

### Appendix 3. Findings for States Within Conceptual Areas of Comprehensive Cancer Control

Outcomes*	Arkansas	Illinois	Kansas	Kentucky	Maine	Utah
<i>Assess/Address Cancer Burden</i>						
<b>Target areas for cancer prevention and control are selected and prioritized. (PL)</b>	Work groups were established according to the anticipated structure of the plan. Had not yet begun to select and prioritize target areas as of the end of the study period.	Cross-cutting work groups were formed in the areas of Data and Surveillance, Legislation and Policy, Quality Assurance, and Awareness and Education.	Site-specific cancer work groups began developing priorities for breast, cervical, skin, colorectal, prostate, and lung cancer. Two cross-cutting work groups were also formed: Cross Cultural Competency, and Rehabilitation and Pain.	Draft plan was organized by cross-cutting issues: Prevention, Early Detection, and Cancer Care (including quality of life and end of life care).	Cross-cutting work groups were formed in the areas of Prevention, Early Detection, Treatment, Rehabilitation, and Palliation. Additional topics covered in the plan include Data and Cancer Surveillance, Implementation, and Evaluation.	Cross-cutting work groups in the areas of Prevention, Early Detection, Treatment, and Quality of Life have developed problem statements and begun selecting strategies. Groups plan to later reform into cross-cutting issue areas.
<b>Priority strategies are designed, implemented, and evaluated. (IM)</b>	No findings as of 1/2001.	Priority-setting work groups became action groups charged with implementing individual strategies under broad priorities as resources permit. Evaluation strategies are built into Action Reports developed for each strategy to be implemented. Partner organizations use the state's Action Plan to develop own strategies.	No findings as of 1/2001.	Exploring ways of implementing Plan strategies through existing means, such as Leadership Institute sponsored by American Cancer Society (ACS).	Some partners began working within their own organizations to pursue plan priorities as plan was being finalized.	No findings as of 1/2001.
<i>Enhance Infrastructure</i>						
<b>Management and administrative structures and procedures are developed. (PL)</b>	A core team took responsibility for comprehensive cancer control during an extended period of organizational restructuring. An internal work group assisted by	The planning coordinator was supported by Prevention Block Grant funds. Both a core team (including the Chronic Disease Director) and an internal advisory group were formed.	A planning coordinator was funded at 1/4 time by the Prevention Block Grant. An intern, a core team, and an expanded team (including the Chronic Disease Director) supplemented the minimal staffing.	The health department (HD) contracted with the Kentucky Cancer Program (KCP) located at the University of Kentucky, University of Louisville Medical Centers, to write the state's comprehensive cancer plan. KCP	A CDC public health prevention specialist coordinated comprehensive cancer control activities. A 3-member core team received extensive support from the head of the Division of Community and Family Health and from health	A planning coordinator was hired through unobligated categorical funds. The coordinator was assisted by an <i>ad hoc</i> core team and championed by the Cancer Program Director. Support from the Division Director for chronic disease programming

\* PL = planning outcome; IM = implementation outcome; PR = program outcome; HD = Health Department.

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	<p>developing a preliminary vision statement, criteria for partners, and a proposed subcommittee structure. Categorical funds helped support a planning coordinator who worked closely with the Chronic Disease Director. Toward the end of the study period, a 40-member external task force was formed.</p>	<p>Illinois made extensive use of interns from local academic institutions, several of whom have continued to work at the Department of Public Health in various capacities after completing their degrees. Core team members facilitated work groups. External partners were active but not in formal leadership roles.</p>	<p>Other staff and partners served as: “backgrounders” (data experts both from within and outside the health department), work group facilitators (health department staff members), and work group spokespersons (non-health department staff members asked to represent their work group to the larger partnership).</p>	<p>developed a 3-member core team experienced in community outreach, research, and evaluation. A technical writer was later added. The Chronic Disease Director at the health department participated in team meetings and oversaw the contract.</p>	<p>department data staff. External partners assumed leadership roles throughout the process, both on work groups and for the cancer consortium as a whole. Some were affiliated with a pre-existing cancer advisory board to the Maine Bureau of Health (BOH).</p>	<p>has been strong. External partners have assumed leadership positions in work groups; partners facilitate meetings and disseminate minutes.</p>
<p><b>Planning products are produced, disseminated, and archived. (PL)</b></p>	<p>A draft vision and mission statement was distributed to the task force for review. Task force reviewed cancer plans from other states and an earlier state cancer control plan focused on breast cancer.</p>	<p>Illinois documented meetings and used the minutes as a forum for information exchange. A chronological log of planning events was maintained through regular communication and dissemination of materials to members by mail and e-mail. The statewide Action Plan was published in September 1999.</p>	<p>A file is maintained of planning documents, although it is not complete due to staff changes in the coordinator position.</p>	<p>KCP distributed the draft plan to a wide group of individuals and organizations involved in cancer control-related activities before and during the Kentucky CARE conference in September 2000.</p>	<p>Maine produced planning products steadily, including documentation of meetings. Planning materials were organized in a set of 3-ring binders. A chronological log of planning events was maintained, along with regular communications and dissemination of materials to members by telephone, mail, and e-mail. The statewide CCC plan was published in January 2001.</p>	<p>Utah maintained a file of planning documents, organized by meeting, with a separate binder for events leading to the first meeting. A chronological event calendar was maintained. Mailings were sent to partners with materials related to the meetings. E-mail was used to share the minutes of work group meetings with all partners.</p>
<p><b>Sound yet flexible structures are in place, including structure for ongoing monitoring. (IM)</b></p>	<p>No findings as of 1/01.</p>	<p>Illinois transformed work groups into action groups. A Resources Action Group was added to explore funding opportunities and the Quality Assurance Work Group was changed to Cancer Care Assessment Action Group to better reflect the group’s activities. The core team was expanded to</p>	<p>No findings as of 1/2001.</p>	<p>No findings as of 1/2001.</p>	<p>Regular meetings of the work group chairs and the planning coordinator were added when it was observed that chairs experienced common issues and challenges. Coordinating committee was expanded to include additional external partners to prepare for implementation and transition to new body. Pre-existing cancer advisory group, a source of support and members for new consortium,</p>	<p>No findings as of 1/2001.</p>

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		include staff members from the cancer registry and interns.			was recast into an advisory role with the cancer registry.	
<b>Partnership members assume increasing responsibility. (IM)</b>	No findings as of 1/2001.	HD assumed responsibility for directing and facilitating the partnership. There were no formal external chairs for the partnership or its work/action groups; a few partners said they served as work group "chairs." Most partners expressed satisfaction with facilitation by HD staff and did not seem to seek greater responsibility.	No findings as of 1/2001.	No findings as of 1/2001.	Maine increasingly sought input from partners at key decision points. For example, Maine developed a volunteer <i>ad hoc</i> committee to join the Consortium Coordinating Committee in deliberations about program institutionalization.	No findings as of 1/2001.
<b>Partnership is a new entity - self-governing and greater than the sum of its parts. (PR)</b>	No findings as of 1/2001.	No findings as of 1/2001.	No findings as of 1/2001.	No findings as of 1/2001.	A plan for institutionalization was developed for presentation to the Consortium in conjunction with publication of the CCC Plan in January 2001.	No findings as of 1/2001.
<b>Mobilize Support</b>						
<b>Partnership develops priorities for allocation of existing resources. (PL)</b>	No findings as of 1/01.	Illinois is allocating existing resources on a strategy -by- strategy basis. When an action group elects to support a strategy, it is required to submit an action report that outlines existing resources available to support implementation or level of new resources required.	Objectives were prioritized within work groups (ongoing).	Recommendations are contained in draft Plan for future activities.	Maine developed a long list of cancer priorities supported by the Consortium. To implement, many will require coordination among existing resources rather than development of new resources.	No findings as of 1/2001.
<b>Gaps in resources and level of support are identified. (PL)</b>	Attendees at the initial task force meeting (8/16/00) were asked at the	Identification of resource gaps was linked to specific strategies in the action	HD recognized the need to enhance personnel resources to support CCC planning and	Kentucky CARE conference brought together individuals and organizations that are	Maine received a CDC field assignee.	Partners are considering ways to increase input from high-level representatives of organizations, providers,

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	<p>outset to signal organizational support and commitment to CCC planning and implementation.</p> <p>Arkansas Cancer Summit (9/28/00) resulted in strong interest from potential and existing partners. This meeting also was a turning point in leveraging support from HD leadership.</p>	<p>reports. A Resource Action Group was established to identify funding opportunities and match them with specific strategies. Long-term staff support for CCC within the HD was being explored.</p>	<p>implementation, but did not receive its request for staff dedicated to CCC from the state or CDC. The state developed a budget and legislative issues paper and forwarded it to the director of the HD.</p>	<p>interested in supporting plan objectives and strategies. KDPH applied for a CDC field assignee (not received).</p>		<p>insurers, minority groups, and pharmaceutical companies. An ongoing membership assessment process continually identifies potential new members who are then recruited.</p>
<p><b>Existing resources are well utilized. (IM)</b></p>	<p>No findings as of 1/2001.</p>	<p>Partners are supporting implementation of small-scale strategies within their own organizational purview.</p>	<p>No findings as of 1/2001.</p>	<p>No findings as of 1/2001.</p>	<p>No findings as of 1/2001.</p>	<p>No findings as of 1/2001.</p>
<p><b>Resources for cancer control increase, as does coordination of the use of those resources. (IM)</b></p>	<p>The cancer registry received additional funding and personnel after a presentation from the director of the cancer registry at a nearby model planning state.</p>	<p>A partner identified and obtained funds to support a specific strategy. Additional matching funds for this strategy were identified through the HD. Several other partners were pursuing relevant funding opportunities, sometimes working together in teams. Illinois attributed the receipt of additional personnel and funding for its cancer registry to CCC planning.</p>	<p>No findings as of 1/2001.</p>	<p>No findings as of 1/2001.</p>	<p>No findings as of 1/2001.</p>	<p>No findings as of 1/2001.</p>
<p><b>Ongoing support for cancer control activities is secured (e.g., funding from general revenues). (PR)</b></p>	<p>Arkansas received a CDC field assignee. Southeastern States American Cancer Society (ACS) /CDC Leadership Institute led to a commitment</p>	<p>A partner who is a legislator introduced a bill to support CCC with \$500,000 in general revenue funds, although the bill did not make it out of</p>	<p>The American Cancer Society (ACS) made CCC a priority, approaching the HD about contributing support for a staff position.</p>	<p>No findings as of 1/2001.</p>	<p>A Prevention Specialist remained for implementation of the CCC plan as a CDC field assignee. Implementation includes strategy for institutionalization of CCC</p>	<p>No findings as of 1/2001.</p>

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	from Arkansas-based ACS to be a co-partner to CCC in Arkansas.	committee.			initiative.	
<i>Utilize Data/Research/Evaluation</i>						
<b>Planning data and research data are reviewed as a basis for needs assessment and strategy development. (PL)</b>	<p>Identified sources include:</p> <p>The Arkansas Breast and Cervical Cancer Program central database, behavioral surveys, county-level data.</p> <p>As part of the Hometown Health Improvement project, each community conducting a needs assessment.</p>	IL cancer registry staff lead or participate in action groups, are members of the core team and have made data presentations to the full partnership. The Data & Surveillance work group provided data to other work groups as requested.	Designated “backgrounders” (data experts) compiled and presented available data on incidence, prevalence, and mortality to each work group. Backgrounders assisted with the baseline data needed for specific objectives developed by each work group.	Core team members reviewed data on cancer incidence and mortality in Kentucky to focus on priority areas.	The medical director of the cancer registry is an active member of the CCC core team. BOH staff provided cancer registry and other HD data to work groups for review in priority-setting activities. Some partners (e.g., the Hospice Association) shared data with relevant work groups. Work group requests for scientific literature were fulfilled by the planning coordinator (a CDC employee) who had access to CDC library services.	Some background data were provided to partners at the first meeting (e.g., BRFSS, other sources). The Utah Cancer Registry is an active partner in the treatment work group. The Registrar gave a presentation to the Partnership at the second meeting about data available from that source. Work groups are collecting and reviewing data as they work to develop their problem statements.
<b>Data/research gaps are identified. (PL)</b>	Concurrent with CCC planning, the cancer registry has undergone its own complementary improvement process (see implementation below).	Strategies in the state cancer prevention and control plan include techniques to improve melanoma reporting (working closely with the dermatological professional association), several strategies that involve new data collections, and a strategic plan to enhance the cancer registry over time.	Work group members proposed data elements to be added to existing data sources. The skin cancer work group proposed (1) adding to the BRFSS a question to collect baseline data on skin cancer and (2) adding to the cancer registry incidence data on basal cell and squamous cell carcinomas.	Several priority areas in the state cancer prevention and control plan call for further research (e.g., research on environmental carcinogens).	One section of the Maine cancer plan is devoted to addressing data gaps and strengthening data resources. The Prevention Work Group in Maine was concerned about lack of evidence on the effectiveness of prevention. Data were particularly sparse for areas farthest along the continuum of care (such as rehabilitation) where little surveillance has been done.	Work groups determined what baseline data were needed to support the development of problem statements.
<b>Data and research are used to support priority setting. (IM)</b>	No findings as of 1/2001.	Data were used to select target cancers and to prepare Cancer-at-a-Glance and county cancer profiles. A cancer data book was prepared in cooperation	No findings as of 1/2001.	No findings as of 1/2001.	Work groups reviewed available data to identify areas to target for action and to develop issue statements, goals/ objectives, and strategies in these target areas. Where work group members	No findings as of 1/2001.

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		with ACS. Data development, enhancement, and use are a focal point of the Data and Surveillance action group.			could not identify sufficient data to inform their decisions, they included new research and new data collection among their proposed objectives and strategies.	
<b>Gaps in data and research begin to be addressed. (IM)</b>	An invited presentation by Tom Tucker of the Kentucky cancer registry generated support for adding funds to the budget of the Arkansas registry for developing community-level data and for using data for planning.	New data collections have been initiated on the needs of local health departments and on the location of mammography screening sites in Illinois. A new melanoma reporting strategy is in place.	Identification of a lack of adequate behavioral baseline data for some cancers led to the addition of questions to BRFSS.	No findings as of 1/2001.	No findings as of 1/2001.	No findings as of 1/2001.
<b>Cyclical process in place to assess, strategize, prioritize, implement, evaluate. (PR)</b>	No findings as of 1/2001.	A decentralized process for management, monitoring, and evaluation of implementation is established with responsibility resting in action groups.	No findings as of 1/2001.	No findings as of 1/2001.	Maine has identified staff members to support centralized procedures for the management, monitoring, and evaluation of implementation.	No findings as of 1/2001.
<b><i>Build Partnerships</i></b>						
<b>Original members remain committed as new members join. (PL)</b>	About 40 partners attended first task force meeting on 8/16/00, followed by Cancer Summit on 9/28/00 where 90 additional individuals expressed interest in participating in the summit as external partners. Arkansas currently is deciding how to include different levels of participation in the summit to receive maximum input without becoming	The Illinois partnership consists of 60 external members (including several legislators). New members continued to join often after hearing about the partnerships at conferences or speaking events.	The Kansas partnership consists of 30 -- 40 members. New members continued to join - at the June 2000 meeting there were five individuals attending for the first time.	Kentucky did not elect to develop a partnership for CCC planning. The core group obtained input from stakeholders as it developed the draft plan.	The planning consortium consisted of about 50 member organizations with room for additional growth.  As the CCC plan is implemented the transitional body will retain original consortium members while new members will join.	The Utah partnership consists of approximately 60 members. New members continue to join.

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	unwieldy.					
<b>Coalition and subcommittee meetings are held and attended regularly. (PL)</b>	The work group/subcommittee structure was established at the second task force meeting held in October 2000.	Partnership and work group meetings were held regularly throughout the priority-setting process. Since publication of the plan, full partnership and some action group meetings are held less frequently. (Some HD staff members serving as work group facilitators were assigned to new duties and had to be replaced.)	Partnership and work group meetings have had good attendance, with work groups meeting on an as-needed basis between the partnership meetings held every 3 to 6 months.	No findings as of 1/2001.	Consortium meetings were held quarterly and work group meetings more frequently throughout planning process. The coordinating committee met almost monthly between consortium meetings to discuss emerging issues and strategize. Work group chairs met regularly as a group with the planning coordinator when setting priorities for the plan.	The partnership meets approximately quarterly and the work groups more frequently between partnership meetings.
<b>Members commit to and are accountable for implementation of the plan. (IM)</b>	No findings as of 1/2001.	Accountability for plan implementation rests with the action groups rather than with individual members. Action groups are currently implementing strategies for which funding and other support has been identified.	No findings as of 1/2001.	No findings as of 1/2001.	At the consortium meeting in February 2000, members signed up to indicate their willingness to support implementation for specific goals and their objectives.	No findings as of 1/2001.
<b>Coordination between programs and services improves and the atmosphere grows more collaborative. (IM)</b>	A small group associated with an earlier planning process questioned the need for a new CCC plan. A review of the old plan by the task force led to a consensus that it was not comprehensive in scope and to the decision to move forward with CCC.	Advocacy groups that had been in disagreement in the recent past had become active members of the partnership. Hospitals that in the past refused to work with one another have now agreed to work and together with a newly formed cancer center that is an active partner.	Partners brainstormed on ways of bringing in representatives from organizations not at the table.	Kentucky was completing a statewide breast cancer planning effort at the same time that it began CCC planning. Several participants in the Governor's Task Force on Breast Cancer stated that they saw their issues overlapping with those of cancer control in general.	Work group chairs worked together to make decisions for the plan as a whole, rather than focusing solely on the objectives for a specific work group's issues.	The partnership includes a broad base of partners, including some in public and private sector leadership roles.
<b>Partners advocate and act in a concerted manner and themselves adopt a</b>	No findings as of 1/2001.	Partners advocated for support for CCC in the state legislature, with their federal legislative representatives, and	No findings as of 1/2001.	No findings as of 1/2001.	Consortium leadership is committed to implementation of the state plan and to institutionalization of the initiative. One partner has	No findings as of 1/2001.

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<b>comprehensive approach. (PR)</b>		elsewhere. Partners also assisted in identifying funding for specific projects. Individual partner organizations reported using the Illinois state plan as a framework for focusing their own work in cancer prevention and control.			agreed to in-kind contributions to support program institutionalization. Partners made presentations at the consortium about using the state cancer prevention/control plan as a model for developing internal plans for achieving joint priorities.	
<b><i>Institutionalize Initiative</i></b>						
<b>Members represent broad base and all believe they are being heard and benefiting. (PL)</b>	<p>The Cancer Summit resulted in a broad base of support for planning as evidenced by the number of people who responded to a request to drop off cards stating interest.</p> <p>Task force members disagreeing with comprehensive approach were invited to air their concerns. Leadership used a consensus-building process that resulted in commitment to a CCC Plan.</p>	The Partnership is considered to be broad and representative. Greater input may be desirable from representatives of minority and grass-roots organizations, and from cancer center directors and academics.	The Partnership has broad representation from a variety of organizations from all of the urban areas, but involvement of rural area representative remains a challenge. Members state that they feel comfortable bringing their issues and agendas to the table.	During Kentucky CARE conference, participants decided that the plan would be implemented through the coordinated actions of individual organizations and their ongoing relationships rather than through a new Partnership structure.	The Consortium is broad and representative. Strong clinical representation was achieved due to active recruitment by the cancer registry medical director and consortium co-chair, themselves physicians. One partner expresses concern that geographic representation was not broad enough, and involving cancer survivors has been a challenge. Partners have input into all major decision- making.	The Partnership has broad representation of the key organizations in the state. However, some participants expressed concern that some representatives are difficult to include as active members. This includes those in high-level positions (e.g., in medical centers). Recruitment is ongoing, and new organizations and members continue to join who can fulfill active roles.
<b>Members and facilitators express satisfaction with the process. (PL)</b>	Support increased support at the health director level after the September Cancer Summit.	A recently administered survey of partners revealed satisfaction with the CCC process. Partners and core team members voiced enthusiasm for the process and their respective roles in it.	Partners and core team members thought the large group meetings were organized and productive. A training for facilitators helped to focus and clarify the roles of the work groups and contributed to improved satisfaction.	Kentucky CARE conference garnered an enthusiastic response from participants.	Partners and core team members thought the large group meetings were well organized and productive. Those interviewed also voiced enthusiasm for and satisfaction with the process as a whole and with their respective roles in it.	Partners and core team members thought the large group meetings were well organized and productive, particularly through the use of a trained facilitator for the first few meetings. Work group members were pleased with their progress, but some groups thought that more direction would be helpful.
<b>Partnership is</b>	No findings as of	Core team members are	No findings as of	District Cancer Councils	CCC initiative has support	No findings as of 1/2001.

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<b>visible and a focal point for cancer-related policy and activities. (IM)</b>	1/2001.	frequently invited to present at meetings and conferences. A CCC exhibit draws attention at events. The CCC planning coordinator fields inquiries to the HD on cancer-related matters. A CCC web page at the HD site links to other relevant HD sites. Several partners were invited to the President's cancer panel regional meeting.	1/2001.	exist throughout state, but their role in implementation of the CCC plan is unclear.	among HD management, the ACS region, and consortium members. A core team member was invited to the President's cancer panel regional meeting.	
<b>Mechanisms are developed to ensure the collaborative process is sustainable. (IM)</b>	No findings as of 1/2001.	The Chronic Disease Division is seeking funding from health department management for one or two permanent staff positions for CCC.	No findings as of 1/2001.	No findings as of 1/2001.	From early in the CCC process, partner input was sought at key intervals; the coordinating committee developed matrices for decision-making and invited partners to discuss options. Partners and core team members are developing an approach to implementation and institutionalization, as outlined in the state cancer plan.	No findings as of 1/2001.