Maine Comprehensive Cancer Control Program

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

Prepared by:

Amy N. Black, PhD
Research Associate
Maine Center for Public Health
One Weston Court, suite 109
Augusta, ME 04330
207-629-9272 ext 207
ablack@mcph.org

Table of Contents

List of Tables

List of Figures

Executive Summary

Background

The Maine Center for Disease Control and Prevention, Department of Human Services contracted with the Maine Center for Public Health to develop an evaluation plan for the Comprehensive Cancer Control Program. This evaluation plan is consistent with the framework developed by the U.S. Centers for Disease Control and Prevention.

Purpose

This plan is intended to serve as a guide for conducting Maine's Comprehensive Cancer Control program evaluation. It is not intended to be rigid or prescriptive. On the contrary, this plan supports an evolving and participatory approach that allows flexibility for responding to emerging needs or particular contextual circumstances. The plan has been designed to engage stakeholders and encourage participation throughout the evaluation process.

Audience

This plan is intended for a broad audience of governmental and nongovernmental stakeholders including:

- Comprehensive Cancer Control program managers and staff
- Maine Cancer Consortium members and partners
- Others interested in comprehensive cancer control efforts

Components

The evaluation plan provides background and introductory information about the burden of cancer. In addition, it incorporates a description of Maine's Comprehensive Cancer Control initiative including information about the Maine Cancer Consortium and the Maine Cancer Plan.

This document places particular emphasis on the evaluation approach and design. The plan proposes evaluation questions, data collection strategies, and specific activities that should be addressed during each of the phases or components of the evaluation. For the purpose of this program, the evaluation has been segmented into three components that will be used to assess the:

1. Process and implementation of activities
2. Contextual factors
3. Outcomes

Background and Context

The Maine Center for Disease Control and Prevention (ME-CDC), Department of Health and Human Services contracted with the Maine Center for Public Health (MCPH) to develop an evaluation plan for the Comprehensive Cancer Control (CCC) Program. This plan focuses on the evaluation of select goals and objectives identified as a priority by the CCC Program and the Maine Cancer Consortium, hereafter referred to as the "Consortium." The purpose of this evaluation is to track progress in achieving these cancer-related goals and objectives. In addition to evaluating the short- and long-tem results of the program and components of Maine's Comprehensive Cancer Control Plan, this evaluation also seeks to examine the environment in which the program operates and the processes involved in the program's development. For example, a crucial element of the evaluation is examining the effectiveness of the Consortium.

The intended audience for this plan includes:

- CCC managers and program staff
- Consortium members and partners
- Others interested in supporting CCC efforts

Guiding Principles of the Evaluation Plan

The Maine Center for Public Health places a high value on evaluation efforts. MCPH recognizes that well-designed program evaluations have the ability to reduce uncertainties, improve effectiveness, and ultimately influence programmatic and policy decisions. The guiding principles of this evaluation are addressed below.

Strengthen the Initiative
Our charge is to design a high-quality, practical and effective evaluation plan. The intent is to gather reliable and valid information that can be used to track progress and improve the program.

Support Flexibility
MCPH recognizes that there is more than one way to do evaluation. Our evaluation plan is not intended to be rigid or prescriptive. On the contrary, this plan supports an evolving and participatory approach that allows flexibility for responding to emerging needs or particular contextual (i.e.: resources, politics) circumstances.

Develop a Participatory Approach
MCPH encourages all program stakeholders to participate in the evaluation process. Experts agree that the best evaluations are based on multiple perspectives and broad representation. This approach is consistent with the evaluation framework developed by the Centers for Disease Control and Prevention.

Build and Enhance Capacity

This evaluation process has been designed to encourage stakeholders to play an active role in the evaluation. Technical assistance is an important component of the MECDC-MCPH contract.

Introduction

Comprehensive Cancer Control is defined as an "integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation."[1] This approach integrates a multitude of activities designed to:

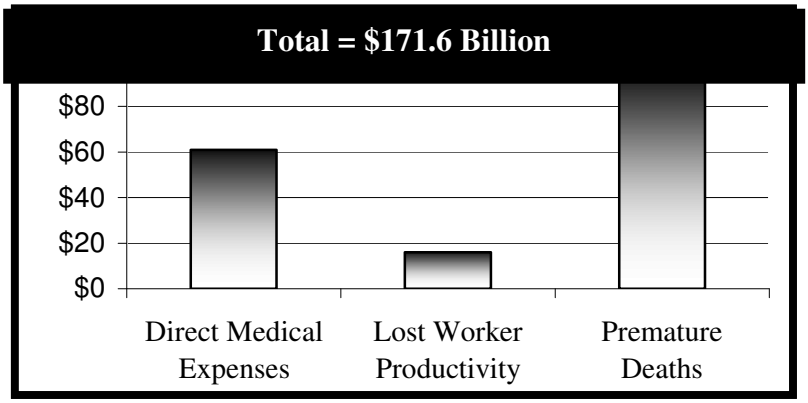
- Enhance coordination
- Maximize limited resources
- Strengthen collaboration
- Improve service delivery
- Increase capacity

According to the Centers for Disease Control and Prevention (CDC), comprehensive cancer control provides a coordinated public health approach. This approach helps to organize, communicate, and integrate a myriad of cancer prevention and control activities leading to less duplication and new opportunities. The framework for comprehensive cancer control involves four phases including: 1) setting optimal objectives; 2) determining possible strategies; 3) planning feasible strategies; and 4) implementing effective strategies. This approach allows states to assess and address the cancer burden through public and private partnerships.

Unfortunately, the burden of cancer is significant in both the United States and Maine where, in the first time in history, it is the leading cause of death[2]. Each day approximately 1,500 U.S. residents die from cancer. One in four deaths in the U.S. is a result of cancer. The American Cancer Society estimates that there will be approximately 1.3 million new cases of cancer diagnosed in the U.S. and 7,300 new cases diagnosed in Maine in 2003.

The economic cost of cancer is high. According to the National Institutes of Health, the overall annual costs for cancer in 2002 exceeded $171.6 billion. Figure 1 depicts the costs for direct medical expenses, lost worker productivity, and premature death.[3] Moreover in 2004, 7,778 hospitalizations occurred in Maine as a result of cancer with direct and indirect costs of cancer totaling nearly $700 million

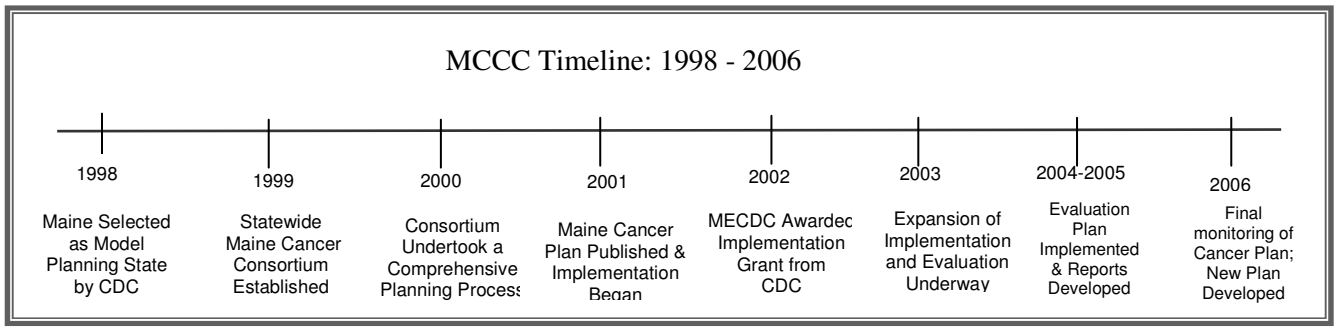
Figure 1. *Annual Cost of Cancer, 2002*



Comprehensive Cancer Control in Maine

The Maine Comprehensive Cancer Control Program is housed within the Division of Chronic Disease at the Maine Center for Disease Control and Prevention (MECDC), Department of Health and Human Services. In 1998, the MECDC was selected, along with five other states, by the Centers for Disease Control and Prevention to serve as a model planning state for comprehensive cancer control. A timeline of select activities and accomplishments over the past six years is depicted below in Figure 2.

Figure 2. *Comprehensive Cancer Control Program Timeline, 1998-2006*



Maine Cancer Consortium

As noted above, the Maine Cancer Consortium was created in 1999. This Consortium includes representatives from public and private organizations involved in all aspects of cancer prevention, control, and care. There are over 70 organizations involved in the Consortium. An organizational chart is provided in Appendix A.

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

1. Increase statewide integration, coordination, and provision of quality prevention, treatment, palliative, and end of life care services in Maine.
2. 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.
3. Increase the proportion of Maine residents who appropriately utilize screening, follow-up, treatment, rehabilitation, survivorship, hospice and palliative care services.
4. 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.
5. Increase support from policy and grant makers for comprehensive cancer control in Maine.

Maine Cancer Plan

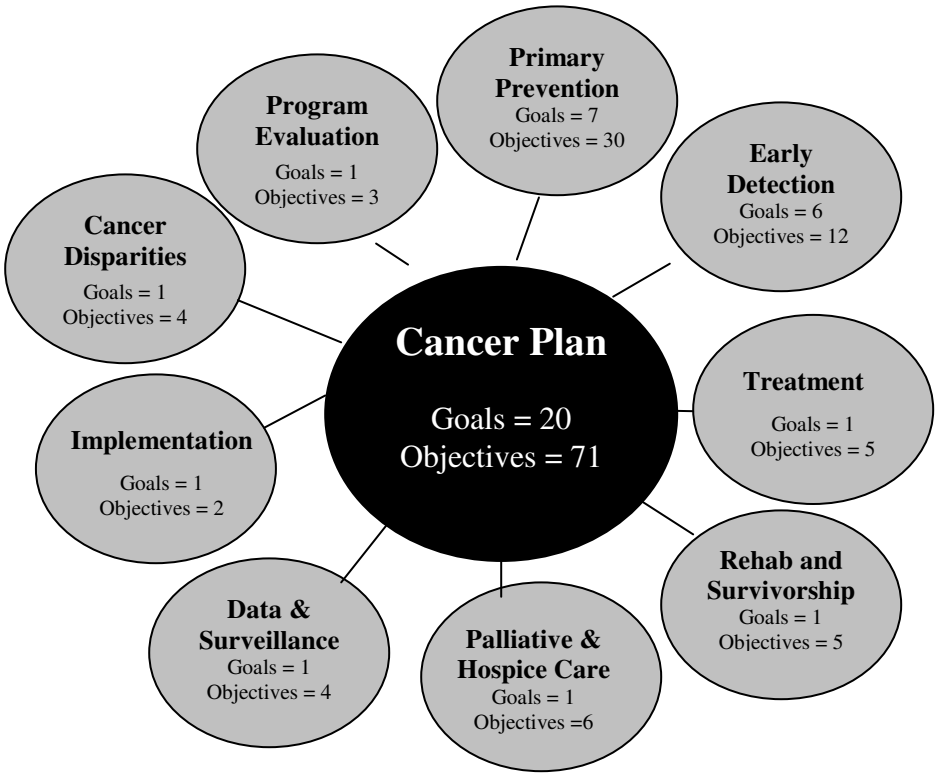
The Consortium worked collaboratively to create the *Maine Cancer Plan*. The purpose of the Plan is to provide a template for what should be done to provide statewide coordination of cancer control efforts in Maine. The components of the Maine Cancer Plan include:

- Cancer Disparities
- Prevention
- Detection
- Treatment
- Rehabilitation/Survivorship
- Palliation and Hospice Care
- Evaluation
- Data and Surveillance
- Implementation

Goals and Objectives

There are approximately 20 goals, 71 objectives and hundreds of strategies identified in Maine's Cancer Plan (see Figure 3). This evaluation plan focuses on all measurable goals and objectives identified in the statewide Cancer Plan.

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



Evaluation Approach

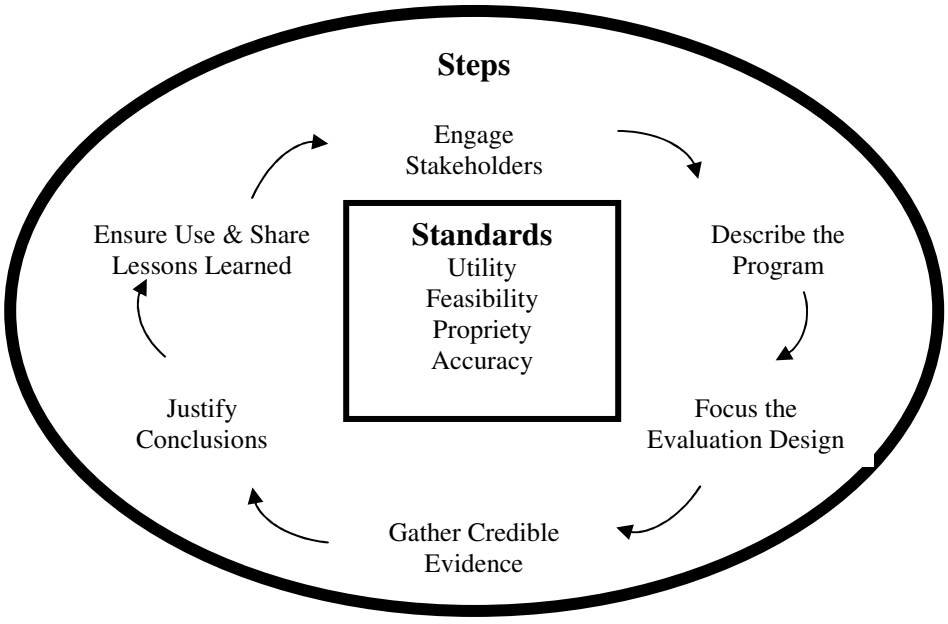
The definition used for this evaluation is based on one proposed by Michael Quinn Patton in *Practical Evaluation* (1982):[4]

> The practice of evaluation involves the systematic collection of information about the activities, characteristics and outcomes of programs, personnel, and products for use by specific people to reduce uncertainties, improve effectiveness and make decision with regard to what those programs, personnel, or products are doing and affecting.

Evaluation Framework

This plan is consistent with the proposed framework developed by the Centers for Disease Control and Prevention.[5] The framework is composed of six steps that should be taken in any public health program evaluation. In addition, the model includes a set of standards that can be used to assess the quality of evaluation activities. These standards have been adopted by the Joint Committee on Standards for Educational Evaluation. The figure below depicts the essential components of this framework.

Figure 4. *Framework for Program Evaluation in Public Health*



This evaluation has been designed to address the six major components. The processes and activities used to address each component are embedded in this plan and described in more detail below. It is important to recognize that the steps are interdependent and in some instances, they may be presented in a nonlinear process.

Step 1: Engaging stakeholders

Engaging stakeholders is the first step to any effective evaluation. The evaluation of the CCC program is conducted using a participatory framework through which the intended users of the evaluation (e.g., CCC program) are involved in all aspects of the evaluation – from planning to dissemination of results. Specifically, stakeholders have been involved in developing the program's logic models, establishing evaluation questions and priorities, developing evaluation tools, and interpreting data. Finally, the CCC program and evaluator worked collaboratively on the development of this evaluation plan and will continue to collaborate on all aspects of the evaluation.

Step 2: Describe the Program

Successful evaluation necessitates an accurate, detailed and measurable description of the program. The MCCCP staff is continuously engaged in conversations with the evaluator for the purpose of describing the program and its activities. Other sources of information describing the program or aspects thereof include previous evaluation reports, documents and materials from the Centers for Disease Control and Prevention, and conversations with other key partners. This information has been integrated into current reports and is reflected in the various logic models, program descriptions and selected indicators outlined in this plan.

Step 3: Focus the Evaluation Design

The use of both qualitative and quantitative measures will be used in this evaluation. At the program component and activity-level, both methods will be used when appropriate for the process and outcome evaluation. Methods will be decided through a participatory process involving the evaluator and key stakeholders. Finally, surveillance data will be used to track intermediate (e.g., behavioral) and long-term (e.g., mortality and morbidity) outcomes. These outcomes will be based on the *Maine Comprehensive Cancer Plan.* Additional outcomes will be tracked through collaboration with a chronic disease epidemiologist and aligned with the CCC surveillance plan.

The CCC logic models depict the proposed link between the program component outcomes and the overall long-term health outcomes. In an effort to support such linkage, program component outcomes will be assessed each year through a targeted evaluation of a specific intervention. The design of these targeted evaluations will comprise of experimental and quasi-experimental methods.

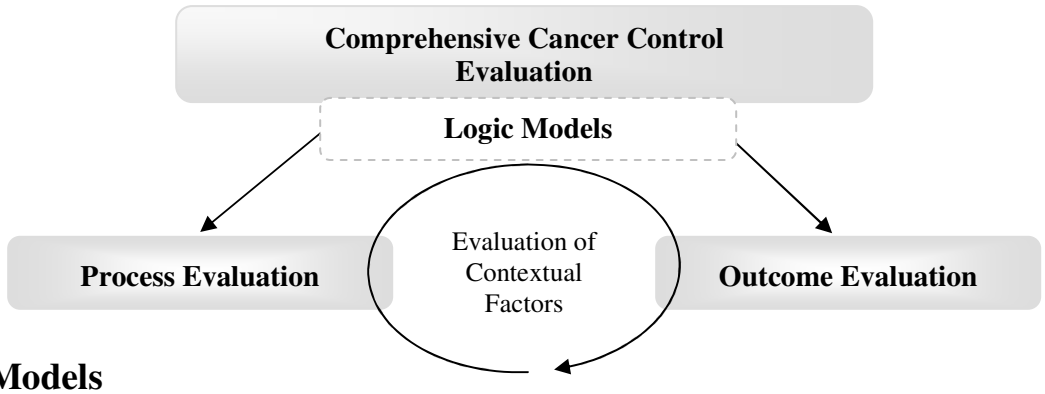
Steps 4, 5, and 6: Gather Credible Evidence, Justify Conclusions, Ensure Use and Share Lessons Learned

The methods for data collection, management and analysis are included in the evaluation plan and address step 4. Planning for reflection and strategic redirection is recommended as part of implementing this evaluation plan, and addresses step 5. Step 6 is addressed in the subsection on dissemination and utilization of evaluation findings. A crucial element of the evaluation is to ensure use of the evaluation findings in order to improve program planning, activities and policies. Finally, one pragmatic purpose for engaging in a participatory process is the intent to increase use.

Evaluation Design

This section details the proposed methods for evaluating: 1) the context of the program; 2) the implementation or process; and 3) the outcomes. If used together, these three components can improve the program's effectiveness and promote future sustainability.[4] This section also provides information on logic models, a tool that has been incorporated into the design in an attempt to facilitate the evaluation process. The overarching structure of the evaluation design is depicted in Figure 5.

Figure 5. *Comprehensive Cancer Control Evaluation Design*



Logic Models

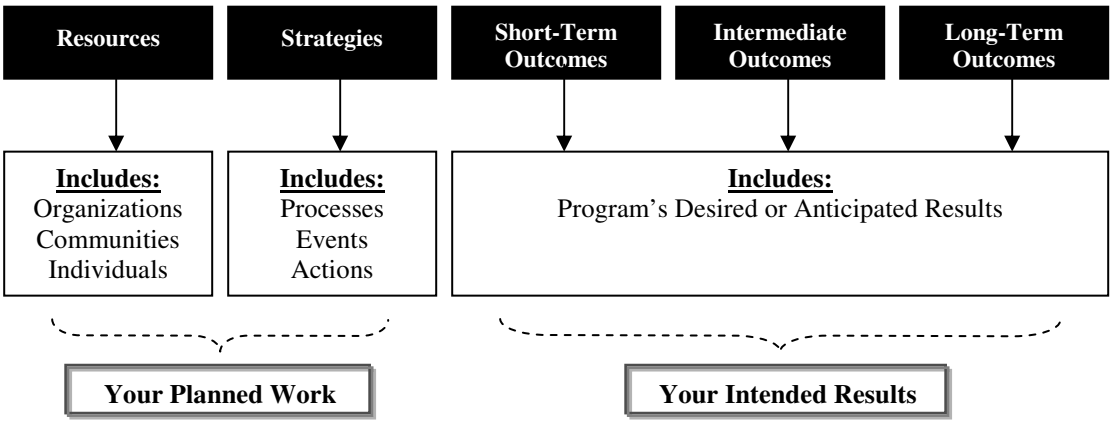
A logic model is a systematic way to visually depict a program including the resources, activities, and intended changes or results.[6] The basic logic model components are depicted in Figure 6 on the following page. The literature suggests that developing logic models can help build ownership of the program and the evaluation. In addition, taking time to develop a logic model helps to explicitly identify the intended outcomes and makes evaluation more feasible and effective. Finally, a logic model can:

- Increase awareness of program components, activities, and anticipated outcomes
- Serve as an evaluation framework and can be used as a management/ learning tool
- Promote communication and enhance participation in the evaluation process
- Help to prevent over-promising and can help identify the limits of a program

This evaluation design incorporates the use of several logic models, created during the first phase of implementation in 2003. The Consortium Board of Directors recommended the development of a logic model for each program component as well as the Consortium. In addition, a logic model was developed specifically for the overarching Comprehensive Cancer Control Program.

As they are based on the previous Cancer Plan, the program component logic models are not included in this plan. Upon the completion of the Consortium work plans, the logic models may be revised to reflect the current work of the workgroups. The logic models for the CCC Program and the Consortium are included in Appendix B.

Figure 6. *Basic Logic Model Components*



Process Evaluation

This component of the evaluation focuses on the implementation of activities and strategies designed to bring about changes that are directly linked to program goals. Process evaluation examines the extent to which implementation has taken place, the people being served and the degree to which the program operates as expected (Posavac & Carey, 1997). As many program managers well know, the implementation process can often be challenging due to contextual issues, organizational dynamics, and programmatic uncertainties. Often, programs need to be fine-tuned and this part of the evaluation provides valuable information that can be used to make improvements along the way (Valente, 2002).

Proposed Evaluation Questions

Typical questions that are addressed by this component of the evaluation process include:

- Which initial strategies or activities are being implemented?
  - Which of these strategies *are* successfully implemented and why?
  - Which of these strategies *are not* successfully implemented and why?
- Which initial strategies or activities are not being implemented and why?
  - Are there specific strategies or activities that have been revised or disregarded?
  - What are the potential barriers?
  - What can be done to overcome the barriers?
- What lessons have been learned during the initial implementation phase?
  - What has been done but did not work?
  - How can these lessons be incorporated into the existing plan?

Data Collection

An activity monitoring tool, used during the evaluation of the first Cancer Plan, has been developed to track progress and aid in the collection of implementation information. Through a participatory process involving Consortium members and MCCCP staff, the tool has been revised to reflect all of the goals and objectives as outlined in the new Cancer Plan. A copy of this monitoring tool and an example of how it is completed is available in Appendix C. This

monitoring tool provides a systematic approach and efficient method for gathering information about specific strategies. It also allows stakeholders to participate in the process.

The tool is intended to be completed by program stakeholders and work group members at consistent points throughout the implementation phase (e.g., six months and 12 months). These groups will also decide on the process through which it will be completed. The tool has been divided into ten areas based on the Maine Comprehensive Cancer Plan. This information will be compiled and analyzed by the Comprehensive Cancer Control Program staff and program evaluator. The data analysis will include frequencies and the coding of qualitative data based on themes that arise. Finally, in an effort to increase usability and accessibility, this tool may be adapted to create an on-line tool or database

Timeline and Activities

The proposed timeline for completing the process evaluation activities is detailed in Table 1. The timeline begins at the end of the 2006 to reflect work already completed. These activities are based on an ongoing participatory process to be completed throughout the project period.

Table 1. *Process Evaluation Timeline (2006-2010)*

Activity	Six-month period								Responsible Party
	7 /06 - 12/06	1/07 - 6/07	7 /07 - 12/07	1/08 - 6/08	7 /08 - 12/08	1/09 - 6/09	7/09 - 12/09	1/10 - 6/10	
Reach consensus on process evaluation questions and activities, including program-sponsored initiatives	X		X		X		X		Program Evaluator CCC Program Staff Board of Directors
Solicit feedback on data collection strategies and activity monitoring tool	X		X		X		X		Program Evaluator CCC Program Staff Consortium Members
If appropriate, revise activity monitoring tool to reflect stakeholder needs and feedback	X		X		X		X		Program Evaluator
Develop a process for routinely completing the activity monitoring tool	X		X		X		X	X	Cancer Work Groups CCC Program Staff
Complete the activity monitoring tool on routine basis		X		X		X		X	Consortium Members CCC Program Staff Program Evaluator
Enter and analyze data in timely fashion	X	X	X	X	X	X	X	X	CCC Program Staff Program Evaluator
Summarize all results, limitations, and lessons learned in annual evaluation report		X		X		X		X	CCC Program Staff Program Evaluator
Provide feedback on evaluation results	X	X	X	X	X	X	X	X	Program Evaluator
Develop strategies and timeline for disseminating the annual findings	X		X		X		X		CCC Program Staff Program Evaluator
Disseminate the findings	X		X		X		X		CCC Program Staff Program Evaluator Workgroup Chairs

Evaluation of Contextual Factors

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. This component of the process evaluation will answer several broad questions agreed upon by stakeholders. Example questions are identified below.

Proposed Evaluation Questions

- What resources (e.g., funding, staffing, expertise, organizational support) are available and how are these resources used?
- What external factors (e.g., environment, social, economic, political) can be identified as having been strengths or barriers to the CCC initiative?
- What internal factors can be identified as having been strengths or barriers to the CCC initiative?

- How does partnership functioning (e.g., partner involvement, leadership, efficiency, administration and management, sufficiency of resources) and partnership synergy influence the program's effectiveness?

Data Collection

Once the evaluation questions have been agreed upon by stakeholders, a survey will be designed to collect this information. This survey will include the *Partnership Self-Assessment Tool* designed by the New York Academy of Medicine. The evaluator will collaborate with the CCC program staff and other stakeholders to identify the most appropriate vehicle and setting for survey administration. Depending on resources, staff, and time constraints, additional in-depth information may also be collected via focus groups to complement the survey information.

Timeline and Activities

Table 2 provides a list of activities that have been proposed in order to conduct the contextual component of the evaluation. While the program evaluator will take the lead on these responsibilities, the process is participatory and necessitates input from multiple groups and stakeholders.

Table 2. *Contextual Evaluation Timeline (2006-2010)*

Activity	Month 2007								Year			Responsible Party
	Jan-Mar	April-June	July	Aug	Sep	Oct	Nov	Dec	2008	2009	2010	
Develop process for reaching consensus on evaluation questions				X								Program Evaluator CCC Program Staff
Reach consensus on "context " evaluation questions				X								Program Evaluator Board of Directors Data Work Group
Develop process for collecting contextual information on routine basis throughout project period				X	X							Program Evaluator CCC Program Staff
Collect, analyze, report information on routine basis throughout project period, as appropriate				X	X	X	X	X	X	X	X	Program Evaluator CCC Program Staff
Revise *Partnership Self-Assessment Tool* for use with Consortium, if appropriate	X					X						CCC Program Staff Board of Directors Program Evaluator
Develop process for administering the survey	X						X					CCC Program Staff Data Work Group Board of Directors
Administer the survey	X						X		X	X	X	Program Evaluator CCC Program Staff
Enter data and analyze the findings of the survey; compare with previous findings	X							X				Program Evaluator CCC Program Staff Data Work Group
Determine feasibility and necessity of collecting additional in-depth information								X	X			Program Evaluator CCC Program Staff Data Work Group
Summarize survey results, limitations, and lessons learned (include in annual evaluation report)		X						X	X	X	X	Program Evaluator CCC Program Staff
Develop strategies and timeline for disseminating the findings			X						X	X	X	CCC Program Staff Program Evaluator Consortium Board
Disseminate the findings				X					X	X	X	CCC Program Staff Program Evaluator Consortium (?)

Outcome Evaluation

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. For example, it can help to:

- Determine outcomes
- Demonstrate effectiveness
- Answer program questions
- Elucidate program strengths
- Expose program weaknesses

Proposed Evaluation Questions

Typically, there are two sets of questions that are addressed by the outcome component of the evaluation process. The first set of questions can be addressed during the initial phase using the logic model as a guide. The second set of questions is often dealt with as the program is fully established and implemented. These questions are frequently data driven and include lessons learned throughout the project period.

Initial Outcome Questions:

- What are the important initial, intermediate, and long-term outcomes we are trying to achieve?
    - What are our measures of success?
    - How do we know when we have achieved the expected outcomes?

Summary Outcome Questions:

- What impact is the program having on the intended audiences?
    - Have we achieved our program objectives?
    - Have we achieved our initial, intermediate, and long-term outcomes?
    - What, if any, unanticipated impact has the program had?
- How effective was the program and its sponsored initiatives?
    - What works, for whom, and why?
    - What improvements, if any, can be made?

Data Collection

The data collection techniques utilized in this component of the evaluation will be multifaceted. For example, surveillance data from sources such as the Behavioral Risk Factor Surveillance System and Maine Cancer Registry will be used to track intermediate (e.g., behavioral) and long-term (e.g., mortality and morbidity) outcomes. Additional outcomes will be tracked through collaboration with a chronic disease epidemiologist and aligned with the CCC surveillance plan.

The Data Work Group has been working collaboratively with the Maine Cancer Consortium to identify data gaps and needs, specifically in the area of cancer disparities. This work group will take the lead on determining appropriate and available data sources, and when necessary, assisting in the development of new sources that are both reliable and valid.

In an effort to examine the linkages between activities and outcomes, program component outcomes will be assessed each year through a targeted evaluation of a specific intervention. The design of these targeted evaluations will comprise of experimental and quasi-experimental methods.

The anticipated initial, intermediate, and long-term outcomes for the program and each of its components are outlined in the Maine Comprehensive Cancer Control Plan and will be tracked and reported annually (see Appendix D). Additional outcomes will include:

- Initial and long-term outcomes related to specific program initiatives
- Select indicators provided by the Centers for Disease Control and Prevention, National Cancer Prevention and Control Program

A table of long-term outcomes as of January 2008 is included in Appendix D.

Timeline and Activities

The proposed timeline for completing the "outcome evaluation" activities is detailed in Table 3. As with the contextual and implementation components, these activities are based on an ongoing participatory process.

Table 3. *Outcome Evaluation Timeline (2007 - 2010)*

Activity	Six Month Period (2007 - 2010)							Responsible Party
	1 /07 - 6 /07	7 /07 - 12 /07	1 /08 - 6 /08	7 /08 - 12 /08	1 /09 - 6 /09	7 /09 - 12 /09	1/10 - 6/10	
Reach consensus on "outcome" evaluation questions; outcomes to be tracked (re-assess annually)		X		X		X		Program Evaluator CCC Program Staff Data Workgroup Consortium Workgroups
Identify data gaps, needs, resources, and potential sources of information/data		X		X		X		Data Work Group Cancer Work Groups
Develop and implement strategies for addressing data gaps and needs		X		X		X		Program Evaluator Consortium Members
Develop initial, intermediate, and long-term outcome measures (data driven, if possible) that signify success		X		X		X		Program Evaluator Data Work Group Consortium Members
Include evaluation plan/design for specific program initiatives, including assessing outcomes of intervention			X		X		X	CCC Program Staff Program Evaluator Data Work Group
Create measures, tools, etc for outcome evaluation; recruit participants, design implementation			X		X		X	Program Evaluator Epidemiologist
Review and solicit feedback on outcome measures, tools, etc (ongoing activity)			X	X	X	X	X	Cancer Work Groups Consortium Members
Revise outcome measures based on feedback, if appropriate (ongoing)			X	X	X	X	X	Program Evaluator
Collect and analyze information to assess objectives and additional outcomes			X		X		X	CCC Program Staff Program Evaluator Data Work Group

Summarize results, limitations, and lessons learned during outcome evaluation process		X		X		X		CCC Program Staff Program Evaluator
Develop strategies and timeline for disseminating the findings		X		X		X		CCC Program Staff Program Evaluator
Disseminate the findings		X		X		X		CCC Program Staff Program Evaluator

Dissemination Activities

Dissemination is the process of communicating program results, evaluation processes, lessons learned, and recommendations to appropriate audiences in a timely and unbiased manner.[6] This process requires planning effective communication strategies including consideration of the timing, style, tone, message source, vehicle, and format of information products.[3]

There are several avenues that can be used to disseminate program evaluation results, each component of this evaluation plan includes an activity designed to address the most appropriate information dissemination strategies. Several examples are provided below. They include: 1) formal evaluation technical reports; 2) community-focused evaluation reports; 3) journal articles; and 4) local, regional, and national presentations.

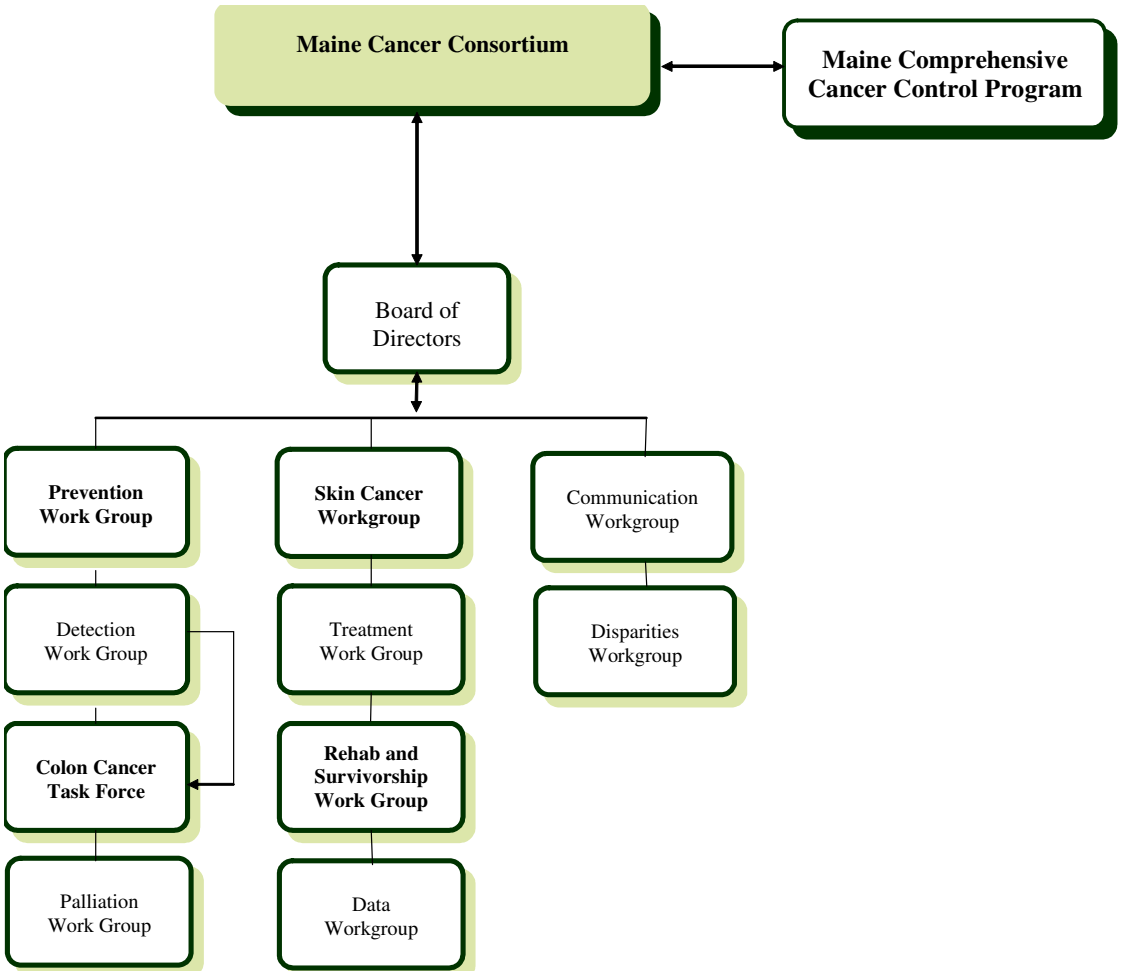
In addition, findings can be disseminated by participating in networks of communities that are struggling with similar issues, and by providing consultation and technical assistance to similar programs.[4]

The Maine Comprehensive Cancer Control Program staff has primary responsibility for disseminating the evaluation results to the appropriate audiences in a timely manner.

Appendix A

Maine Cancer Consortium
Organizational Chart

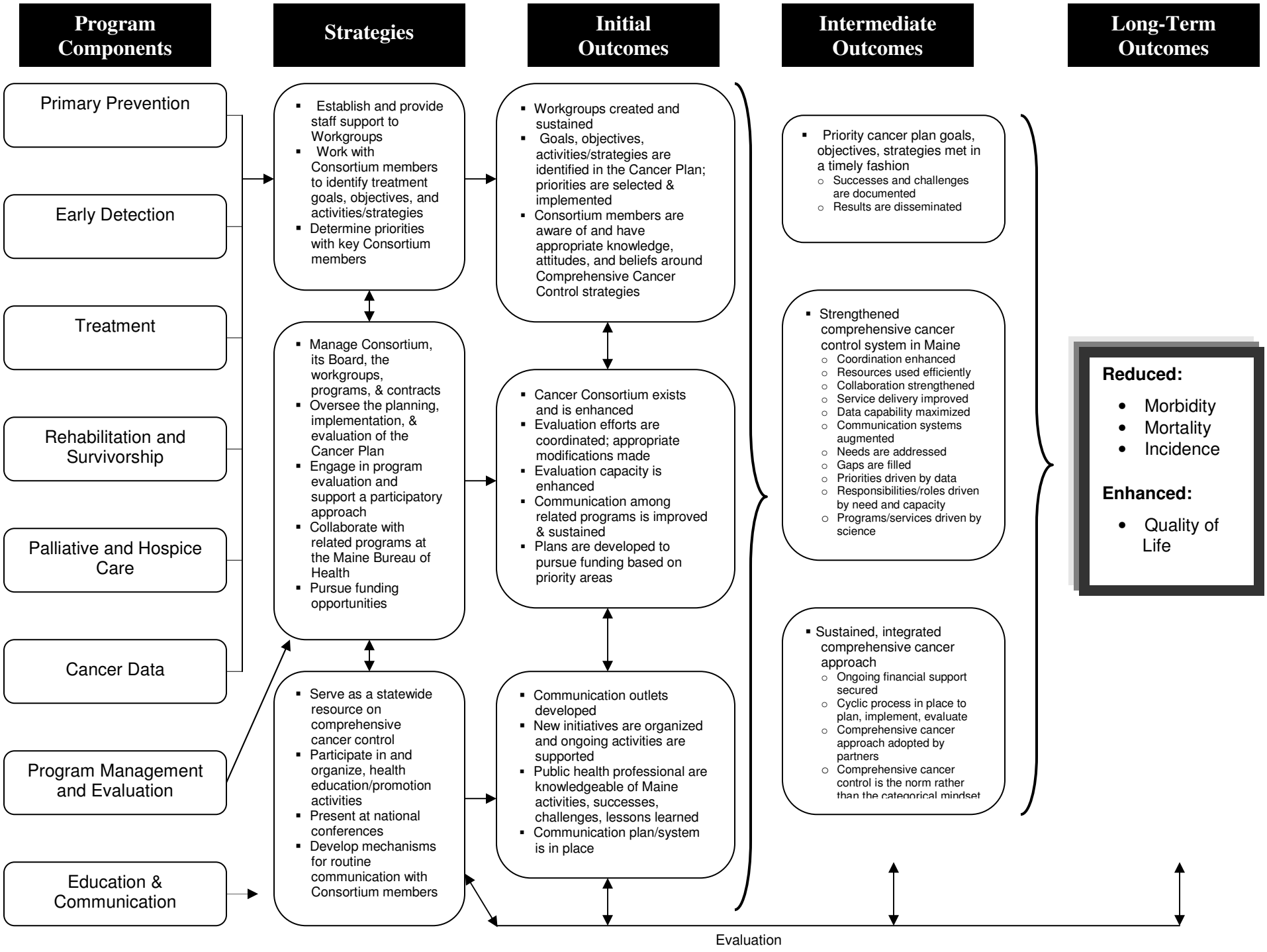
Appendix A. Maine Comprehensive Cancer Control Organizational Chart



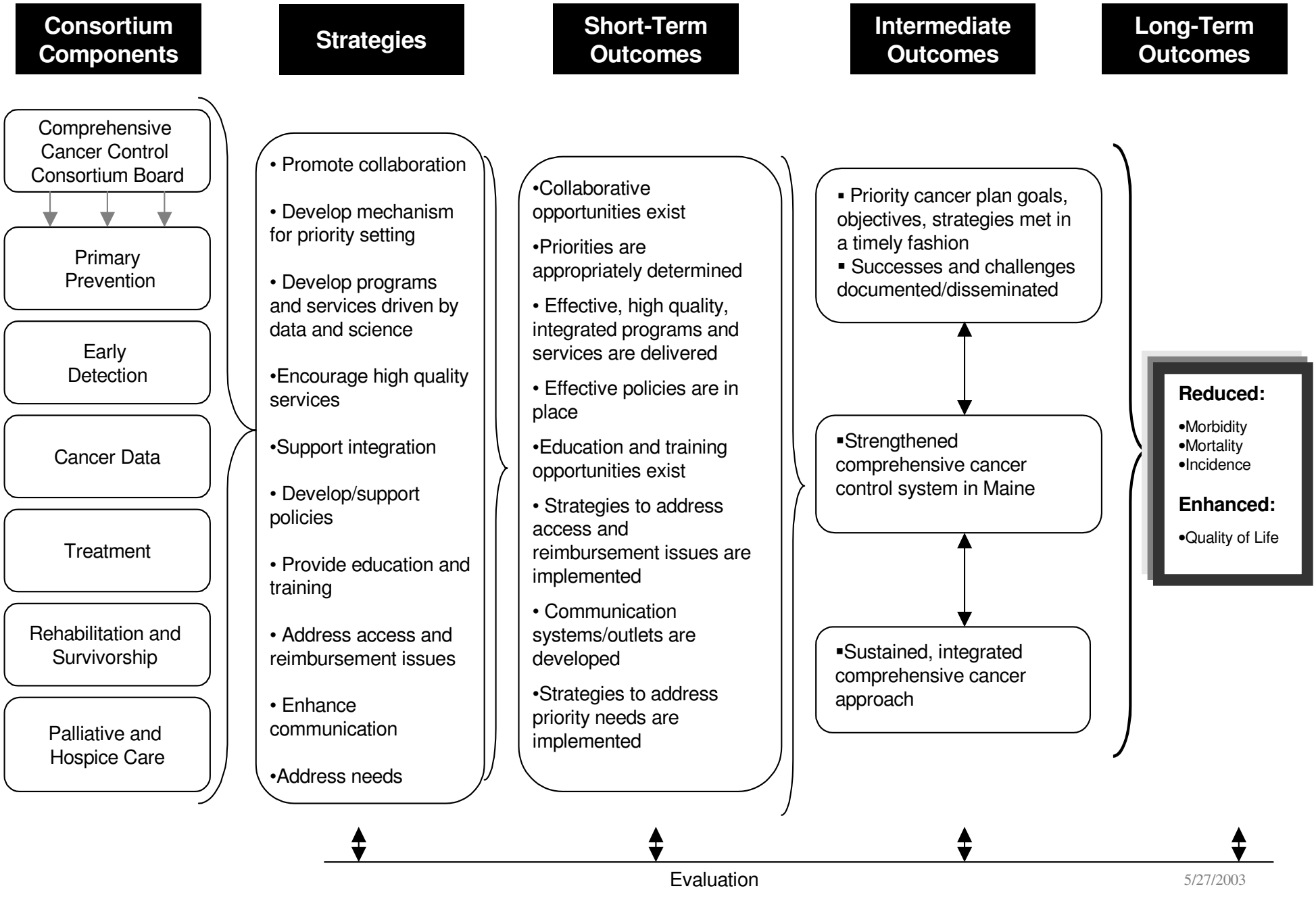
Appendix B

Comprehensive Cancer Control Logic Models

Comprehensive Cancer Control Program



Maine Comprehensive Cancer Control Consortium Logic Model



Appendix C

Comprehensive Cancer Control Activity-Monitoring Tool

Appendix C. Activity-Monitoring Tool Example

Purpose: This activity monitoring tool has been developed to track progress and aid in the collection of implementation information. The tool tracks level of progress (e.g., full achieved, partially achieved) and tracks accomplishments, strengths and challenges related to achieving each objective. This tool provides a systematic approach and efficient method for gathering information about specific strategies through a participatory approach.

Directions: Each CCC program component (e.g., primary prevention, early detection, etc.) should develop a plan for completing the monitoring tool annually based on the goals and objectives outlined in the *Cancer Plan*. This information should be submitted for each strategy to the CCC program staff to be entered into a database at a designated time interval.

Primary Prevention

Goal 1: To reduce the initiation of tobacco use, to increase the numbers who successfully quit using tobacco, and to reduce exposure to secondhand smoke.

Objective/Strategy	Progress							Comments
	Fully Achieved	Partially Achieved	Not Achieved	Not Sure	No Response	Not Pursued	Other	
Objective 1.1 Reduce the proportions of Maine adults aged 18 and older who use tobacco products to 18% by 2010.								
1 Implement and maintain community-based tobacco prevention and control initiatives throughout Maine								
2 Advocate for maximum funding to address tobacco and tobacco-related chronic disease through the Fund for Healthy Maine and other sources.								
3 Promote voluntary policies that reduce exposure to secondhand smoke at home								
4 Determine and promote effective messages and culturally appropriate communication methods regarding smoking and cessation for disparate populations								
5 Increase the availability of cessation for disparate populations								
6 Increase the number of college campuses with 24/7 tobacco-free policies								
Accomplishments (all strategies combined):								
Strengths (all strategies combined):								
Challenges (all strategies combined):								

Objective/Strategy	Progress							Comments
	Fully Achieved	Partially Achieved	Not Achieved	Not Sure	No Response	Not Pursued	Other	
Objective 1.2 Reduce cigarette smoking among pregnant women to 15 percent by 2010.								
1 Increase implementation of health care professional-based education and patient counseling programs for pregnant women.								
2 Advocate for accessible, affordable, and proven cessation programs statewide for pregnant and postpartum women.								
Accomplishments (all strategies combined):								
Strengths (all strategies combined):								
Challenges (all strategies combined):								

Appendix D

Comprehensive Cancer Control Outcome Measures

Primary Prevention: Measurable Objectives	Data Source
Tobacco Use: Adults and Youth	
• Reduce proportion of Maine adults aged 18 and older who use tobacco products to 18% by 2010*	ATS
• Reduce cigarette smoking among pregnant and postpartum women to 15% by 2010 o Pregnant women who smoked during last 3 months of pregnancy o Postpartum women who smoked after pregnancy	PRAMS
• Reduce tobacco use of 9-12th graders to 15% by 2010*	YRBS
• Reduce tobacco use of 6 -8th graders to 5.5% by 2010	YRBS
• To increase the proportion of adults who receive advice to quit smoking from a health care professional by 2010	ATS
• Reduce involuntary exposure to secondhand smoke for all Maine residents o Proportion of Maine adults who report no exposure to secondhand smoke at their workplace o Proportion Maine workplaces that do not allow smoking in any work areas o Proportion of Maine adults who do not allow smoking in their homes	ATS
• *Youth tobacco initiation***	YRBS
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	BRFSS
• Reduce the proportion of adults that are overweight to 35% by 2010	BRFSS
• Reduce the proportion of adults that are obese to 20% by 2010*	BRFSS
• Increase to 80% the proportion of adults who participate in any physical activities in the past month**	BRFSS
• 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	BRFSS
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 20105.	MYRBS
• Reduce the proportion of youth who are overweight to 5% or at risk for being overweight to 10% by 2010	MYRBS
• Reduce the proportion of kindergarten students who are overweight to 5% or at risk for being overweight to 10% by 2010	*Maine Child Health Survey*
• 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**	MYRBS
Sun Safety: Youth	
• 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	MYRBS
Sexual Health Behaviors: Youth	

• Increase abstinence to 60% among sexually active 9-12th graders by 2010.	MYRBS
• Increase condom use at last intercourse to 63% among sexually active 9-12th graders by 2010	MYRBS
Early Detection: Measurable Objectives	
Screening Behavior: Breast Cancer*	
• 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.	BRFSS/ Maine Breast and Cervical Health Program
• 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.	BRFSS/ Maine Breast and Cervical Health Program
Screening Behavior: Cervical Cancer*	
• Increase the proportion of Maine women with a uterine cervix who have ever received a Pap test to 98% by 2010	BRFSS/ Maine Breast and Cervical Health Program
• 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	BRFSS/ Maine Breast and Cervical Health Program
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.	BRFSS
Screening Behavior: Prostate Cancer**	
• *The proportion of med aged 50 and older who have had a PSA in the past year*	BRFSS
Stage at Diagnosis	
• *Incidence of early-stage breast cancer***	Maine Cancer Registry (MCR)
• *Incidence of advanced stage breast cancer***	MCR
• *Incidence of invasive cervical cancer***	MCR
• *Incidence of advanced stage colon cancer***	MCR
Cancer Diagnosis*	
Proportion of Maine women who receive timely breast cancer biopsy	Special study (MCR)

* CDC core indicator
** CDC optional indicator
ATS: Adult Tobacco Survey
PRAMS: Maine Pregnancy Risk Assessment System
MYRBS: Maine Youth Risk Behavioral Surveillance System
BRFSS: Behavioral Risk Factor Surveillance System

Long-Term Outcomes: Reduced Incidence and Mortality Rates		
Incidence	**Data Source**	**Most recent data year**
All cancers	Maine Cancer Registry	2004
Lung cancer		
Colorectal cancer		
Melanoma		
Breast cancer		
Cervical cancer		
Prostate cancer		
Oropharyngeal cancer		
Bladder cancer		
Mortality	**Data Source**	**Most recent data**
All cancers	CDC Wonder	2004
Lung cancer		
Colorectal cancer		
Melanoma		
Breast cancer		
Cervical cancer		
Prostate cancer		
Oropharyngeal cancer		
Bladder cancer		

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