screened
    ( ) I am somewhat less likely to be screened
    ( ) I am much less likely to be screened
    ( ) The ads did not change my opinion about colon cancer screening
    ( ) Don't know (don't read)
    ( ) Refused (don't read)

Those are all of the health questions that I have. Finally, I have a few questions to allow us to group your responses with other individuals like yourself.

23. In which of the following age groups do you belong? [READ LIST]

    ( ) 50-55
    ( ) 56-60
    ( ) 61-65
    ( ) 66-70
    ( )] 71-75
    ( ) 76 and older

24. What is your marital status? [READ LIST]

    ( ) Married
    ( ) Single
    ( ) Partnered
    ( ) Divorced/Separated
    ( ) Widowed

25. What is the highest grade or year of school you completed?

( ) Never attended school or only attended kindergarten
- ( ) Grades 1 through 8 (elementary school)
- ( ) Grades 9 through 11 (some high school)
- ( ) Grade 12 or GED (high school graduate)

( ) Some College
- ( ) College Graduate (4 year)

( ) Some Post Graduate work
- ( ) Post Graduate Degree (e.g. masters, doctorate, Ph.D)

26. Are you currently…?

- ( ) Employed for wages
- ( ) Self-employed
- ( ) Out of work for more than 1 year
- ( ) Out of work for less than 1 year
- ( ) A homemaker
- ( ) A student
- ( ) Retired
- ( ) Unable to work
- ( ) Refused (do not read)

27. Which of the following best describes your race or ethnic background? **[READ LIST]**

- ( ) White or Caucasian
- ( ) Black, African American
- ( ) Hispanic, Latino
- ( ) Native American or Alaska Native
- ( ) Asian
- ( ) Other (Please Specify) [Text Box]

28. Please stop me when I read the category that includes your total annual household income.

- ( ) Less than $15,000
- ( ) $15,000 -- $24,999
- ( ) $25,000 -- $49,999
- ( ) $50,000 -- $74,999
- ( ) $75,000 -- $99,999
- ( ) $100,000 or more

29. Finally, what is your zip code? [INTERVIEWER NOTE: IF RESPONDENT WILL NOT PROVIDE THEIR ZIP CODE, WRITE IN ZIP CODE FROM LIST IF AVAILABLE.]

____

30. (Interviewer record gender): ( ) Male ( ) Female

Thank you very much for your time.

Appendix C

Elementary Schools Sun Safety Mini-Grants: Final Report

Mini-Grants to Support Skin Cancer Prevention in Schools
Final Report

Directions:

Please take a few minutes to answer the following questions. This Final Report takes the place of the Final Report that was included in your grant application. Your responses will help us to evaluate your efforts and the collective efforts of the mini-grant initiative. **Please submit your Final Report on or before July 27, 2007. You may mail or fax it to**: Ruth Dufresne, MS; Evaluation Consultant; Maine Center for Public Health; One Weston Court, Suite 109; Augusta, ME 04330; Fax: 207-629-9277.

Questions:

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

   ___ Yes   ___ No →

   > What is your anticipated completion date? ___________________
   > May we contact you after this date? ___ Yes ___ No
   >
   > ---------------- Please stop here ------------------

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

   ____
   ____
   ____
   ____
   ____

3. How was your mini-grant funding used?

   ____
   ____
   ____
   ____
   ____

   a. What percent of the funds went to the following:
      - Purchase of shade structures (or materials for shade structures) = _____ %
      - Purchase of sun safety education program materials = _____ %

- Sponsor special event day(s) = _____ %
- Develop educational materials for students, faculty, staff = _____ %
- Other__________________________ _________%

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

5. Does your school currently have, or are you developing, sun protection guidelines?
___ Yes ___ No (skip to question #6)

   a. If yes, were these guidelines developed as a result of the mini-grant?
   ___ Yes ___ No

   b. If yes, what are your guidelines? (Note: Please include a copy with the returned report)
   ____
   ____
   ____
   ____
   ____

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

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

8. What was the anticipated impact of your efforts?

   a. Did you achieve this impact? Why or why not?

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

Thank You!