Comprehensive Cancer Control

Evaluation Report:

Maine Comprehensive Cancer Control Program
Maine Cancer Consortium
Maine Cancer Plan

September 2005
Final Report

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Executive Summary

Background

The Maine Bureau of Health, 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

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 Findings

A total of 54 Consortium members completed a partnership survey for a response rate of 26%. Overall, the results suggest that the Consortium has several areas of strength, yet more effort may be needed to increase the partnership's level of synergy in an effort to maximize the collaborative potential of the group.

Additional qualitative information revealed several strengths of the Consortium as well as limitations and challenges. Many of the strengths identified were:

- Vision of the Consortium
- Partners and their commitment
- Support from organizations.

The challenges were consistent with other broad-based statewide initiatives that consist primarily of volunteer members such as lack of time and resource to carry out the work. Lack of communication was also cited as a limitation.

Comprehensive Cancer Control Program Results

A number of notable program accomplishments were identified. For example, the Program has successfully created two staff positions since its inception. The Program has also successfully competed for federal support amounting to over $500,000 annually. Much of this money has been used for implementation and specific comprehensive cancer control activities that support the goals of the Maine Cancer Plan.

The challenges faced by the Program included limited staff time to carry out activities, lack of administrative support, and somewhat limited flexibility in terms of activities due to funding. Issues consistent with working within a bureaucracy were also identified.

Maine Cancer Plan Preliminary Findings

This evaluation report provides information on select goals, objectives, and strategies delineated in the Maine Cancer Plan. A modified *Activity-Monitoring Tool* was developed to track progress, to date, with regard to implementation for all strategies listed in the existing Maine Cancer Plan. Overall, the results suggest that some progress has been achieved for approximately 68% 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 the Consortium's membership.**
    - Identify specific opportunities for individuals to remain involved and actively participate in Consortium efforts.
    - Develop a subgroup to address membership issues. 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.
    - Suggestions:
        - 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.).

2. **Reach consensus on the various functions of the Workgroups, Board, and Program, as well as the role of Consortium members and potential staff.**

   - Develop a guiding document that details the structure, relationship, and agreed upon functions for each Workgroup, the Board of Directors, and the Program for a five-year period.
   - Considerations:
     - Disseminate this document to all members through multiple channels.
     - Modify and/or review the document annually, if appropriate.
     - Ask members to sign a letter indicating their understanding of these functions and their given role. Provide clarity when necessary.

3. **Narrow the Consortium's focus to select priorities.**

   - Maintain an emphasis on a comprehensive approach, yet establish a small number of objectives and accompanying strategies to support in one year. These objectives should be based on a priority setting process. Continue establishing priority objectives to focus on for subsequent years.
   - Considerations:
     - Identify a process for determining priority objectives (e.g., priorities based on criteria established by workgroups, priorities selected at annual meeting).
     - Develop an annual Consortium workplan with measurable objectives. This workplan should be used as the basis for workgroup activities.
     - Monitor the workplan and provide updates at Workgroup and Board meetings.

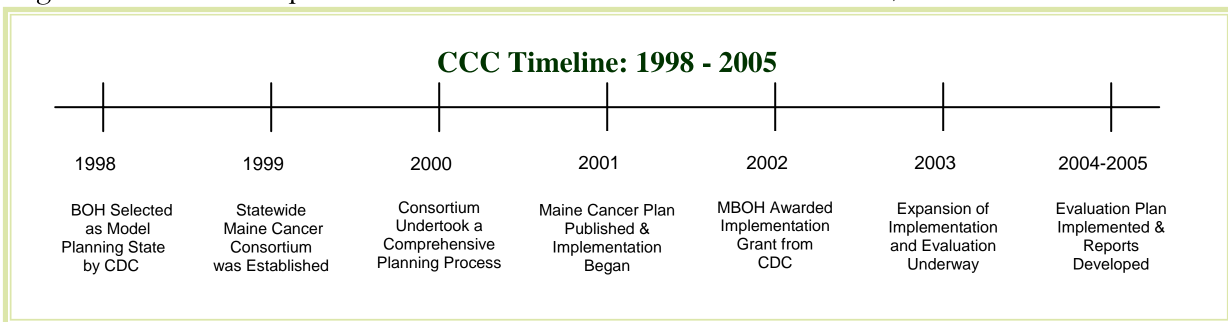
4. **Enhance communication.**

   - Develop, implement, and evaluate routine mechanisms for communicating with members.
   - Showcase, celebrate, and publicize accomplishments among Consortium members and others.
   - Utilize partner expertise to support and organize a public relations campaign for the launch of the new Maine Cancer Plan.

BACKGROUND

The Maine Bureau of Health (BOH), Department of Health and Human Services 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 second phase of the evaluation otherwise known as implementation of the plan. Figure 1 depicts the timeline.

Figure 1. Maine Comprehensive Cancer Control Initiative Timeline, 1998-2005



As depicted in the figure above, the actual implementation of the Maine Cancer Plan has been underway since 2001. This report attempts to capture activities, successes, and challenges that have occurred, to date, related to three major areas of the initiative. They include: 1) the Maine Comprehensive Cancer Control Program housed within the Maine Bureau of Health; 2) the Maine Cancer Consortium; and 3) the Maine Cancer Plan. These three areas complement one another and many of the activities overlap.

Maine Comprehensive Cancer Control Program

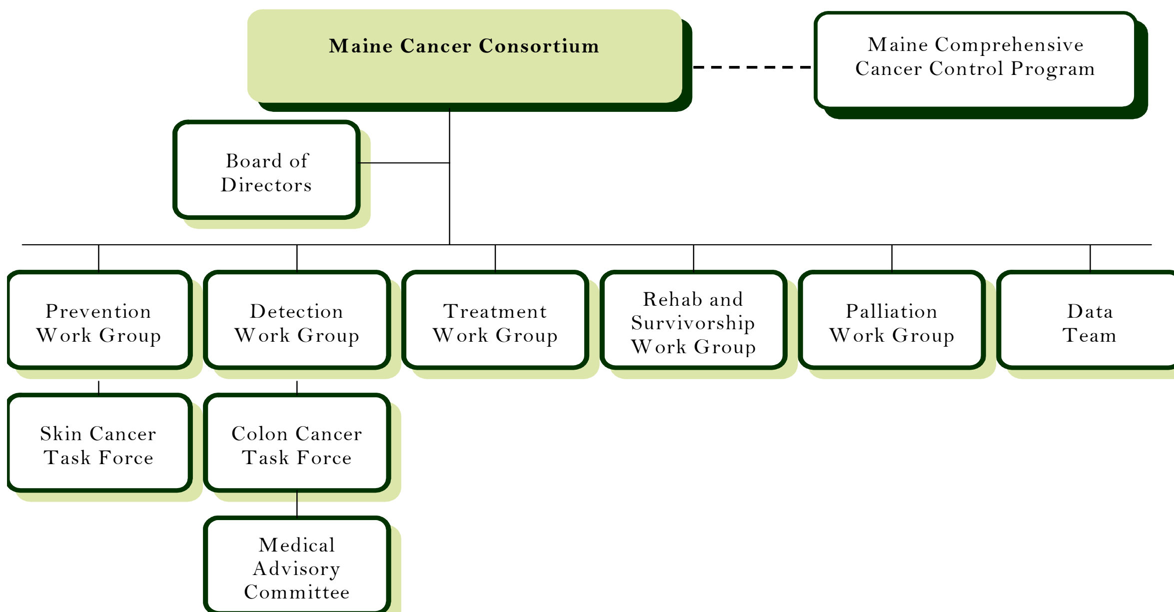
The Comprehensive Cancer Control (CCC) Program is a state-run program funded by the Centers for Disease Control and Prevention. The program provides leadership for, and coordination of, Maine's statewide comprehensive cancer control efforts and is guided by the goals and objectives delineated in the 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). 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 70 organizations involved in the Consortium. An organizational chart is provided below. Currently, all of the Workgroups are active with the exception of Treatment and the Medical Advisory Committee.

Figure 2. Maine Cancer Consortium Organizational Chart



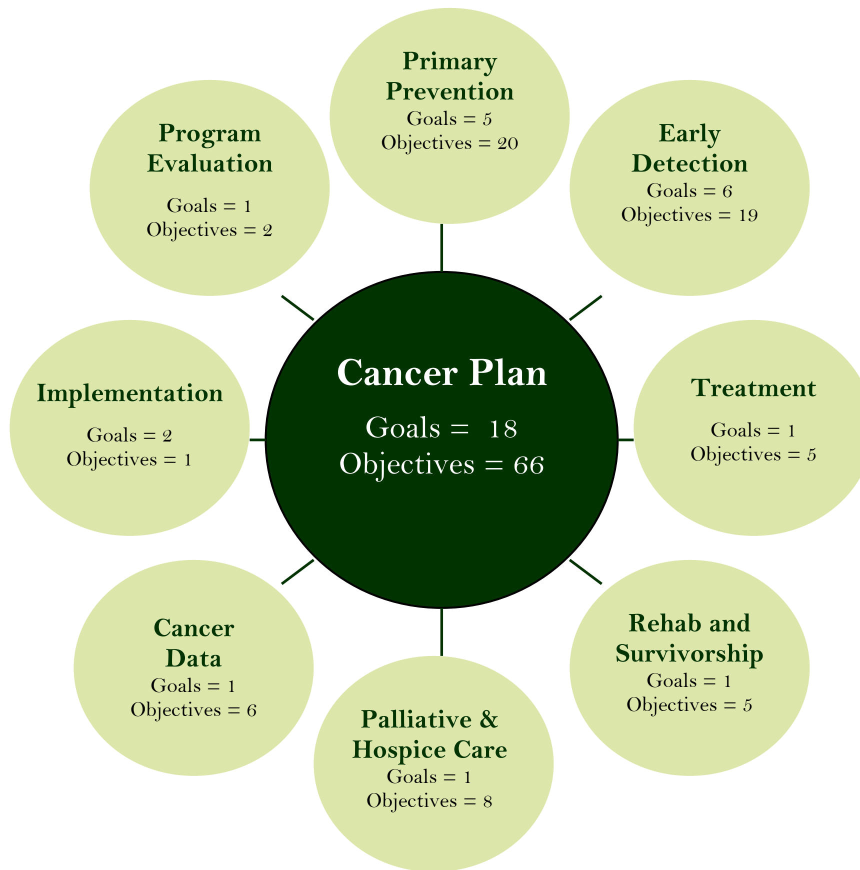
The mission of the Consortium is to reduce the burden of cancer in Maine by working collaboratively to optimize quality of life by improving access to care, prevention, early detection, treatment, rehabilitation, survivorship, palliation, and end of life care. The Consortium seeks to:

- 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 2001. 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: 2001-2005



This evaluation report focuses on ***select*** goals and objectives identified in the Cancer Plan. Goals and objectives meeting the following criteria (determined at the onset of the evaluation) were selected:

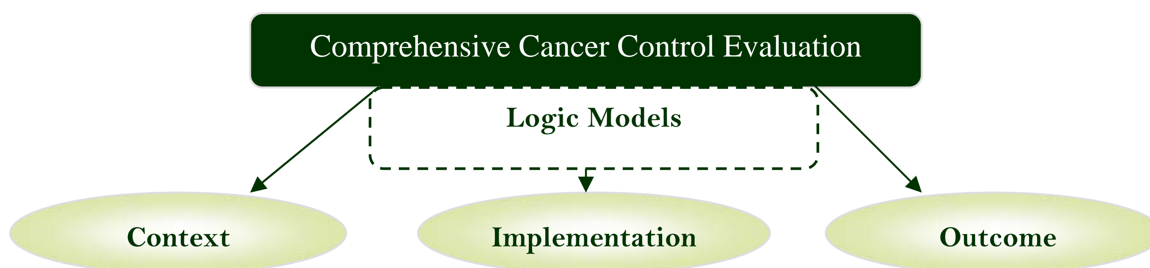
1. All Workgroup-related objectives that were listed in the year one or year two Comprehensive Cancer Control Program workplan submitted to the Centers for Disease Control and Prevention were included.
2. All measurable objectives that were directly linked to a goal identified in the workplan were included, contingent upon baseline data.

Due to the needs of the Consortium, all strategies identified in the Maine Cancer Plan were tracked in 2005. 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 context 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 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.

Table 1. Data Sources

Evaluation Component	Source
Context Evaluation	
• **Partnership Survey** - Web-based survey - Includes *The Partnership Tool*	• Center for the Advancement of Collaborative Strategies in Health • Maine Center for Public Health
• **Key Informant Interviews** - Telephone (14 items, 8 domains)	• Developed 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
• **Key Informant Interviews** - Telephone (14 items, 8 domains)	• Developed by the Maine Center for Public Health
Outcome Evaluation	
• **Maine Cancer Registry, CDC Wonder** - Secondary data (incidence and mortality)	• Maine Bureau of Health • CDC
• **Youth/Behavioral Risk Factor Surveillance System** - Secondary data (behaviors)	• Maine Bureau of Health • CDC

RESULTS PART I: CONTEXT

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 evaluation focused on two important areas: 1) an assessment of the partnership; and 2) a review of Consortium and Program-specific findings.

Cancer Consortium Findings

The web-based *Partnership Self-Assessment Tool* was administered as part of a larger web-based survey to a total of 202 members of the Maine Cancer Consortium during the spring of 2005. Members were selected to participate in this survey if they met the following two criteria: 1) were listed in the master database maintained by the CCC Program and, 2) had an e-mail address. Of the 240 potential participants, 84% were asked to participate in the survey.

The survey included a series of 89 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.[1] 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, the level of involvement, and factors impacting the Consortium's ability to carry out its intended activities. Supplemental qualitative data was also collected through a series of open-ended questions in an effort to solicit additional in-depth information.

Response Rate and Participant Characteristics

A total of 52 members completed the survey during the two week timeframe for a response rate of 26%. Approximately 40% of respondents indicated that they had been involved in the Consortium for one year or less. Approximately 17% classified themselves as "very active," and over one-third (38%) self-classified as "not active" when asked about their involvement during the past year.

Table 2 provides a summary of responses. The results suggest that both new and old members participated in the survey. The responses also reflect a mix of views from both active and inactive members. In terms of workgroup and Board participation, less than half of respondents were involved in a workgroup and the majority (87%) did not serve on the Board.

[1] Written permission to utilize this tool as part of a larger web-based survey was obtained.

Table 2. Involvement in Consortium (n=52)

Involvement in Consortium	Percent
Length of Time Involved In Consortium	
▪ Less than or equal to one year	40%
▪ More than one year	54%
▪ Don't know	6%
Level of Involvement over Past Year	
▪ Very active	17%
▪ Somewhat active	17%
▪ Rarely active	28%
▪ Not active	38%
Currently a Member of One or More Workgroups	
▪ Yes	37%
▪ No	57%
▪ Don't know	6%
Currently a Member of Board of Directors	
▪ Yes	13%
▪ No	87%
▪ Don't know	0%

Reasons Participants Have Remained Involved

When asked about reasons for staying involved in the Consortium, many participants indicated that the work and mission of the Consortium is aligned with their work and the work of the organization they represent.

> *"The goals of the Consortium and our Cancer Program are aligned in such a way that the partnership is beneficial"*

> *"Strongly believe in the mission and enjoy working with the board and committee members. The Consortium's mission is an extension of my organization's mission."*

Others perceive the Consortium as a vehicle for staying abreast of cancer resources and activities within Maine.

> *"Knowledge of what is going on in the area of Cancer"*

> *"As a health care colleague. Just staying in touch…"*

Several people also indicated interest in certain aspects or topical areas in which they feel they can contribute or learn more about.

> *"Interested in appropriate screening"*

Consortium Goals

Respondents were asked to rate the Consortium's progress in achieving the five overarching goals of the group. These goals were established by the Consortium and are separate from the goals identified in the Maine Cancer Plan.

The results are depicted below in Table 3. The findings indicate that a significant portion of those who responded were not sure about the status of the delineated Consortium objectives.

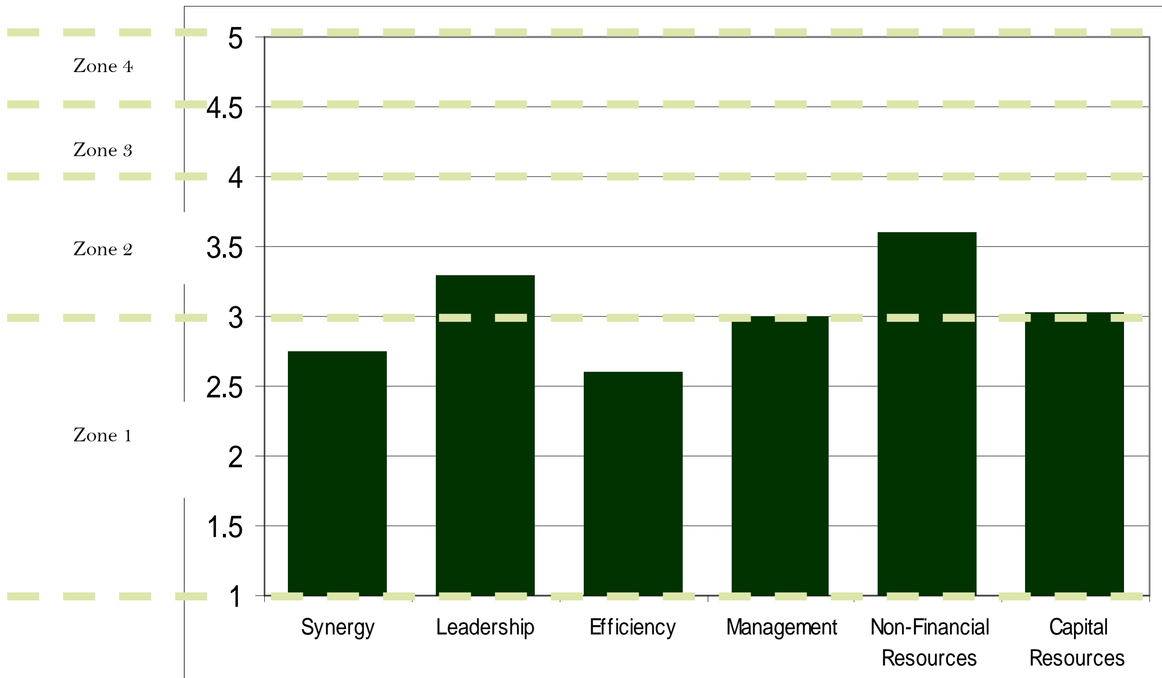
Table 3. Maine Cancer Consortium Goals and Survey Results

Goals	Percent
#1: Increase statewide integration, coordination and provision of quality services	
▪ Excellent	4%
▪ Very good	14%
▪ Good	33%
▪ Fair	14%
▪ Poor	2%
▪ Don't know	33%
#2: Increase access to cancer and cancer-related services for all Maine residents	
▪ Excellent	0%
▪ Very good	12%
▪ Good	20%
▪ Fair	26%
▪ Poor	4%
▪ Don't know	39%
#3: Increase the proportion of residents who utilize services	
▪ Excellent	0%
▪ Very good	12%
▪ Good	16%
▪ Fair	18%
▪ Poor	2%
▪ Don't know	52%
#4: Improve the quality/coordination of cancer surveillance and other data systems	
▪ Excellent	2%
▪ Very good	10%
▪ Good	35%
▪ Fair	12%
▪ Poor	0%
▪ Don't know	41%
#5: Increase support from policy and grant makers	
▪ Excellent	2%
▪ Very good	12%
▪ Good	24%
▪ Fair	18%
▪ Poor	4%
▪ Don't know	41%

Overall Partnership Tool Results

The overall results of the *Partnership Self-Assessment Tool* are illustrated below in Chart 1. The findings indicate that the Consortium scored within the first and second 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 zone four (optimal performance or target zone).

Chart 1. Maine Cancer Consortium Self-Assessment: Overall Results, 2005



Despite scoring in zones one and 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

The self-assessment tool focuses, in large part, on a construct known as partnership synergy. This construct is used to determine how well a collaborative process is working. The term synergy is defined as a partnership's ability to accomplish more collectively compared to what could be achieved individually.

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 2.8. This score can be interpreted to mean that more effort is needed to maximize the Consortium's full potential. The mean scores depicted below indicate that the Partnership is doing "somewhat well" with regard to the items listed in Table 4.

Table 4. Partnership Synergy Results

Synergy Items	Mean 1 = Low 5 = High
How well, by working together, the members of the Consortium are able to:	
• Communicate to people how the Partnership will address problems	3.1
• Carry out comprehensive activities	2.9
• Respond to the needs and problems of the community	2.8
• Identify how different programs relate to select problems	2.8
• Obtain support from those that can block the Partnership's plans	2.7
• Implement strategies that are likely to work in the community	2.7
• Develop goals that are widely understood and supported	2.6
• Include the views of people affected by the Partnership's work	2.6
• Identify new ways to solve problems	2.5

Leadership Results

Table 5 highlights the results of specific leadership attributes that are linked to high levels of synergy. The results are based on all of those who provided both formal and informal leadership within the Maine Cancer Consortium since its inception. Overall, the findings suggest several strengths including resolving conflict among partners, helping the Partnership to be creative, working to develop a common language, and recruiting diverse people and organizations. The one area with the greatest room for improvement relates to fostering respect, trust, and inclusiveness.

Table 5. Leadership Effectiveness Results

Leadership Effectiveness Items	Mean 1 = Poor 5 = Excellent
Leadership attributes:	
• Resolving conflict among partners	3.8
• Helping the Partnership to be creative	3.6
• Working to develop a common language within the Partnership	3.6
• Recruiting diverse people and organizations	3.6
• Inspiring and motivating people in the Partnership	3.4
• Communicating the Partnership's vision	3.4
• Taking responsibility for the Partnership	3.2
• Creating an environment where different opinions can be voiced	3.1
• Combining partners' perspectives, resources, and skills	3.1
• Empowering the people in the partnership	3.1
• Fostering respect, trust, and inclusiveness	2.9

When asked to identify the informal leaders of the group many participants listed workgroup chairs and members as well as program and organizational staff. The formal leaders were frequently identified as CCC program staff, the Board of Directors and members of the Board, and the American Cancer Society staff.

Efficiency Results

Table 6 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 6. Efficiency Results

Efficiency Items	Mean 1 = Poor 5 = Excellent
How well the Consortium is using its partners':	
• Time	2.9
• Financial resources	2.3
• In-kind resources	2.1

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 7, the Consortium's "management team" has been successful at providing orientation to new members, coordinating communication with those outside the Consortium, securing funding, and evaluating the initiative. The scores suggest that performing secretarial duties and organizing Partnership activities are two areas that may require additional emphasis.

Table 7. Administration and Management Effectiveness Results

Administration and Management Items	Mean 1 = Poor 5 = Excellent
Consortium administration and management activities:	
• Providing orientation to new partners	4.0
• Coordinating communication with those outside of the Consortium	3.7
• Applying for and managing grants and funds	3.6
• Evaluating the Partnership's progress and impact	3.4
• Minimizing barriers for participation in meetings, and activities	3.3
• Preparing materials that inform partners	3.2
• Coordinating communication among partners	3.1
• Performing secretarial duties	2.9
• Organizing Partnership activities	2.9

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 8. Overall, the Consortium has "most of what it needs" in terms of political connections, the ability to bring people together for meetings, and connections to people affected by cancer. The Consortium also has "some of what it needs" in terms of expertise and skills (e.g., leadership, administration, evaluation, community organizing, etc.).

Table 8. Sufficiency of Non-Financial Resources Results

Non-Financial Resources Items	Mean 1 = None 5 = Most of what it needs
Kinds of non-financial resources:	
• Connections to political decision-makers, government, and others	3.4
• Influence and ability to bring people together for meetings	3.2
• Connections to people affected by the problem	3.2
• Data and information	3.1
• Legitimacy and credibility	3.1
• Skills and expertise	2.6

Financial and Other Capital 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 9 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 the area of money and "some of what it needs" in terms of equipment, goods, and space.

Table 9. Sufficiency of Financial and Other Capital Resources Results

Financial and Other Capital Resources Items	Mean 1 = None 5 = Most of what it needs
Kinds of financial and other capital resources:	
• Money	4.1
• Equipment and goods	3.9
• Space	3.7

Decision-Making and Satisfaction Results

As seen in Table 10, the results suggest that members of the Consortium are relatively comfortable with the decision-making process as a whole. In terms of overall satisfaction, members of the Consortium indicated moderate 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.

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Table 10. Decision-Making Process and Satisfaction with Participation

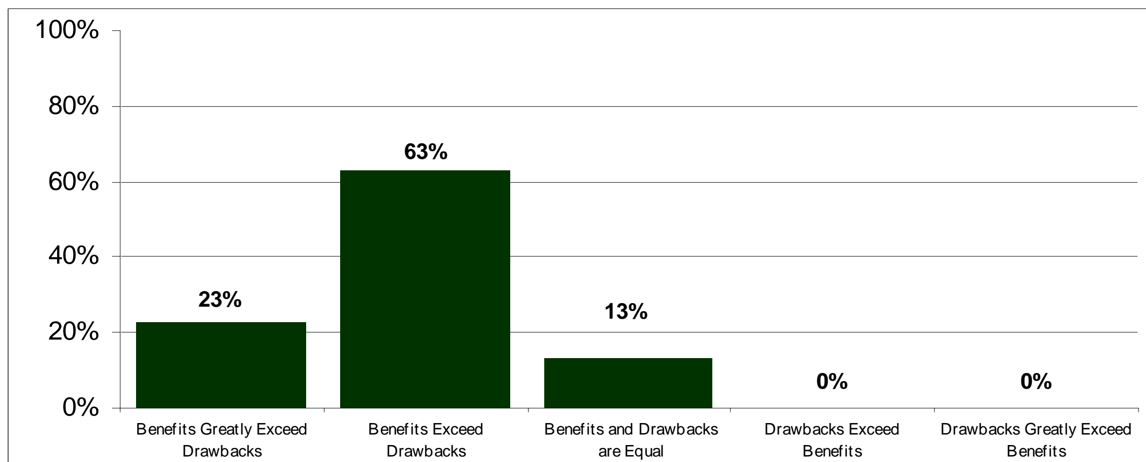
Items	Scale				
Decision-Making:	Extremely Comfortable	Very Comfortable	Somewhat Comfortable	A Little Comfortable	Not at All Comfortable
• Comfort with way decisions made	9%	67%	15%	3%	6%
Decision-Making:	All of the Time	Most of the Time	Some of the Time	Almost None of the Time	None of the Time
• How often decisions supported	3%	84%	9%	0%	3%
• How often left out of decision-making	3%	6%	19%	40%	34%
Satisfaction with Participation:	Completely Satisfied	Mostly Satisfied	Somewhat Satisfied	A Little Satisfied	Not at All Satisfied
• The way partners work together	7%	67%	26%	0%	0%
• Influence in Consortium	7%	63%	19%	11%	0%
• Role in the Consortium	7%	55%	24%	10%	3%
• Consortium's plans for achieving goals	0%	50%	43%	4%	4%
• Implementation of the plan	0%	54%	39%	7%	0%

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. Experts also agree that 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. Chart 2 depicts the findings. Overall the results suggest that, of those who completed the survey, approximately 86% believed that the benefits exceeded or greatly exceeded the drawbacks.

Chart 2. Benefits versus Drawbacks of Consortium

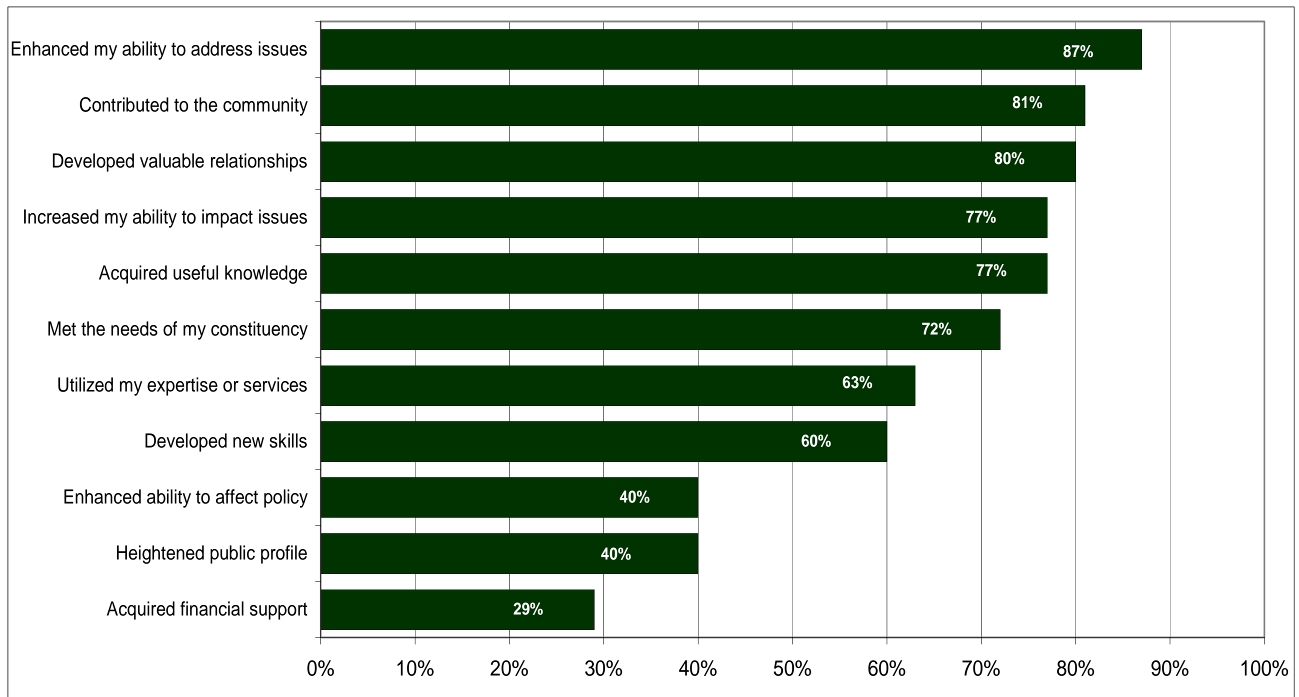


Specific Benefits Results

Respondents were also asked to identify whether or not they received 11 specific benefits as a result of their participation in the Consortium. Chart 3 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.

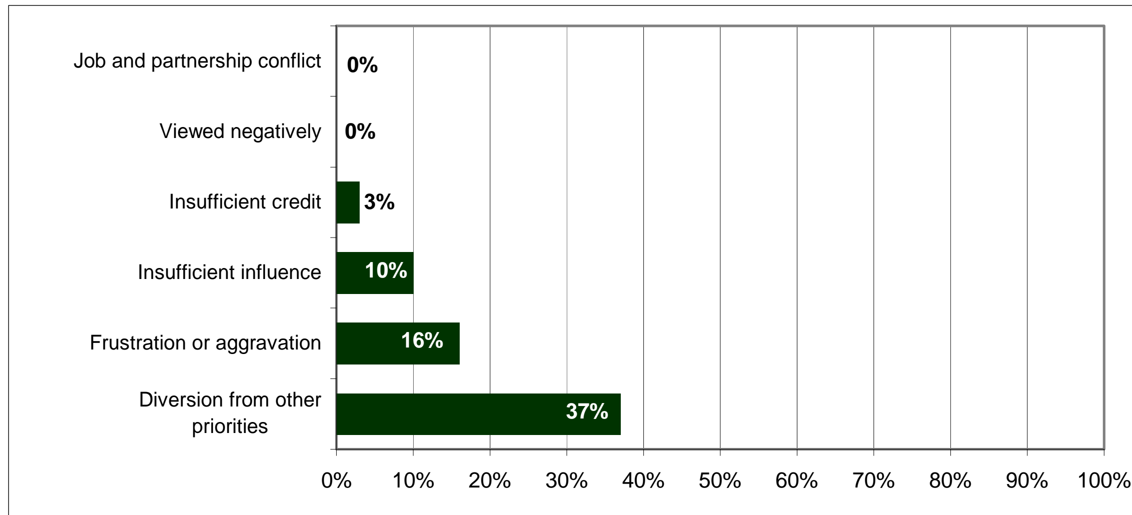
Chart 3. Kinds of Benefits Experienced by Members



Specific Drawbacks Results

Respondents were asked to identify whether or not they experienced a set of six drawbacks resulting from their participation in the Consortium. Chart 4 illustrates the results. The one drawback experienced by 37% of those who completed the survey was diversion from other priorities. Of those who indicated experiencing frustration or aggravation, the reasons included: 1) lack of personal contact outside of e-mail communication, 2) lack of financial resources and political clout to change policy for use of tanning beds by minors, 3) lack of motivation among members, and 4) lack of educational opportunities for a wide audience.

Chart 4. Drawbacks Experienced by Respondents



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 202 identified members, only 54 (27%) completed the computer-based survey. This group of participants may not adequately reflect the views of all Consortium members.

Additional Consortium & Program Findings

In addition to the computer-based survey, telephone interviews were conducted and a membership survey was administered to learn more about the Consortium and the CCC Program.

Membership Survey

The membership survey was administered by the CCC Program to members of the Maine Cancer Consortium in the winter of 2005. The survey was intended to be used to:

- Update the Maine Cancer Consortium list of members
- Identify those who wish to remain involved in the Consortium
- Learn about members' involvement in, and knowledge of, the Consortium's efforts
- Identify those who are interested in helping to develop the next Maine Cancer Plan
- Identify opportunities for Consortium members to become more involved.

Telephone Interviews

A telephone interview of 13 members of the Consortium was conducted during a three-week period in the late spring of 2005. The purpose of the interview was twofold: 1) to collect in-depth information about the initiative that would complement the results of the partnership survey; and 2) to provide additional insight on the Maine Cancer Consortium and the CCC Program.

Individuals in a leadership position within the Comprehensive Cancer Control Program and the Maine Cancer Consortium were interviewed including: CCC Program staff at the Bureau of Health, the division director, Consortium chair, and well as workgroup chairs or co-chairs. In addition, four at-large members of the Consortium were interviewed.

Summary Findings

While most respondents were able to clearly articulate their interpretation of the various functions of the Consortium, Board of Directors and CCC Program, there was significant inconsistency in the responses. For example, some respondents indicated that the workgroups were responsible for planning only, while others indicated implementation of specific activities as a primary function of the groups. Tables 11-13 highlight the various functions that were identified for each group. A summary of the reported types of "needed" support to fulfill the functions and a list of those identified to provide the support are highlighted below.

Table 11. Workgroup Functions, Support, and Responsible Parties

Functions	Support Needed	Who Should Provide Support
Workgroup/Taskforce Functions		
• Monitor/evaluate activities • Implement new activities • Plan for new Cancer Plan • Coordinate meetings/efforts • No implementation • Identify gaps • Develop new initiatives • Achieve objectives in Plan	• Staff support overall • Staff support for workgroups • Designated staff • Executive Director • Administrative support • Strong leadership	• CCC Program staff • Partner organizations • Doesn't matter • Others (e.g., interns)

The functions identified for the Board of Directors ranged from advisory to conducting a gap analysis, to setting the direction of the Consortium and delineating the charge of individual workgroups. The need for administrative support was frequently mentioned as necessary for the Board to adequately fulfill their functions. One individual Board member was not sure what types of support were needed, and several participants were not sure who should provide the necessary support to the Board.

Table 12. Board of Directors' Functions, Support, and Responsible Parties

Functions	Support Needed	Who Should Provide Support
Board of Directors Functions		
• Assure that workgroups are functioning properly • Give workgroups their charge • Convene stakeholders • Develop strategic plan • Not sure • Evaluate efforts • Conduct gap analysis • Communicate with members • Provide leadership • Serve in advisory capacity • Identify resources	• Administrative support • Strong leadership • Designated staff paid through the contributions of the Consortium • Guidance on how to improve membership	• CCC Program staff • CCC Program Manager • ACS • Other partner organizations • Not sure

The primary functions of the Maine Comprehensive Cancer Control Program were also varied. They included the identification of components of the state plan that could be accomplished in specified timeframes (e.g., one year, two years), the implementation of various aspect of the Maine Cancer Plan, and the implementation of specific programs based on funding. Several people indicated that they were not sure what the primary functions of the Program should be.

Table 13. CCC Program Functions, Support, and Responsible Parties

Functions	Support Needed
CCC Program Functions	
• Implement aspect of Cancer Plan • Coordinate with state government • Not sure • Provide staff support to Consortium • To drive work of Consortium • To assure that Cancer Plan is implemented • To fulfill contract obligations • To serve as an equal partner on the Consortium	• Consistent full-time paid staff • External support from the Consortium • Federal funding • Administrative support • Support from all levels within the Bureau of Health • Not sure

Prioritization of Efforts

Given the broad scope of work several strategies were identified to assist the Consortium in prioritizing efforts including: 1) delineating the top three priorities each year, 2) focusing on the "low hanging fruit," 3) using data to assess impact and need, 4) identifying those issues that serve as barriers to implementation of the cancer plan (e.g., reimbursement, access to care), and 5) focusing on those areas with existing or potential resources.

Accountability

The issue of holding a group or groups accountable for the implementation of certain priority areas is one that has recently received attention. Clearly this is an area of challenge for a volunteer group with limited resources. While some respondents believed that there is no way to actually hold any one group responsible, others suggested that Memorandums of Understanding or Memorandums of Agreement with a lead agency might prove worthwhile. Others also suggested that documenting the progress of lead agencies and developing report cards to be shared publicly may be an additional approach.

Membership in the Consortium

Table 14 provides a summary of the various reasons why participation in the Consortium has waned in the past several years. Suggestions for enhancing involvement and interest are also provided.

Table 14. Consortium Participation

Maine Cancer Consortium	
Reasons for Low Participation	**Opportunities for Enhancing Participation**
• Planning is easier "more exciting" than implementation • Lack of communication regarding meeting, activities, accomplishments • Not easy to be involved if "not paid to think about it" • Lack of time • Competing priorities • Unclear purpose and role • Lack of recognition • Perception that "you are not making a difference" • Disconnect between those working in cancer and those in Consortium • Priority changes of organizations	• Publicize new Maine Cancer Plan to increase "energy" and momentum • Provide routine updates to members • Enhance communication among members • Consortium should focus on less rather than "trying to do too much with too little" • Share successes • Secure additional resources • Provide participants with opportunities to learn, develop relationships, share their expertise • Recognize contributions • Acknowledge members • Structure meetings to meet the needs of members

Consortium and Program Strengths and Limitations

The strengths of the Consortium and Program are listed below in Table 15. Several strengths were listed for both including program staff, funding, and a strong history of collaboration. The limitations of the Consortium included: 1) lack of communication; 2) limited emphasis on interventions; 3) a scope of work that is too large given the resources; 4) lack of participation; 5) unclear roles and functions; and 6) lack of dedicated staff. The limitations of the program were limited funding and administrative support, limited staff time, confusion about roles, limited flexibility in terms of activities based on funding, and issues consistent with working within a bureaucracy.

Table 15. Strengths of Consortium and Program

Strengths	
Consortium	**CCC Program**
• Good history of collaboration • Strong support from CCC program • Commitment of members • Collective vision and clear focus • CCC Program Manager's role • Good multi-sector representation • In-kind support from partner agencies • Connections to the national CCC process • Workplans consistent with other programs • Funding is available • Credibility of the Consortium	• Leadership • Funding • History of collaborations • Strong and competent staff • Connections to the national CCC process • Connections to other state-related initiatives • Strong relationships with partners • Focus of the program • Flexibility of funding to support non-traditional areas (e.g., hospice)

Additional Considerations

Several internal and external factors were noted as having helped the Consortium move forward to achieve their desired goals. They include:

- Staff support from the CCC program and others (e.g., intern)
- Enthusiastic program leadership
- Political will to "get people together"
- Staff "willing to work with everyone"
- Resources (albeit limited)
- The efforts of the local Healthy Maine Partnerships
- Cancer-friendly legislation
- Strong support from the American Cancer Society
- The commitment of Board and Workgroup members
- Wide acceptance of the Maine Cancer Plan
- Recruiting recognized and experienced members to hold leadership positions

Several internal and external factors were also noted as having hindered the Consortium in their ability to move forward and achieve their desired goals. They include:

- Lack of accountability
- Lack of guidance or leadership with some workgroups
- Lack of attention on broad issues that could impact systems change (e.g., reimbursement)
- Objectives and strategies that were not measurable
- Lack of communication
- Limited attention focused on social factors that could affect our work
- Too few resources
- "Constant attack on the Fund for a Healthy Maine"

RESULTS PART II: IMPLEMENTATION

This component of the 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

A monitoring tool was developed in 2004. This tool was then modified in 2005 to meet the changing needs of the Consortium. The monitoring tool tracks progress towards achievement of the stated measure and reports feedback on accomplishments, strengths, and challenges. While the revised Monitoring Tool was used to collect information on all strategies depicted in the Maine Cancer Plan, the evaluation plan and previous reports were based on criteria listed on page eight of this report.

However, due to the modifications made to the tracking tool, and the Consortium's desire to track all workgroup strategies as listed in the Cancer Plan, this report focuses solely on those strategies, regardless of the measurability of the accompanying objective. 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 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 Workgroups. The Primary Prevention and Early Detection Workgroups focus primarily on coordinating and monitoring existing related efforts that are consistent with their program goals. Yet, the remaining Workgroups are more directly involved in strategy implementation. The progress results reported in the *Activity-Monitoring Tool* may reflect this difference in oversight versus participation.

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 changed during the course of the initiative, and some may have been dropped since the initial inception and dissemination of the Maine Cancer Plan. Finally, many workgroups used a workplan to guide their efforts and often times these workplans only included subcomponents of the Cancer Plan. Therefore, there may have been certain areas of the Cancer Plan that received little to no attention during the five-year implementation period.

Chart 5 illustrates the overall combined status of all Active Workgroups. Approximately 16% of strategies were not pursued. The lack of attention given to select strategies was often deliberate and a result of new knowledge, technology, or strategic direction.

Chart 5. Overall Combined Strategy Status of All Active Workgroups

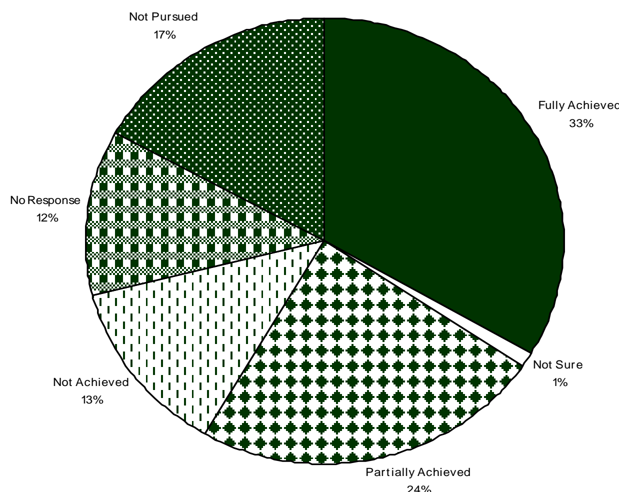


Table 16 provides a summary of the status of strategies for each active Workgroup. Due to the diversity among Workgroup functions and roles, this information should be interpreted with caution and should not be used for comparison purposes.

Table 16. Summary of Strategy Status for All Active Workgroups

Work Group & Goals	Total Strategies	Progress					
		Fully Achieved	Partially Achieved	Not Achieved	Not Sure	No Response	Not Pursued
Primary Prevention	70	36%	23%	9%	1%	30%	1%
Early Detection	50	32%	22%	2%	2%	0%	42%
Data and Surveillance	9	44%	33%	22%	0%	0%	0%
Rehabilitation & Survivorship	23	17%	17%	39%	0%	0%	26%
Palliative and Hospice Care	28	39%	36%	18%	0%	4%	4%

Strengths

A review of strengths for all strategies combined revealed several consistent themes:

- Network of partners and the existing local Healthy Maine Partnerships
- Funding to pursue strategies, objectives, and goals
- Dedicated members who continue to support Consortium efforts
- Support from state programs (e.g., Maine Breast and Cervical Health Program)

Challenges

For the strategies that have not been fully achieved or in some case, pursued, there are a variety of explanations. Many of the challenges faced by the Workgroups are specific to their unique objectives. For example, some of the technologies reported in the original cancer plan are no longer promoted (e.g., female condoms). Other challenges are more general, such as limited time and funding, both of which were commonly reported.

Program Accomplishments

Unlike other state programs, Maine's Comprehensive Cancer Control Program is relatively new and directly tied to the development of this overarching initiative. Since the Program's inception there have been a number of notable accomplishments achieved. They include, but are not limited to:

- Recognized as a state program
- Developed two state positions
  - Program manager
  - Health educator
- Received federal funding for *implementation* from the Centers for Disease Control and Prevention
  - Amount: Over $250,000 annually for five years
  - Type: Competitive award
- Received federal funding for a *colorectal cancer social marketing campaign* from the Centers for Disease Control and Prevention
  - Amount: Over $200,000 annually for four years
  - Type: Competitive award
- Received federal funding to support specific skin cancer efforts
  - Amount: Over $36,000 annually for two years
  - Type: Competitive award
- Recognized as a model program and state throughout the country
  - Existing staff serve as a resource for other states
- Served as a catalyst for several initiatives and activities
- Recognized as a model for evaluation
- Developed several requests for project proposals and selected qualified applicants
- Provided significant staff support to the Maine Cancer Consortium, individual workgroups, and the Board of Directors
- Sponsored and organized Maine Cancer Consortium annual meetings
- Served as a resource for comprehensive cancer control efforts
- Worked to integrate and link comprehensive cancer control efforts with other state programs
- Developed and managed multiple contracts
- Maintained the database of Consortium members
- Assisted the Board of Directors in organizing and facilitating annual planning meetings
- Established educational seminars for Consortium members and others interested in comprehensive cancer control
- Communicated with Consortium members via paper, email, the website, and newsletters
- Developed Institutional Review Board applications through the Bureau of Health, when appropriate

RESULTS PART III:

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. 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 the objective, there are a series of additional factors, depicted in Figure 5, that clearly can impact program replication. Until these factors are better understood, generalizations about changes in the data should be made with caution.

Intermediate Outcomes

Intermediate outcomes often focus on behavior and systems change. Tables 17-20 provide data from the Behavioral Risk Factor Surveillance System (BRFSS) in Maine. These data are collected annually through a random digit dial telephone survey of Maine adults. Data pertaining to youth are collected utilizing the Youth Risk Behavior Surveillance System (YRBS). This school-based survey is administered to 9th – 12th grade students every two years.

Table 17. Intermediate Outcomes: Tobacco Use

Measurable Objectives	Pre Plan		Plan	Post Plan		
	98/99[1]	2000	2001	2002	2003	2004
Tobacco Use						
• Reduce proportion of Maine adults aged 18 and older who use tobacco products to 15% by 2005[2]	22.0	23.8	NA	23.6	23.6	21.0
• Increase proportion of young people who have never tried smoking to 60% (8th grade) by 2005	51.0	- -	61.9	- -	67.1	- -
• Increase proportion of young people who have never tried smoking to 45% (12th grade) by 2005	37.8	- -	NC	- -	NC	- -

Notes:

[1] Baseline data as reported in the Maine Cancer Plan. BRFSS baseline results compiled for 1998, YRBS results compiled for 1999 (not weighted)

[2] Results based on current cigarette smokers

NA = Data not available/not yet provided

NC = Data not comparable due to discrepancies in questions

- - = Data not collected (YRBS 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 Youth Risk Behavior Survey. Although data pertaining to 12th graders who ever tried smoking was not available, results from the YRBS suggest that the percentage of high school students who used any tobacco during the past 30 days decreased from 29.2% in 2001 to 23.7% in 2003. In terms of cigarette use, the percent of high school students who smoked on one or more of the past 30 days also decreased from 24.8% in 2001 to 20.5% in 2003.

Table 18 Intermediate Outcomes: Physical Activity and Nutrition

Measurable Objectives	Pre Plan		Plan	Post Plan		
	97-99[1]	2000	2001	2002	2003	2004
Physical Activity and Nutrition						
• Increase proportion of persons who eat "Five-A-Day" to 30% of adults (18+) by 2005	26.4	24.5	NA	29.3	- -	- -
• Increase proportion of persons who eat "Five-A-Day" to 35% of high school students by 2005	26.7	- -	25.0	- -	22.6	- -
• Increase proportion of adults (18+) who engage in 30 minutes of activity daily to 30% by 2005	24.1	- -	NA	- -	NA	- -
• Increase proportion of youth who engage in 20 minutes of activity ($\geq$ 3 days) to 75% by 2005	70.6	- -	65.9	- -	60.6	- -
• Decrease proportion of adults (18+) who are overweight to 50% by 2005[2]	53.2	54.1	NA	59.0	58.2	61.0

Notes:
[1] Baseline data as reported in the Maine Cancer Plan. BRFSS baseline results compiled for 1998 or 1997, YRBS results compiled for 1999
[2] Overweight based on Body Mass Index of $\geq$ 25
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 18 suggest that adults have increased fruit and vegetable consumption over the past several years, nearly achieving the objective. However, 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.

Reported levels of physical activity also appear to be decreasing for youth. The findings suggest that youth were less active in 2003 when compared to 1999 and 2001. Trends in adult physical activity rates were not able to be determined based on lack of data pertaining to the objective above.

Overall, the rates of overweight and obesity (BMI > 25) for those 18 and older suggest an upward trend. The overweight/obesity results for 2003 are relatively consistent with 2002 data, although the 2004 data reflect a slightly higher percent.

Table 19. Intermediate Outcomes: Sun Safety

Measurable Objectives	Pre Plan		Plan	Post Plan		
	98/99[1]	2000	2001	2002	2003	2004
Sun Safety						
• Increase proportion of adults who "always" or "nearly always" stay in shade to 35% by 2005	29.7	- -	- -	33.3	- -	26.4
• Increase proportion of adults who "always" or "nearly always" wear a hat to 45% by 2005	37.3	- -	- -	27.6	- -	- -
• Increase proportion of adults who "always" or "nearly always" use sunscreen to 40% by 2005	32.2	- -	- -	33.3	- -	37.8
• Reduce the proportion of adults who use artificial sun tanning to 5% by 2005	11.0	- -	- -	- -	- -	- -

Notes:

[1] Baseline data as reported in the Maine Cancer Plan. BRFSS baseline results compiled for 1999
- - = Data not collected as part of Maine Survey

Questions pertaining to sun safety were not included in the BRFSS Maine survey in 2000, 2001, and 2003. However, based on the 2002 and 2004 results, the findings suggest a modest improvement in reported behavior related to wearing sunscreen.

Table 20. Intermediate Outcomes: Screening Behavior

Measurable Objectives	Pre Plan		Plan	Post Plan		
	98/99[1]	2000	2001	2002	2003	2004
Screening Behavior						
• Increase proportion of women (40-49) who get mammogram and breast exam to 80% by 2005	70.2	NA	- -	71.3	NA	80.3
• Increase proportion of women (50+) who receive mammogram and breast exam to 70% by 2005	59.5	NA	- -	NA	NA	85.5
• Increase proportion of women (18+) who ever receive Pap test to 98% by 2005	95.3	95.4	- -	95.6	NA	96.0
• Increase proportion of adults (50+) who receive FOBT within past two years to 60% by 2005	35.9	- -	42.4	43.5	NA	39.8
• Increase proportion of adults (50+) who receive sigmoidoscopy/colonoscopy to 45% by 2005	42.4	- -	47.7	42.5	NC	NC

Notes:

[1] Baseline data as reported in the Maine Cancer Plan. BRFSS baseline results compiled for 1999
NA = Data not available/not yet provided
NC = Data not comparable due to discrepancies in questions
- - = Data not collected as part of Maine Survey

Based on the results provided, screening behavior appears to have increased for mammograms and clinical breast exams. Both objectives in this category have been achieved. There also appears to have been an increase in sigmoidoscopy/colonoscopy screenings in 2001. This increase may be due, in part, to what has been reported in the scientific literature as the "Couric effect" following Katie Couric's (Today Show host) live colonoscopy in 2000.

Long-Term Outcomes

Long-term outcomes often focus on changes in incidence, mortality, and quality of life. Table 21 provides data from the Maine Cancer Registry on incidence and data from CDC Wonder on mortality rates for select types of cancer.

Table 21. Incidence and Mortality Rates for Select Cancers

Objectives	Baseline	Pre Plan		Plan	Post Plan		
	1996[1]	1999	2000	2001	2002	2003	2004
Incidence[2]							
• Lung cancer	76.9	71.7	NA	NA	NA	NA	NA
Men	99.0	93.3	100.4	99.6	96.0	NA	NA
Women	61.2	54.6	60.2	65.0	60.7	NA	NA
• Colorectal cancer	56.5	60.6	NA	NA	NA	NA	NA
Men	67.9	71.1	62.6	65.2	74.3	NA	NA
Women	48.4	53.0	54.4	46.8	51.8	NA	NA
• Melanoma	14.6	18.0	NA	NA	NA	NA	NA
Men	17.8	21.5	22.9	23.5	24.1	NA	NA
Women	12.0	16.2	12.2	17.1	18.6	NA	NA
• Breast cancer[3]	129.2	126.0	133.5	140.9	126.1	NA	NA
• Cervical cancer	11.0	7.5	6.5	9.2	7.1	NA	NA
Mortality[2]							
• Lung cancer	65.3	58.0	NA	NA	NA	NA	NA
Men	88.9	77.1	79.8	NA	NA	NA	NA
Women	49.5	44.9	49.0	NA	NA	NA	NA
• Colorectal cancer	22.3	23.3	NA	NA	NA	NA	NA
Men	28.9	27.7	24.2	NA	NA	NA	NA
Women	18.4	20.1	21.5	NA	NA	NA	NA
• Melanoma	3.0	2.6	NA	NA	NA	NA	NA
Men	5.1	2.8	3.4	NA	NA	NA	NA
Women	1.6	2.4	2.1	NA	NA	NA	NA
• Breast cancer[3]	28.1	27.1	24.2	NA	NA	NA	NA
• Cervical cancer	3.0	2.6	26.2	NA	NA	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 data available, no trends were identified based on the long-term outcome measures listed above. In order to determine the potential preliminary impact of the CCC initiative, to date, additional years are necessary.

Recommendations

The following three recommendations have been provided.

1. **Enhance the Consortium's membership.**
    - Identify specific opportunities for individuals to remain involved and actively participate in Consortium efforts.
    - Develop a subgroup to address membership issues. 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.
    - Suggestions:
        - 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.).

2. **Reach consensus on the various functions of the Workgroups, Board, and Program, as well as the role of Consortium members and potential staff.**
    - Develop a guiding document that details the structure, relationship and agreed upon functions for each Workgroup, the Board of Directors, and the Program for a five-year period.
    - Considerations:
        - Disseminate this document to all members through multiple channels
        - Modify and/or review the document annually, if appropriate.
        - Ask members to sign a letter indicating their understanding of these functions and their given role. Provide clarity when necessary.

3. **Narrow the Consortium's focus to select priorities.**
    - Maintain an emphasis on a comprehensive approach, yet establish a small number of objectives and accompanying strategies to support in one year. These objectives should be based on a priority setting process. Continue establishing priority objectives to focus on for subsequent years.
    - Considerations:
        - Identify a process for determining priority objectives (e.g., priorities based on criteria established by workgroups, priorities selected at annual meeting).

- Considerations (continued):
    - Develop an annual Consortium workplan with measurable objectives. This workplan should be used as the basis for workgroup activities.
    - Monitor the workplan and provide updates at Workgroup and Board meetings.

4. Enhance communication.

- Develop, implement, and evaluate routine mechanisms for communicating with members.
- Showcase, celebrate, and publicize accomplishments among Consortium members and others.
- Utilize partner expertise to support and organize a public relations campaign for the launch of the new Maine Cancer Plan.

Appendix A:

Interview Protocol, 2005

Interview Protocol and Questions

Project: Comprehensive Cancer Control Evaluation

Prepared by Brenda M. Joly
Revised June 17, 2005

This component of the evaluation involves face-to-face structured interviews with key individuals involved with the Comprehensive Cancer Control (CCC) Program and the Maine Cancer Consortium including: 1) CCC Program staff, 2) the Bureau of Health Division Director, 3) the Maine Cancer Consortium Chair, 4) the Workgroup Chairs or Co-chairs, and 5) other members of the Maine Cancer Consortium.

Introduction

- Greeting
- Role of MCPH
- Purpose of interview
- Length of interview
- How information will be used

Section #1: Function of the Consortium and Program

As you know, the Maine Cancer Consortium was established over five years ago. Since then we've learned a lot about our efforts including the things that have worked well and those that haven't worked as well. This first section of the interview focuses on the functions of the Maine Cancer Consortium, including the governing body and the workgroups, and the division of labor.

1. Based on your experience with the Maine Cancer Consortium, what should the primary function(s) of the Workgroups and Task Forces be?
    a. What types of support are needed to fulfill these functions and who should provide this support? (e.g., staffing, other resources)

2. What should the primary functions of the Board of Directors be?
    a. What types of support are needed to fulfill these functions and who should provide this support?

3. What should the primary functions of the Maine Comprehensive Cancer Control Program be?
    a. What types of support are needed to fulfill these functions and who should provide this support?

Section #2: Scope of Work, Priorities, and Accountability

4. As you know, the Maine Cancer Plan is a multi-year planning document with a broad scope of work in the area of comprehensive cancer control. Given the fact that the Consortium is based primarily on a group of volunteers, how should the Maine Cancer Consortium prioritize its efforts?
   a. What would the prioritization process look like, who would be involved, and what would the results be?
   b. Who would be responsible for implementing the priority areas of the Consortium?
   c. How would they be held accountable?

Section #3: Membership

5. During the past year, several workgroups have experienced low rates of participation and several people have opted to remove themselves from the Partnership. In your opinion, what are the reasons for this?

6. How can the Consortium maintain a high level of involvement and interest among members?

Section #4: Strengths and Limitations

7. In your opinion, what are the strengths of the Maine Cancer Consortium?

8. In your opinion, what are the weaknesses of the Consortium?

Section #5: Internal and External Factors

9. The efforts, successes, and limitations of the Maine Cancer Consortium are shaped, in some way, by the broader political, economic, and social environment. They are also due, in part, to the internal dynamics, structure, and personnel involved in the initiative. In your opinion, what have been the most significant factors that have *positively* impacted the implementation of the Maine Cancer Plan during the past five years?

10. What have been the most significant factors that have *negatively* impacted the implementation of the Maine Cancer Plan during the past five years?

Section #6: Evaluation

11. Evaluating our efforts provides us with an opportunity to recognize our successes, understand our failed attempts, and learn from our experiences in an effort to strengthen the initiative and make sound decisions. Based on your knowledge of the evaluation, what was effective?

12. What would you do differently (in terms of the evaluation) in the future?

Section #7: Next Steps

13. What, if anything, should we do differently as we embark on a new phase for the Maine Cancer Consortium?

Section #8: Summary & Wrap-Up

14. Is there anything else you want to tell me about the implementation, workgroups, Consortium, or program?

Program Feedback – Staff Only

15. What are the major program accomplishments that have taken place over the past five years?
    - During the past year?

16. What are the strengths of the program?

17. What are the limitations of the program?

18. Where do you see the CCC Program five years from now?