Evaluation of Team Up

Cancer Screening Saves Lives (2003 – 2008)

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Westat®

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This report summarizes the initial descriptive results of the evaluation. More extensive analyses are continuing and will be added to this report as they are completed.

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EXECUTIVE SUMMARY

Introduction

The 6-year pilot program *Team Up: Cancer Screening Saves Lives* (Team Up) was undertaken to consider approaches to improve cervical and breast cancer detection among women who are rarely or never screened for these cancers. Four national partners—the American Cancer Society (ACS), Centers for Disease Control and Prevention (CDC), National Cancer Institute (NCI), and United States Department of Agriculture (USDA)—worked with their state and county-level public health counterparts from eight states: Alabama, Georgia, Illinois, Kentucky, Mississippi, Missouri, South Carolina, and Tennessee. These states were chosen because they had counties with the highest cervical and breast cancer mortality and the lowest related screening rates (National Center for Health Statistics, 2002). The core set of pilot-wide goals that guided Team Up were to: (1) facilitate partnership development among the primary stakeholders in cervical and breast cancer screening; (2) encourage the adoption and implementation of evidence-based approaches to improve cervical and breast cancer screening; and (3) encourage women to receive routine screening for these two cancers.

The Team Up approach was to provide support for an extensive multiyear program to facilitate public health initiatives that guided the translation of cancer control research into practice. Specifically, Team Up was intended to be a focal point for addressing screening health disparities through the formation of partnerships and application of implementation approaches to lessen the morbidity and mortality differences among women not receiving screening. Each state focused on a population identified by their leadership as high-risk because of the link to cancer health disparity.

As the Institute of Medicine (IOM) reported, the health of racial and ethnic minorities, poor people, and other disadvantaged groups in the United States is worse than the health of the overall population (Institute of Medicine, 2006). The IOM report described that these 'health disparities', and their associated excess mortality and morbidity have been given a high priority in national health status reviews, including Healthy People 2010 and Healthy People 2020. Similarly, the Department of Health and Human Services (HHS) ranks health disparity issues third among its top five priorities. To address these priorities, the Team Up pilot project worked to bring together two challenging public health strategies—the translation and implementation of evidence-based interventions to other places and populations, and partnership among diverse people and organizations.

Origins of the Team Up Pilot

To begin to address the question of screening disparities and to consider approaches for framing solutions that would advance scientific knowledge into practice, researchers turned to epidemiologic data to understand the problem. Thus, research from the mid to late 1990s suggested that many medically underserved women in the United States did not receive recommended cervical cancer screening, despite the proven effectiveness of the Papanicolaou (Pap) test in reducing morbidity and mortality (Hewitt, Devesa & Breen, 2004). Overall, 17.6 percent of women (confidence interval [CI], 81.7-83.1) over the age of 25 reported they did not have a Pap test within the last 3 years. Of those least likely to have had the test, 58.3 percent (CI, 55.3-61.3) were women without a usual source of health care, and 62.4 percent (CI, 58.1-66.8) were women without health insurance (Swan, Breen, Coates, Rimer & Lee, 2003).

Similarly, large proportions of women who could benefit from regular mammography are not screened (Institute of Medicine, 2006). Among women over the age of 40, 29.9 percent (CI, 69.0-71.2) reported they did not have a mammogram within the previous 2 years. Women who were least likely to have had a mammogram were women with no usual source of health care (34.6%; CI, 30.7-38.6), and women without health insurance (38.4%; CI, 31.5-45.4) (Swan et al., 2003). For both screening tests, the greatest disparities were among women with lower levels of education and limited incomes, and those who lived in nonurban locations (Lawson, Henson, Bobo & Kaeser, 2000). Consequently, the lack of uptake of screening modalities was a persistent public health issue in general and specifically in certain regions of the country.

While the existence of health care disparities was firmly established by the late 1990s, the field had not yet found a practical blend of strategies and interventions that effectively worked to reduce these disparities (Robert Wood Johnson Foundation, 2008). This was due in part to the wide range of contributions to the problem. Women remained unscreened for numerous personal, social, and environmental reasons, including lack of a physician recommendation, lack of a usual source of public or private health care, inadequate health insurance coverage, living in rural communities, or being low income, and recent immigration to the United States (Grady, Lemkau, McVay & Reisine, 1992; Breen, Wagner, Brown, Davis & Ballard-Barbash, 2001; National Cancer Institute, 2001; Breen & Meissner, 2005; Hiatt et al., 2001). A large number of federally funded community health centers, hospitals, clinics, and voluntary associations provide Pap testing and mammography

screening services to underserved women. The numbers of women screened by these programs are not readily available. However, data from the 2003 National Health Interview Survey (NHIS) suggest that only 42.3 percent of women with no health insurance and who have family incomes less than 250 percent of the poverty level reported having had a mammogram during the previous 2 years (Sabatino et al., 2008).

In response to the epidemiological evidence, practical population-based strategies to increase cervical and breast cancer screening have been developed in recent years. For many years, researchers assumed that when these intervention strategies were found to be effective in a research context they could easily be disseminated into organizational and practice settings (Glasgow & Emmons, 2007). Unfortunately, this ease of dissemination has not been the case. As the IOM (2001) suggests, "in order for the interventions to make the transition from the research setting to the field setting, they must be 'transferred' – that is, disseminated and adapted to community-based organizations and other groups that can implement them on a local level." The challenge then for public health professionals is the translation of intervention science into successful program delivery, such that communities affected by cancer can benefit from the investment in intervention research. Team Up was developed to further encourage the implementation of evidence-based interventions in community settings.

Team Up Pilot Overview

The Team Up partners chose several strategies as mechanisms to reach women never or rarely screened for cervical and breast cancer. Built on an underlying principal that different people and organizations can capitalize on their complementary strengths and capabilities (Lasker, Weiss & Miller, 2001), one Team Up objective was to develop and sustain dedicated partnerships that embraced population-based health principles to reach the desired population. A second Team Up objective was to use the best evidence-based approaches, and leverage the partnership approach to implement interventions within counties targeted for their cancer health disparities.

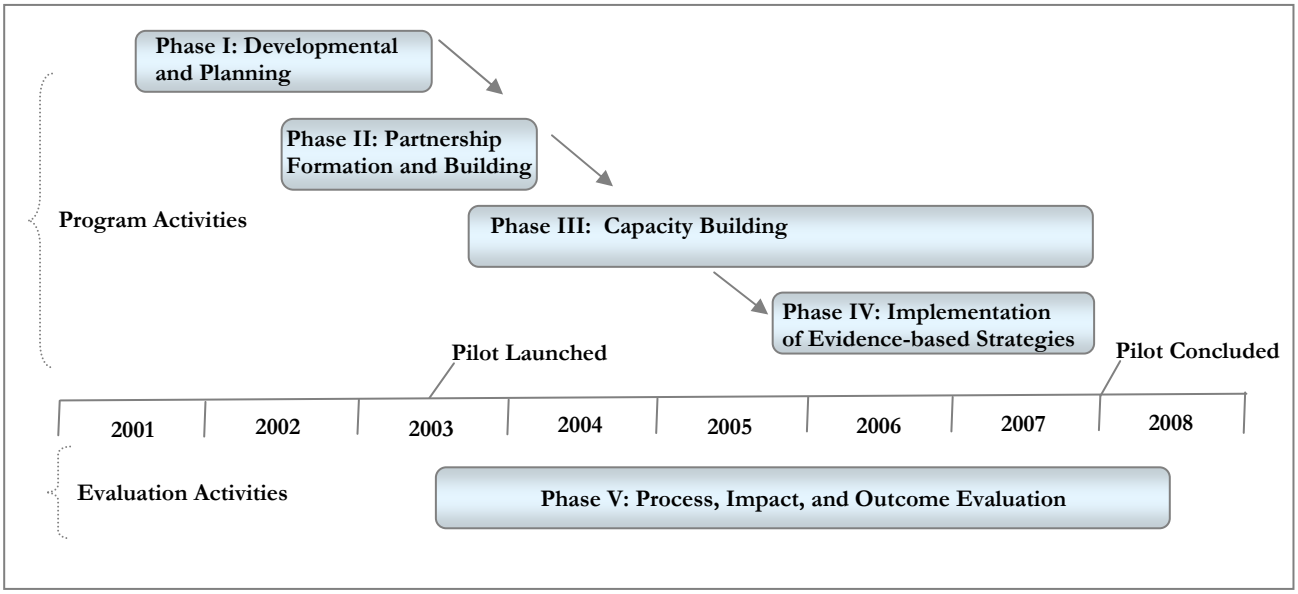
Short-, mid-, and long-term outcomes were established to evaluate achievement of these objectives. Guided by the best available scientific interventions and access to practitioners willing to adopt or adapt these new approaches into a field setting, a short-term outcome was to optimize the transfer and use of effective evidence-based interventions for cancer prevention and control. A second short-term outcome was to build and sustain a network of partnerships involving national, regional,

and state stakeholder groups. By focusing on the tremendous untapped potential to prevent illness, a mid-term outcome was an expected increase in cancer screening appointments. It was expected that the increase in screening appointments would, over time, result in the long-term outcome, reduction in cervical and breast cancer mortality. The essential question tested in the Team Up pilot was whether viable partnerships could be formed among public and private entities to solve a problem that no single agency or organization seemed to be able to solve alone.

Framework for Team Up Pilot Programmatic and Evaluation Phases

Both organizational and coalition literature suggest a sequence of phases through which organizations or pilot programs move as they establish themselves to meet their goals (Kreuter, Lezin & Young, 2000). In general, these conform to the chronological phases of formation for planning, implementation, maintenance, and accomplishing goals or outcomes through evaluation (Butterfoss, Goodman & Wandersman, 1993). Each of these phases can be expanded, as in the case of Team Up, to include more discrete phases. For instance, the expansion of the formation phase included partnership and capacity building, as well as precursors to implementation activities. Since the maintenance phase of programmatic activities usually extends over a lengthy period of time, it was not included in the Team Up schematic (Figure 1).

Figure 1. Team Up: Pilot Program (2001-2007) and Evaluation (2003-2008) phases



Phase I: Developmental and Planning (November 2001–June 2003)

Historically, cancer prevention and control efforts have been undertaken by different agencies and organizations targeting specific cancers, with a lack of coordination and collaboration between and among them (Abed et al., 2000). By design, the development and planning for Team Up took time and included a series of events that occurred prior to the official formation of the pilot. For example, a cervical cancer roundtable in November 2001 identified that cervical cancer was a major health disparity problem among certain subpopulations and in distinct geographic regions of the United States.

Throughout 2002, groups of cancer control scientists from ACS, CDC, and NCI convened to understand both the magnitude of the epidemiologic problem and to assess what could be done to remedy these disparities. Forming partnerships with those who had knowledge of high mortality counties, and were able to reach and educate low-income and medically underserved populations of women became a priority. Furthermore, discussion among the Federal partners permitted the development of comprehensive strategies that laid the foundation for the pilot and subsequent solutions to target those likely to experience health disparities.

Team Up national partners were open to new solutions to solve old problems, and recognized the value of being open to include 'nontraditional' cancer control partners that were diverse in terms of their perspectives, areas of expertise, populations, and sectors represented. Since the USDA served a wide array of public and private organizations throughout the United States, they were invited to participate in the Team Up pilot. Through their extension program, USDA had the potential for greater access to medically underserved women because of their service coordination efforts between public and private agencies and community-based organizations.

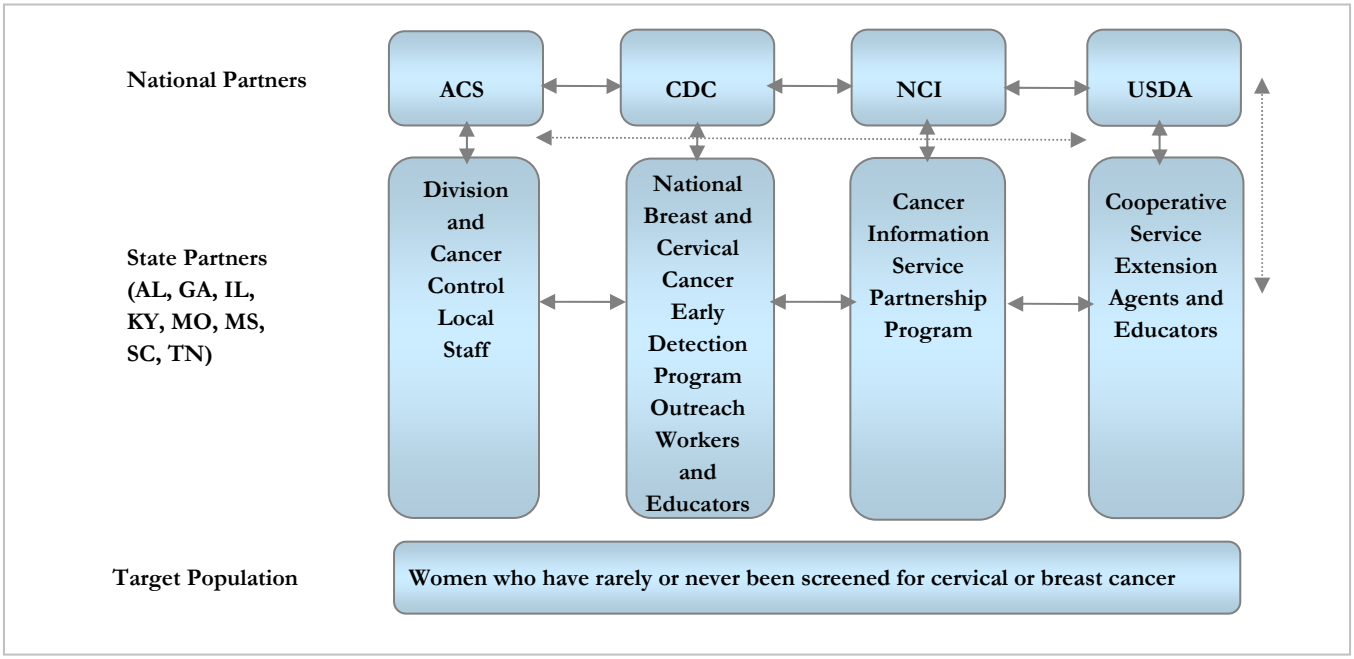
In 2003, a planning group from ACS, CDC, NCI, and USDA conducted a participatory needs assessment and developed a structure to guide potential programmatic and evaluation activities. The programmatic structure was developed collaboratively and included two components. First, Concept Mapping, a comprehensive map of the outcome domains that needed to be addressed, was done (Trochim, 1985; Trochim & Linton, 1986). Second, the resulting Concept Map was further expanded into an outcome logic model that depicted the sequential and causal relationships among the outcome constructs (W.K. Kellogg Foundation, 2001). Engaging in both processes facilitated narrowing the programmatic planning and identifying evaluation measures.

Phase II: Partnership Formation and Building (June 2002–December 2003)

Developing partnerships between national, Federal, and non-Federal institutions that conduct research and deliver health care represents an important mechanism. Partnerships bridge the gap between knowledge and practice (Bazzoli et al., 2003; Elsinger & Senturia, 2001; Israel, Schulz, Parker & Becker, 1998).

For the national partners, an important facilitator of the pilot startup was to make use of preexisting health program infrastructures that could be accessed by state-level partners (Figure 2). Sources of existing infrastructure included the regional offices of ACS, National Breast and Cervical Cancer Early Detection Program (NBCCEDP) from CDC, the Cancer Information Service from NCI, and the Cooperative Extension Agents affiliated with the USDA. Team Up recognized the important contribution of state and county partners and made efforts to engage local partners throughout the life of the pilot program.

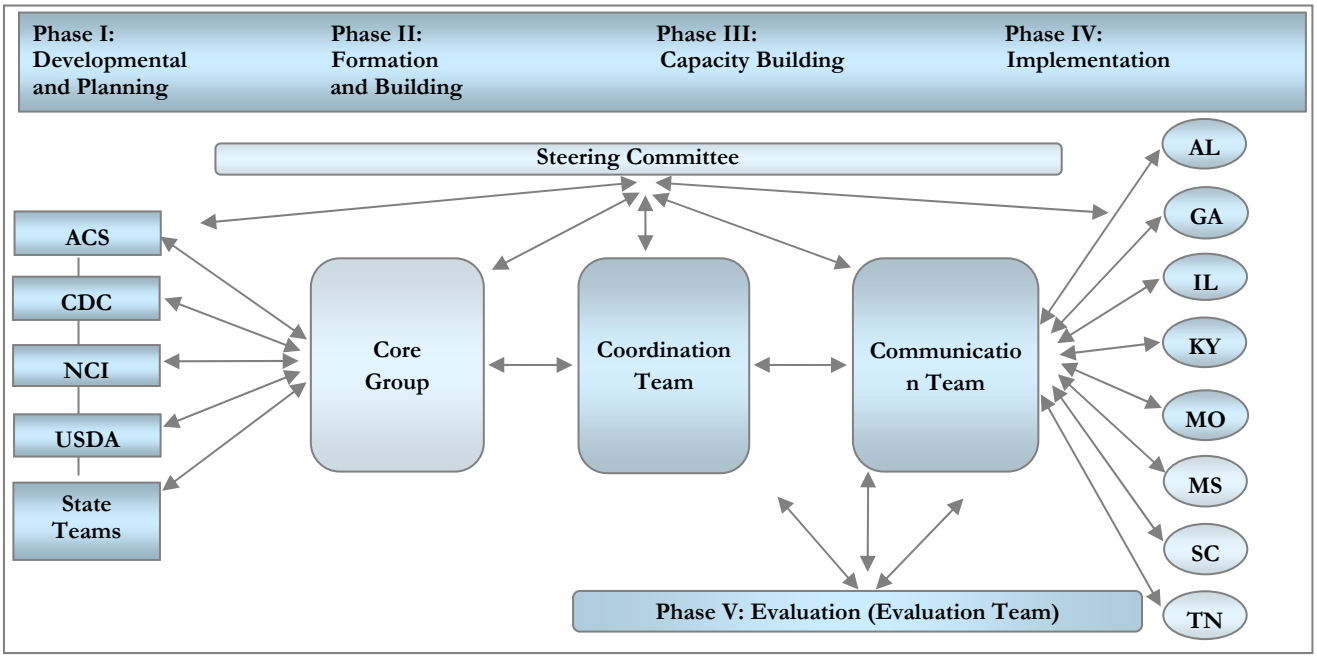
Figure 2. Structural framework of Team Up partnership



The partnership structures are depicted in the formal operational structure (Figure 3) of the Team Up pilot phases. The top of Figure 3 represents the different phases of the pilot, and within the body of the figure, the involvement of different partners and committees. The national steering committee comprised members from national and state partners, and was charged with overseeing

the pilot. The core group addressed strategic issues and also comprised members from the national and state partners. The core group also supported the coordination team with the execution of technical activities. The communication team was responsible for disseminating information on all facets of the Team Up pilot to all Team Up members.

Figure 3. Team Up: Operational structure and pilot phases



Phase III: Capacity Building (July 2003–September 2007)

To ensure that the pilot was carried out as designed, Team Up developed a series of capacity-building activities beginning in July 2003. These activities were intended to ensure that local partners received adequate skills and training to deliver complex evidence-based interventions. Capacity building also provided tailored technical assistance for implementation activities. These activities were intended to be limited to a single kickoff meeting, but as the pilot matured it became apparent that Team Up was more complex, and to strengthen the infrastructure would require ongoing mentoring for the life of the pilot. The nine capacity-building activities, all financially supported by Team Up national partners, are described below:

1. **Kickoff meeting (July 2003).** The national partners developed a pilot training program for state- and county-level public health practitioners from the eight states. Team Up commenced in July 2003 with a kickoff meeting entitled, *"The Partnership to Increase Cervical and Breast Cancer Screening in High Mortality Counties: Pilot Training."* The training and followup activities were designed to: (1) develop, create, strengthen, and support state-

and local-level partnerships; (2) identify, access, adapt, and implement evidence-based approaches for use in high mortality regions; and (3) identify and encourage women who have rarely or never been screened for cervical or breast cancer to be screened. All states developed a state action agenda (SAA) to guide their next steps.

2. **Web Forum (June 2004–October 2006).** State partnerships requested a web-related forum to communicate with each other and with the national partners. States also requested an open and ongoing medium to share common documents including presentations, and formal documents from the national partners that could be used locally, as well as information about planning the implementation, and training announcements. The web forum, led by CDC, was also intended to encourage overall communication with regular online 'live chats' among various state partners.

3. **Newsletters (October 2004–April 2007).** Newsletters were the most frequent formal communication used to share: (1) broad technical assistance needs through education; (2) highlight partnership success with specific states; (3) document the implementation progress of Team Up; and (4) general communication with states. In all, 11 issues of the Team Up newsletter documented the implementation of the pilot.

4. **Coaches (October 2004–December 2007).** Since progress after the kickoff meeting was slow, the states asked for additional assistance to clarify issues, strengthen relationships, and provide assistance on how best to accomplish the multifaceted Team Up objectives. Two coaches were identified to work one-on-one with state team partnerships to build capacity and provide technical assistance in the three areas related to the basic Team Up components, which were to: (1) reach rarely or never screened women; (2) use evidence-based interventions as the approach; and (3) forge partnerships as the overarching strategy.

5. **PATH Visits (April 2005–May 2005).** The Partnership Assistance and Technical Help (PATH) visits were conducted with each state partnership to support the development of the state technical assistance plan (STAP). Coaches conducted tailored teleconferences and 1-day, in-person state visits. In conjunction with the coaches, the resulting STAPs and SAAs included priority action steps that states were expected to follow throughout their involvement with Team Up. States understood that the STAPs and SAAs comprised the foundation for ongoing technical assistance from the coaches.

6. **Regional Meetings (June 2005, August 2005).** Bringing national and state partners together was an essential face-to-face communication strategy used by Team Up national partners. One-and-a-half day regional meetings led by content area experts were both didactic and interactive. They were designed to convey a common understanding of Team Up goals, objectives, concepts, methods, and timelines. They also provided a venue for states to use the forum to share general technical strategies, express needs, and convey concerns.

7. **Webinars (October 2005–April 2006).** Webinars were web-based seminars held via the Internet on different topics identified by state partnerships. The purposes of the three webinars were to: (1) address specific technical assistance needs, and (2) facilitate live-time

8. **Retreats (June 2006–January 2007).** New technical assistance options were in demand throughout the pilot, and especially as states matured. It was apparent that at all times, each state was at a different stage of partnership, development, planning, and implementation. States found they needed to regroup on more than one occasion, and to strengthen specific elements of their partnership before they moved forward to the next phase. For those states that already executed the action steps, and that needed to refine their plans, or wished to evaluate progress in completing action steps or wanted to solidify a particular aspect of their partnership, an invitation was extended to all state partners to participate in facilitated planning retreats using the ACS Retreat model. ACS convened 2-day planning retreats for the three partnerships ready to commit (Georgia, Missouri, and Tennessee).The overall goal of the retreats was to further operationalize strategic planning and implement identified action steps that would lead to increasing cervical and breast screening for medically underserved women.

9. **National Meetings (August 2006, June 2007).** The two national meetings hosted by the national partners provided an opportunity for national and state partners to network, share progress and experiences, and receive training or technical assistance from experts.

Phase IV: Implementation of Evidence-Based Interventions (July 2005–December 2007)

The implementation phase was the period in which state partnerships were required to translate research into practice with the delivery of evidence-based approaches to reach rarely or never screened women. Aside from the technical assistance offered by the national partners, implementation was a state-managed activity. States moved through a sequence of stages as they familiarized themselves with the new terminology and activities. Preparatory stages included state staff conducting needs assessments, collecting surveillance data, and convening planning groups. In many instances, these groups became the nucleus for larger state initiatives to reach specific subpopulations of women. Next, states identified sources of evidence-based interventions to understand if the externally developed interventions were appropriate for their target populations. If they were, then the selected intervention was adopted and subsequently went through a lengthy process of adaptation so the specific intervention would fit their 'real world' or 'field' settings. States also trained staff to deliver the intervention to their medically underserved populations and evaluated their efforts.

Phase V: Evaluation (July 2003–April 2008)

National Team Up partners recognized that program evaluation was a critical function of all public health initiatives, but that it was especially important to understand how this program was implemented, and whether it was working as planned. A three-part evaluation was conducted to determine whether Team Up achieved its goals and provided information and data with which a decision could be made to advance beyond the pilot phase. Part I of the evaluation, the process evaluation, assessed the success of the four core state organizations in building a viable partnership. Part II, the impact evaluation, measured the ability of the Team Up states to adopt, adapt, and implement evidence-based interventions. Part III, the outcome evaluation, assessed whether state partnerships were able to increase short-term screening rates. The following research questions framed the evaluation:

- **Process Evaluation**

  1. How successful have the state partnerships been in building and sustaining their partnerships?

  2. How has the national partnership been helpful to the states in building and sustaining their partnerships among the four core organizations (ACS, CDC, NCI, and USDA)?

- **Impact Evaluation**

  3. To what extent has an evidence-based intervention been adopted, adapted, and implemented by state and local partners in each of the target counties?

  4. What factors (e.g., characteristics of the selected innovation) influenced the adoption, adaptation, and implementation of evidence-based interventions by individual partnerships?

  5. How and to what extent has the national partnership assisted in the process of adopting, adapting, and implementing an evidence-based intervention?

- **Outcome Evaluation**

  6. To what extent did state partnerships increase screening rates in their targeted areas among women who have rarely or never been screened for cervical and/or breast cancer?

To assess the multiple dimensions of the Team Up pilot, a mix of data collection strategies was employed. For the process and impact evaluations, methodologies included semi-structured telephone interviews of state leadership from each organization, and self-administered web-based

and electronic surveys completed by the entire state partnership. In addition, the following archival data was also reviewed: reports and evaluations of specific Team Up capacity-building activities, feedback on the content of regional and national meetings, and what services and interventions state partners provided to whom, when, and in what context. The outcome evaluation involved an analysis of the Behavioral Risk Factor Surveillance Survey (BRFSS) county-level cervical and breast cancer screening rate data. These analyses included pre-intervention measurement of intervention and matched control counties.

Findings

Key findings are described for the first 4 years of Team Up and center around each of the evaluation phases and respective questions.

Process Evaluation

Question 1: How successful have state partnerships been in building and sustaining their partnerships?

Team Up was able to develop viable partnerships that remained throughout the pilot program (2003 to 2007). Six of the original eight states completed the pilot. Two states (Illinois and Mississippi) terminated their involvement by early 2006. For each partnership, the rationale for terminating was unique. In Illinois, the duplication of statewide programmatic efforts resulted in the redistribution of resources, and for Mississippi the profound effects of Hurricane Katrina redirected their interests away from the Team Up focus.

Based on survey data, the national partners were the guiding force behind the state partnership involvement. They designed the concept and provided the support for developing the state partnerships. Even though the pilot was launched in July 2003, it was not until October 2004 that the national partners provided technical assistance resources to clarify the expectations of Team Up and assist states in achieving their goal of implementing an evidence-based intervention. The delay was associated with a prolonged startup at the state level and the national partners' assessed recognition of the type of additional technical assistance needed.

The states' level of success in moving from a team of individuals functioning in independent organizations to a viable partnership was measured by their level of synergy, and the extent to which the perspectives, resources, and skills of participating individuals and organizations contributed to and strengthened the work of the group (Lasker et al., 2001; Lasker & Weiss, 2003). The states with higher synergy levels by the end of the pilot had strong leaders, the full participation of all (or most) members, had obtained external resources, and were committed to implementing an evidence-based intervention. The partnerships with lower synergy levels were more likely to have encountered different inter-organizational cultural challenges and beliefs that required considerable partner efforts to reconcile. Many of the partners who participated on their state's team had not worked together before, and those who had brought different cultures, agendas, and resource capacities to Team Up.

Since each partner brought a unique perspective to the Team Up state partnership, those that did not have involvement from all partners had difficulty achieving the goals of Team Up. As in any partnership initiative, reconciling these different partnership cultures and beliefs, and identifying and integrating complementary resources took time and considerable effort. Nonetheless, the partnerships worked to overcome these challenges; at times, it seemed that it would have been much easier to agree to disband a state partnership and move on, but collective commitment to the goals of the Team Up project and often, a respect for each other, kept the partnerships from separating.

Question 2: How has the national partnership been helpful to the states in building and sustaining their partnerships among the four core organizations (ACS, CDC, NCI, and USDA)?

The national partners were the impetus for developing the partnerships in the eight states. The July 2003 kickoff meeting, sponsored by the national partners, provided an opportunity for participating states: (1) to develop, create, or strengthen a partnership at the state and local level; and (2) to understand how to access and adapt evidence-based screening interventions for use in high mortality regions.

A key goal of the Team Up pilot was to establish partnerships that could sustain themselves. The national partners implemented a series of activities aimed at building and sustaining viable partnerships among the collaborators in each of the Team Up states. Among the activities were team building exercises through PATH visits, regional meetings and ongoing technical assistance from coaches.

Three of the original eight partnerships planned to continue Team Up activities in some capacity after the pilot ended. One of the three partnerships decided to forgo future Team Up efforts in favor of combining their efforts with another statewide initiative.

Although the national partners encouraged the sustainability of all partnerships, they did not have the means to support sustainability financially. Even without financial support for sustainability, in most of the partnerships, it was clear that the efforts to reach rarely and never screened women need to be ongoing, and reaching these women is now recognized more broadly in each of the states. Five partnerships plan to continue their intervention in some capacity, and three partnerships plan to continue the partnership. Of note, several partnerships institutionalized the outreach and education curricula of the USDA Cooperative Extension Agents into their states' cancer control efforts. State partnerships reported that should they move forward, the intervention and the partnership will likely take a different form. Partnership sustainability may include folding into a larger, preexisting local initiative, or expanding beyond cervical and breast cancer to include colorectal as well as other cancers. A main determinant in sustainability is grant-related funding for infrastructure support and expanded educational activities.

Impact Evaluation

Question 3: To what extent has an evidence-based intervention been adopted, adapted, and implemented by state and local partners in the target counties?

Six states adopted, adapted, and implemented an evidence-based intervention. Initially, state partners were not cognizant that they were to select an evidence-based intervention and build consensus around what an 'evidence-based intervention' means. This lack of awareness resulted in initial resistance to ideas presented at the July 2003 kickoff meeting. States were resistant because they felt that they knew what worked best in their communities, even if it was not evidence-based; others were resistant because they felt they did not have the (financial or personnel) resources necessary to implement an evidence-based intervention (Team Up did not provide implementation funds). Table 1 outlines the evidence-based interventions selected, the specific components selected, and the selection date.

The national partners provided technical guidance for identifying evidence-based interventions such as the Cancer Control P.L.A.N.E.T. web portal. Most state partnerships selected and adopted their interventions in 2005 following a series of regional meetings. The meetings were designed to support

implementation strategies, and to facilitate technical assistance. Ultimately, all six partnerships adopted an evidence-based intervention that was most appropriate for their partnership and locale.

Adapting evidence-based interventions was a particularly difficult process. Even after adaptation, states still had questions about specific adaptation processes for their interventions, including the kinds of adaptations that were appropriate and how much the evidence-based intervention could be modified before it transitioned into an entirely new intervention. In addition, states faced contextual challenges in the adaptation process, which subsequently caused delays in implementation. It turned out that adaptation was more complicated and time consuming than expected. For instance, items from the original intervention, such as the original curricula, were not available and had to be developed de novo; all materials needed to be re-designed for the new target population; new items needed to be tailored to either the intervention or the new population; and with one state the Institutional Review Board approval process took longer than expected. Also, state partners struggled with the meaning of implementation fidelity (exact replication of the program process as it was originally demonstrated) to the original evidence-based intervention.

Table 1. Evidence-based intervention, components selected, and selection year

State	Intervention selected	Components selected	Selection year
A	FoCaS[1]	Media campaign, educational classes, one-on-one sessions, inclusion of church/religion	2005
B	FoCaS, Filipino American Women's Health Project[2]	Educational classes, inclusion of church/religion	2005
C	FoCaS	Media campaign, educational classes, one-on-one sessions, inclusion of church/religion, educational games to teach examination skills, distribution of literature in the waiting room	2004
D	Breast Cancer Screening Among Non-Adherent Women[3]	Tailored telephone counseling, tailored print communications	2005
E	FoCaS	Educational classes, inclusion of church/religion, in-service and primary care conference training for providers	2005
F	FoCaS	Media campaigns, educational classes, one-on-one sessions, direct mail, inclusion of church/religion, community events, in-service and primary care conference trainings for providers, distribution of literature, one-on-one counseling sessions, and personalized followup letters for women with abnormal test results	2005

1. Forsyth County Cancer Screening Program (FoCaS)
2. Filipino American Women's Health Project
3. Breast Cancer Screening Among Non-Adherent Women

Consequently, most partnerships did not begin full intervention implementation until the latter half of 2006 and the beginning of 2007. In most cases, implementation was not as problematic as the adaptation phase. However, by the end of the pilot, several partnerships questioned whether they truly implemented an evidence-based intervention after all the major modifications made. This questioning was not unusual since much is still unknown about what it means to implement evidence-based interventions to other places and populations.

Question 4. What factors (e.g., characteristics of the selected innovation) influenced the adoption, adaptation, and implementation of evidence-based interventions by individual partnerships?

Even though each state developed a state action agenda and vision in July 2003, it was not until the national partners provided explicit strategies, distinct steps, and additional technical assistance that progress was made. In all states, selection and adoption of an evidence-based intervention involved vetting by the full state partnership or designated subcommittees to ensure that the selection was appropriate for a particular partnership and locale. All states used the Cancer Control P.L.A.N.E.T. web portal to select either the Forsythe County Cancer Screening Program (FoCaS) or Breast Cancer Screening Among Non-Adherent Women; and Filipino American Women's Healthy Project (selected by one state in addition to FoCaS). The three most prominent factors that influenced the adoption process were the ease in identifying and then selecting the intervention, whether it matched the overall state program goals, and whether it addressed the local population needs.

States described a two-part adaptation process. The first occurred during planning at the state level, and the second during implementation at the local level. In some cases adaptation was anticipated and in others it was not. Adaptation occurred because all of the interventions contained multiple components, which was their appeal. However, no state implemented any of the original intervention in its entirety as initially developed. Interventions underwent change to fit local circumstances (i.e., the target population, location, or limited resources), which included changing materials so they were more understandable, or tailoring components for a specific population's literacy or cultural needs. Other changes included adding an emergency room component to target uninsured women obtaining services, or adding a cooking demonstration to classes since these interventions were being delivered by USDA Cooperative Extension Agents. The lack of guidance on how far an intervention could be adapted before fidelity to the original intervention was lost was of concern to state partners, and states wanted guidance and feedback from the national partners on

this point. Two factors determined the extent of the adaptation process: direct evidence, which consisted of access to the original intervention materials that provided relevant guidance, and indirect evidence, which consisted of practitioners who altered the original intervention because guidance was insufficient to meet local programmatic needs. Even if the direct evidence was available through contact with the original investigator, there was a paucity of information to suggest which and how much materials could be altered to 'fit' the new intervention within existing state programs and target populations.

All partnerships developed some kind of written implementation plan, which was used as a replication guide. However intervention activities were carried out in designated counties, and evolved over time and varied from county to county and within each state. State partners gave counties flexibility in the area of implementation due to the diversity (i.e., both delivery modes and target population differences) within their state. Based on experience, many felt that a 'one-size-fits-all' model would be inappropriate for their states. Often, the need to accommodate different intra-state demographics and landscapes resulted in loose implementation strategies. It was during implementation that USDA Cooperative Extension Agents were most actively involved, if they were not already involved from the planning phases. As a vital link to many of the medically underserved populations, USDA Cooperative Extension Agents were relied on heavily for program delivery. In summary, factors that were instrumental in implementation included: (1) collaboration and teamwork at all levels of a state's partnership; (2) acceptance that some contextual influences are more conducive than others; (3) availability of human and fiscal resources; and (4) access to a dedicated facilitator who was adept at coordination, troubleshooting, and communicating progress.

Question 5. How and to what extent has the national partnership assisted in the process of adopting, adapting, and implementing an evidence-based intervention?

An underlying assumption was that disseminating sound research evidence involves a triangle that includes: (1) dedicated partnerships that embrace population-based principles; (2) the best available scientific interventions; and (3) practitioners willing to adopt, adapt and implement new approaches.

To create knowledgeable public health partnerships, the national partners worked to develop opportunities throughout the pilot that would make it easier for states to identify and apply different types of evidence. To facilitate access to the best scientific approaches and to help states play an active role in making decisions regarding the dissemination and implementation process, a series of capacity-building strategies were employed. These strategies were intended to: (1) improve

knowledge about evidence-based interventions; (2) result in greater agreement and more realistic expectations from states once they were able to develop and implement their state action agendas; and (3) lower the conflict surrounding accomplishing Team Up objectives. Finally, to assist practitioners with the dissemination process, the national partners responded in the distinct ways that are described below.

- **Improve Knowledge.** States reported that they were not initially aware of the requirement to implement evidence-based strategies (at the July 2003 kickoff meeting). They stated that it consumed considerable time and involved extensive partnership consensus to reach an understanding of how to define evidence, and then how to identify and use evidence-based strategies. State partners were instructed on how to access an evidence-based intervention during a demonstration of the Cancer Control P.L.A.N.E.T. web portal. They were also familiarized with the CDC's Guide to Community Service. They were linked to experts working within the dissemination and implementation field through webinars and meetings. Experts were made available to discuss strategies and recommend steps to move forward. Of note, assimilating the complex dissemination and implementation processes required Team Up stakeholders to work together to explore their own disparate perspectives and learn how to speak a similar language until agreement was reached. Even with the ongoing technical assistance, states requested more assistance with the adaptation phases, as discussed above.

- **Increase Agreement With State Action Agendas.** To determine that evidence-based principles were being integrated into competing state priorities and that states were applying agreed-on planning to their state action agendas, the national partners conducted a brief 3- and 6-month evaluation after the July 2003 kickoff meeting. To guide states, more personalized communication was introduced with the PATH visits, coaches, and the retreats. Information from the latter efforts enabled the national partners to tailor subsequent meetings to address identified challenges and barriers to carrying out the state action agendas. These included persistent requests for supplemental fiscal resources to: (1) support implementation outreach efforts; (2) hold face-to-face meetings; and (3) deal with the physical distance between rural partners. States considered these to be essential infrastructure issues, which, without funds, impacted the operational dimensions of their partnership and the type of activities states needed to perform for Team Up.

- **Lower Conflict Surrounding Accomplishing Team Up Objectives.** Foremost in most discussions with states was a need to improve communication between states themselves and with the national partners. Clear evidence suggested that the failure of simple communication, such as holding regular meetings and presenting regular updates, can inhibit the social influence of common agenda-setting, achievement of group consensus, and building collaborators beyond the immediate group (Kreuter et al., 2000). National partners recognized that complex interactions within and among partners heightened awareness, however the national partners acknowledged that there was no one best way to encourage success of partnership objectives, so they offered choices. Throughout the pilot, national partners used every opportunity to reinforce the

> Team Up's vision, goals, and objectives, and the coaches and retreat facilitators ensured that states were talking the same language when they reviewed the state action agendas. What persisted as a constant conflict was the challenge of staff turnover within partnering organizations. This frequent turnover resulted in some individuals becoming less integral to Team Up activities or others who were unaware of how state action agendas were connected to evidence-based efforts.

There was a steady tension throughout Team Up between what states wanted and what the national partners delivered. This tension led to the states' perception that the national partners needed to be more involved initially, a need for communication to improve knowledge about the technicalities and practicalities of the implementation process, and a call for targeted training to advance understanding among states.

Outcome Evaluation

Question 6: To what extent did the state partnerships increase screening rates in their targeted areas among women who have rarely or never been screened for cervical and/or breast cancer?

Results from the outcome evaluation suggest that the objective of identifying whether Team Up state teams increased screening rates in the short term proved to be more challenging than originally realized. Although analyses from the cross-sectional 2000, 2002, and 2004 BRFSS data did not show significant differences between intervention and control counties overall, there were differences by BRFSS survey year that showed minimal screening increases. More than likely, these increases were due to ongoing national and local efforts to improve cancer screening health disparities among women, since the earliest Team Up intervention was implemented in late 2004.

BRFSS post-intervention screening rate data were not available at the time of this evaluation. Therefore, whether intervention county screening rates increased implementation of an evidence-based intervention could not be determined from the national perspective. Also, given that states did not begin to field the interventions until 2004, and some as late as 2007, it made sense to collect only baseline screening rates, rather than make short-term outcome judgments of changes in screening. Future work will focus on the mid-term outcomes associated with out-year data from BRFSS, and additional analyses will incorporate state findings to gain insight to understand the influence of the numerous processes involved in the uptake of screening.

Recommendations

Due to the complexities of Team Up, the challenges the partnerships faced as well as its accomplishments, this pilot project achieved what pilots should—it has yielded important lessons that can be applied to future cancer prevention and control efforts. Team Up sought to build state-level public-private partnerships with the goal of implementing evidence-based strategies that reached the medically underserved women who are not screened. The following are recommendations for moving forward with such a model.

Process Evaluation

Recommendation 1: Building and sustaining partnerships.

Involve and listen to local residents and professionals during the planning phases of inter-organizational public health partnerships. In some partnerships, contextual challenges that had an impact on successes could have been addressed and/or avoided in some measure with earlier input from local residents and those who work in the target communities. Consequently, both a 'bottom-up' and 'top-down' approach is appropriate to employ at different stages in the developmental trajectory of partnerships.

Facilitate membership continuity in complex partnerships. Those who have experience working in the target communities and diverse constituents typically know what is feasible, realistic, and improves 'buy-in' and participation in later phases of the project. Involve individuals who will carry out the intervention early on during project planning to increase ownership, communication, commitment, and reduce turnover. Member satisfaction is correlated with increased commitment and involvement.

Encourage partnership consensus to establish synergistic collaborations. Collaborations formed early in the partnership can be sustained throughout and beyond a project, and are able to overcome obstacles in successful and creative ways.

Recommendation 2: National partnership helping states facilitate and sustain their partnerships among core organizations.

Provide project participants with clear project expectations from the inception, and confirm that those expectations are understood. Ongoing communication and technical assistance need to be consistent with and supportive of these expectations.

Maintain ongoing support throughout the entire project. A favorable organizational environment supports tasks to be accomplished during planning and throughout the project. Programmatic support needs to include clarification of the organization's mission, recruitment of members, formalized roles and procedures, an outline of dissemination and implementation strategies, and incorporation of evaluation as part of the program.

Integrate researcher and practitioner experiences. Foster collaborations during planning phases (not the implementation phase) with original researchers and practitioners available to communicate. Dialogue will help narrow the research-to-practice chasm. Both have a common goal to solve a particular health problem. Both want to ensure the integration and utilization of evidence into practice.

Impact Evaluation

Recommendation 3: The adoption, adaptation, and implementation of an evidence-based intervention.

Develop a consensus of what counts as evidence and in what circumstances when adopting an intervention. Interventions that do not contain the entire 'suite' from the original research intervention may not be able to maximize effectiveness in the new practice environment.

Monitor the multiple levels and continuously evolving adaptation of an interview that occurs due to geographic and demographic diversity. Key is systematic tracking of all of the adaptation progress throughout the implementation processes. Partners repeatedly expressed the idea that 'one size does not fit all,' and in their diverse states this translated into innovative, county- and community-level adaptation, beyond what was planned by the state partnerships. Consequently, adaptation and implementation becomes an organic process by necessity rather than by design.

Repackage evidence-based interventions for dissemination to facilitate the adoption, adaptation, and implementation processes for practitioners. State partners need to continue to talk with researchers and other state partners to exchange information and advice throughout implementation. The practice of combining, customizing, and piecing together intervention components in less-than-ideal field conditions is valuable information for researchers to know. Researchers need to understand what is involved when others translate research into practice.

Recommendation 4: Factors influencing the adoption, adaptation, and implementation of evidence-based interventions.

Match of state action agenda and dissemination and implementation processes. Spend time during the planning phase to link state action agendas to implementation goals and processes. Identify clear implementation strategies that collapse steps and document activities to be accomplished, describe processes, and determine whether goals have been accomplished.

Develop a better understanding of implementation methodologies such as fidelity requirements (to the original intervention) for evidence-based. Once the appropriate adoption process is clearly defined, national partners should work closely with state partners to ensure that evidence-based approaches are adapted as intended, and to ensure that the new intervention becomes a faithful replication of what was proposed. Even though dissemination and implementation are evolving efforts, it is essential that practical and replicable solutions are available to others who wish to build on this work and address a similar health disparity problem.

Recommendation 5: National partnership assistance in adopting, adapting, and implementing an evidence-based intervention.

Provide seed money (at a minimum) for timely and effective partnership implementation efforts. For the Team Up state-level partnerships to achieve their goals, it is desirable for the national partners to provide financial resources to: (1) assist in developing the state partnership (e.g., hiring a partnership coordinator); and (2) fund continued implementation of the evidence-based intervention. If financial resources are not possible, then in-kind resources that lend themselves to supporting technicalities associated with dissemination and implementation processes are essential.

Promote standardized ways to deliver programmatic capacity building that supports partnerships to implement evidence-based approaches. Promotion of consistent technical support across states will permit site-to-site and partnership-to-partnership comparisons and subsequent improvements on a larger scale.

Outcome Evaluation

Recommendation 6: State partnerships increase of screening rates among women who have rarely or never been screened for cervical and/or breast cancer.

Develop more rigorous evaluation designs focused at the local level to evaluate the short- and mid-term outcomes of implemented screening programs. The BRFSS data is not likely to provide the sensitivity needed to detect changes in screening rates for rarely or never screened women.

Defer the BRFSS data analysis for assessing screening rates in favor of first examining fidelity to the evidence-based intervention in each locale. In addition, national partners should work with state partners to develop a method for tracking the number of women who receive screening as a direct result of Team Up intervention.

Summary

Team Up, as an innovative pilot, offered promising strategies for accelerating the delivery of research-based approaches into practice (Glasgow, Marcus, Bull & Wilson, 2004). Through partnerships, the pilot generated collaboration among diverse people and organizations, and enhanced understanding of implementation concepts and strategies, many still evolving (Stetler, Mittman & Francis, 2008). As a whole, the resultant Team Up pilot encountered many difficulties while moving forward. It also overcame significant hurdles and enjoyed a number of key accomplishments that will be a valuable template for other public health projects seeking to apply dissemination and implementation approaches to lessen the health disparity gap.

Promoting and encouraging the transference of evidence from research into practice requires a mix of methodological approaches, a long discourse between those who are moving the evidence from one environment to another, and those who are being asked to practice in a new public health way so that it becomes familiar. While Team Up was highly variable, successes were realized, and the Team Up pilot generated many important lessons. For one, since the reduction of mortality could not be realized with this evaluation, interim measures of program process and impact were used to determine whether the state-level screening programs delivered expected benefits. Future programs would do well to consider building in a cost assessment associated with implementing such a program in multiple states that is conducted over numerous years.

Description of Report

This report is intended to provide practical information that other national, Federal, and state partnerships can use to address cancer health disparities. It presents a summary of the Team Up program, a discussion of evaluation methods, a summary of findings, and what was learned from the three-part evaluation undertaken between 2003 and 2008. The report's aim is to contribute to the evolution of work that is rapidly progressing in the public health area of disseminating and translating applied research into practice within cancer control and prevention.

The report is organized into 3 sections and 8 chapters. The first section describes the development of the pilot, presents a framework for the organizational structure of Team Up, and explains the capacity-building efforts that spanned much of the life of the pilot. The second section is devoted to the mixed-method evaluation approaches undertaken to assess the pilot, and subsequent findings and lessons to be incorporated into future projects. The third section comprises the appendices, which describe both components of the Team Up pilot as well as evaluation approaches and reports that were not included within the first two sections.

More specifically, Chapter 1 explains the purpose of the report. Chapter 2 describes the programmatic background of Team Up as a pilot. Chapter 3 discusses the evaluation goals, framework, and methodology. Chapters 4, 5, and 6 describe the results of the process, impact, and outcome evaluation, respectively. Chapter 7 synthesizes the overall findings of the evaluation. Chapter 8 provides recommendations to be considered if the national partners decide to continue using the Team Up model.

Introduction 1

1.1 Background

Cervical cancer mortality, while having decreased over the past 50 years, remains a persistent public health issue in certain regions of the country. Many women in the United States do not receive recommended cervical cancer screening, despite the proven effectiveness of the Papanicolaou (Pap) test in reducing morbidity and mortality (Hewitt, Devesa & Breen 2004). In 2004, an estimated 3,900 women died from cervical cancer (Jemal et al., 2004). One-half of women with newly diagnosed invasive cervical cancer have never had a Pap test, and another 10 percent have not had a test in the past 5 years (Jemal et al., 2008; National Institutes of Health, 1996). Similarly, the early detection of breast cancer through mammography screening can reduce mortality from breast cancer in approximately 15 to 40 percent of women aged 40 and older, with greater absolute risk reduction in older women (American College of Obstetricians and Gynecologists, 2003; Humphrey, Helfand, Chan, & Woolf, 2002). However, many women who would benefit from mammography do not undergo regular screening (Institute of Medicine, 2006). Even though there have been robust and rapid increases in reported use of mammography by women in the United States since 1987, estimates from the 2005 National Health Interview Survey (NHIS) showed a decline in screening rates compared with 2000 (from 70 percent to 66 percent) (Breen, Wagner, Brown, Davis & Ballard-Barbash, 2001).

Recent reports suggest that women remain unscreened for numerous reasons. The major reason women report not having a recent cancer screening test is lack of a physician recommendation (Grady, Lemkau, McVay & Reisine, 1992; National Cancer Institute, 2001). Other common reasons include lack of a usual source of health care, inadequate health insurance coverage, and having recently immigrated to the United States (Breen et al., 2001; Breen & Meissner, 2005; Hiatt et al. 2001). Women not getting screening services tend to be low income, have low educational attainment, reside in rural or inner cities, be older, and have a lack of awareness about screening (Swan, Breen, Coates, Rimer & Lee, 2003).

Structural factors that influence the use of cancer screening tests are well known. These include increasing access to use, generally improving quality, and promoting cost-effective services (Breen & Meissner, 2005). Programs already exist that have improved cancer screening in the United States.

They operate nationally in plans and clinics delivering health care around the country (Breen & Meissner, 2005). The Centers for Disease Control and Prevention (CDC) program, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is an excellent example of a national intervention that influences breast and cervical cancer screening behavior. Despite its popularity and success, current funding for the program covers only about 21 percent of eligible women ages 50 to 64 years, and coverage varies among states (F. Tangka, CDC, personal communication, 2004). While both individual and structural factors are necessary ingredients to increase screening rates among those who need it most, successful research strategies need to be delivered and adopted in community and clinical practice.

Much is known about how to successfully increase uptake of cervical and breast cancer screening structurally and individually, and for many years researchers assumed that an intervention deemed effective in a research context could easily be diffused into organizational and practice settings. Unfortunately, this has not been the case. While a large amount of empirical work has extended our knowledge and evidence base for good practice, less has been accomplished on how to implement evidence-based interventions (Grol & Grimshaw, 2003). The gap between research and routine practice in many areas of public health is large and troubling. These gaps occur across disease management behaviors, and across community and clinical settings, and population groups (Glasgow & Emmons, 2007). In fact, discrepancies between evidence-based, efficacious interventions and what actually occurs in practice are frequently so large as to be labeled a "chasm" by the Institute of Medicine (Glasgow & Emmons, 2007; Institute of Medicine, 2001). The spread of best practices and the use of best evidence remain sporadic, and there has been a shift away from the traditional notion that getting evidence into practice is straightforward. Despite a growing awareness that getting evidence into practice is a complex, multifaceted process, there also remains a lack of knowledge about what methods and approaches are effective, with whom, and in what contexts proven interventions can be generalized to community settings (Kitson et al., 2008). Team Up was developed to further study the implementation of evidence-based interventions in community settings.

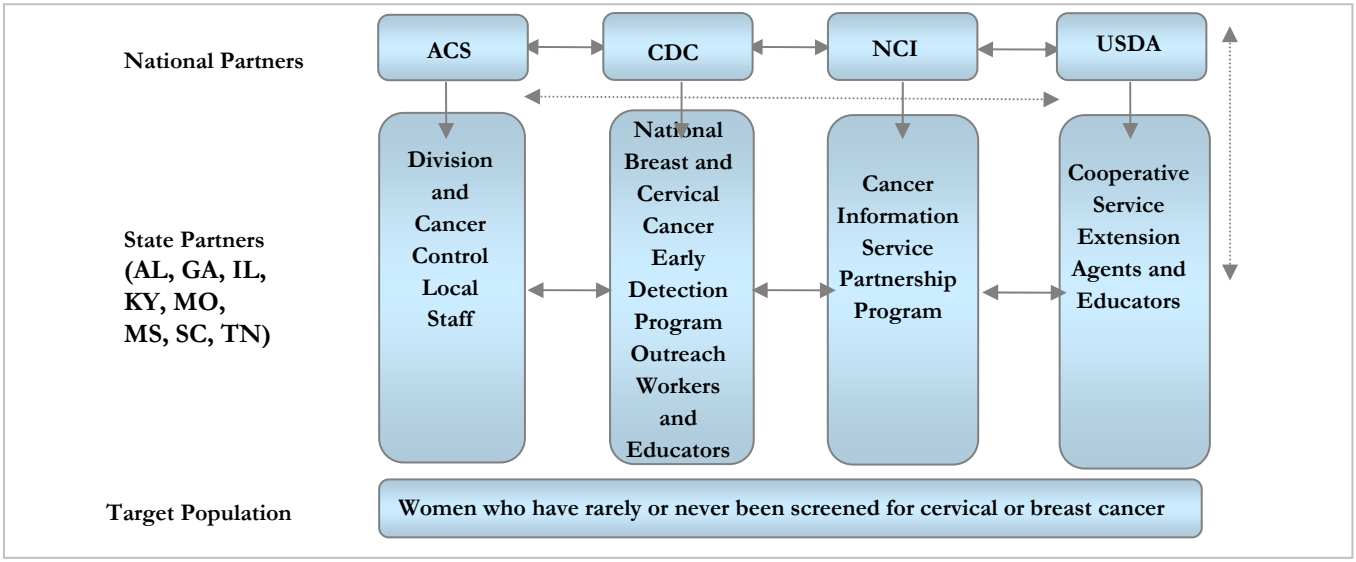
1.2 Team Up Formation

Meetings between three federal agencies—the CDC, the National Cancer Institute (NCI), and the United States Department of Agriculture (USDA), and one national nonprofit agency, the American Cancer Society (ACS)—were held between 2001 and 2003 to explore ways to reduce the cervical and

breast cancer burden among certain populations. The result was the formation of a 5-year (2003 to 2008), $2 million national partnership, funded by the ACS, CDC, NCI and USDA. Together, the partnership (given the name of "Team Up: Cancer Screening Saves Lives" and referred to hereafter as Team Up) was formalized as a pilot program in 2003. In addition to national partners, the initiative comprised state- and county-level public health practitioners from eight states, including Alabama, Georgia, Illinois, Kentucky, Mississippi, Missouri, South Carolina, and Tennessee. These states were chosen because they had counties with the highest cervical and breast cancer mortality and lowest screening rates for these cancers for African American and White women (National Center for Health Statistics, 2002).[1]

Figure 1-1 shows the framework for the Team Up management, an illustration of the interrelated and multiple partnership layers and structure for all partners. National, federal, and nonfederal institutions that conduct research and deliver health care represent an important mechanism to reach populations of need. Since each of the national partners had regional staff members that participated on a state partnership level, these partners were considered an important facilitator of the pilot startup, and it was assumed that they could make use of preexisting health program infrastructures that could be accessed by state-level partners. Further, state partner activities tended to more closely mirror the real world activities of their diverse local populations, particularly the medically underserved, and were more directly involved in improving the health of their communities.

Figure 1-1. Structural framework of Team Up partnership



[1] Mortality data are shown in Sections 2.1.1 and 2.1.2 of this report.

Each national organization has a specific mission that contributed to this pilot program. ACS is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer through research, education, advocacy, and service. Throughout the United States, ACS has 13 regional divisions responsible for program delivery and more than 3,400 local offices nationwide organized to deliver cancer prevention, early detection, and patient services programs at the community level.

CDC is the primary federal agency for conducting and supporting public health activities throughout the United States. The NBCCEDP, started in 1991 and administered by the CDC, is a significant public health program that provides breast and cervical screening services. This federal-state partnership establishes structures of breast and cervical cancer service delivery at county and local levels. NBCCEDP is implemented in all 50 states, 4 U.S. territories, the District of Columbia, and 13 American Indian and Alaska Native organizations. Consequently, outreach and education are integral components of the NBCCEDP with supporting resources for low-income and medically underserved women.

Nationally, the NCI coordinates the National Cancer Program, which conducts and supports research, training, and health information dissemination programs. In addition, NCI examines the cause, diagnosis, prevention, and treatment of and rehabilitation from cancer. NCI provides continuing care of cancer patients and their support systems. At the state and county level, the NCI's Cancer Information Service Partnership Program (CIS) communicates and disseminates research and cancer health information to practitioners and the public. In addition, the CIS collaborates with partner organizations to deliver cancer control and evidence-based education programs to improve the health of underserved populations. CIS staff is located at cancer centers and universities across the United States and serve all 50 states, the U.S. Pacific Territories, Puerto Rico, and the U.S. Virgin Islands.

The USDA provides nationwide leadership on food, agriculture, natural resources, and health-related issues based on sound public policy, the best available science, and efficient management. Within each state and county throughout the United States, the USDA's Cooperative State Research Education and Extension Service (CSREES) has agents and educators that reach low-income and medically underserved populations. The charge of CSREES is to advance knowledge for agriculture, the environment, and human health and well-being within communities by supporting research,

education, and extension programs in the Land-Grant University System, and with other partner organizations.

As described above, each organization has a distinct approach to partnership at multiple levels. It has been well recognized that the right mix of partners makes it feasible to create and sustain educational, behavioral, and structural interventions that respond to the particular barriers and concerns within diverse communities—communities Team Up was trying to reach (El Ansari, 2005; Lasker & Weiss, 2003). The focus on partnerships was fundamental to Team Up. Long-standing partnerships already existed with the ACS, CDC, and NCI as leaders in cancer prevention efforts. For the USDA, however, the interface with cancer screening as a priority and as a partner with the other three national organizations was a unique venture. The USDA represented a new and nontraditional partner to join in the Team Up partner composition.

1.3 Operational Structure of Team Up

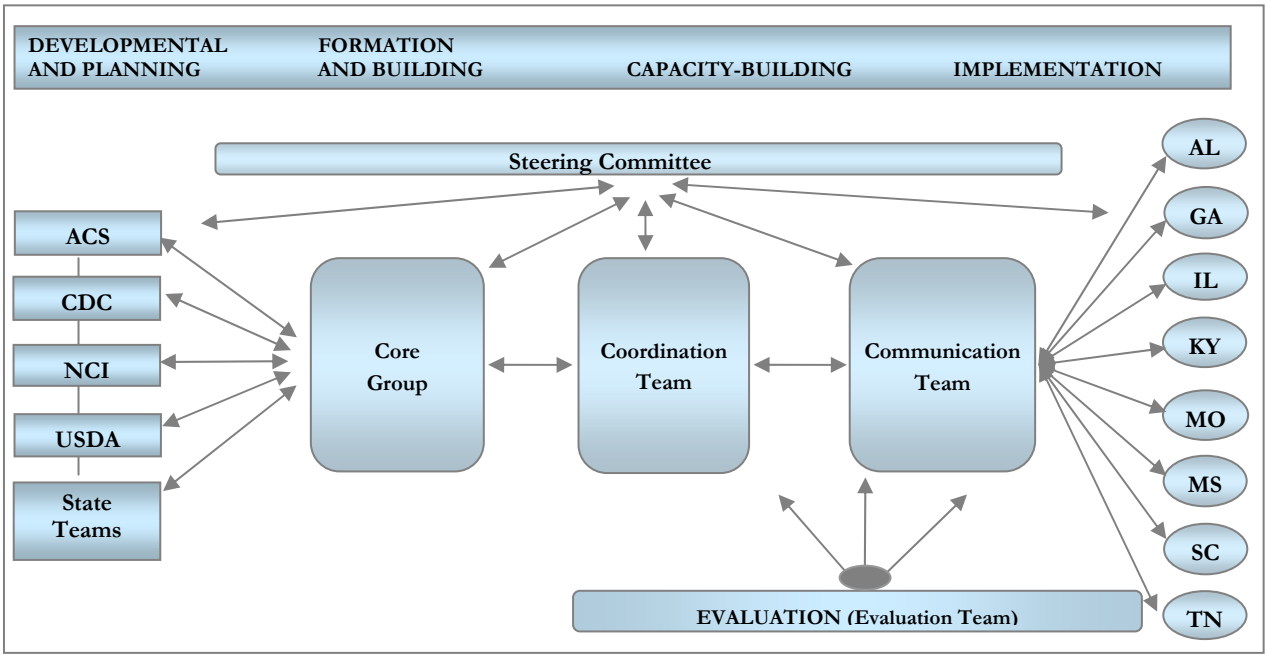
To coordinate programmatic activities across the Team Up pilot, a formal operational structure was created (Figure 1-2). The Team Up pilot was composed of eight state partnerships, members from each of the four national partners. Guiding all phases of the pilot was the National Steering Advisory Committee, known as the **core group**. The core group, a subgroup of the National Steering Advisory Committee served in an advisory capacity and comprised organizational representatives from national and state partners. Members of the **National Steering Advisory Committee (Steering Committee)** were scientists, researchers, or practitioners within communities at the state level. Core group members were asked to contribute their unique strengths and to share responsibilities around the Team Up vision, progress, and resources, and were expected to address issues raised at both the national and state level.

The Coordination Team, also made up of national and state partners, was tasked with organizing and implementing all administration and communications between the national and state partners, managing administrative support across the project, planning meetings, and monitoring major project tasks with assistance from state partnership team leaders.

The Communication Team consisted of core group national and state partners and was charged with coordinating communication activities for the national partners and between the national and state partnerships. This included using web sites, newsletters, and communication plans. Two

subgroups of the communication team were the Partnership Assistance and Technical Help (PATH) team and the Technical Assistance and Training Team (TATT). These members identified areas where training or technical assistance was needed within states, devised a plan to implement and conduct help as needed, and worked with the evaluation team to assess the training outcomes.

Figure 1-2. Team Up operational structure



The Evaluation Team consisted of representatives from each of the four national partner organization and ad hoc state partners. The evaluation team developed, managed, and implemented the evaluation and communicated findings to the national and state partnerships throughout the pilot.

Since each committee member straddled dual-duties at either the national or state partner level, the assumption was that individual teams affiliated with a specific state would be able to work with each other's community, gain insight from, and understand the contribution each was making overall to the pilot. The organizational goal of the Team Up operational structure was to foster a level of trust at all levels of the pilot that would enhance accomplishing the Team Up mission.

1.4 Objective of Team Up

Based on the principal that different people and organizations can capitalize on their complementary strengths and capabilities (Lasker, Weiss & Miller, 2001), an objective of Team Up was to develop and sustain dedicated state partnerships that embraced population-based health principles to reach unscreened or rarely screened women for cervical and breast cancer. Guided by the best available scientific interventions and access to practitioners willing to adopt or adapt these new approaches into a field setting, a short-term outcome was to optimize the transfer and use of effective evidence-based interventions for cancer prevention and control. By focusing on the tremendous untapped potential to prevent illness, a mid-term outcome was an expected increase in cancer screening rates among rarely or never screened women in selected target counties. The long-term outcome was an expected reduction in cervical and breast cancer mortality. The essential question tested in the Team Up pilot was whether viable partnerships could be formed among public and private entities to solve a problem that no single agency or organization seemed to be able to solve alone. It was expected that a practical blend of strategies and evidence-based approaches could measurably reduce health care disparities among women.

Team Up was built around three core elements:

1. **Rarely/Never Screened Women as the Audience.** For cervical cancer, women who have had an initial Pap test, but have not been screened within the past 3 years, or have never had a Pap test. For breast cancer, women who have had an initial mammogram, but have not been screened within the past 2 years, or have never had a mammogram. Rarely or never screened women are at higher risk for delayed diagnosis of cancer when the chances of successful treatment are reduced.

2. **Evidence-Based Interventions as the Approach.** Adoption and/or adaptation of interventions whose efficacy has been demonstrated by a credible body of scientific work. The intervention must have shown to have held greater promise for improving overall health, saving time and money and increasing the chance of successful outreach efforts.

3. **Partnerships as the Overarching Approach.** The goal of the Team Up partnership was to create synergy—a state in which each partner is a resource, resulting in a stronger partnership unit. Synergy provides the opportunity for each partner to contribute strengths, experience, skills, and knowledge in order to achieve what the individual could not do alone.

To assume a consistent vision, this core set of pilot-wide elements were highly communicated and repeated often to all partners. They came to be known as the Team Up's "REP".

1.5 Evaluation of Team Up

In 2003, the evaluation team, composed of representatives from each of the four national partner organizations, convened to develop and implement a three-part evaluation. The evaluation objective was to determine the extent to which Team Up was able to implement and sustain state-level partnerships in each of the eight states. The **process evaluation** assessed the partnerships' development and workings; the **impact evaluation** described the short-term and intermediate-range ability of the partnerships to implement evidence-based interventions; and the **outcome evaluation** assessed two short-term changes. First, it documented baseline cervical and breast cancer screening rates within each of the targeted states, and second, it was designed to determine if the Team Up approach should move beyond a pilot phase. Because this was a brief pilot program, it was not realistic to expect that the outcome evaluation measures changes in cervical and breast cancer screening rates, which would require examining screening rates 1 to 2 years post-intervention.

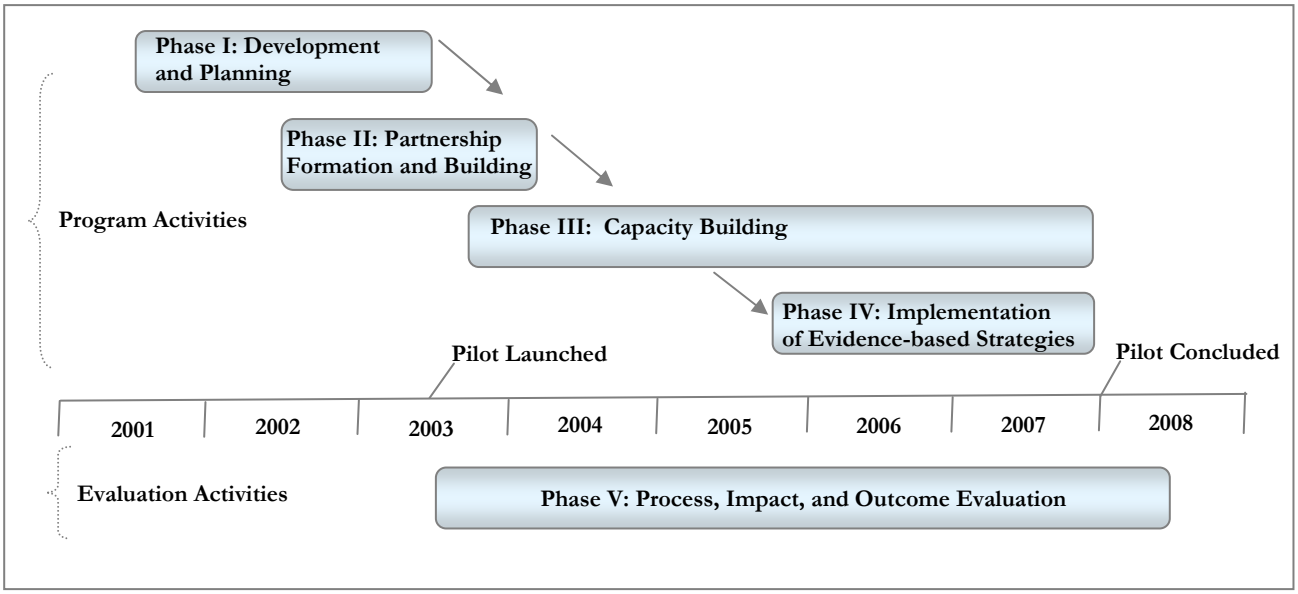
1.6 Structure of This Report

This report presents a synopsis of the Team Up pilot and a summary of the findings of the three-part evaluation. Chapter 1 explains the purpose of the report. Chapter 2 describes the background of Team Up. Chapter 3 discusses the goals, conceptual framework, and methodology of the evaluation. Chapters 4, 5, and 6 describe the results of the process, impact, and outcome evaluation, respectively. Chapter 7 synthesized the overall findings of the evaluation, and Chapter 8 provides recommendations that should be considered if the national partners decide to continue using the Team Up model.

Background 2

This chapter describes the historical context associated with planning (November 2001) that led to the formation of Team Up (July 2003–December 2007), and subsequent steps that led to the resulting evaluation. The chapter explains each of the four Team Up programmatic phases and the fifth phase, the evaluation, shown graphically in Figure 2-1.

Figure 2-1. Team Up: Pilot Program (2001–2007) and Evaluation (2003–2008) phases



The four Team Up pilot programmatic phases were as follows:

1. **Developmental and Planning (Phase I).** This phase included activities undertaken prior to the official formation of Team Up, such as the collection of surveillance data and convening planning groups. Two methodologies, a needs assessment and the creation of a conceptual framework for programmatic activities, were used. These theoretically grounded activities provided the background for guiding the evaluation.

2. **Partnership Formation and Building (Phase II).** The processes to build teams that foster strong partnerships, first with the national partners, and then locally with state partners.

3. **Capacity Building (Phase III).** An expansion of the partnership formation phase that included the range of technical assistance provided to state partners. These state-specific

activities were intended to support partnership growth and progress; capacity building to ensure states had adequate knowledge and skills about practical steps to deliver complex evidence-based interventions. Capacity building also provided technical assistance for implementation activities throughout the project. As a partnership, it was important for the national partners to offer expertise where possible so that state partners could integrate this new knowledge into practice within their communities.

4. **Implementation of Evidence-based Strategies (Phase IV).** This phase involved the use of evidence-based cancer screening interventions[1] and other efforts by state partners to reach their populations of need. Team Up was interested in evidence-based strategies that activated women to be more engaged in their own preventive care.

5. **Evaluation (Phase V).** This final phase was designed to be a functional component of the overall Team Up pilot effort. The evaluation comprised a three-part assessment of whether Team Up achieved its short-term and intermediate-term outcomes, and whether it provided practical information or replicable solutions with which a decision could be made to advance beyond the pilot phase. Throughout each evaluation component, underlying theories guided the development and integration of key constructs to assess the pilot's partnership and implementation activities. It is hoped that the resulting evaluation findings may yield best practices for those interested in understanding how to apply research to practice strategies on a larger scale.

Both the organizational and community literature suggest a sequence of stages through which organizations or pilot programs move as they establish themselves and meet their goals (Kreuter, Lezin & Young, 2000). In general, these conform to the chronological phases of partnership formation for the planning, implementation, maintenance, and accomplishment of outcomes through evaluation (Butterfoss, Goodman & Wandersman, 1993). Each of these phases can be expanded or individualized, as in the case of Team Up, to include more discrete phases. For instance, the expansion of the formation phase included partnership and capacity building, precursors to the implementation activities. Since maintenance usually extends over a lengthy period of time, it was not included in the Team Up schematic. Figure 2-1 illustrates the sequential phases of Team Up and explains the complexity of this multilayered pilot project. As with any sequence of stages, there is likely to be considerable overlap from one stage to another. For example, although the essence of planning occurred during the developmental stage, planning also transpired during implementation, which included devising and applying evidence-based solutions to reduce health disparities. Below we describe the details of each programmatic phase and the course of the evaluation.

[1] An evidence-based intervention (EBI) is an intervention in which efficacy is demonstrated by a credible body of scientific work. (Team Up National Steering Committee, July 2003).

2.1 Phase I: Developmental and Planning Phase (November 2001–June 2003)

The developmental phase began in 2001 when NCI analyzed data that explained why certain populations in the United States had higher cervical cancer mortality rates than other populations. This isolation of cervical cancer as a major health disparity took root as a concern that needed to be addressed. Developmental components included a series of events that occurred prior to the official formation of the Team Up pilot. These events are identified below and then described in the following sections:

- 2001 Cervical Cancer Roundtable;
- Review of breast cancer screening and mortality rates;
- Concept mapping; and
- Logic model.

2.1.1 2001 Cervical Cancer Roundtable

Data on cervical cancer incidence and mortality together with data describing disparities between White and African American women were presented at a Cervical Cancer Roundtable meeting, sponsored by the NCI Center to Reduce Cancer Health Disparities (CRCHD). This meeting (November 28-30, 2001) brought together 150 researchers, practitioners, and representatives from local, state, and federal funding agencies.

Two maps (Figures 2-2 and 2-3) illustrate cervical cancer mortality rates between 1970 and 1998, and they indicate significant geographic differences at the county level. This timeframe represents data that was available at the time of the 2001 meeting. Compared to the rest of the United States, high mortality counties for White women began in Maine, moved through the Appalachian Mountains, and continued down to the Texas/Mexico border and included some counties in the central valley of California (Figure 2-2). High mortality counties for African American women were concentrated in the southeast and Mid-Atlantic states (Figure 2-3).

Figure 2-2. Cervical cancer mortality rates by county by age-adjusted 1970 U.S. population; White females, 1970-1998

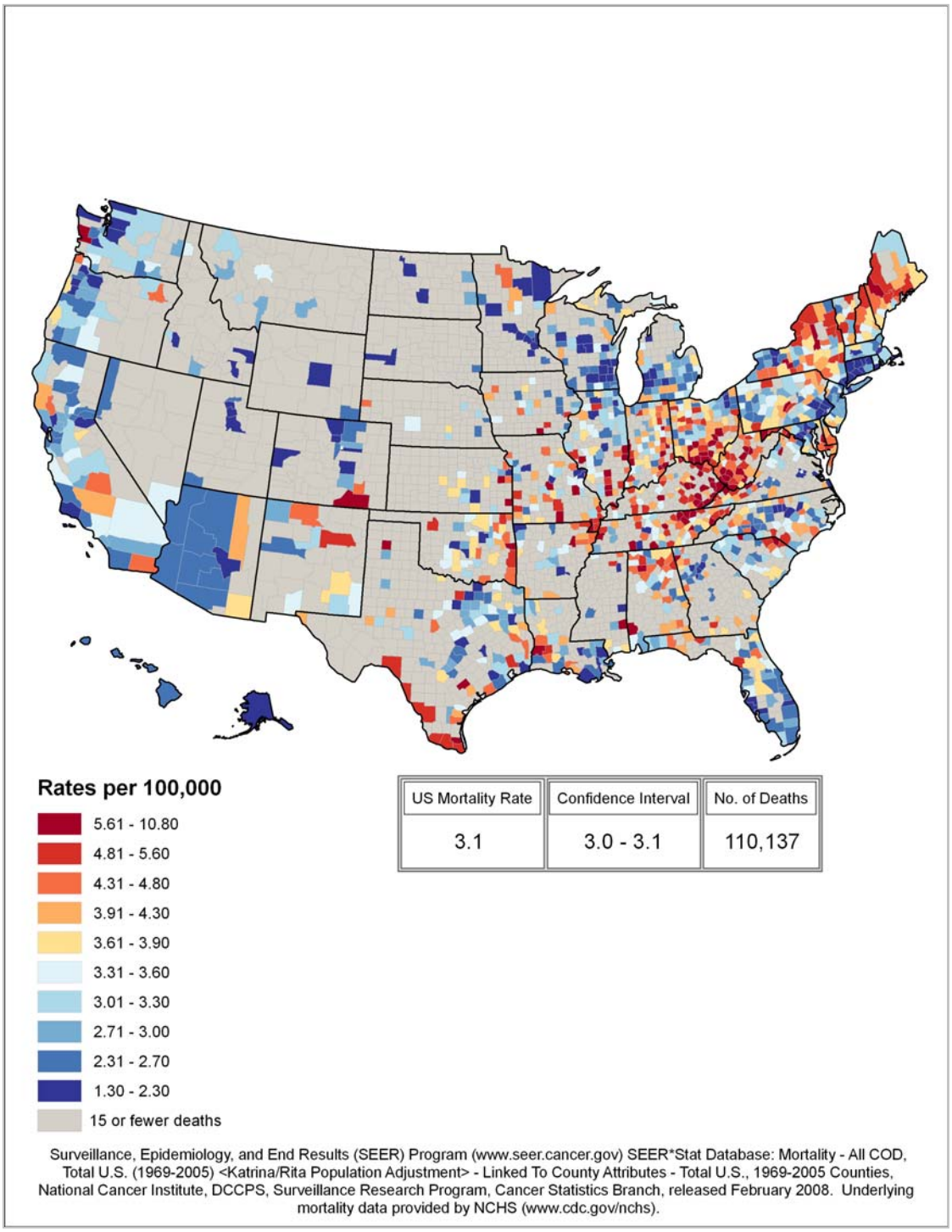
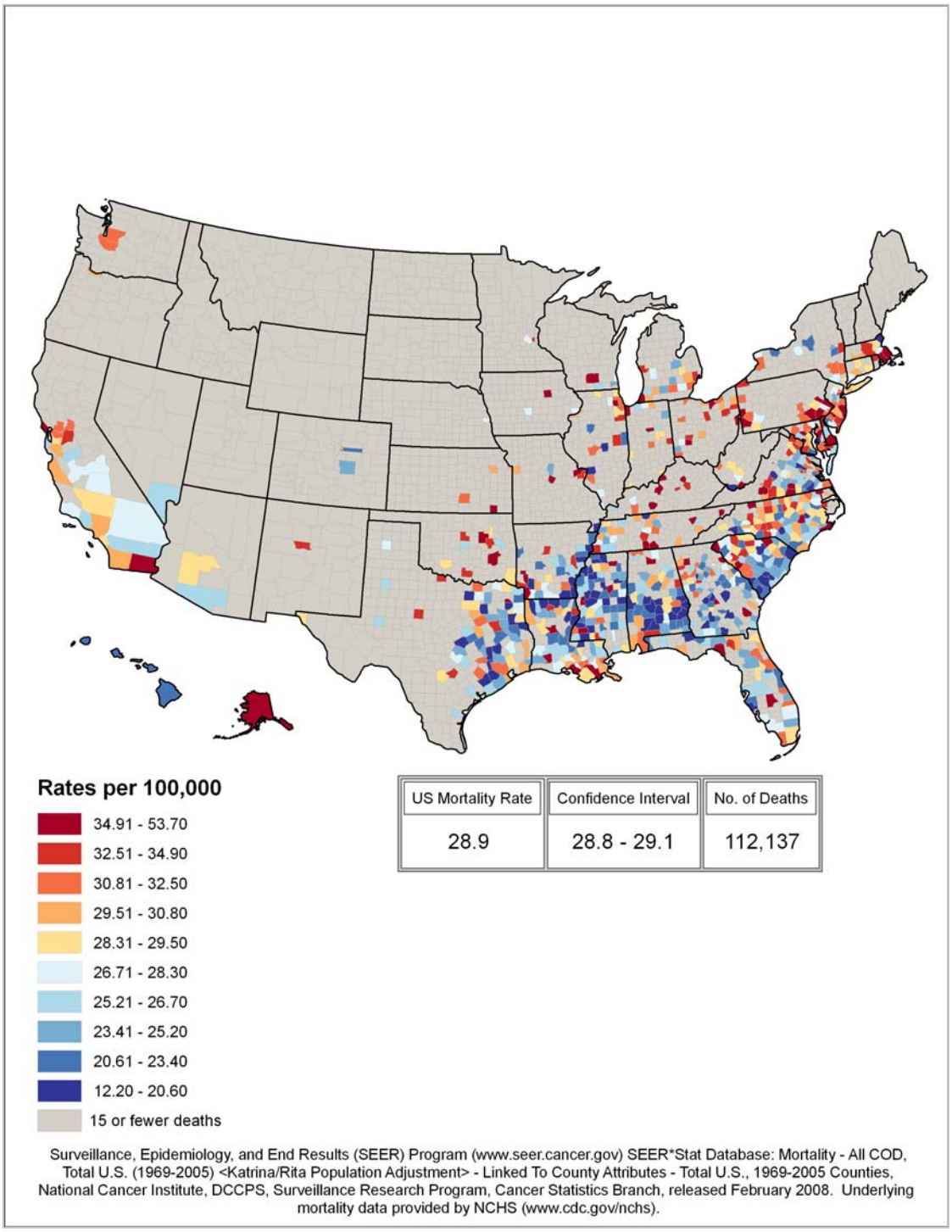


Figure 2-3. Cervical cancer mortality rates by county by age-adjusted 1970 U.S. population; African American females, 1970-1998



Counties experiencing the highest rates of cervical cancer mortality were either rural or suburban, and had higher proportions of individuals with low incomes and low education levels. Using data from the NHIS for the period 1990 to 1998, Table 2-1 shows the top three counties for African American and White females. Appendix A contains more comprehensive individual county-level tables for African American and White females with high mortality within states.

Additional factors identified as influencing screening behavior and corresponding mortality rates include age, lack of insurance coverage, limited access to care, and recent immigration status (Breen et al., 2001; Breen & Meissner, 2005; Hiatt et al. 2001). Common reasons women gave for not receiving screening is that a doctor did not order or say that they needed a screening test, and many of these women had no contact with a primary care provider in the last year (Hewitt et al., 2004). In addition to medical care access, cultural issues and health communication and education issues disproportionately affect poor and other underserved women (Coughlin & Uhler, 2000; Kagawa-Singer & Pourat, 2000).

Table 2-1. Cervical cancer mortality by county: 1990-1998

Cervical cancer mortality by counties: 1990-1998[a]						
	Top 20% counties					
State, county and county population	Rate[b] White females	Count White females	Population White females	Rate[b] African American females	Count African American females	Population African American females
Alabama						
Wilcox County (01131)	0.0[c]	0	19,340	20.3	8	45,928
Monroe County (01099)	6.8	5	65,534	14.7	6	45,788
Dallas County (01047)	2.6	4	92,896	14.2	16	139,364
Winston County (01133)	6.2	7	105,367	0.0	0	267
Jackson County (01071)	5.5	12	215,449	0.0	0	9,331
Lawrence County (01079)	5.5	7	115,155	5.3	1	28,844
Georgia						
Echols County (13101)	0.0	0	30,539	27.8	6	27,908
Ware County (13299)	3.5	6	164,305	17.1	6	44,894
Clinch County (13065)	2.5	14	628,189	14.8	11	236,285
Baker County (13007)	15.6	6	39,089	0.0	0	8,341
Cherokee County (13057)	9.7	11	94,847	9.3	1	10,659
Columbia County (13073)	7.3	11	127,334	10.4	4	48,228
Illinois						
Bureau County (17011)	3.9	36	1,248,935	12.2	12	156,94
Pope County (17151)	8.7	9	101,531	0.0	0	71
St Clare County (17163)	7.5	6	78,553	0.0	0	96
Jo Daviess County (17085)	7.0	10	138,094	0.0	0	1,842

Table 2-1. Cervical cancer mortality by county: 1990-1998 (continued)

Cervical cancer mortality by counties: 1990-1998[a]						
	Top 20% counties					
State, county and county population	Rate[b] White females	Count White females	Population White females	Rate[b] African American females	Count African American females	Population African American females
Kentucky						
Pulaski County (21199)	12.8	16	55,162	0.0[c]	0	353
Lincoln County (21137)	11.5	7	59,648	0.0[c]	0	133
Boone County (21015)	11.2	15	147,832	22.8	1	3,769
Missouri						
Callaway County (29037)	1.3	1	45,449	22.2	10	56,330
Jackson County (29095)	6.7	5	68,814	14.9	9	79,272
Clinton County (29049)	3	17	591,921	14.7	18	165,906
Montgomery County (29139)	8.7	6	65,985	3.1	1	38,469
Morgan County (29141)	7.0	6	77,817	0.0[c]	0	16,768
Iron County (29093)	6.9	7	81,147	0.0[c]	0	38,855
South Carolina						
Dorchester County (45035)	4.3	4	74,716	17.3	9	63,780
Florence County (45041)	5.3	3	42,564	16.4	8	61,675
Williamsburg County (45089)	2.7	3	102,215	16.2	6	44,888
Newberry County (45071)	8.1	6	66,543	5.1	3	69,448
Dillon County (45033)	6.1	12	178,297	5.1	5	128,010
Calhoun County (45017)	5.6	18	431,065	8.2	9	152,241
Tennessee						
Giles Country (47055)	1.5	4	177,528	17.1	8	47,200
Moore County (47127)	4.8	15	391,246	15.9	9	94,152
Dickson County (47043)	12.5	9	69,559	0.0[c]	0	1,002
Franklin County (47051)	9.2	7	70,206	0.0[c]	0	18
Carter County (47019)	7.8	12	115,876	7.7	1	16,276

a) Mortality data provided by National Center for Health Statistics (NCHS) [http://www.cdc.gov/nchs].

b) Rates are per 100,000 and are age-adjusted to the 2000 U.S. (5-year groups) standard.

c) Some county rates are not reported because of small race-specific population counts.

The Cervical Cancer Roundtable generated recommendations for improving cervical cancer screening and treatment in the states experiencing disparities in cervical cancer mortality. One recommendation was to coordinate federal undertakings to strengthen outreach efforts to women who have rarely or never been screened for cervical cancer. It was suggested that federal agencies and other national organizations provide local resources and find new ways to reach these women with screening and education. The rarely or never screened women are at the greatest risk of being diagnosed with advanced stage cervical cancer, and are the most likely to die from the disease since they are not adhering to current guidelines.

2.1.2 Review of Breast Cancer Screening and Mortality Rates

Since breast cancer is a mission of both the ACS and CDC, the national partners included an assessment of this cancer as well. Figures 2-4 and 2-5 show the breast cancer mortality rates by county for White and African American females for 1970 to 1998. This period was selected since it

Figure 2-4. Breast cancer mortality rates by county by age-adjusted 1970 U.S. population; White females, 1970-1998

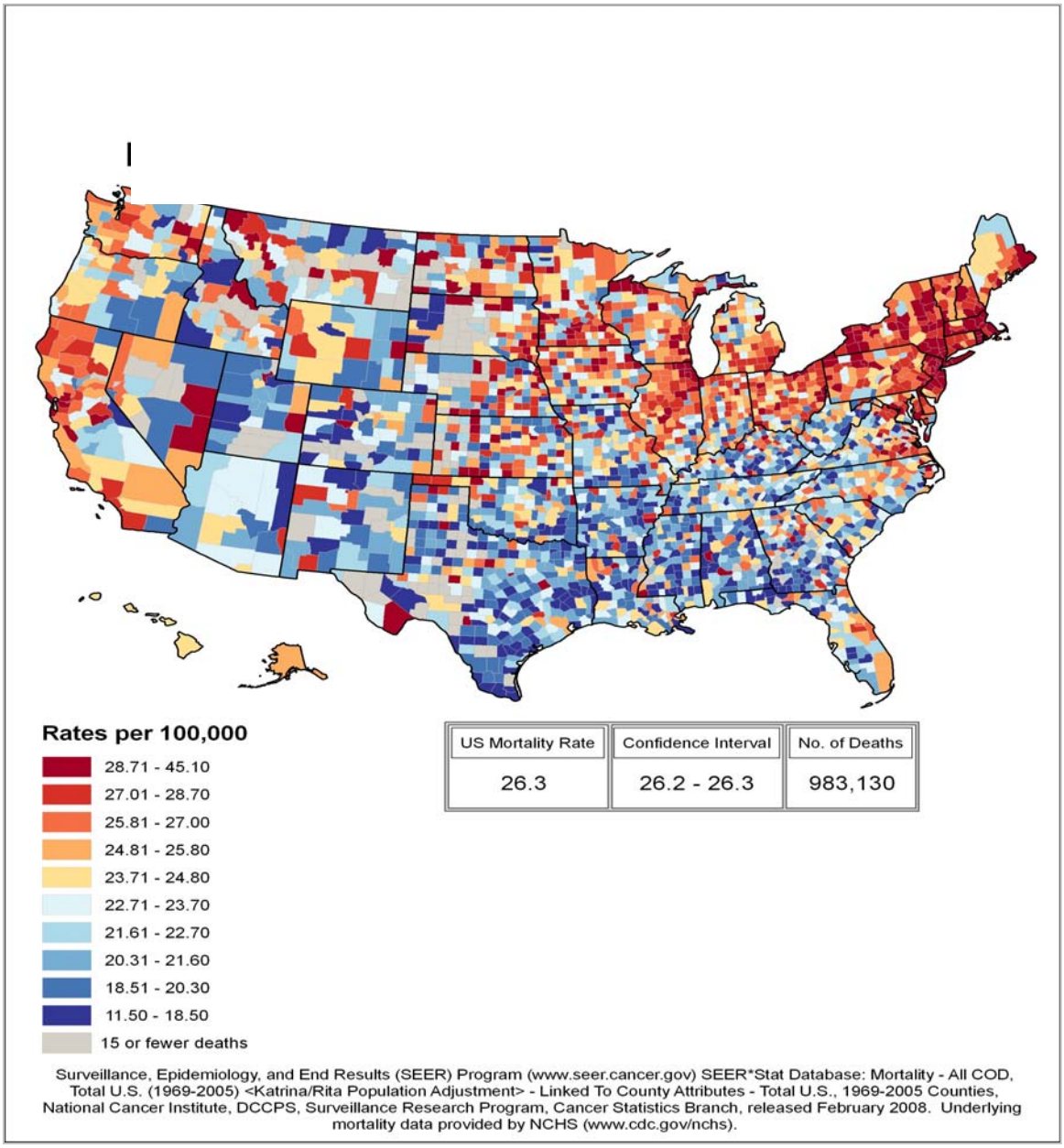
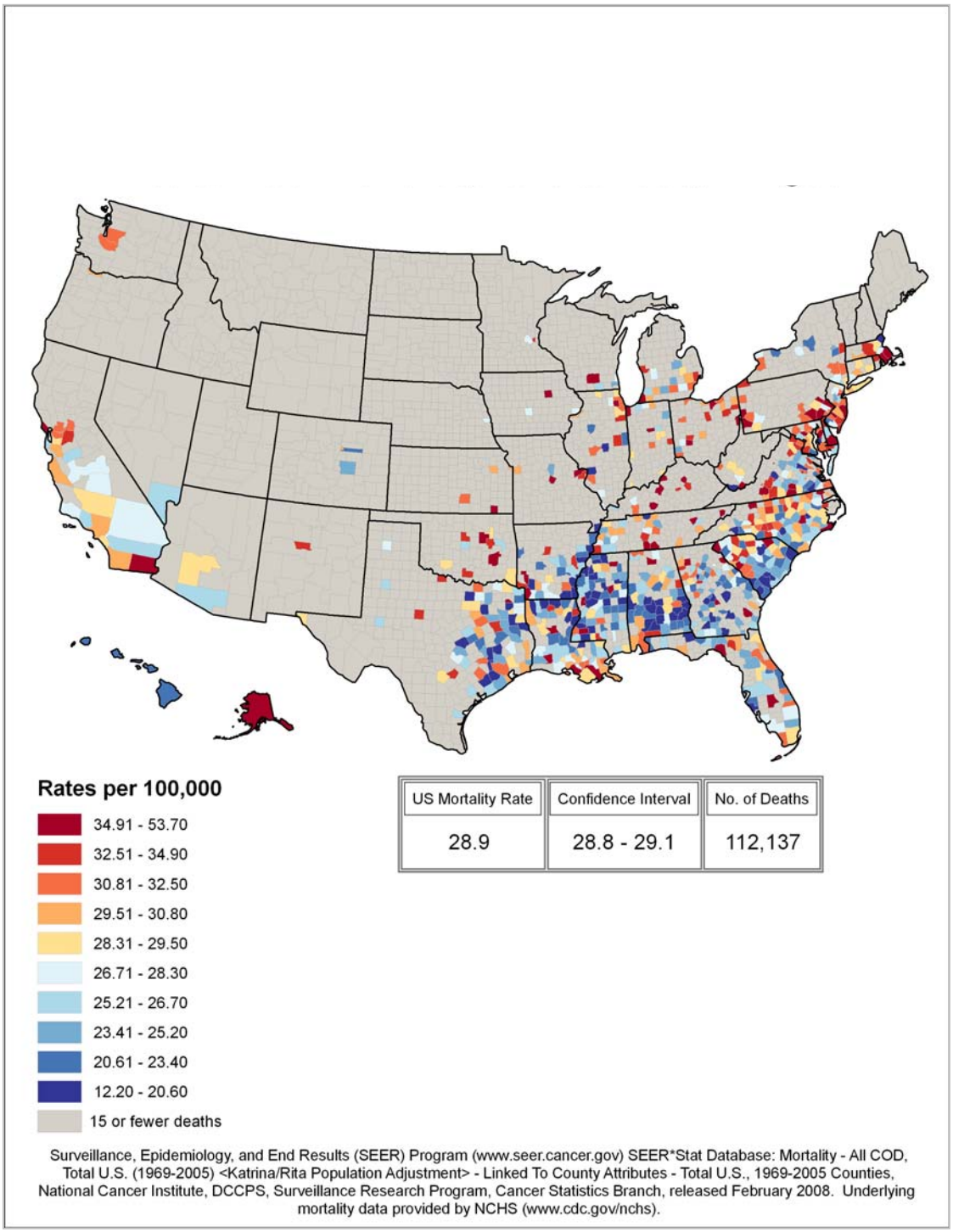


Figure 2-5. Breast cancer mortality rates by county by age-adjusted 1970 U.S. population; African American females, 1970-1998



corresponded to the period used for the cervical cancer mortality assessment. As with cervical cancer, significant differences can be seen at the county level. Compared to the rest of the United States, high mortality counties for White women began in Maine and moved through pockets of the Appalachian Mountains to Missouri and states south (Figure 2-4). High mortality counties for African American women were concentrated in the southeast and Mid-Atlantic states (Figure 2-5).

Other breast cancer screening and mortality data from 1987 to 2000 suggest that the percentage of women in the United States aged 40 years and over who reported that they had a mammogram in the previous 2 years increased dramatically, from 39.1 percent to 70.1 percent, exceeding the Healthy People 2010 target of 70 percent (Swan et al., 2003; U.S. Department of Health and Human Services, 2000). This increase in the use of mammography over time has helped to make early detection of breast cancer more common and has reduced mortality.

However, more recent data suggests a decline in the rates of mammography use among women from 2000 to 2005 (Breen et al., 2007). For instance, 33 states reported a decline in mammography claims for Medicare beneficiaries. Similarly, a report using data from the BRFSS in most states indicated a statistically significant decline in mammography rates in women aged 40 years and over from 76.4 percent in 2000 to 74.6 percent in 2005 (Breen et al., 2007). Data were also used to examine trends and patterns in the recent use of mammography and to identify states with highest mortality for breast cancer.

Table 2-2 describes breast cancer mortality by county (for the top 20 percent) from 1990 to 1998 among White and African American women; screening rates available during Team Up's developmental phase. Again, these data show both geographic and racial/ethnic disparities.

For consistency, breast cancer mortality maps for White (Figure 2-4) and African American (Figure 2-5) females correspond to the maps developed for the cervical cancer timeframe 1970 to 1998. As with cervical cancer, significant geographic differences can be seen at the county level especially in the northeast and throughout Appalachian regions.

Table 2-2. Breast cancer mortality by county: 1990-1998

Breast cancer mortality by county: 1990-1998[a]						
	Top 20% counties					
State, county and county population	Rate[b] White females	Count White females	Population White females	Rate[b] African American females	Count African American females	Population African American females
Alabama						
Lauderdale County (01077)	26.0	102	345,530	53.8	19	40,988
Morgan County (01103)	27.5	128	430,708	46.8	20	52,711
Wilcox County (01131)	37.0	9	19,340	45.6	17	45,928
Greene County (01063)	41.7	7	8,749	34.6	12	40,284
Perry County (01105)	38.3	11	20,202	19.9	6	40,223
Georgia						
Baldwin County (13009)	23.6	27	98,018	72.6	6	9,852
Webster County (13307)	14.4	1	4,811	67.3	12	24,037
Wilkinson County (13319)	42.3	14	26,740	65.3	16	24,723
Jasper County (13159)	55.8	17	26,064	40.6	5	16,565
Chattahoochee County (13053)	51.4	3	29,557	33.1	123	437,784
Lincoln County (13181)	44.2	13	21,174	50.5	23	100,297
Illinois						
Wabash County (17185)	44.1	35	59,558	52.7	9	18,688
DuPage County (17043)	36.0	1,147	3,500,275	48.9	15	37,546
Iroquois County (17075)	31.6	63	142,906	48.0	9	23,184
De Witt County (17039)	37.4	37	75,812	0.0[c]	0	1,378
Kentucky						
Boyd County (21019)	36.5	106	229,471	66.5	6	8,189
Bracken County (21023)	22.3	10	37,489	60.2	7	10,881
Magoffin County (21153)	31.7	16	61,389	62.9	18	32,815
McLean County (21149)	50.6	26	43,885	0.0	0	79
Fulton County (21075)	47.8	23	30,438	59.3	6	16,363
Clay County (21051)	37.5	33	100,183	45.9	6	8,479
Missouri						
Buchanan County (29021)	31.9	155	374,689	63.7	7	13,918
Pike County (29163)	34.9	30	69,482	59.5	11	22,968
Andrew County (29003)	33.9	28	68,897	53.6	45	86,469
Clark County (29045)	47.7	21	33,755	26.5	10	46,340
Linn County (29115)	40.3	44	65,489	46.2	33	85,788
Nodaway County (29147)	36.8	37	96,507	48.1	6	16,378
Tennessee						
Cumberland County (47035)	31.1	70	181,519	70.6	7	11,135
McNairy County (47109)	37.4	49	100,032	69.7	7	10,676
Hickman County (47081)	32.5	29	77,996	48.0	8	14,733
Lake County (47095)	46.2	13	23,270	36,5	53	162,5655
Van Buren County (47,177)	43.6	10	22,419	0.0[c]	0	27

Table 2-2. Breast cancer mortality by county: 1990-1998 (continued)

Breast cancer mortality by county: 1990-1998[a]						
	Top 20% counties					
State, county and county population	Rate[b] White females	Count White females	Population White females	Rate[b] African American females	Count African American females	Population African American females
Texas						
Carson County (48065)	22.8	8	29,954	85.0	11	12,867
Calhoun County (48957)	16.0	15	85,985	54.8	6	12,797
Limestone County (48293)	34.9	40	77,223	51.0	16	36,283
Briscoe County (48045)	87.3	9	8,146	0.0[c]	0	300
Hartley County (48205)	47.9	10	17,325	40.3	33	82,192
Wilbarger County (48487)	36.4	30	59,253	48.0	21	57,235

a) Underlying mortality data provided by NCHS (http://www.cdc.gov/nchs).

b) Rates are per 100,000 and age-adjusted to the 2000 U.S. (5-year groups) standard.

c) Some county rates are not reported because of small race-specific population counts.

In summary, the identification of states with elevated cervical and breast cancer mortality provided a compelling epidemiological need for the four national partners to move forward and establish a pilot program to address these health disparities. In particular, the greatest need to improve disparities was for African American women in Alabama, Georgia, Missouri, and South Carolina, and for White women in Illinois, Kentucky, Tennessee, and Texas.

2.1.3 Team Up Concept Mapping

Team Up needed a definitive mechanism, such as a needs assessment, to integrate and translate the health status indicators into a more narrow focus and to link them to identifiable outcomes. So, in 2003 a planning group from ACS, CDC, NCI, and USDA conducted a participatory needs assessment to develop a structure for the pilot to guide potential programmatic and evaluation activities.

Guided by the literature, Goodman and others note that to build credibility with a new program, it is essential to consider undertaking a needs assessment by all involved in the program (Goodman & Steckler, 1989; Goodman & Wandersman, 1994; Goodman, Wandersman, Chinman, Imm & Morrisey, 1996). A theory-based participatory needs assessment tool called Concept Mapping was used. The resulting product is a comprehensive map that depicts the outcome domains that would

need to be addressed by Team Up (Kane & Trochim, 2006; Trochim, Marcus, Masse, Moser & Weld, 2008; Trochim & Linton, 1986).

The purpose of Concept Mapping was to provide an essential starting point to understand steps to increase screening among women who have rarely or never been screened for cervical or breast cancer. A second purpose was to identify key elements of the Team Up pilot and show their relationship to one another. A third purpose was to incorporate individual and group-oriented perspectives from researchers and practitioners (i.e., national and state partners). The national partners wanted to reach a collective consensus about Team Up as a pilot program from as many partners as possible. A final purpose was to engage those involved in the planning, decisionmaking, and execution of Team Up plans—researchers and practitioners with cancer control expertise. The goal was to use the collaborative Concept Mapping process to make decisions that minimize the gap between what researchers and practitioners deemed an important need and what could be done to prioritize a blend of strategies and practical steps to address the health disparity gaps.

Concept mapping is based on the cognitive psychologist theory of constructing meaning, developed by Novak and Gowin (1984) and Novak (1990). The methodology encourages a delineation of specific knowledge that is then anchored into a conceptual framework. More recently, Trochim (1985) refined the structured conceptualization process, applying mixed methods to incorporate both planning and evaluation strategies to facilitate the organization and representation of participant ideas and their relationships into structured visual maps. Thus, this systematic collection of information encapsulates data into a hierarchy of recommendations that participants consider feasible and important to focus on (Peterson & Alexander, 2001).

In March 2003, a Concept Mapping exercise was undertaken with multiple stakeholders—individuals from each of the national partners (n=26; n=19 responded) as well as individuals affiliated with each of the high mortality states (n=75; n=52 responded). Trochim (1985) recommends a series of five steps in conducting a Concept Mapping exercise within groups. The five steps for the Team Up Concept Mapping process were:

1. **Preparation**, which included inviting cancer screening experts and establishing a planning committee (March 27–April 23, 2003);
2. **Generation**, which included the selection of a set of concept terms, called 'brainstorming' in response to the statement, "Steps we can take to increase screening among women who have rarely or never been screened for cervix and breast cancer are..." and the process of sorting through the concepts and identifying those that are related, called 'categorizing ideas' (April 28, 2003);

3. **Structuring**, which included assessing 199 statements for duplication and sorting them into similar categories or themes (n=77) (May 7–June 3, 2003);

4. **Representation**, which included quantitative methods (e.g., multivariate statistical analyses including multidimensional scaling and hierarchical cluster analysis). At this point the maps were cross-linked and hierarchies of meaning were identified on a series of maps (June 2003); and finally

5. **Interpretation** of the data ensured the focal statement was addressed and recommendations were feasible. Participants rated the concepts on level of importance and feasibility, called 'assigning value ratings.' Appendix B describes in detail the five-step process for Team Up (June 2003).

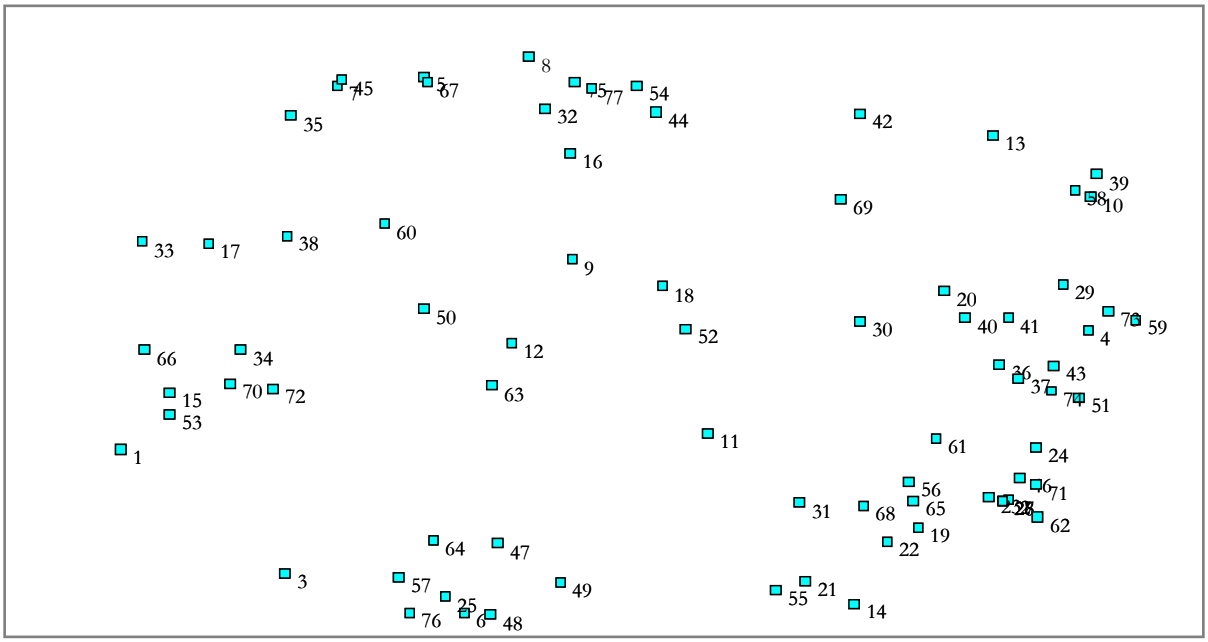
A unique feature of Concept Mapping methodology is the emphasis given to represent ideas visually through a series of cluster maps. Cluster maps are pictures derived from analytic techniques (i.e., multidimensional scaling and cluster analysis) that depict the relationship of ideas in the form of illustrative clusters, groups of individual statements on the map that reflect similar concepts. The content of the map is entirely determined by participants (Concept Systems, 2003).

The first map, known as a Point Map (Figure 2-6), displays a cluster-point or statement map, which locates the 77 brainstormed statements as a point on the map. Next to each point is the number of the statement, so each point is identified. Statements in close proximity to each other were more likely to have been sorted together more frequently and represent thematic similarity in comparison with more distant statements, with peripheral correspondence. More distant statements were sorted together less frequently.

A second map, known as a cluster-point map, showed all points that were thematically linked to each other (Figure 2-7). Partitions were drawn on the cluster map to indicate the different regions enclosed by polygon-shaped boundaries. The larger clusters encompass broader concepts and the smaller clusters contain concepts that are narrower in scope.

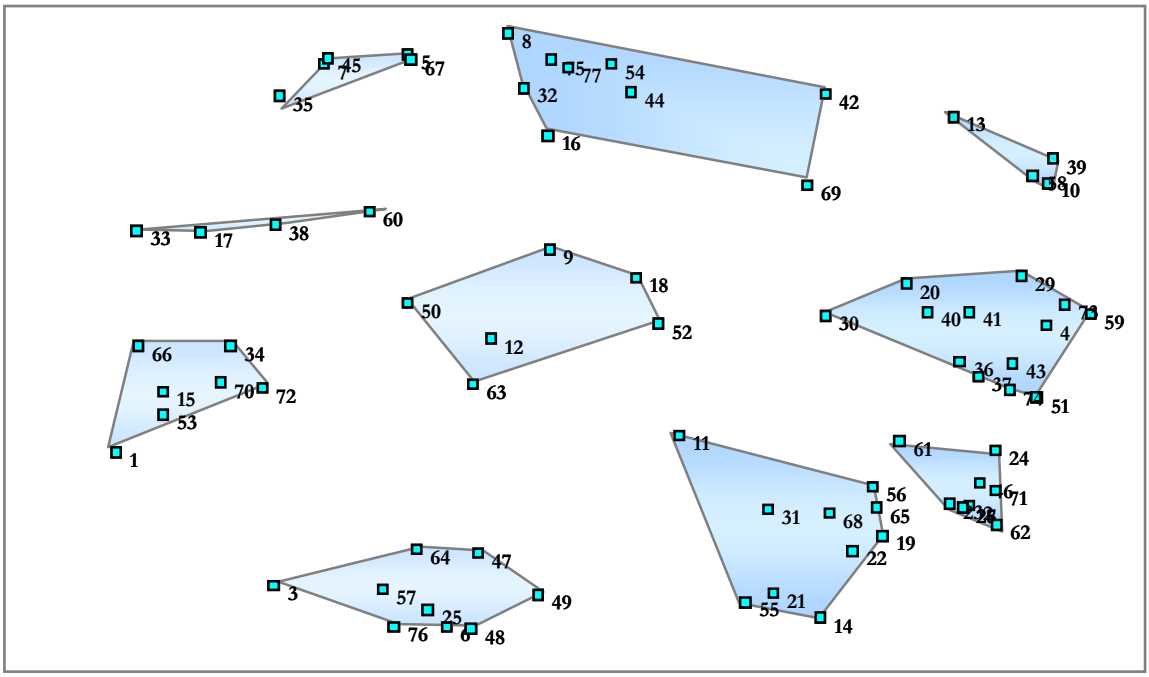
Since the content of the maps is entirely determined by participant input, each map emphasizes a brainstormed statement as a point, and the average rating for each statement. The result is a picture of conceptual information generated by participants. Each map tells something about the major ideas and how they are interrelated. Similarly, each map emphasizes a different part of the conceptual information.

Figure 2-6. Point map, indicating the array of all statements and their relationship to each other



Source: Concept Mapping, 2003.

Figure 2-7. Point cluster map, showing point values groups within statement clusters

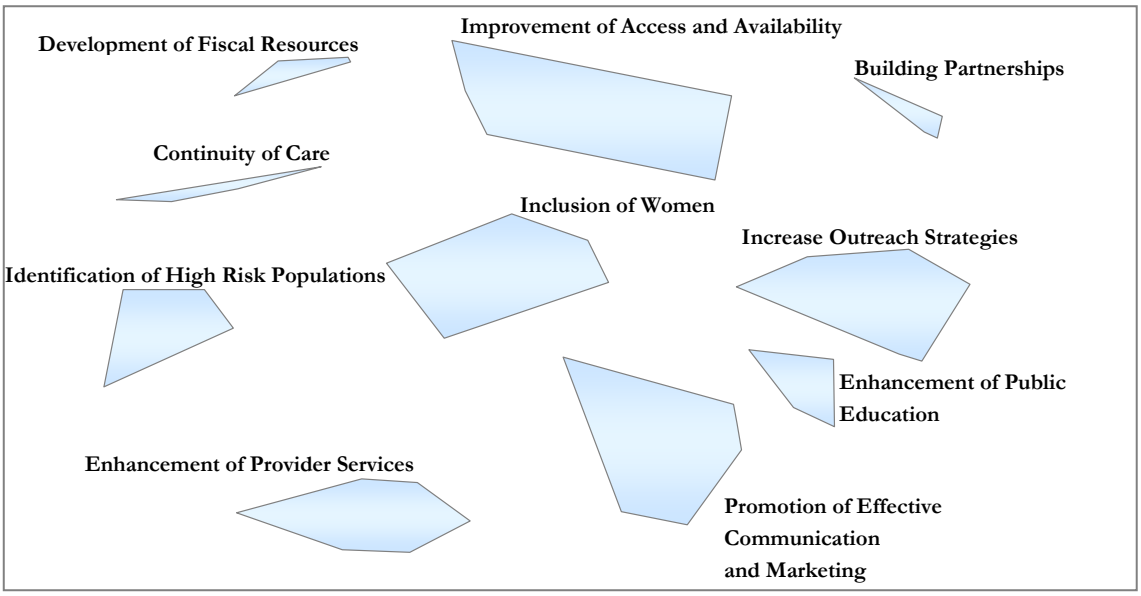


Source: Concept Mapping, 2003.

The third Concept Map, Figure 2-8, highlights 10 distinct priority groups (derived from the 77 brainstormed statements). Individuals from both groups (the core group and the extended group) discussed distinctions in the point cluster maps and labeled them as priority themes that should be considered when working to increase cervical and breast cancer screening rates among rarely or never screened women at the state level:

- Development of fiscal resources;
- Improvement of access and availability;
- Building partnerships;
- Increase outreach strategy;
- Enhancement of public education;
- Promotion of effective communication and marketing;
- Enhancement of provider services;
- Identification of high risk populations;
- Continuity of care; and
- Inclusion of women in the process.

Figure 2-8. Final cluster map



Source: Concept Mapping, 2003.

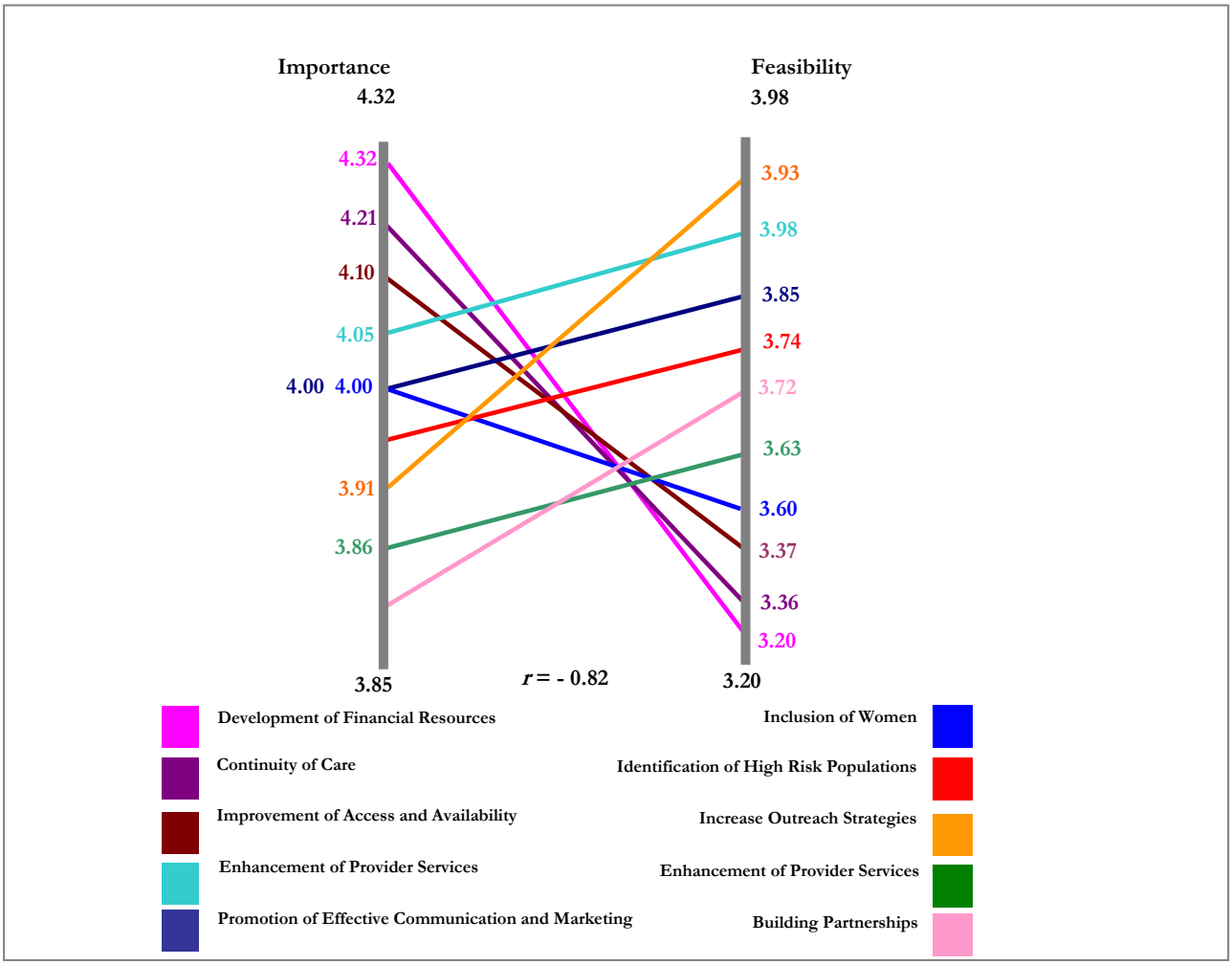
In the final step, participants rated the 10 clusters on two dimensions—"importance" (compared with other statements in a cluster) and "feasibility" (relative to the next 3 to 5 years)—on a 5-point Likert-type scale (where 1=relatively unimportant compared with the rest of the statements in a cluster and 5=extremely important compared to the rest of the thematic statements) for relative "importance" to Team Up.

The final map, Importance and Feasibility Rating Map (Figure 2-9), showed how the 10 priority areas were rated in terms of "importance" and "feasibility." The ladder graph showed correlated average scores for those priority areas. The map shows divergence between what was considered "important" and "feasible" since clusters that rated as high on "importance" were considered less "feasible" and vice versa. As suggested by this graph, six thematic areas ranked as highly "important" (4.0 and above) while no thematic area rated as being highly "feasible" (i.e., all were 3.9 and below). The pattern matches that showed some consistency were in three areas: inclusion of women, enhanced physician services, and continuity of care for women.

It was interesting that while participants identified many characteristics felt to be important influences to increase screening such as developing fiscal resources, having continuity of care, improving access and availability, and enhancing provider services, not all important elements considered were deemed feasible. On the other hand, the most feasible elements recommended for Team Up to adopt were to consider enhancing public education for the women not screened, increasing outreach strategies, and promoting communication and marketing to populations who need screening. Notably, building partnerships was rated at the very bottom of important influences, although remained relatively high as a feasible element. The feasibility rating was the rationale for selecting partnerships as a strategy for Team Up and, consequently, building partnerships became a key foundation of Team Up.

The Concept Mapping process was a natural congruence between the integration of health status indicators and the interests of Team Up stakeholders as a way to obtain meaningful impressions of what was important and what was feasible for the pilot. Through collective consensus, the participatory process narrowed the research focus and provided valuable information that would be used in the subsequent developmental step, building a logic model.

Figure 2-9. Importance and feasibility rating map



Source: Concept Mapping, 2003.

2.1.4 Team Up Logic Model

Information derived from the Concept Mapping application was incorporated into a logic model that depicted the sequential and causal relationships among the outcome constructs (W. K. Kellogg Foundation, 2001). Together, Concept Mapping and the logic model facilitated narrowing the focus of programmatic planning and aided in identifying evaluation measures.

In April 2004, representatives from the four national partners (ACS, CDC, NCI, USDA) gathered to construct a logic model to assist in understanding the iterative nature of the Team Up pilot program (Figure 2-10). The logic model was selected as the second part of the needs assessment to provide a

visual sequence of programs to be implemented, relationships among program elements, and to aid in the identification of short-, intermediate-, and long-term markers for evaluation efforts. It was recognized that the logic model would be influenced by all levels of partners and the dynamic nature of working across multiple interrelated geographic environments, and would be subject to change as activities modified over time (Bickman, 1987; McLaughlin & Jordan, 1999).

The purpose of the logic model was to: (1) integrate Concept Mapping data considered feasible and important; (2) develop an overall program description and identify important programmatic determinants; and (3) identify short, interim, and long-term outcomes of the Team Up pilot that can be integrated into the evaluation.

The logic model (Figure 2-10) flows from programmatic inputs on the far left (immediate short-term markers) to activities in the center (intermediate markers) to outputs on the right (long-term markers). The concept map data (importance and feasibility) was integrated into the appropriate columns of the logic model's program input, activity, or outcome.

Following is a description of each of the components in the Team Up logic model.

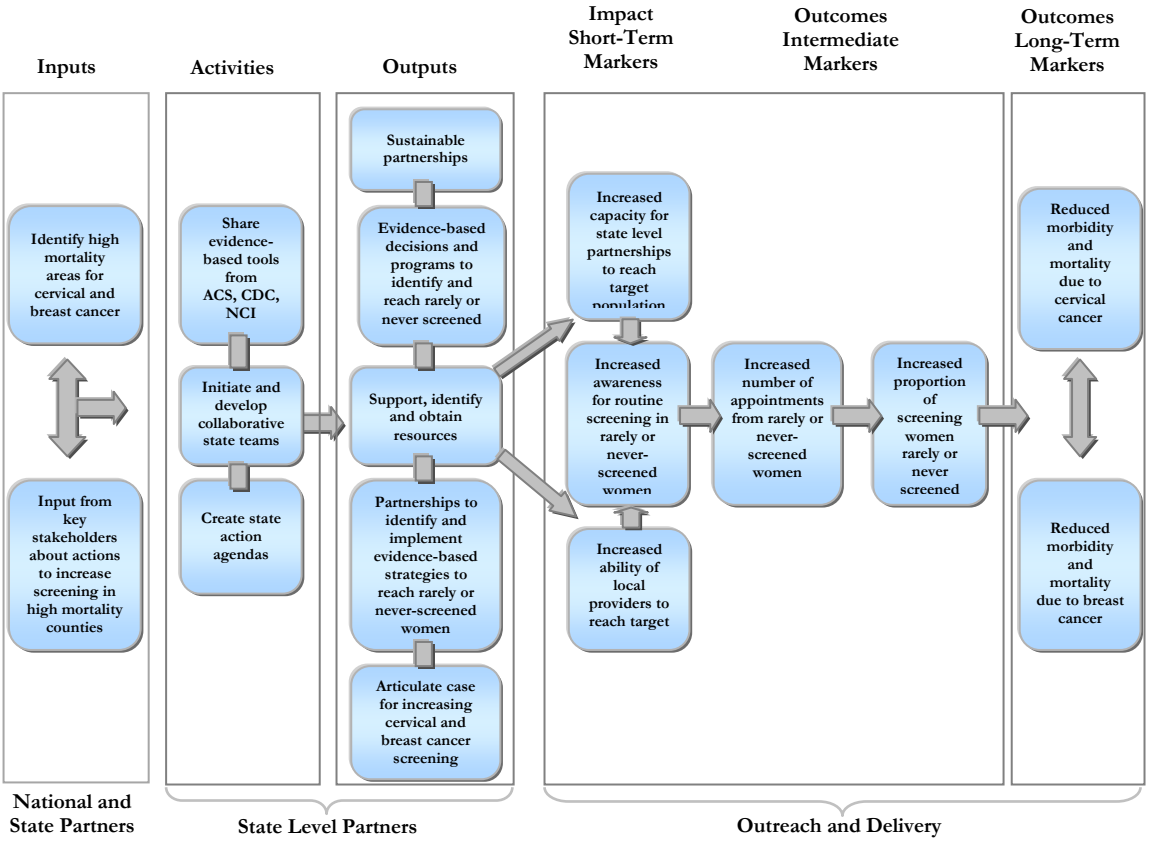
Inputs included human and financial resources that were essential support to making the Team Up pilot work. Financial inputs were used to identify high-mortality regions for cervical and breast cancer, and human resources provided by key stakeholders included specific actions to be undertaken to reduce these health disparities among the identified medically underserved populations.

Activities included those planned to be implemented to produce program outputs: (1) the dissemination of evidence-based research tools and programs from each national partner, especially those available from the Cancer Control P.L.A.N.E.T. (Plan, Link, Act, Network With Evidence-based Tools) web portal; (2) the development of collaborative partnerships; and (3) the creation of state action agendas (SAA). It should be noted that over time activities were increased at the request of states to include technical assistance, regional trainings, and financial support for teams to evaluate their programs.

Outputs were the products, services, and events delivered through accomplishing the planned activities. For Team Up, states were expected to: (1) sustain their partnerships throughout the pilot program; (2) articulate a case for increasing cervical and breast cancer screening; (3) develop and use

evidence-based decisions and programs to reach the desired screening population; and (4) identify resources to conduct their implementation program.

Figure 2-10. Team Up logic model



Outcomes were characterized as changes or benefits resulting from activities and outputs. Team Up, like other programs, had multiple and sequential outcomes across the full program performance story. First, the short-term outcomes are changes or benefits most closely associated with or caused by the program's outputs, specifically the partnerships' influence on state capacity to increase awareness of routine screening among identified women. Second, intermediate outcomes are changes that resulted from an application of the short-term outcomes, specifically increases in the proportion of women being screened. Finally, long-term outcomes, or program impacts, follow from the benefits accrued though the intermediate outcomes, specifically reductions of morbidity and mortality for cervical and breast cancer through the use of evidence-based interventions.

The logic model with a written narrative was circulated to both core group members and a small group who participated in the Concept Mapping exercise for feedback. As a result of comments, the logic model underwent minor changes, with the final model shown in Figure 2-10.

In summary, one benefit of the logic model was that it was based on concepts derived from researchers and practitioners who participated in the Concept Mapping exercise. The Concept Map and underlying statements served as the foundation for the logic model refinement process. The iterative process of logic model development has been used with public health practitioners, and less so with researchers. Engaging both researchers and practitioners in the process helped the two groups to clarify the importance of the Team Up goal of reaching women rarely and never screened for cervical and breast cancer. As noted above, the logic model process included open discussions, compromise among people with conflicting views, transparent use of feedback and decisionmaking, inclusion of stakeholder perspectives, and repeated explanations of the process—all of which were important methods for keeping all participants positively engaged and supportive of the final product (Sundra et al., 2006). Ultimately, developing a logic model fostered collaboration among national partner members and helped them build consensus as a group. Finally, the resulting logic model provided a framework for identifying key scientific questions, which ultimately guided the evaluation.

2.2 Phase II: Partnership Formation and Building (June 2002–December 2003)

The partnership-building phase consisted of building the national and state partnerships. Partnership building of the national partnership began in 2002 when the CDC, NCI, and USDA discussed ways of working together to increase cervical and breast cancer screening. Partnership building of the state partnerships began at the July 2003 kickoff training where state partners affiliated with each of the four national partners were invited to become familiar with the Team Up pilot.

2.2.1 National Partnership

Partnerships between national federal and nonfederal institutions and organizations that conduct research and deliver health care and social services can represent an important strategy that offers promise in terms of bridging the gap between knowledge and practice (Bazzoli et al., 2003; Elsinger

& Senturia, 2001; Israel et al., 1998). However, the structure of these partnerships can be highly variable due to their infancy and uniqueness (Fielden et al., 2007). This was true of Team Up. In early 2002, an existing relationship between individuals was explored between NCI and USDA. The purpose of this connection was to provide access to NCI communication materials relating to cervical cancer screening so that USDA Cooperative Extension workers could provide resources to medically underserved women. With a focus on moving research into practice, this initial relationship expanded to include CDC.

In 2002, CDC, NCI, and USDA discussed how they could focus on increasing cervical and breast cancer screening using CDC's NBCCEDP that was already in place in identified states. Because the NBCCEDP long-term goal is to reduce breast and cervical cancer-related morbidity and mortality, and to decrease breast and cervical cancer-related disparities, important benefits could be gained from collaborating. During these initial discussions, the ACS was invited to join the discussion. ACS saw a value and a need to be involved because of its penetration with regional offices and their focus on breast cancer. Throughout much of 2002 and early 2003, a series of meetings between these four institutions were held to explore the feasibility of moving toward a formal partnership structure, clarifying the mission, and formalizing roles and procedures. To match the Team Up mission with potential partners, many questions needed to be addressed prior to agreeing on a formal partnership structure. As described below, it was clear that each organization recognized that a unique opportunity existed to pool resources and to partner at the national and state level to reduce the burden of mortality for breast and cervical cancer.

American Cancer Society (ACS). As part of the ACS's organization-wide priority for cancer prevention and detection, an important focus area is to reduce disparities in the early detection of breast (and cervical) cancer, primarily through advocacy and partnerships. ACS has worked with CDC, state departments of health, and other partners to increase the reach of and funding for the NBCCEDP since the program's inception. Team Up was an avenue for building partnerships with additional organizations to help reduce disparities.

Centers for Disease Control and Prevention (CDC). The CDC administers the NBCCEDP, which is grounded in public law (the Preventive Health Amendments of 1993 [Public Law 103-183] was enacted December 14, 1993) and is regulated by the federal government. As such, NBCCEDP is required to fulfill certain screening functions with specific populations of women. The *priority* population for NBCCEDP mammography services is women between the ages of 50 and 64 who are low income (up to 250 percent of federal poverty level), who have not been screened in the past year, and who have no other source of health care reimbursement, such as insurance. For cervical

cancer screening services, the *priority* population for NBCCEDP is women between the ages of 40 and 64 who have low incomes (up to 250 percent of federal poverty level), who have never been screened or not been screened in the past 5 years, and who have no other source of health care reimbursement, such as insurance (Centers for Disease Control and Prevention, 2006). Team Up was seen as a vehicle to link to NBCCEDP practitioners to reach the priority population they served.

National Cancer Institute (NCI). In 2001, the NCI began development of a web-based tool that would help move cancer prevention and control research into practice. In 2003, the Research Tested Intervention Programs (RTIPs) web site, co-sponsored by the Substance Abuse and Mental Health Services Administration was launched as part of the Cancer Control P.L.A.N.E.T. web portal. Cervical cancer was one of the first two topic areas featured on the web portal and was designed to align with the creation of the Team Up pilot. The Cancer Control P.L.A.N.E.T. web portal goal for NCI was twofold. First, provide easy access to evidence-based tools and programs for practitioners, and second, provide assistance to practitioners from the CIS program partners staff to encourage the adoption and adaptation of evidence-based cancer control programs in the field.

United States Department of Agriculture (USDA). All universities engage in research and teaching, but the nation has more than 100 land-grant colleges and universities, of which a third have a critical mission—extension. Extension means 'reaching out,' and along with teaching and research these land-grant institutions 'extend' their resources to address public needs and solve problems by making nonformal, noncredit programs available through these designated colleges or universities. These programs are largely administered through thousands of county and regional extension offices, which bring land-grant expertise to the most local of levels of the United States. Both the universities and their local offices are supported by the CSREES, the USDA federal partner in the Cooperative Extension System (CES). One of the key areas that Extension focuses on is Family and Consumer Science, which helps families become resilient and healthy by teaching nutrition, food preparation skills, positive child care, family communication, financial management, and health care strategies. The access to medically underserved women, the ability to deliver health education programs, and the focus on health care strategies was the link that brought USDA into the Team Up partnership on cervical and breast cancer.

2.2.2 State Partnerships

Partnership building of the state teams began with a kickoff training meeting in July 2003. The Team Up national partner sponsored training in Atlanta, Georgia, was entitled, "*The Partnership to Increase Cervical and Breast Cancer Screening in High Mortality Counties: Pilot Training.*" The purpose of the training was to develop and support state-level partnerships in their efforts to identify and implement an evidence-based approach to improve screening rates for cervical and breast cancer among rarely or never screened women. National partners invited representatives from the eight Team Up states, including ACS regional planners and other practitioners or educators from the identified states, CDC NBCCEDP staff, NCI's CIS Partnership Program directors and outreach staff and regional CIS staff, and USDA CES Educators. CDC and NCI cancer control specialists attended the training as observers.

Since partnership building was an activity that continued throughout the life of the Team Up pilot, the other partnership-building strategies are described Section 2.3, which explains the capacity-building phase of Team Up. These partnership strategies were tailored to specific state needs and were designed to elicit decisionmaking strategies surrounding the selection and implementation of evidence-based interventions, promote the sharing of knowledge and experience, and to facilitate ongoing partnership-building activities. Team Up partnership-building activities were organized in stages according to need and corresponded with the basic stages of strategic planning and activities as shown in the logic model (Figure 2-10).

During all state meetings, teams were given time to work within their own team and were encouraged to interact with national partners to build and strengthen their partnerships. While the state partners worked on developing their partnerships, the national partners worked through many of the same issues and strove to be a model for the states on benefits and challenges regarding partnerships. The literature widely acknowledges that partnership building requires a multipronged approach that necessitates collaboration at all levels, not just coordination among all organizations. Collaboration includes sharing complementary knowledge, expertise, resources, and influence (de Souza Briggs, 2003; El Ansari, 2005; Green & Kreuter, 2002; Israel et al., 2000; Roussos & Fawcett, 2000; Wildridge et al., 2004).

2.3 Phase III: Capacity Building (July 2003–September 2007)

Capacity building is developing an infrastructure to deliver particular types of programs, and can also be thought of as 'service development.' Based on the earlier work of Meissner, Bergner, and Marconi (1992) in cancer control, the core components of community work are to build capacity within states to create appropriate structures and to ensure that particular evidence-based activities are carried out. Similarly, capacity-building activities can be devoted to promoting the problem-solving capability of organizations to facilitate collaborative action at all levels.

In Team Up, capacity building was offered during the initial July 2003 kickoff training and continued throughout the life of the pilot until 2007. It became apparent as Team Up matured that it was more complex than originally anticipated, and it was recognized that to strengthen the infrastructure it would require ongoing mentoring. For instance, the national partners provided training and technical assistance to help state teams acquire new information, increase their skills, engage in project input and assist decisionmaking. In addition, more tailored technical assistance was provided with coaches who were available to facilitate in the identification and implementation of the evidence-based interventions. At the request of the states, formal technical assistance began in October 2004 and continued until September 2007. The menu of training and technical assistance included Coaching, PATH visits, Regional Meetings, Webinars, a Web Forum, Newsletters, Retreats, and National Meetings.

2.3.1 Kickoff Training Meeting (July 2003)

As discussed in Section 2.2.2, the 1½-day, July 2003 kickoff training meeting in Atlanta, Georgia, was entitled, "*The Partnership to Increase Cervical and Breast Cancer Screening in High Mortality Counties: Pilot Training*." The purpose of the training was to develop and support state-level partnerships in their efforts to identify and implement an evidence-based approach to improve screening rates for cervical and breast cancer among rarely or never screened women. Specifically, the training provided an opportunity for participating states: (1) to understand how to access and adapt evidence-based screening interventions for use in high mortality regions; and (2) to develop, create, or strengthen a partnership at the state and local level.

The initial intensive training was broken into eight sections:

1. Opening Session;

2. Overview and Introduction;
3. Build and Sustain Partnerships;
4. How to Use Science;
5. Mobilize Support/Resources;
6. Plan and Develop Implementation Strategies;
7. Making the Case for Increased Screening; and
8. Closing Session.

Throughout the training, there were state partnership activities that corresponded with each section. This allowed state teams the opportunity to begin developing the partnership. Appendix C contains the pilot training evaluation report.

Since the concept of evidence-based interventions was a relatively new concept to state practitioners, the national partners recognized that state partners needed to be familiarized with these concepts and have access to technical experts to assist them with the selection, adoption, and implementation of evidence-based interventions. The formal sessions included presentations by cancer control experts with epidemiologic information and data describing state-level cervical and breast cancer mortality, and instruction on accessing evidence-based screening approaches using tools from a variety of sources, including the Cancer Control P.L.A.N.E.T. web portal (http://cancercontrolplanet.cancer.gov), cancer screening interventions identified as efficacious in *The Guide to Community Preventive Services* (Zaza, Briss & Harris, 2005), personal experience of using tested interventions, and professional organizations.

During small group planning activities, state partners were tasked to: (1) develop a shared vision of priorities for reducing cervical and breast cancer mortality rates; (2) strengthen partnerships at the state and local level by focusing on their community to better understand their target population; (3) determine what interventions met the needs of their community members, and which would have the greatest impact of reaching women of need; and (4) identify resources and experience among state members to effectively implement these interventions.

The primary deliverable from the training program was an SAA developed by each state team. These agendas identified priorities and potentials for building local partnerships and plans to explore next steps (i.e., tasks, timelines, and resources) for creating a state plan to screen women who have rarely or never been screened for cervical and breast cancer (Appendix D). Participants from each state

who attended the July 2003 training were contacted 3 and 6 months post-training to assess their partnership's progress (Appendix E).

2.3.2 Web Forum (June 2004–October 2006)

State partnerships requested a web forum for document sharing and communicating within and across state teams and with the national partners. The forum, initiated in June 2004 by CDC, was intended to increase information and resource sharing while improving overall communication throughout Team Up. State partners posted information or news and raised questions with colleagues and national partners. State partners primarily used the forum to post documents such as formal PowerPoint presentations, information about planning implementation activities for shared viewing, and training announcements. The national steering committee used the forum to post communications materials and project documents for sharing with state teams. Due to lack of use, the web forum was terminated by CDC in October 2006.

2.3.3 Newsletters (October 2004–December 2007)

The Team Up newsletter was launched in October 2004, and was designed to: (1) communicate with state partnerships; (2) address broad technical assistance needs through education; (3) highlight partnership successes; and (4) document the implementation of Team Up. The newsletter content was guided by feedback from coaches and emails to steering committee members about technical assistance needs across state partnerships. Additionally, it was a forum for communicating new information, addressing frequently asked questions, dispelling myths, and creating a project identity. Regular newsletter features included: *A Message from the National Partners*—a greeting with updates from the national steering committee; *Coach's Corner*—an article from the coach addressing a broad technical assistance area*; On the Horizon*—updates on future activities*; A Model of Team Up Success*—a description of implementation in one of the Team Up states; and *Braggin' Rights*—which acknowledged project success by state partnership or steering committee members. Special issues included national meeting issues, an issue describing the purpose of the project and explaining project components, as well as issues describing evaluation efforts and findings. In all, there were 11 issues of the Team Up newsletter that documented the implementation of the pilot.

2.3.4 Coaches (October 2004–December 2007)

Several national reports have underscored the need for visionary leadership with both technical and management expertise in public programs to accommodate demands of practitioners who need to solve emerging problems and respond to evolving public health needs (Ibrahim, House & Levine, 1995; Institute of Medicine, 1998). In addition to these reports, results from the 3- and 6-month evaluation, together with conversations with state partners, led to the recognition that insufficient resources had been devoted to the preparation of practitioners. In response, two coaches were introduced to state teams via the Team Up newsletter in October 2004.

Each coach came to Team Up with expertise in research and evaluation, partnership and team building, and subject knowledge in breast and cervical cancer screening, health education, and community outreach. Additionally, they each had more than 15 years of experience working in the field of cervical and breast cancer and experience working with the four national partners. Combined, the coaches had more than 40 years of experience in community outreach—including work in cervical and breast cancer education with the national organizations.

The coaches began their formal intervention by conducting PATH visits (described in Section 2.3.5) with each of the eight states to assess their progress and to identify specific technical assistance needs. The two coaches were to work one-on-one with state partnerships to build capacity and provide technical assistance in the three areas related to the basic program components: rarely or never screened women as the audience; evidence-based interventions as the approach; and partnerships as the overarching strategy.

In addition to their targeted education, the coaches also contributed articles to the quarterly Team Up newsletter to address broad technical assistance needs and assisted in training development as needed. In 2005, one of the coaches left Team Up to pursue graduate study. For the remainder of the project, one coach provided technical assistance across all participating states. Coaches were a unique contribution since they reinforced the Team Up mission, facilitated communication between partner members as well as the national partners, and established a foundation of support for those within the state practice sectors of Team Up.

2.3.5 Partnership Assistance and Technical Help (PATH) Visits (April 2005–May 2005)

PATH visits were conducted with each state partnership in the spring of 2005 to further assist in partnership building, and to help them develop and execute a viable plan to adopt, adapt, and implement an evidence-based intervention. PATH visits were 5-hour, on-site technical assistance visits facilitated by Team Up coaches. Visits to states included an in-depth facilitated discussion of major issues identified by coaches during pre-telephone interviews with team members as well as interpretation and application from the Lasker and Weiss PSAT. Each team approved the agenda items prior to the meeting. Basic agenda items across all teams included the following items:

- Welcome and Introductions;
- Setting the Stage (Overview of the Day);
- Partnership Progress and Perceived Needs;
- Evidence-Based Program Planning Resources;
- Program Planning and Evaluation – *Action Steps*;
- Training, Communication, and Technical Assistance Needs; and
- Next Steps and Adjourn.

Building on the SAA developed during the kickoff meeting, a product of the PATH meetings was a State Technical Assistance Plan (STAP) for each state prepared by the teams in conjunction with the coaches.

Based on each site visit, the coaches developed a STAP for each state, and in conjunction with the national partners coaches provided tailored technical assistance including regularly scheduled meetings (teleconferences and in-person) with each state to help them identify, adapt, implement, and evaluate evidence-based approaches to encourage women from high-risk counties to be screened for cervical and breast cancers. This STAP plan included priority action steps for the following 6 to 9 months and was the foundation for technical assistance provided over the next year (Appendix F).

2.3.6 Regional Meetings (July 2005)

Two regional meetings took place during the summer of 2005 in Atlanta and Nashville. The 1½-day meetings were convened by the national partners in order to accomplish the following:

- Enhance the relationship among the state partners and between state and national partners;
- Achieve a common understanding of the Team Up goals, objectives, concepts, methods, and timeline;
- Discuss how to identify, adapt, and evaluate evidence-based programs;
- Understand the national evaluation and how the state evaluations relate to the national evaluation;
- Discuss sources of funding and how to access additional funds;
- Discuss 'burning issues' with state and national partners;
- Identify action steps necessary for the state partners to establish productive communication and collaboration among the state partners and to continue to assess, adapt, implement, and evaluate evidence-based cancer control programs in a sample of high-risk counties; and
- Discuss technical support needs and next steps.

Half of the state partnerships attended each training (Atlanta: Alabama, Georgia, Mississippi, and South Carolina, and Nashville: Illinois, Kentucky, Missouri, and Tennessee). Appendix G contains the regional meeting evaluation report.

2.3.7 Webinars (October 2005–April 2006)

Webinars are web-based seminars held via the Internet on different topics that were identified by state partnerships as broad technical assistance needs. The purposes of the three Webinars were to: (1) address broad technical assistance needs and specific areas of interest; and (2) facilitate the exchange of information between state partnerships.

The first Webinar provided an overview of the Forsythe County Cancer Screening Project (FoCaS), an evidence-based intervention (October 25, 2005). The second discussed developing proposals to obtain evaluation funds (January 19, 2006). The last discussed the national evaluation and the role of

the state partners in the evaluation, and answered any questions participants had about the national evaluation (April 12, 2006). Each Webinar was led by a content area expert (Appendix H, Webinar evaluation).

2.3.8 Retreats (June 2006–December 2007)

In early 2006, states were in different stages of partnership development, planning and implementation. For those whose states already executed the action steps, and who needed to refine their plans, or wished to evaluate progress in completing action steps, or wanted to solidify a particular aspect of their partnership, an invitation was extended to all state partners to participate in facilitated planning retreats using the ACS Retreat model. ACS convened 2-day planning retreats for the three partnerships ready to commit (Georgia, Missouri, and Tennessee).

The purpose of the retreats was to further the goals of the Team Up partnership by increasing awareness of each partner's organization, identifying and addressing concerns that limit the effectiveness of the collaborative relationship, establishing and refining procedures for working together, and identifying and committing to collaborative activities. Each partnership completed a pre-retreat survey that helped tailor their retreat to meet their specific needs. While the structure and functioning of each collaboration varied widely, several common outcomes were identified:

- **Improved collaborations.** Three of the states thought that the collaboration among partners had been improved as a result of their retreats. Retreats initiated or increased dialogue, helped formalize the collaboration and 'make it public,' contributed to communication processes, educated participants about organizational structures and individual roles, and improved coordination.

- **Establishment of procedures for working together**. There was some variation in the degree to which the retreats helped the collaborations establish procedures for working together.

- **Implementation of action steps.** Specific action steps varied by state and covered such topics as outreach to women, developing a memorandum of agreement, developing a mammogram incentive project, monitoring and supporting a grant-making strategy, and advocacy campaigns.

In summary, retreats were conducted while state partnerships were focused on building infrastructure and initiating implementation of their interventions. While the timing of the retreats was very useful for some states that were further along in the implementation phase, it was less

beneficial for other states that were still planning. It may be that the development of each partnership needs to be examined for the appropriate timing of a retreat, and it may also be worthwhile to consider whether to plan retreats at several key stages throughout the future partnership projects. Appendix I contains the retreat evaluation.

2.3.9 National Meetings (August 2006, June 2007)

The national partners hosted annual meetings in August 2006 and June 2007 for the state partners. The 2-day national meetings provided an opportunity for the national and state partners to network, share their experiences, and receive training and technical assistance. The August 2006 meeting convened in Charleston, South Carolina, in order to accomplish the following objectives:

- Share successes and challenges from the past year;
- Provide strategies for building on the successes and addressing the challenges;
- Present options for enhancing sustainability;
- Build capacity in evaluation;
- Provide expert, tailored consultations to help state teams address their unique challenges to evaluation; and
- Energize teams as they continue to nurture partnership as well as the implementation and evaluation of their evidence-based programs.

The June 2007 meeting was convened in Lexington, Kentucky. The national meeting was designed to achieve the following objectives:

- Share lessons learned from the state partnerships' implementation efforts;
- Discuss sustainability issues and strategies;
- Celebrate successes;
- Learn creative ways to tell the Team Up story to potential partners, funders, and policymakers;
- Learn about updates in the field of cervical and breast cancer; and
- Provide guidance for the future of Team Up.

2.4 Phase IV: Implementation Phase (July 2005–December 2007)

The implementation phase was the period in which state partnerships used evidence-based cancer screening interventions to reach rarely or never screened women. States were first introduced to the concept of evidence-based interventions during the July 2003 kickoff meeting. They learned more about evidence-based interventions during the 2005 regional trainings and the FoCaS Webinar. All states selected their evidence-based interventions by 2005, but implementation dates varied. The implementation process for the states is discussed in detail in Chapter 5.

2.5 Phase V: Evaluation (December 2004–April 2008)

To monitor Team Up as it progressed, to understand whether the pilot was being implemented as planned, and to determine how well the program was working, a multilevel evaluation was developed. A program monitoring system was developed to observe and measure activities at each stage of the pilot. Since Team Up was a pilot program with a limited timeframe, the evaluation was for a limited assessment period. Hence, it was not possible to evaluate long-term outcomes. Given that a primary focus of the pilot was partnership building within a small number of states and the use of identifying and disseminating evidence-based approaches into practice with the intent of increasing screening rates, the Team Up evaluation should be considered a case study rather than an evaluation with a rigorous experimental design. In addition to the national evaluation, states were given the opportunity to apply for a $15,000 grant to evaluate their program through a request for proposals released in January 2006. Applications were submitted to the national partners by five states for review, and funds were distributed to all five states. A sixth state received evaluation funds from an outside source. Chapter 3 discusses the goals, framework, and methodology of the evaluation.

2.6 Summary

In summary, this chapter provided a synopsis of the historical context for the formation and planning of Team Up. When Team Up was initiated, there was not a consolidation of efforts across federal, state, and local bodies with the common goal of improving screening for cervical and breast

cancer among medically underserved women. Team Up offered approaches and methods to bridge the research to practice gap by introducing the concept of collaborative partnerships designed to facilitate access and use of evidence-based interventions to reach medically underserved women.

Evaluation Goals, Framework, and Methodology 3

This section discusses the goals of the case study evaluation, provides a description of the framework that guided the evaluation operations, and discusses underlying theories that influenced development of the Team Up evaluation. Methods used to evaluate Team Up are then presented.

3.1 Goals of the Team Up Evaluation

The main purpose of the Team Up evaluation was to examine the use of evidence-based cancer screening interventions at the community level through the use of the Team Up partnership approach. To address the overall evaluation purpose, each component of the evaluation had a specific research question.

The purpose of the process evaluation was to examine the success of the four core state organizations in building and sustaining their partnership. The following research questions derived from the Lasker and Weiss's Partnership Framework of Synergy framed the **process evaluation** (Lasker, Weiss & Miller, 2001; Lasker & Weiss, 2003):

- How successful have the state partnerships been in building and sustaining their partnerships?
- How has the national partnership been helpful to the states in building and sustaining their partnerships among the four core organizations (ACS, CDC, NCI, and USDA)?

The purpose of the impact evaluation was to measure the ability of the Team Up states to adopt, adapt, and implement evidence-based interventions. The following research questions, derived from Roger's (1995, 4th ed.) *Diffusion of Innovations,* framed the **impact evaluation:**

- To what extent has an evidence-based intervention been adopted, adapted, and implemented by state and local partners in the target counties?
- What factors (e.g., characteristics of the selected innovation) influenced the adoption, adaptation, and implementation of evidence-based interventions by individual partnerships?

- How and to what extent has the national partnership assisted in the process of adopting, adapting, and implementing an evidence-based intervention?

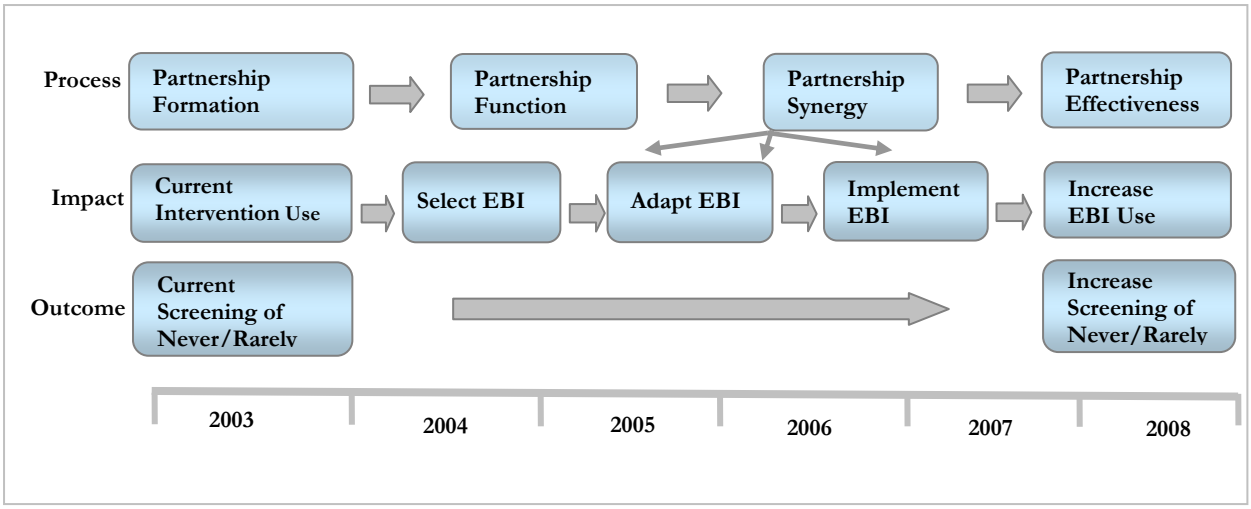
The purpose of the outcome evaluation was to determine whether state partnerships increased short-term screening rates. The research question framing the **outcome evaluation** was:

- To what extent did state partnerships increase screening rates in their targeted areas among women who have rarely or never been screened for cervical and/or breast cancer?

3.2 Team Up Evaluation Framework

In the spring of 2005, the national partner evaluation team convened to develop an overarching conceptual framework to guide data collection and analysis. Using information from the logic model (Figure 2-10), the three-level framework was organized around the process, impact, and outcome evaluation questions (Figure 3-1).

Figure 3-1. Team Up evaluation conceptual framework



EBI: Evidence-based intervention

Process Evaluation

The process evaluation was designed to examine the complex procedures associated with each state in creating and maintaining a well-functioning public health partnership. As shown in Figure 3-1, conceptually the process evaluation was organized around four quadrants including (each with

instrumental components): partnership formation, function, synergy and effectiveness. *Partnership* was used here to encompass all types of collaboration (e.g., consortia, coalitions, and alliances) that bring people and organizations together to improve health outcomes (Mitchell & Shortell, 2000). The partnership concepts drew on the Model of Community Health Governance as proposed by Lasker and Weiss (2003). The framework, more commonly known as the Lasker and Weiss framework, is described in Section 3.2.1. Lasker and Weiss (2003) and others note that partnership *functioning* consisted of the partnership's ability to create an environment that enabled the members to combine their unique skills, expertise, and resources invested for the success of a partnership (Garland et al., 2004; Wildredge, Childs, Cawthra & Madge, 2004; Wolff & Maurana, 2001; Zukoski & Shortell, 2001). It further measured how leadership functioned in each state, and the way information was handled, both at the technological and basic communication levels. *Effectiveness* was measured by synergy, a state in which each partner served as a resource, resulting in a stronger unit (Lasker et al., 2001; Lasker & Weiss, 2003; Weiss et al., 2002). *Synergy* was the ability of a collaborative group to accomplish stated goals. Synergy was hypothesized to have a direct influence on the success in implementing evidence-based interventions.

The first level of the framework shows the four interrelated components (e.g., partnership formation, partnership function, partnership synergy, and partnership effectiveness) that influenced the **process evaluation** and were intended to address the process research questions. The purpose of the process evaluation was to examine the success of each state in forming and maintaining an effective (viable) partnership as a means to enhance outcomes. In this sense, the approach of assessing partnership was intended to be continuous over the course of the pilot. The assessment was process-oriented in both the sense that it examined the way by which partners interacted and provided services (i.e., implemented evidence-based approaches). *Partnerships* are dynamic relationships among diverse groups that pursue a shared understanding of agreed objectives (Brinkerhoff, 2002).

Partnership synergy suggests an ability of a collaborative group to accomplish stated goals. *Partnership effectiveness* was measured by synergy, a state in which each partner serves as a resource, resulting in a stronger unit (Lasker et al., 2001; Lasker & Weiss, 2003; Weiss et al., 2002). In establishing synergy, the process evaluation focused on partnership formation and functioning. The Lasker and Weiss framework, described in Section 3.2.1, served as the theoretical framework for understanding the success of building and maintaining the state partnerships.

The impact evaluation, guided by Roger's (1995, 4th ed.) Diffusion of Innovations theory (described in Section 3.2.2), examined the process of adopting, adapting, and implementing evidence-based interventions, and whether partnerships ultimately decided to continue to use the interventions beyond the pilot project. Like the process assessment, the impact evaluation was intended to focus on the ongoing events surrounding the contextual activities of dissemination and implementation of evidence-based approaches. Guided by Rogers (1995, 4th ed.), the more general dissemination implementation literature and the logic model, implementation thinking was influenced by five interrelated elements (current intervention use, selection, adaptation, implementation, and use of evidence-based methods). Each element was intended to represent the multiple factors that may influence the implementation of evidence into practice. It was proposed that successful implementation depends on the nature of the evidence being used—the context and the type of facilitation required to enable the change process. Through this dissection, the impact evaluation set out to analyze the five elements described in the evaluation framework.

The outcome evaluation was concerned with two issues: screening rates and each state's success in achieving their implementation goals. Screening rates (of rarely or never screened women) were expected to increase with implementation of the evidence-based intervention, as compared to pre-implementation of the evidence-based intervention. In addition, each state was provided funding to assess success in achieving their implementation goals. These evaluation efforts were guided by local needs as opposed to being guided by the national evaluation.

3.2.1 Lasker and Weiss Partnership Framework: Process Evaluation

To assess partnership work in progress with an eye to improving partnership practice as a means to enhance outcomes, and in order to support a theory-based evaluation, synergy was the construct chosen to measure the success of the state partnerships for the process evaluation. *Synergy* has been defined as "a state in which each partner is a resource, resulting in a stronger unit" (Lasker et al., 2001; Lasker & Weiss, 2003; Weiss et al., 2002). Researchers have examined the relationship between partnership functioning and achieving health and health system goals. The pathway through which partnership functioning influences partnership effectiveness was considered an important outcome in Team Up, especially if it could help explain the dissemination and implementation process.

As illustrated in Figure 3-2, Lasker and Weiss (2001) suggest that a unique advantage of successful collaborations is synergy. As defined by this framework, a partnership's level of synergy is "the extent to which the perspectives, resources, and skills of its participating individuals and

organizations contribute to and strengthen the work of the group (i.e., partnership functioning)." Synergy is a product of group interaction. Shown here, synergy is the proximal outcome of partnership functioning that influences whether a particular collaboration results in partnership effectiveness. *Partnership effectiveness* captures the attributes of each partner with respect to staff commitment and motivation, resulting in a stronger unit that seeks to achieve high levels of partnership synergy (Lasker et al., 2001; Lasker & Weiss, 2003; Weiss et al., 2002).

Figure 3-2. Lasker and Weiss partnership framework

Source: Lasker & Weiss (2001)

In the broadest sense, synergy provided the opportunity for each partner to volunteer strengths, experience, skills, and knowledge in order to achieve what the individual could not do alone—a whole that is greater than the sum of its individual parts. Consequently, partnership collaborations that combine perspectives and resources of a group of people and organizations have the potential to create something new and valuable together.

Further, since the benefits of partnership work derive from the relationships themselves, and because all relationships are dynamic, partnership assessment should be seen as an evolving process (Brinkerhoff, 2002). This means that partnerships cannot be expected to yield immediate results, though this might occur. More likely, as partners become more familiar with each other's strengths, weaknesses, operations, and representatives the synergistic rewards will emerge (Brinkerhoff, 2002).

The Lasker and Weiss Partnership Framework identified five determinants of partnership functioning that are related to synergy: (1) resources, (2) partner characteristics, (3) relationships among partners, (4) partnership characteristics, and (5) external environment. The framework discusses specific attributes of each determinant (shown in Table 3-1) that influence a partnership's level of synergy and resulting effectiveness (Lasker et al., 2001). A more detailed description of the determinants is included in Appendix J.

Table 3-1. Influence of partnership functioning determinants on synergy

Determinant	Description of influence on synergy
Resources	Both financial and in-kind resources are basic building blocks of synergy. Resources include money, space, equipment, goods, skills and expertise, information, connections to people, organizations, and groups, endorsements, and convening power.
Partner characteristics	Partners are the source of most partnership resources. They provide the partnership with resources directly, as well as obtain external funding and in-kind support. Therefore, it is important for partnerships to recruit and retain a mix of partners who can provide the resources needed to obtain the partnership goals.
Relationships among partners	Building relationships is the most difficult and time-consuming challenge partnerships face. Trust, respect, conflict, and power differentials are all aspects of partner relationships that influence a partnership's synergy level.
Partnership characteristics	Characteristics of a partnership that influence the synergy level include leadership, administration and management, governance, and efficiency.
External environment	Factors that are beyond the control of any individual partner or partnership, and include the conduciveness of the community to the work of the partnership. There are also public and organizational policy considerations, such as the short-term nature of external funding, categorical program requirements, and inadequate funding for administration and management support.

Source: Lasker et al., 2001.

3.2.2 Roger's Diffusion of Innovations Model: Impact Evaluation

The Diffusion of Innovations theory guided the impact evaluation by providing a framework to evaluate the ongoing contextual processes that influenced the partners to select, adapt, and implement evidence-based interventions and ultimately decide if the intervention was sustainable.

The development of evidence-based interventions is a resource-intensive process, and one means of accelerating the development process is to adapt existing evidence-based interventions for new populations. *Adaptation* has been defined as "the degree to which an innovation is changed or modified by a user in the process of its adoption and implementation" (Rogers, 1995, 4th ed.; Rogers, 2003, 5th ed.) or "deliberate or accidental modification of a program" (Centers for Substance Abuse Prevention, 2001). In the broadest sense, adaptation can include deletions or additions, modifications of existing components, changes in the manner or intensity of components, or cultural modifications required by local circumstances (Centers for Substance Abuse Prevention, 2001). *Adopters* of the new evidence-based intervention then alter the original evidence-based

intervention and adapt it, a process that is perceived as necessary to make the intervention more relevant to the new target population. The literature suggests that extensive intervention adaptation is associated with a decrease in intervention fidelity, and fidelity to each intervention element (as originally planned) is most likely to produce a strong intervention effect (Blakely et al., 1987; McEleroy et al., 2006).

Much of the dissemination and implementation work that has been done on adaptation is based on Roger's Diffusion of Innovations theory. According to Rogers, *diffusion* is "the process by which an innovation is communicated through certain channels over time among members of a social system," and *innovation* is "an idea, practice, or object that is perceived as new by an individual or some other unit of adoption." The four major elements of diffusion of innovation are: (1) the innovation, (2) communication channels, (3) time, and (4) a social system (Rogers, 1995, 4th ed.). Table 3-2 presents a summary of the four elements.

Table 3-2. Elements of Diffusion of Innovations

Element	Description
Innovation	Critical attributes of an innovation are: relative advantage; trialability; observability; communication channels; homophilous groups; pace of innovation/reinvention; norms, roles and social networks; opinion leaders; compatibility; and infrastructure.
Communication channels	The means (i.e., mass media, interpersonal, interactive communication via the Internet) by which participants create and share information with one another in attempts to reach a mutual understanding or common goal.
Time	The innovation-decision period is the length of time required to pass through the innovation-decision process. There are five stages: agenda-setting, matching, redefining/restructuring, clarifying, and routinizing.
Social system	The set of interrelated units that are engaged in joint problem solving to accomplish a common goal are part of the larger external social system. Members of a distinct social system may be individuals, informal groups, organizations, and/or subsystems. A change agent is an individual who influences clients' innovation-decisions in a direction deemed desirable by a change agency.

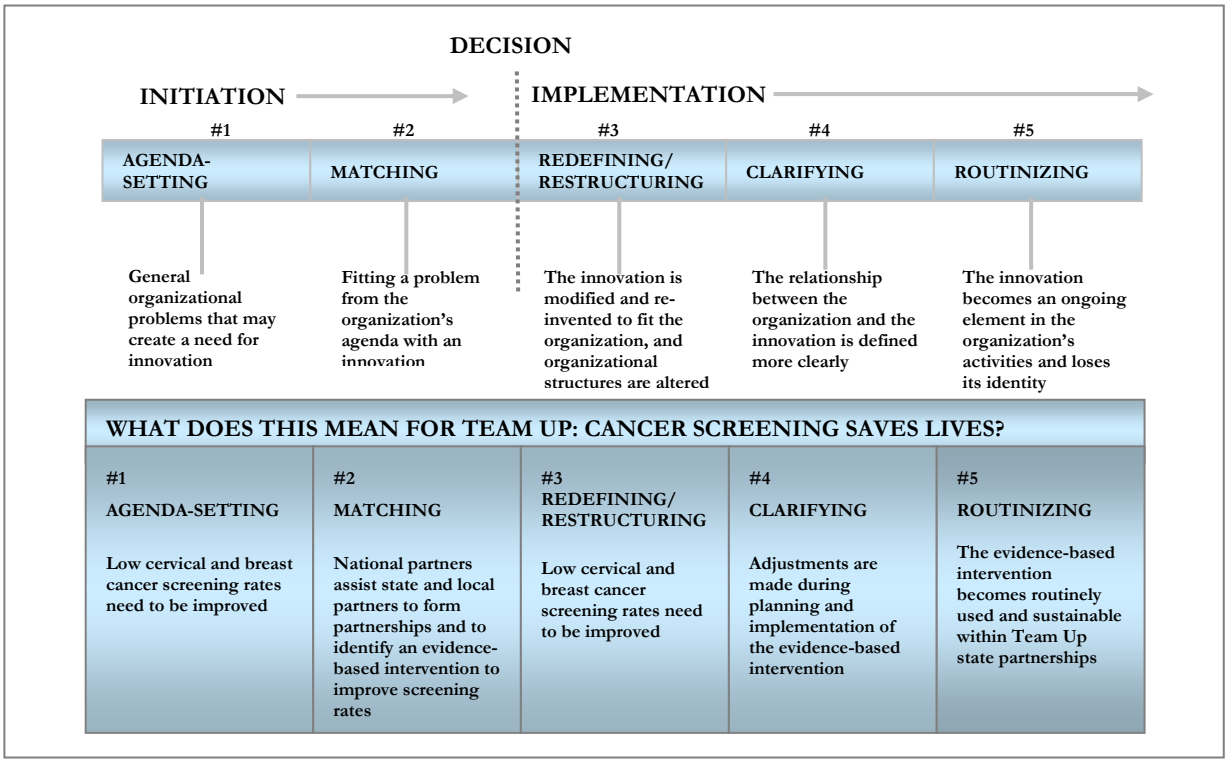
Source: Rogers, 1995, 4th ed.

There are five stages in the innovation process. In the *agenda setting stage*, a general organizational problem that may create a need for innovation is identified. In the *matching stage*, a problem from the organization's agenda is fitted with an innovation. In the *redefining/restructuring stage*, the innovation is modified and re-invented to fit the organization, and organizational structures are altered. During the *clarifying stage,* the relationship between the organization and the innovation is defined more

clearly; and finally, in the *routinizing stage*, the innovation becomes an ongoing element in the organization's activities and loses its identity. Here in this final stage, the intervention is subsumed into practice and become sustained as usual practice.

Figure 3-3 illustrates the five stages of the Diffusion of Innovations process for Team Up. The diffusion of innovations process recognizes the potential linkages between components and processes that contextualize the movement of an intervention from one environment to another. In the *agenda setting stage*, national partners realized that cervical and breast cancer screening rates needed to be improved. In the *matching stage*, state partnerships searched for and selected an evidence-based intervention that fit their unique needs and target population. In the *redefining/restructuring stage*, state partners made the decision to adopt a particular evidence-based intervention and then to modify it so that it would fit their population. In addition, state partners developed systems to support the implementation plan. In the *clarifying stage*, adjustments were made during the planning and implementation of the intervention. Finally, the *routinizing stage* seeks to incorporate the evidence-based interventions into the operations of each partnership and sustain them.

Figure 3-3. Team Up Diffusion of Innovations process for the implementation of evidence-based interventions



Source: Rogers, 1995, 4th ed.

3.2.2.1 Team Up's 'Innovation'

The innovation for Team Up was using evidence-based interventions to reach rarely or never screened women. Team Up defined the term *evidence-based intervention* as an intervention "whose efficacy is demonstrated by a credible body of scientific work." Evidence-based interventions are grounded in consistent research findings and are based on substantial scientific evidence (Team Up National Steering Committee, July 2003). The strongest level of evidence (most objective) comes from epidemiologic surveillance data, followed then by a systematic review with multiple (randomized controlled) intervention research studies, then an intervention research study, then a program evaluation, then word-of-mouth, and the weakest evidence (least objective) is personal experience. To help state partners make an informed decision when selecting an evidence-based intervention, the national partners developed a descriptive matrix of what interventions could be considered strongly (1) or weakly (9) evidence-based (Table 3-3).

Table 3-3. Matrix of relative levels of evidence for types of interventions

	Types of programs			
	RTIPs eligible program (peer reviewed funded research and publication)	Evaluated program (peer reviewed publication)	Evidence-informed program (based on literature)	Program based on personal experience/tacit knowledge (no reference to literature)
Systematic review (e.g., community/clinical guides)	1	2	4	N/A
Other systematic evidence review (e.g., Cochrane Review)	2	3	6	N/A
Individual efficacy or effectiveness study	4	5	7	N/A
Individual program evaluation	N/A	6	8	9

Source: Kerner & Vinson, 2005, personal communication.

The numbers in each cell of Table 3-3 reflect relative levels of evidence that should be considered when selecting a research program to implement, with 1 representing the most objective level of evidence and 9 representing the least objective level of evidence. While the numbers range from 1 to 9, the implementation context also counts. Thus, in a particular setting or for a particular population, a program with less objective evidence may be more appropriate than a program with more

objective evidence (i.e., where and how the intervention is implemented). Consequently, practitioners were to review the full range of intervention options (from systematic review to individual program evaluation) and choose an intervention with the most objective level of evidence available, but one that also best fits the practice context in which it will be implemented.

In many situations there may be no interventions that have been tested for a given population in a given setting, so starting with an intervention between level 7 and 9 may be the best available choice. Moreover, when tested and rigorously evaluated, an individual practice-based intervention may be more likely to be chosen by other practitioners in the future because the intervention is contextually relevant, and over time the new research findings (from an individual practice-based intervention) may move the intervention up and to the left of the matrix with respect to the level of evidence.

Using the information in Table 3-3, the national partners encouraged states to consider choosing an intervention based on (peer-reviewed) published material, since research-tested interventions could subsequently be more readily adapted to local circumstances. The national partners recognized that evidence-based interventions developed in a research (or academic) setting once replicated would reach a different population and different contextual environment in the new practice setting. With this in mind, dissemination efforts could potentially affect the fidelity of the original intervention. *Fidelity* is important since it refers to the degree to which an intervention program is delivered as intended with the core intervention components maintained; a significant consideration since these components (staff training, coaches, and administrators) must be present for implementation to occur with fidelity and the desired outcomes.

3.3 Methodology

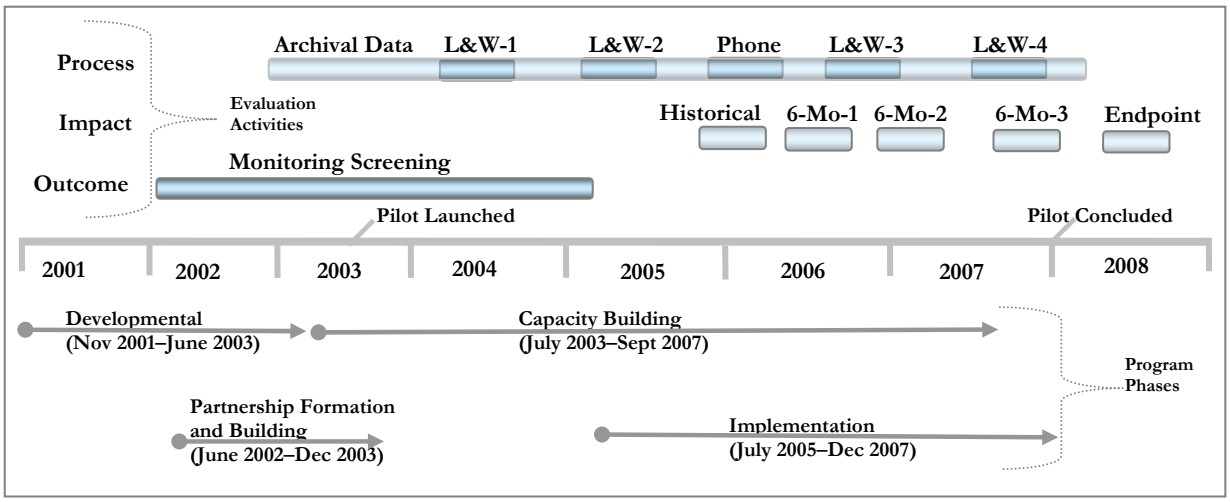
This section presents the methods used for each component of the evaluation. We describe the wide array of qualitative and quantitative data collection sources, and discuss instrument development and testing, administration procedures, and analysis plans.

Figure 3-4 shows the timeline for data collection as well as the various data sources for each evaluation phase. The process evaluation, beginning in 2004, consisted of four administrations of the Lasker and Weiss Partnership Self-Assessment Tool (L&W-1, L&W-2, L&W-3, and L&W-4), as well as telephone interviews (Phone) conducted in the spring of 2006 (described in Section 3.3.1). The impact evaluation began in spring 2006 with the Historical Assessment, followed by four

administrations of the Six-Month Assessment (6-Mo-1, 6-Mo-2, and 6-Mo-3), and concluded with the Endpoint Interview (Phone) in spring 2008 (described in Section 3.3.2). Conducting the outcome analysis began in 2006, although the data for these analyses are from as early as 2000 (described in Section 3.3.3).

During all survey collection, respondents were assured of confidentiality and were informed that their comments would not be identified in any reports. In addition to individual confidentiality, states are identified by alphabetical lettering rather than their given state name.

Figure 3-4. Evaluation activities (Dec 2004–April 2008) and pilot phases (Nov 2001–Dec 2007)



3.3.1 Process Evaluation (December 2004–April 2007)

The process evaluation focused on developing and sustaining partnerships throughout Team Up. To assess partnership, three data sources were used: the Lasker and Weiss PSAT, telephone interviews, and archival data.

3.3.1.1 Lasker and Weiss Partnership Self-Assessment Tool (December 2004–May 2007)

Members of each Team Up state partnership were asked to complete the Lasker and Weiss PSAT in each of four rounds throughout the lifetime of the partnership: December 2004, September 2005, October 2006, and May 2007 (Appendix K describes the tool in detail). The first process evaluation

data source, the Lasker and Weiss PSAT measures a partnership's level of synergy and identifies the partnership's strengths and weaknesses in areas that are known to be related to synergy—leadership, efficiency, administration and management, and sufficiency of resources. The instrument also measures partners' perspectives about the partnership's decisionmaking process, the benefits and drawbacks they experience as a result of participating in the partnership, and their overall satisfaction with the partnership. Table 3-4 describes the constructs and measures used in the Lasker and Weiss PSAT.

Table 3-4. Lasker and Weiss PSAT

Determinants	Definition
Leadership effectiveness	Formal and informal leaders influence a partner's involvement in collaborations. Partnerships need leaders that can promote productive interactions among diverse people and organizations both formally and informally. Assessed with a 10-item, 5-point scale (1-poor to 5-excellent) that measures leadership attributes
Administration and management	Administration measures what it takes for multiple, independent people and organizations to work together so that they are able to combine their knowledge, skills, and resources to work together as a collaborative partnership. Assessed with an 11-item, 5-point scale
Efficiency	Measures how well member involvement is optimized by maximizing people and keeping partners engaged. Assessed with a 3-item, 5-point scale
Nonfinancial resources	Measures the contributions of nonfinancial members, such as skills they bring to the project and influence within the partnership as well as connection and influence outside the partnership. Assessed with a 5-item, 5-point scale.
Financial resources	Measures the money, space, and equipment and goods that are essential for carrying out the partnership program. Assessed with a 3-item, 5-point scale.
Partner's view about their own participation	Measures individual partner views and comfort level with their willingness to participate in the partnership and how they view the decisionmaking process (i.e., frequency with which they support decisions), as well as the benefits and drawbacks experienced as a result of participation. It also measures satisfaction with the partnership. Assessed with a 5-item (1-extremely comfortable to 5-not at all comfortable), 5-point scale (1-all of the time to 5-never).
Benefits and drawbacks of partnership participation within the partnership and with the community	Measures the perceptions partners have with regard to minimizing drawbacks associated with benefits of participating in the partnership. Assessed with 11-items (benefits) and 5-items (drawbacks) (1-benefits greatly exceed drawbacks to 5-drawbacks greatly exceed benefits), 5-point scale.
Satisfaction with partnership involvement	Measures individuals who are satisfied with their involvement in the partnership. Assessed with a 5-item (1-not at all satisfied to 5-completely satisfied), 5-point scale.

Source: Lasker et al., 2001.

With each survey round, a number of procedures were taken to maximize the state partners' response rate and to minimize nonresponse bias. During the startup phase for Round 1 (December 2004), the CIS representative (the partnership coordinator) of each state-level team was asked to register the partnership with the Center for the Advancement of Collaborative Strategies (a center within the New York Academy of Science) on their health web site. Because the focus was on characteristics of state and national partnerships as a whole, data were collected from all knowledgeable team members within each partnership who could provide valid and reliable information about the partnership. A *knowledgeable partner* was defined as any partner who interacted with other partners and was familiar with the work of the Team Up partnership, as well as its leadership, administration, resources, decisionmaking process, and challenges faced. Partners identified as knowledgeable included individuals who represented one of the core partners (ACS, CDC, NCI, USDA). Each knowledgeable partner was asked to complete the online web-based Lasker and Weiss PSAT anonymously within a 30-day period. In the first two rounds, the Lasker and Weiss PSAT was administered via the Internet (http://www.partnershiptool.net/index.htm) by the Center for the Advancement of Collaborative Strategies in Health.

At the end of the 30-day period, tailored reports were generated for partnerships with a minimum of a 65 percent response rate; Lasker and Weiss PSAT coordinators suggested that data with a less than 65 percent input would not provide an accurate picture of partnership collaboration activities. In the first round, only three of the six teams reached the required response rate. However, in the following rounds the Team Up survey administration approach changed, and all six states reached or exceeded the required response rate.

In Round 2 (September 2005), Round 3 (October 2006), and Round 4 (May 2007), all partnerships were encouraged via email to respond to the survey. For both Round 3 and Round 4, the Lasker and Weiss PSAT was completed via email, since the tool was no longer available to be completed online. Administration procedures were coordinated by an identified leader within each state and completed surveys were mailed to one of the originators of the Lasker and Weiss PSAT for analysis and preparation of summary reports.

Table 3-5 shows the number of participants and response rate by state for each administration of the Lasker and Weiss PSAT. Note that for each survey iteration, the number of respondents changed since the density of individual partnerships expanded or contracted according to specific maturation needs. For example, some partnerships started small, then evolved into more complex interactions as tasks became more complex and the partnership expanded to encompass emerging opportunities.

To protect individual state identity, all data in this report will be described alphabetically rather than by state name.

Table 3-5. Lasker and Weiss PSAT response rates, by state partnership

	Round 1 (2004)		Round 2 (2005)		Round 3 (2006)		Round 4 (2007)	
State	R/Total[a]	%	R/Total[a]	%	R/Total[a]	%	R/Total[a]	%
A	N/A[b]	N/A[b]	5/6	83.3	7/9	77.7	8/9	88.8
B	N/A[b]	N/A[b]	9/13	69.2	16/19	84.2	30/34	88.2
C	9/13	69.2	10/14	71.4	11/13	84.6	9/11	81.8
D	8/10	80.0	11/11	100.0	6/8	75.0	7/8	87.5
E	4/6	66.7	5/7	71.4	10/12	83.3	10/15	66.7
F	N/A[b]	N/A[b]	6/7	85.7	23/30	76.6	25/28	89.3

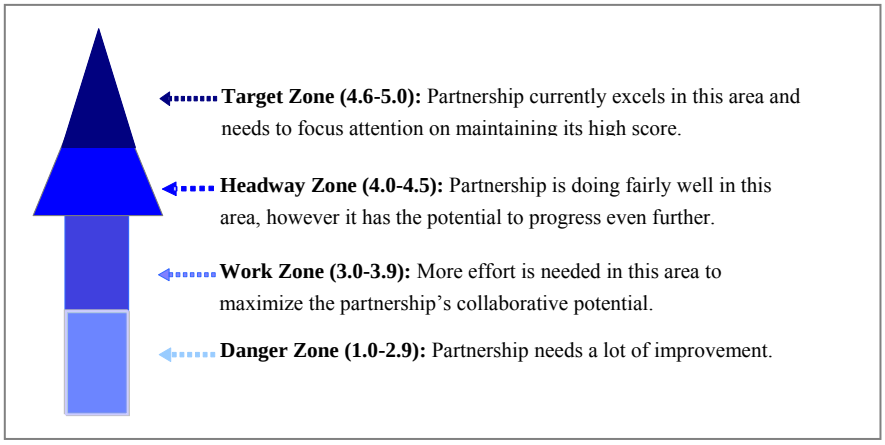
a) Number of R=respondents/Total=total partners.

b) Three states (A, B, and F) either did not participate in the (Round 1) 2004 survey or did not reach the required 65 percent enrollment.

The tailored reports were given to the state partners at the conclusion of each survey administration. Reports included an executive summary that described the overall score for synergy and included the three scores that most influenced a particular partnership's synergy score for that specific round. To improve partnership synergy, states were encouraged to focus on specific partnership areas that were relevant to their state and their partnership dimension. Reports contained overall scores (possible scores ranged from 1.0 to 5.0) for synergy, leadership effectiveness, administration and management, efficiency, sufficiency of financial and other resources, and sufficiency of nonfinancial resources. Individual state reports for each of the four survey rounds are shown in Appendix L.

Lasker and Weiss PSAT survey scores are classified into one of four zones illustrated in Figure 3-5: danger zone (a score of 1.0 to 2.9); work zone (a score of 3.0 to 3.9); headway zone (a score of 4.0 to 4.5); and target zone (a score of 4.6 to 5.0). Figure 3-5 describes the implications of scoring in each of the zones. The reports also provided scores for subitems of each of the items measured and interpreted the health of the partnership.

Figure 3-5. Lasker and Weiss PSAT score zones



The Lasker and Weiss PSAT assessed six dimensions of partnership functioning using scales, and one dimension, duration of partnership, as a single-item measure. Partnership level scores for these six scales were obtained by calculating the six scores for each respondent, and then taking the average score across all respondents within each partnership. Partnership coordinators provided information on the duration of the partnership. Exploratory principal components factor analyses with promax rotation were conducted on all of the scales using the partnership level data as the unit of analysis. These analyses yielded single factor solutions for each of the scales, which suggested that each scale measured a single underlying concept. Using each partnership as the independent variable and individual scale scores as the dependent variable, variability within partnerships was determined using one way analysis of variance (ANOVA) tests. Findings suggested that the mean of the individual responses for each scale within a partnership was a good approximation of the partnership as a whole. Taken together, results of the within partnership variance in relation to the between partnership variance suggested that it was justifiable for individual responses to be aggregated at the partnership level. With this in mind, quantitative data and narrative summaries were prepared for each state at the conclusion of each round.

3.3.1.2 Telephone Interviews (May 2006–June 2006)

In the spring of 2006 (May and June), telephone interviews lasting 30 to 40 minutes were conducted with state team members (one to two members from each of the core organizations) from each state partnership. This second source of process evaluation data included questions that related to the five determinants of partnership functioning (described in Section 3.2.1) and was designed to provide a balance of qualitative data (and minimal quantitative data) to gain insight into partnership synergy.

These data could not be obtained from the quantitative Lasker and Weiss PSAT. Appendix M has the full process evaluation telephone interview guide. Table 3-6 describes the constructs and measures used in the partnership telephone interviews.

Table 3-6. Partnership attributes assessed with the telephone interview questions

Determinants	Definition
Organizational contributions and activities	Measures how individual organizations were related to each other prior to Team Up, and, if they had a prior working relationship, have their activities changed, are they similar?
Partnership attributes and characteristics	Partner characteristics measure the heterogeneity and level of involvement of partners. The critical issue is not the size or diversity of the partnership, but whether the mix of partners and the way they are participating are optimal for achieving the goal of the partnership. To achieve high levels of synergy, partnerships need to build strong working relationships among partners. Aspects of relationship-building that are most important include: trust, respect, conflict resolution, and power differentials among partners.
Financial and nonfinancial assets	Financial and in-kind resources are defined as the basic building blocks of synergy. The most tangible types of resources include: money, space, equipment, and goods. Less tangible resources include connections to people, organizations, groups, endorsements, or convening.
Community facilitators and barriers	External environment includes the characteristics of the community as well as public and organizational policies surrounding the partnership—all affect the synergy of a partnership. In the right environment, new partners and more resources provide access to additional resources. External public policies or public funding difficulties on the other hand could be barriers to building partnership synergy.
National partner activities	Measured by the meetings, technical assistance, communication, and training activities provided by the national partners to build partnership and capacity throughout the life of the pilot program.

Cognitive Testing

Prior to fielding the instrument, input was sought from four partnership experts to cognitively test the questions for completeness, accuracy, validity, and usefulness of information. The purpose of the cognitive testing was to: (1) determine if questions in the interview guide were effective in eliciting desired responses; and (2) ensure that respondents clearly understood the questions asked and that response alternatives were appropriate. Experts familiar with the Team Up goals, specific state programs, and project activities were identified by the national partner evaluation team. These

four individuals were not directly involved in the evaluation activities. Further, each was affiliated with one of the national Team Up core organizations, but not directly involved in the evaluation. The contractor contacted the four experts via email and asked for their participation via telephone. Testing took approximately 1 hour per respondent. Subsequent findings and recommendations from the cognitive testing were then integrated into a revised instrument.

Pilot Testing

After subsequent revisions and refinement, the instrument underwent pilot testing with three individuals familiar with Team Up and who were experts in cancer screening, but who were not directly involved in the project. A standard pilot test was conducted with these interviewees. The purpose of this pilot test was to: (1) test the adequacy of interview procedures generally; (2) test the appropriateness of the interview guide, its questions and its flow; and (3) simulate actual conditions under which data collection would be conducted. Each respondent received the interview guide 1 week prior to participating in the interview. Minor revisions were made to the questions prior to its administration to state partners. Summary reports from the expert review and the pilot test are included in Appendix N.

Telephone Interviews

The national partners identified state-level representatives, which included one representative from each of the four core partners (ACS, CDC, NCI, and USDA) from each of the six state partnerships. In State A, one additional noncore respondent was also interviewed, bringing the total to 25 respondents. Interviewers sent emails to state respondents in April 2006 with a request to schedule the interviews. Individuals who did not respond to the initial email were contacted up to three more times via email and/or telephone to schedule a time to conduct interviews. Respondents were informed that their answers were confidential and that states, partners, and partnerships would not be identified. Once the interviews were scheduled, a confirmation email with a copy of the interview guide attached was sent to the respondent. There was a 100 percent response rate from each state.

The overall goal of the telephone analysis was to assess patterns in each state partnership. A secondary purpose was to examine diverse responses across the six state partners. Therefore, findings were summarized across the six states, identifying common themes, and highlighting and

interpreting differences within and across the states. The analysis was designed to examine both qualitative and quantitative responses beginning with a determination of frequencies and other descriptive statistics, where appropriate. Based on these analyses, summary tables for each state and across the six states were prepared for quantitative responses. For close-ended quantitative questions, the instrument asked statements of fact with the expectation that respondents from each partnership would have the same response. For example, the question, "Does your partnership have a written mission statement?" should all yield the same answer from each partnership. For these factual questions, summary tables of responses by state were presented. There were some instances in which responses from each partnership did not all agree, despite the questions being factual in nature. The tables summarize "concurrence," which was defined as having similar responses for at least three of the four state partner respondents. For states in which concurrence was not reached, further investigation examined possible reasons for discordance.

For the qualitative data derived from open-ended questions, responses were sorted by state and by theme to: (1) identify trends and differences within states; (2) identify trends and differences across states; (3) examine findings by topic; and (4) develop conclusions and recommendations that flowed from the findings.

3.3.1.3 Archival Data (July 2003–December 2007)

The third source of data for the process evaluation was archival data, collected during various national partner activities between 2003 and 2007. These data sources were intended to provide the evaluation with both formal and informal organizational assessments of the partnerships' development and strength. These data include reports and other materials that were obtained from the 3- and 6-month interviews, PATH visits, regional trainings, and coaches' interviews. These data were used to help tailor the process evaluation interview questions, as well as provided a description about the ongoing progress of the state partnerships. These data sources documented and evaluated many of the capacity-building activities. Information from these sources was used to confirm and provide a context or explanation for the process evaluation findings. These sources were reviewed by the contractor and relevant information was pulled from each source.

3.3.2 Impact Evaluation (May 2006–April 2008)

The impact evaluation focused on Team Up state partnerships' capacity to adopt and implement an evidence-based intervention, as measured by the Diffusion of Innovations model (Rogers, 1995, 4th ed.). The five predominantly qualitative data sources used for the impact evaluation were: a Historical Assessment, a series of three Six-Month Assessments, and Endpoint Interview. Initially a single interview protocol was drafted that included questions related to constructs from the Diffusion of Innovations theory. However, since the process of implementing an intervention is continuous, the national partner evaluation team split the interview protocol into separate instruments to document the process of understanding how evidence moves into practice over time.

Like the process evaluation instruments, each of the impact instruments underwent pilot testing prior to fielding, and subsequent revisions were made. The purposes of the pilot test were to: (1) test the adequacy of interview procedures generally; (2) simulate the actual data collection conditions; and (3) test the appropriateness of the interview guide, its questions and flow, on a small number of respondents. Selected interviewees were individuals familiar with the Team Up program, but were not associated with evaluation activities. Appendix O includes the report from the pilot testing.

3.3.2.1 Historical Assessment (May 2006–June 2006)

The first impact evaluation data source, the Historical Assessment, was a one-time, 10- to 15-minute telephone interview with representatives from each core organization (ACS, CDC, NCI, USDA). The purpose was to inquire about intervention activities that state organizations conducted prior to Team Up. Appointments to conduct the interview were scheduled at the end of the process evaluation interview telephone call (May–June 2006), and Historical Assessment interviews took place afterwards in May and June of 2006. One week prior to the interview, a reminder email with the survey attached was sent to respondents. Twenty-four out of 25 respondents completed the Impact Evaluation Historical Assessment (Appendix P). Table 3-7 describes the constructs and measures used in the Historical Assessment.

Table 3-7. Historical assessment constructs

Determinants	Definition
Introduction	Introductory questions were designed to serve as a warm-up to the questions about the key determinants.
Relative Advantage	These questions inquired about what interventions each organization was using prior to the Team Up pilot and the source of these interventions.

The Historical Assessment consisted mostly of qualitative data, so the analysis consisted of summaries of the types of interventions organizations were using prior to the initiation of Team Up. Specifically, summaries described reasons for selecting particular interventions, the sources used to select and develop interventions, the effectiveness of the interventions, and the reasons why the interventions were or were not deemed effective. The interventions used were compared across organizations and across states to determine the similarities and differences in types of interventions being used for cervical and breast cancer prior to Team Up.

3.3.2.2 Six-Month Assessment (June 2006–May 2007)

The second impact evaluation data source, the Six-Month Assessment, comprised a series of three surveys (Round 1, Round 2, and Round 3) and was administered in June 2006, December 2006, and May 2007. The assessments tracked each state partnership's process of adoption, adaptation, and implementation of an evidence-based intervention. Table 3-8 describes the Six-Month Assessment determinants.

Round 1 of the Six-Month Assessment was administered via email and included questions that were linked to the Diffusion of Innovations concepts (see Appendix Q). In spite of reminder emails, 7 out of 25 respondents completed the survey in Round 1.

Round 2 of the Six-Month Assessment was very similar to Round 1; however, due to the low response rate in Round 1, it was administered as a web survey to decrease respondent burden (see Appendix R) and a $150 incentive was provided to each state partnership to encourage respondents to complete the survey. The financial incentive was to be applied to a Team Up activity chosen by the state. The response was 23 out of 25 (92.0 percent). Of the two missing respondents, one was on maternity leave and the other was too new to the Team Up pilot to respond meaningfully to the survey.

Round 3, the final round of the Six-Month Assessment, consisted of more open-ended questions to augment information that was not captured in the previous two assessments (see Appendix S). Again, state partnerships were given a $150 incentive once all completed surveys were returned from their partnership. Twenty-three out of 25 respondents (92.0 percent) completed the survey. Because two respondents were new to the Team Up pilot, most of the questions were not relevant, and they did not respond to the survey.

Table 3-8. Six-month assessment determinants

Determinants	Definition
Introduction	Introductory questions were designed to serve as a warm-up to the questions about the key determinants.
Stage of adoption	Measures the five stages of the adoption process where the partnership (organization level) is in the adoption process. The five stages are: agenda setting; matching; redefining or restructuring; clarifying, and routinizing.
Informed decisionmaking	Measures the source consulted to select the intervention.
Relative advantage	Measures the influence or relative advantage the identified evidence-based intervention has over interventions previously used.
Observability	Measures the evidence-based intervention's demonstrated effectiveness to others. For example, was the chosen evidence-based intervention influenced by published information on the intervention and whether this plays a factor in the selection of an intervention?
Re-invention	Measures whether the intervention selected was able to be adapted to the unique needs of the state.
Trialability	Measures the ease with which the evidence-based intervention was piloted or experimented with on a limited basis by the state.
Complexity	Measures the ease or difficulty of implementing the evidence-based intervention.
Compatibility	Measures the degree to which the intervention is consistent with past experience and needs and goals of the state program.
Reinvention	Measures the change and modification of materials by the state teams during the process of adoption and implementation. Questions asked about the core intervention components: (1) history of the development of the intervention; (2) theoretical basis for the intervention; (3) overall intervention delivery plan; (4) intervention objectives; (5) description of intended population; (6) costs associated with the program; (7) characteristics of the delivery person(s); (8) methods of delivery; (9) location of delivery; (10) languages offered; (11) evaluation tools.
Infrastructure	Measures what internal structures were in place within the partnership to support implementing the evidence-based intervention. Measures the sustainability of the evidence-based intervention: 1-very likely; 2-somewhat likely; 3-somewhat unlikely; 4-very unlikely; 5-not at all likely.
Change agent	Measures the most likely individual in the partnership who influences and champions the evidence-based intervention.

These assessments included both quantitative and qualitative data. For the quantitative data, frequencies and percents were presented in summary tables that list and describe the different sources states used to identify an evidence-based intervention. The frequency and percent of states using a specific source was documented. Since there were multiple time-points, analyses show how responses changed over time. For qualitative data, summaries by state and comparisons across states were developed. Responses from the open-ended questions were used as verbatim quotes to illustrate identified themes.

3.3.2.3 Endpoint Interviews (February 2008–April 2008)

The objectives of the Endpoint Interview, the final impact evaluation assessment, were to: (1) understand how Team Up practitioners viewed the process of implementation of evidence-based interventions in order to guide the development of future initiatives that systematically bridge science and practice; (2) determine the extent to which states were implementing various components of the evidence-based programs they selected, and to identify which populations had been served by these programs; and (3) capture how the characteristics of the Team Up state partnerships and the community context influenced the adaptation and implementation process of bringing evidence-based interventions into practice. Table 3-9 describes the constructs and determinants in the Endpoint Interviews.

The interviews were based on individual preference. State Team Up representatives were given the option to be interviewed either alone, in pairs, or as a group of three or four. Interviews were conducted with the individual or individuals charged with coordinating the implementation activities for each state. In all cases, since coordination was a shared responsibility, group interviews were offered as an option. Representatives included each partnership's chair and co-chair, as well as two individuals who were active in the partnership, as identified by the chair and/or co-chair. A total of 24 respondents (4 individuals from each of the 6 state teams) completed the interviews.

Prior to the interviews, an email request was sent from the national partners to the chairs and co-chairs introducing them to this final phase of the evaluation, and later by the interviewer who obtained the names of additional partnership representatives and made arrangements to schedule interviews. The 45- to 60-minute interviews followed an interview guide made up of structured and semi-structured questions. Appendix T includes the interview guide and summary report.

Table 3-9. Endpoint interview determinants

Determinants	Definition
Introduction	Introductory questions were designed to serve as a warm-up to the questions about the key determinants.
Knowledge and buy-in	Measures the extent that states were aware of the evidence-based concept prior to joining Team Up; perceptions of the state role in disseminating evidence-based interventions; and the state involvement with community stakeholders.
Selection, identification, adoption	Measures the coordination, communication, and decisionmaking within the partnership to assess different options, the partnership's leadership role, and linkages to community organizations.
Planning adaptation	Measures the extent the original intervention was changed and why alternations were made; the role different partners took during this process; what expertise was present or absent in tailoring the intervention to the target community.
Implementation	Measures how well the implementation process went so that it reflected the partnership's plans; whether individual intervention components were 'true' to the original evidence-based intervention; if members were kept informed of what was happening; experience of technical assistance and other outside support; and who from the community was involved in carrying out the intervention.
Partnership reflections	Measures what state partners would have done differently and whether the intervention was successful in altering the behaviors of rarely or never screened women.

The Endpoint Interview included both structured and open-ended data. Quantitative data was analyzed using descriptive summaries to determine the use of evidence-based interventions to increase cervical and breast cancer screening rates. Responses from open-ended questions were analyzed to identify overarching descriptive themes and main ideas presented during the interview. Computer-assisted qualitative data analysis software (Atlas/TI) was used to categorize common and/or dissimilar patterns.

3.3.3 Outcome Evaluation (2000–2004)

The outcome evaluation focused on two short-term goals: the screening rates in target areas for women who have rarely or never been screened for cervical and breast cancer, and the effect of evidence-based interventions within these target areas. A secondary purpose was to determine the feasibility and approach of conducting a pilot with six states to decide whether Team Up could move beyond a pilot phase and become integrated and sustained within states.

3.3.3.1 Evaluation Design

There are numerous acknowledged methodological challenges in the design and analysis of any community intervention study, and Team Up was not immune from them. After the initial evaluation design was developed, the evaluation team decided to use a population-based, repeated-measures pretest posttest design with a cross-sectional designed survey for intervention and control counties (Davis, 2002). This initial design was modified, however, to only assess the baseline screening rates before state partners intervened with evidence-based interventions. The revised design would establish baseline rates for future surveillance and would provide valuable insight for the pilot program later on when additional analyses are conducted. In addition, conducting an intent-to-treat and waiting 2 to 3 years for data would require substantial resources that were not available at the time data were analyzed. Consequently, the intention for future analyses was to consider using a mixed design (time-to-event/intent-to-treat and cross-sectional) and to track the potential success of cervical and breast screening in select intervention and control counties. These short- to mid-term data will be reported separately at a later time. Now, only data from the baseline cross-sectional surveys are reported.

3.3.3.2 Sample: Unit of Analysis: Counties

3.3.3.2.1 Rationale for Choosing Counties

There were several reasons for selecting counties for the geographical analysis rather than individual women. First, counties are genuine political and administrative units. They are also the smallest geographical entity within a state with the social, political, and legal responsibility for providing a broad range of social services, public safety, law enforcement, transportation, schools, workforce policies, tax collection, and health care. A community may be defined as a social entity involving a common territorial space, people, shared institutions and interests, social interaction, distribution of power, and a social system (Warren, 1978; Patrick & Wickizer, 1995). U.S. counties meet most, if not all, of these criteria. Counties may qualify as communities to the extent that individuals and groups within them participate in community action and development by identifying county-wide problems, setting of goals, collecting health, social, and environmental data, and by formulating and implementing specific public policy measures (Warren, 1978). Some counties have even emulated the Federal Healthy People 2010 process and developed local public health goals. Second, counties are the smallest geographic entity for which health, socioeconomic, and population statistics are

consistently available over time. Although census tracts are more homogeneous than counties, they are subject to change in every decennial census depending on the population growth or decrease in a specific area. Counties, on the other hand, are not only more stable sociopolitical and geographic entities, but also provide an appropriate community context within which many social and public health polices are formulated and carried out (Schootman, Jeffe, Baker & Walker, 2006; Singh, 2003; Singh, Miller, Hankey, Feuer & Pickle, 2002). Third, Team Up state partners chose to implement their evidence-based interventions within specific counties in part because women who use federally supported screening programs easily identify with county-based structures.

There are limitations to the use of counties. Counties vary greatly with respect to the level of social interaction, with smaller rural counties being generally more cohesive, socially integrated, and having a greater sense of community than larger urban counties, which may be characterized by diverse social networks and social support systems, anonymity, heterogeneity, and formalized and impersonal relationships (Warren, 1978; Patrick & Wickizer, 1995). Since larger counties may have a substantial degree of intra-county heterogeneity and diverse sociodemographic conditions, comparing large and small counties may make it difficult to extrapolate a community interpretation. Also, BRFSS has sparse numbers of women in some of the intervention and control counties making some analyses unstable and the subsequent interpretation unreliable.

3.3.3.2.2 Selecting Control Counties

Three control counties were selected for each county involved in Team Up. The matching variables included county characteristics such as female age distribution, female race/ethnicity distribution, female educational level distribution, percent of population living in poverty, and the urban-rural continuum code. The data for all these county-level variables, except for the urban-rural continuum code, came directly from the 2000 U.S. Census. The USDA's urban/rural continuum codes are based on information from the 2000 U.S. Census: codes 0-3 correspond to metropolitan counties (including metropolitan areas with populations of about 250,000 to greater than 1 million); codes 4-5 correspond to predominately suburban populations of 20,000 or greater, but less than 250,000; and codes 6-9 correspond to rural populations and small towns of up to 19,999.

The matching variables were all categorical, with two to four categories. In order to develop scores for determining the most similar matches between counties, a weighted, normalized chi square (χ^2) statistic was used. For a specific item, this statistic was calculated as:

$$S_i = w_i \Big/ \frac{1}{J-1} \sum_{j=1}^{J} \frac{\left(t_{ij} - c_{ij}\right)^2}{t_{ij}}$$

where:

w_i	=	weight assigned to the *i*-th variable;
J	=	number of categories for the *i*-th variable;
t_{ij}	=	value for the *i*-th variable in category *j* for the Team Up county; and
c_{ij}	=	value for the *i*-th variable in category *j* for the comparison county.

The denominator of this expression represents a chi square (χ^2) statistic that is normalized by the number of degrees of freedom. The more that the control and Team Up counties differ with respect to race/ethnicity, the larger the χ^2 statistic will be, thus the lower the score for the item. The weight w_i was used to scale up items that were considered to be more important.

Figures 3-6 through 3-8 show the Team Up counties and their matching control counties. When possible, control counties were selected from the same state as intervention counties. However, if there were no suitable control counties in the same state, the potential control counties were expanded to include counties from neighboring states. Note that control counties were selected from neighboring states for Clayton, Georgia; DeKalb, Georgia; Hall, Georgia; and Boone, Missouri. Appendix U includes the matching scores for all of the Team Up control counties.

3.3.3.3 Outcome Variables

The primary outcome variables were cervical and breast cancer screening rates for rarely or never screened women in each of the Team Up targeted counties compared to comparison control counties. Guideline-recommended screening intervals vary for the two screening tests discussed in the outcome evaluation; for simplicity of presentation, baseline and 2- and 3-year intervals are presented for the Pap test by those women aged 18 and older, and for the mammography screening modality reported by women aged 50 and older. Table 3-10 shows the definitions used for each screening test.

Figure 3-6. Team Up counties: Alabama and Georgia

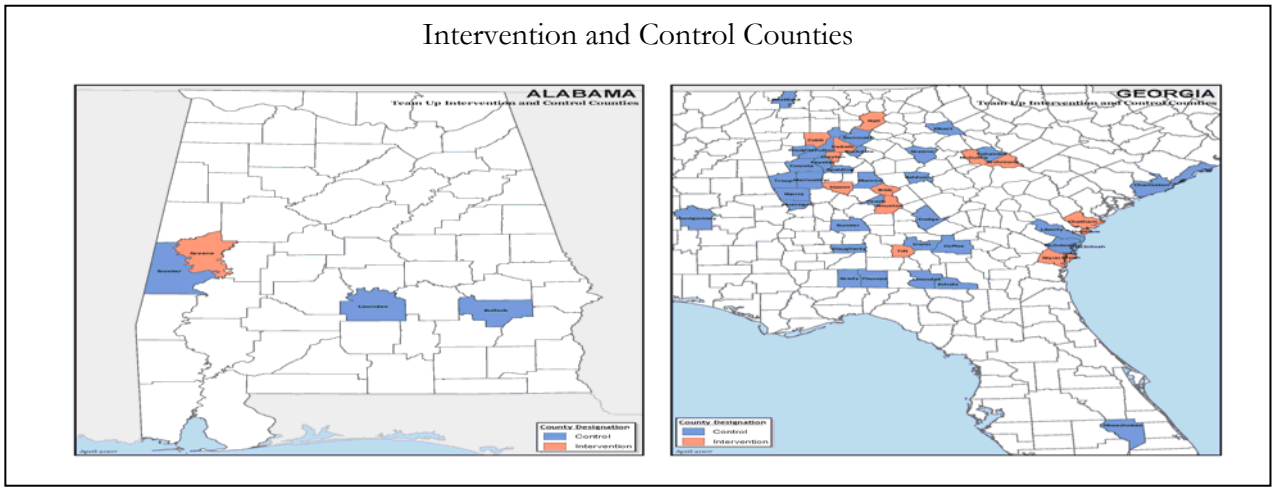


Figure 3-7. Team Up counties: Kentucky and Missouri

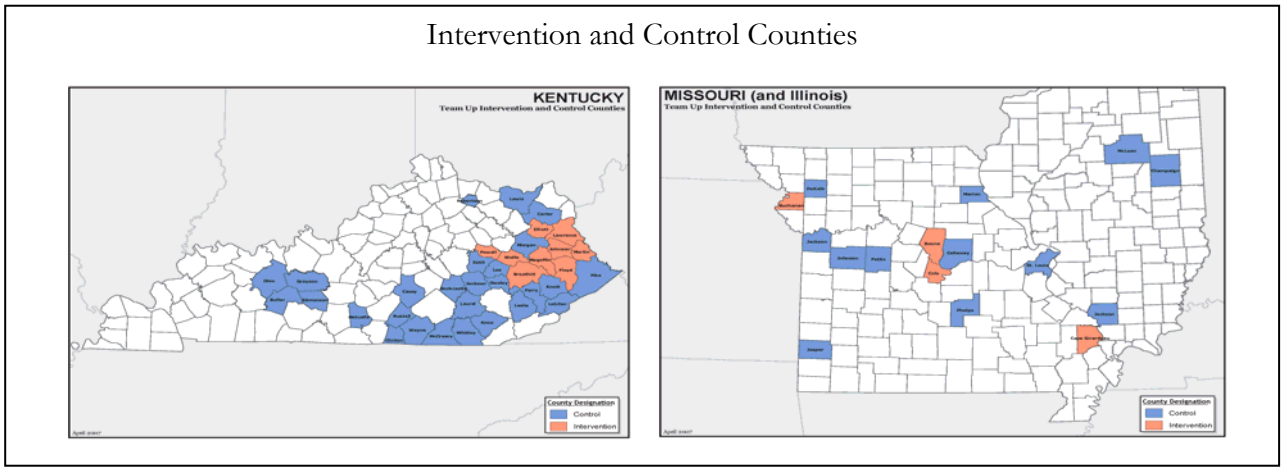


Figure 3-8. Team Up counties: South Carolina and Tennessee

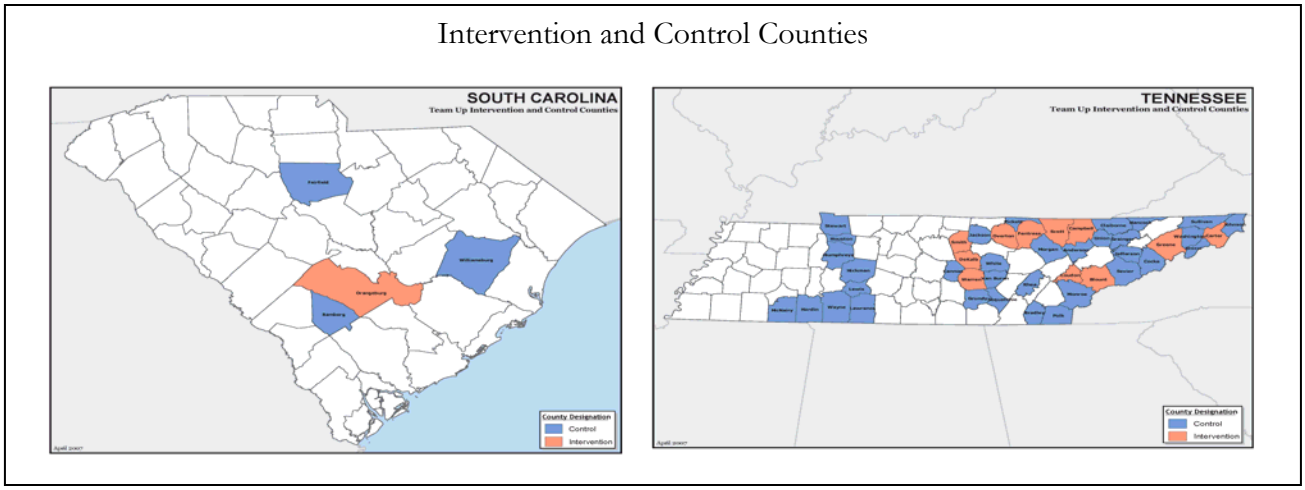


Table 3-10. Outcome variable definitions for rarely or never screened women

Outcome Variable	Definition
Cervical cancer *rarely* screened	No reported history of Pap test in past 3 years (If so, was it in the past 3 years?)
Cervical cancer *never* screened	No reported history of a Pap test prior to baseline (Ever had a Pap smear/test?)
Breast cancer *rarely* screened	No reported history of mammogram in past 2 years (If so, was it in the past 2 years?)
Breast cancer *never* screened	No reported history of a mammogram prior to baseline (Ever had a mammogram?)

3.3.3.4 Data Sources and Analysis Plans

As the content of each state's intervention was ascertained in the impact evaluation, it became apparent to the evaluation team members that it may be more appropriate to use some databases to examine changes in screening rates in certain states, and other databases for different states. For example, the Minimum Data Elements (MDE) data set may be most appropriate in states that specifically targeted women eligible for screening through the NBCCEDP program. However, in states that targeted a broader population of women, the BRFSS may be more appropriate; the 2000, 2002, 2004 county-level BRFSS data would be used to estimate the county-specific prevalence of cervical and breast cancer screening. While no data set could provide a complete picture of the screening rates in one state, consideration was given to the use of multiple data sources to piece together a picture of the breast and cervical cancer screening activities before and after the state's intervention was implemented in contrast to comparison counties.

A key consideration here was that the same databases must be used to evaluate changes in both Team Up intervention and comparison counties. However, because of costs and time constraints a decision was made by the evaluation team to only assess baseline rates and preliminary screening rates immediately following the July 2003 kickoff meeting. At a later date, a followup analysis will be conducted to look at the more mid- to long-range impact of Team Up. For these reasons, it was determined that the BRFSS (described in Section 3.3.4.1) was the more appropriate data source. Rates from the targeted counties where interventions were conducted were then compared to rates from a set of matched control counties. Consequently, the sources of data for the outcome evaluation were the BRFSS county-level data for 2000, 2002, and 2004.

3.3.3.4.1 Behavioral Risk Factor Surveillance Survey

The BRFSS is a cross-sectional random digit dialed telephone survey administered through the state health departments. BRFSS, one of several public health surveillance systems supported by CDC, is designed to collect uniform, state-based data on self-reported preventive health practices and risk behaviors in the U.S. population. Data are collected through monthly telephone interviews with a sample of one adult per randomly selected household. When aggregated, the data show the prevalence of risk behaviors and preventive health practices on an annual basis. The structure of BRFSS allows individual states to select the number of interviews each year, based on a percentage of the population in each state. States use probability samples in which all households have a nonzero chance of inclusion among those with telephones. The sample overall is large and representative of noninstitutionalized persons within a state. A number of states stratified their samples to allow estimation of prevalence for regions within states. The BRFSS contains questions on cervical and breast cancer screening in the Women's Health Module.

The Women's Health Module asks whether a woman has ever had a Pap test or mammogram. Women were considered 'never' to have had a Pap test or mammogram if they answered "no" to these questions. Among women who answer "yes" to these questions, subsequent questions ask women how long it has been since their last Pap test or mammogram. At a minimum, the data from these questions can be used to examine the statewide screening rates in the states participating in Team Up. Data can also be compared in these states before and after the implementation of evidence-based interventions to determine if there were changes in screening rates, and these data can be compared to data in other states that are not participating in Team Up.

The Team Up outcome evaluation variables came from the 2000, 2002, and 2004 BRFSS database. These variables are:

- Have you ever had a Pap smear/test?
- If so, was it in the past 3 years?
- Have you ever had a mammogram?
- If so, was it in the past 2 years?

There are limitations to using BRFSS data to examine these issues. First, the BRFSS data are collected at the state level and, given that some states were targeting specific counties within their state, it may not be possible to detect the effect of a state's implementation of an evidence-based

intervention at the state level. However, BRFSS data are available at the county level through the CDC. Analyses of these data may help detect differences in targeted counties, though some counties may have too few people to make reliable estimates. A second limitation is that the BRFSS is a telephone survey. While approximately 95 percent of the U.S. population has a telephone number, noncoverage is likely to be higher among the target population for this study (i.e., rural, low-income women). Therefore, telephone coverage may also attenuate the ability to detect an effect of the state partnership in women's screening behavior. Another concern of using a telephone interview as a method of data collection is that cervical and breast cancer screening is self-reported, which may overestimate actual cancer screening rates (Gordon, Hiatt & Lampert, 1993). Although some have found self-reported cervical and breast screening to be in close correspondence with data collected from screening agencies, misclassification may still be present so sensitivity and specificity is not 100 percent. As a result, some women who reported not having received cervical or breast cancer screening actually did according to medical records, and vice versa. Our results then may be biased toward not finding an effect when systematic underreporting (nondifferential misclassification) is present but ignored (Bernardinelli, Pascutto, Best & Gilks, 1997). Rarely is this misclassification bias quantified in studies, but methods have been developed to allow calculation of corrected associations (Bernardinelli et al., 1997). Lastly, the BRFSS alters its core sections each year. For example, the Women's Health section is offered in the core section only every other year after the year 2000. See Table 3-11 for additional details.

Table 3-11. BRFSS Women's Health Section, by year

Module	1998	1999	2000	2001	2002	2003	2004
Outcome variables							
Women's health	Core	Core	Core	Optional[a] (GA, MS, TN)	Core	Optional[a] (GA, MS, MO, TN)	Core
Control variables							
Demographics	Core	Core	Core	Core	Core	Core	Core
Health care access[b]	Core	Core	Core	Core	Core	Core	Core

Note. Information on BRFSS sections administered are available on the BRFSS web site from 1984–2004. Information on states that completed each optional module are available from 1998–2004.

[a] Team Up states that completed the optional module are listed. Since not all teams were included in the optional modules, years with the optional module will not be used. Only years 2000, 2002, and 2004 will be used in the outcome evaluation analysis.

[b] Access to health care may be used in selecting comparison counties rather than as a control variable in the analysis if deemed appropriate.

Analysis

Through the combination of multiple data points over time (BRFSS 2000, 2002, 2004), the analytic model allowed for repeated, and thus correlated, measurements over time from the same individual within intervention and control counties (or analytical units). Each time point was a parameter in the model, as were the control versus treatment (intervention) groups. The effect of a state intervention was evaluated by considering interaction terms between time period and group, and by creating additional parameters that indicated which time periods were pre- and post-intervention and then testing these parameters for statistical significance. The statistical model was implemented and analyzed using the SAS MIXED procedure (SAS Institute).

At the conclusion of the Team Up pilot (December 2007), only baseline data were reported as the 2006 county-level BRFSS data were not released at the time of the report. The BRFSS survey data analysis was supplemented by data and information from the state final reports. The outcome evaluation remains incomplete until the BRFSS analyses are conducted in out-years (2006 and beyond). At this time, a parameter could be added to the model to measure change in treatment effect over time to assess short- to mid-term outcomes. Even then, it will be difficult to determine if the state interventions affected screening rates because of other confounders.

3.3.3.4.2 State Data

To augment outcome findings, state evaluation data was used. These data identify what states experienced as they implemented evidence-based interventions within their communities, and will help determine the feasibility of moving Team Up beyond a pilot phase. Many of the reports included data on the number of women screened as a result of the intervention, or at least the intent of women to receive screenings following participation in the evidence-based intervention.

3.4 Summary

In summary, the methodology for the Team Up evaluation is outlined here along with the general procedures for accomplishing the assessment for each phase of the evaluation. The methodology described included a description of the evaluation purpose and objectives, the study questions, the setting, population, and sample along with the units of measurement and analysis. Also described

were the data collection activities, data sources, and timing of activities. The evaluation approach extended from the logic model, which expanded thinking incorporated from the concept mapping described in Chapter 2. The use of mixed methods that involved the integration of information gleaned from multiple sources allowed for the combination of quantitative and qualitative methods to enrich the understanding of program inputs and effects to generate a more holistic understanding of the pilot.

Process Evaluation Findings 4

4.1 Introduction

This chapter presents the results from the process evaluation and focuses on success in building and sustaining state partnerships and the utility of the national partnership in those efforts. Section 4.1 focuses on the success of states in building and sustaining their partnership. The main data sources for these analyses were the Lasker and Weiss PSAT and the process evaluation telephone interviews. Section 4.2 focuses on the utility of the national partner activities in supporting the state partnerships. The data sources for these latter analyses were archival data and the process evaluation telephone interviews.

4.2 Building and Sustaining State Partnerships

The state partnerships were created during the July 2003 training. Each state was tasked with developing a partnership that consisted of core partners from ACS, CDC, NCI, USDA, and any other state or local organization vital to accomplishing the goal of implementing evidence-based interventions to increase cervical and breast cancer screening rates among rarely or never screened women within the state.

Eight states began participation in the Team Up pilot program in July 2003. However, two states (Illinois and Mississippi) terminated their involvement by early 2006. Exit Interviews were conducted with partners from these two state partnerships to determine reasons for their withdrawal from Team Up and to learn what could have been done to prevent withdrawal (Appendix V). In both instances departure was not anticipated. The decision to leave Team Up was not a unanimous decision for either state.

Both states were at different stages in developing their partnerships when they decided to terminate their involvement in Team Up. Illinois established partnership, whereas Mississippi was having difficulty forming their partnership. Illinois' reasons for leaving focused on lack of funding and duplication of efforts (two statewide efforts existed with similar goals to Team Up and the state organizations were already partnering together via those initiatives), whereas Mississippi's reasons

for leaving focused on the inability to establish a working partnership involving all four core partners; however lack of funding and lack of time to dedicate to Team Up were also noted as factors in the decision. These issues were complicated with the impact of Hurricane Katrina and a refocusing of statewide priorities.

The next section presents findings about the success of the remaining six state partnerships in achieving synergy, Team Up's key indicator of partnership success. States are reported alphabetically (i.e., A through F) rather than with their state name (i.e., AL, etc.) to protect their confidentiality.

4.2.1 Partnership Synergy Levels

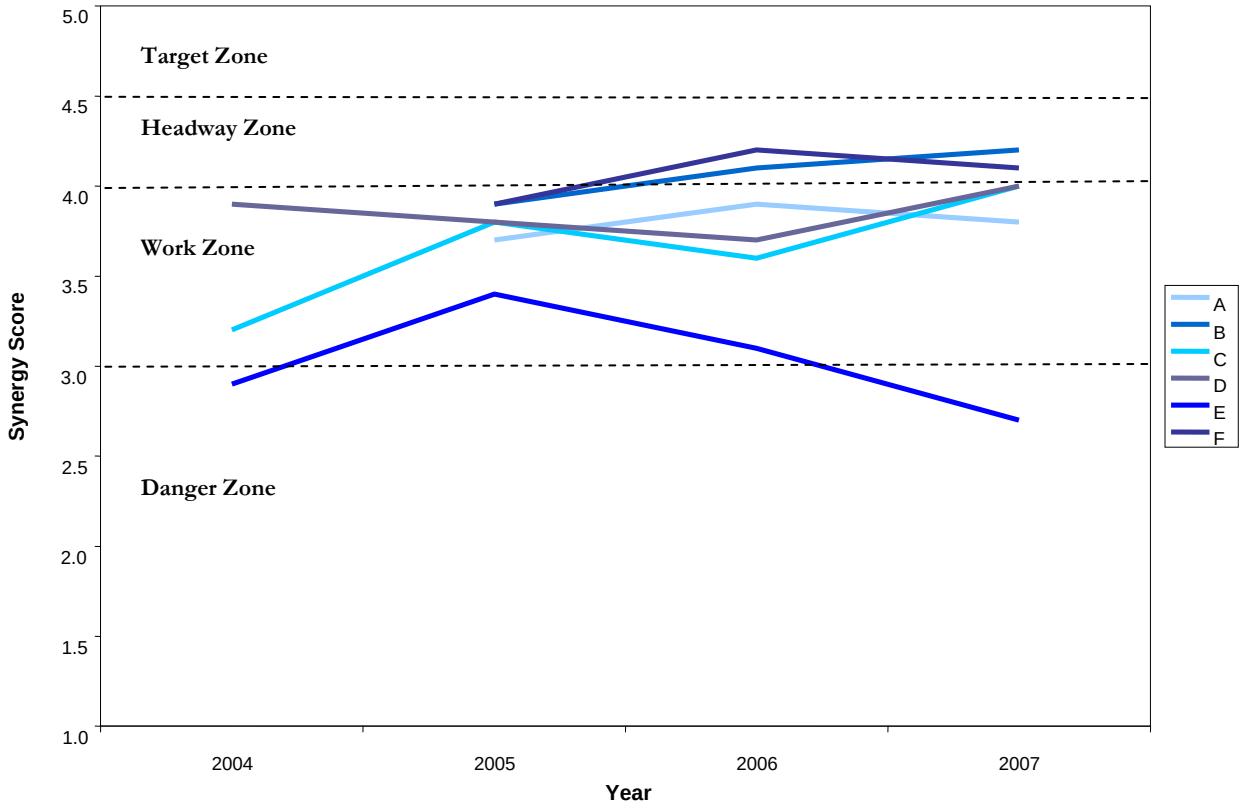
Partnership synergy was chosen as the primary construct to measure the success of Team Up states in building and sustaining their partnerships. Synergy is a robust construct that combines the degree to which collaborative efforts are embedded in one another and complement each other. As Lasker et al. (2001) suggest, "the synergy that partners seek to achieve through collaboration is more than a mere exchange of resources. By combining the individual perspectives, resources, and skills of the partners, the group creates something new and valuable together – something that is greater than the sum of its parts" (184). For this reason partnership synergy was selected as a primary outcome measure. The partnership synergy score from the Lasker and Weiss PSAT encompasses progress in achieving the following items:

- Identifying new and creative ways to solve problems;
- Including the views or priorities of people affected by the partnership's work;
- Developing goals that are understood and supported by partners;
- Identifying how different services or programs in the community relate to problems the partnership is trying to address;
- Responding to community's needs or problems;
- Implementing strategies that are most likely to work in the community;
- Obtaining support from individuals and organizations that can block or help the partnership's plans;

- Carrying out activities that connect multiple services, programs, or systems; and
- Communicating to people in the community about how the partnership's actions will address problems that are important to them.

Partnership synergy was measured at four points in time from 2004 to 2007. Figure 4-1 illustrates the change in synergy scores for each Team Up state partnership. Three states (C, D, and E) had high enough response rates (≥ 65 percent) to yield a score in the first administration of Lasker and Weiss PSAT in 2004; in and after 2005 the initial three and the remaining three states (A, B, and F) all obtained scores, allowing for comparisons across partnerships as a whole. Partnership synergy levels improved among all but one partnership from the first administration of the Lasker and Weiss PSAT to the final administration. Five partnerships began in the work zone (3.0-3.9); State E's score began in the danger zone (1.0-2.9). By 2007, four partnerships rose into the headway zone (4.0-4.5); State A's score remained in the work zone (3.0-3.9) and State E's scores moved into the work zone (3.0-3.9) during 2005 and 2006, but fell back into the danger zone (1.0-2.9) by 2007.

Figure 4-1. Lasker and Weiss PSAT synergy scores over time



Target Zone: 4.6-5.0; Headway Zone: 4.0-4.5; Work Zone: 3.0-3.9; Danger Zone: 1.0-2.9

The following sections describe factors related to synergy (i.e., partnership characteristics, partner characteristics, relationships among partners, resources, and the external environment) and how these factors may have influenced state synergy scores. It should be noted that these factors are not components of the synergy score, but rather determinants likely to influence synergy.

4.2.2 Partnership Characteristics

Partnership characteristics related to synergy include leadership, administration and management, and efficiency. These characteristics are discussed below.

4.2.2.1 Leadership

Team Up state partnership leaders (chairpersons) were selected during the initial training in July 2003, and shortly thereafter, many of the partnerships identified co-chairs to share leadership duties. By 2007, all Team Up state partnerships had co-chairs.

Respondents to the spring 2006 telephone interviews were asked the extent to which they agreed or disagreed with the following statements about their partnership leaders:

- Our partnership has one identified leader who manages and administers the partnership;
- Our leaders understand and appreciate the differences between partner members;
- Our partnership leaders have been effective in coordinating the communication and activities of the partnership;
- Our partnership leaders are able to clearly communicate the partnership's vision; and
- I am satisfied with our partnership leaders.

The scale ranged from strongly disagree (0) to strongly agree (4). Mean scores were calculated for each partnership to determine the overall perception of leadership (Table 4-1). Overall, state partners had a positive perception of their leadership. Although perceptions were relatively high across all states, State F had the highest mean score (3.8). State F's strong leadership may have been facilitated by having a full-time project coordinator assigned to Team Up, a position that strengthened its administrative infrastructure. State E had the lowest mean score (3.1). One

respondent from State E highlighted the importance of effective leadership. "We've come a long way, but late in the game. We need good leaders to articulate direction and mission. We need concrete plans. We are too slow at moving toward our target goal. We need a quicker pace. We need strong leadership and help from the national partners." It is important to note that State E's chair resigned from the partnership in January 2006 (this individual resigned from a position with NCI's CIS Southeast regional office), approximately 5 months before the process evaluation telephone interviews were conducted. The states with the most positive scores showed the least variability in responses, whereas the states with slightly lower scores showed more variability, suggesting a broader distribution of scores and potential differences in leadership perception.

Table 4-1. Perceptions of state partnership leadership, by state partners

Team Up state partnership	n	Mean[a]	SD
A	5	3.6	0.2
B	4	3.2	0.8
C	4	3.2	0.6
D	4	3.6	0.4
E	4	3.1	0.7
F	4	3.8	0.3
Total	25	3.4	0.6

[a] A mean score was developed by averaging responses to the five statements. The maximum possible score was 4 (strongly agree=4; somewhat agree=3; neither agree nor disagree/no opinion=2; somewhat disagree=1; strongly disagree=0).

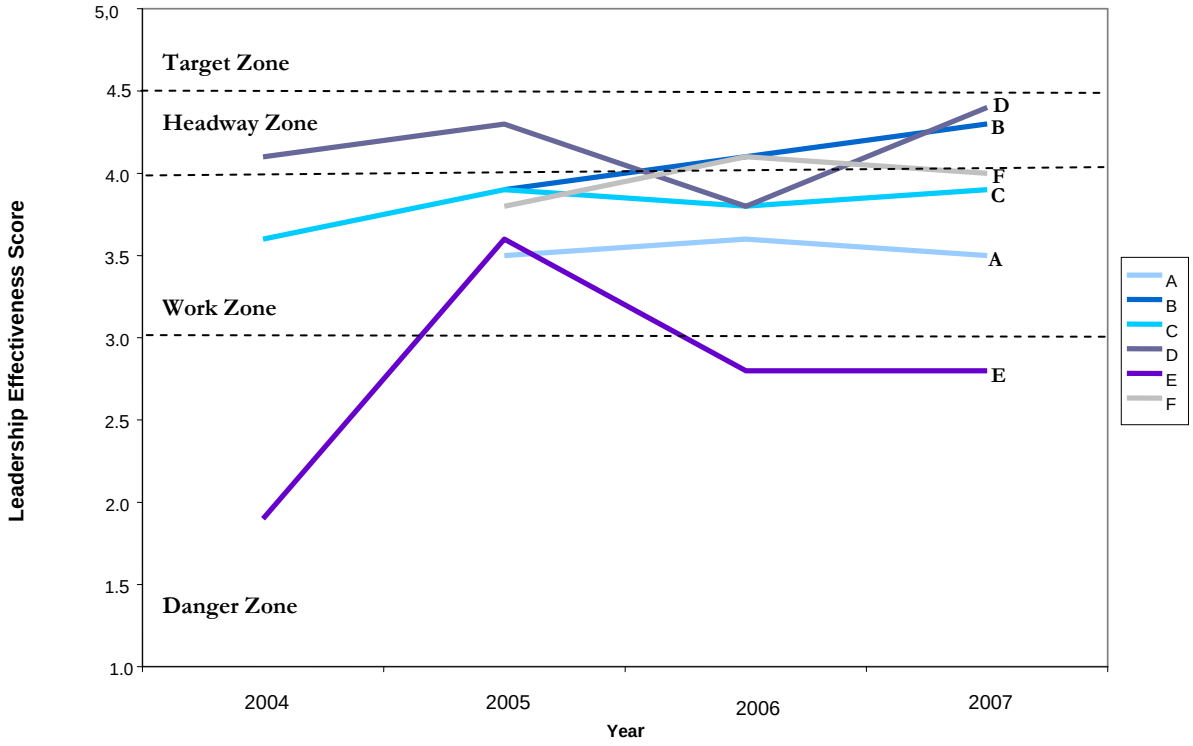
The leadership effectiveness score from the Lasker and Weiss PSAT encompassed the following items:

- Taking responsibility for the partnership;
- Inspiring and motivating people;
- Empowering people;
- Communicating the vision of the partnership;
- Working to develop a common language;
- Fostering respect, trust, inclusiveness, and openness;
- Creating an environment where differences can be voiced;
- Resolving conflict;
- Combining perspectives, resources, and skills;
- Helping the partnership be creative and look at things differently; and

- Recruiting diverse people and organizations.

Figure 4-2 shows how the leadership effectiveness scores changed over time. In 2004, State D had the highest leadership effectiveness score (in the headway zone), while State E had the lowest score (in the danger zone). State B was the only partnership for which the leadership effectiveness score improved during survey administration; by 2007, its score was in the headway zone suggesting that the State B partnership leaders became increasingly effective over time. State D had increasing scores at all time points except for 2006, when its score dropped into the work zone. Leadership effectiveness scores for States A, C, and F remained relatively constant over time, although there were ebbs and flows (States A's and F's scores slightly increased in 2006 and then slightly decreased in 2007). State E had a noticeable increase in its leadership effectiveness score in 2005, however the score dropped back into the danger zone in 2006 and remained there in 2007 suggesting that the transition in leadership in State E continued to impact the partnership. The spike observed in 2005 was likely due to the presence of numerous national partner activities that focused on team building, through the PATH visits and regional meeting. Although State E's leadership effectiveness score returned to the danger zone in 2006 and 2007, the score in those years were higher than the score in 2004, suggesting that some of the progress made in 2005 was lasting.

Figure 4-2. Lasker and Weiss PSAT leadership effectiveness scores over time



Target Zone: 4.6-5.0; Headway Zone: 4.0-4.5; Work Zone: 3.0-3.9; Danger Zone: 1.0-2.9

4.2.2.2 Administration and Management

Administration and management, the unifying factor that makes it possible for multiple, independent people and organizations to work together, is another determinant that influences synergy. The spring 2006 telephone interviews contained several questions about the overall management of the Team Up state partnerships, while the Lasker and Weiss PSAT measured the effectiveness of administration and management.

These telephone interview questions inquired whether or not the partnership had administration and management structures in place, including a written mission statement, operating procedures, a shared vision, a state action agenda, and an orientation for new members (Figures 4-3a and 4-3b).

When viewed by state, the data suggest that two state partnerships showed substantially better performance in the presence of administration and management. In both States D and E, respondents revealed that 75 percent of the administration and management structure were in place in their state (18 out of 24 possible affirmative responses for each partnership). Whereas respondents in the remaining four states stated that between 30 percent and 58 percent of administration and management structures were in place; State A had the lowest number of possible affirmative responses (30.0 percent; 9 out of 30), both States B and C were in the middle (45.8 percent: 11 out of 24), and State F had a higher number of possible affirmative responses (58.3 percent: 14 out of 24).

The Lasker and Weiss PSAT measured the *effectiveness* of administration and management. This score comprised several items, including the following:

- Coordinating communication;
- Coordinating communication with people and organizations outside the partnership;
- Organizing partnership activities;
- Applying for/managing grants/funds;
- Preparing materials that inform partners and help them make timely decisions;
- Performing secretarial duties;
- Providing orientation to new partners;
- Evaluating the progress and impact of the partnership;

- Minimizing barriers to participation in meetings/activities;
- Level of togetherness/teamwork; and
- Partnership's ability to recognize problems/challenges and come up with different solutions.

Figure 4-3a. Team Up state partnerships' perception of the presence of management structures

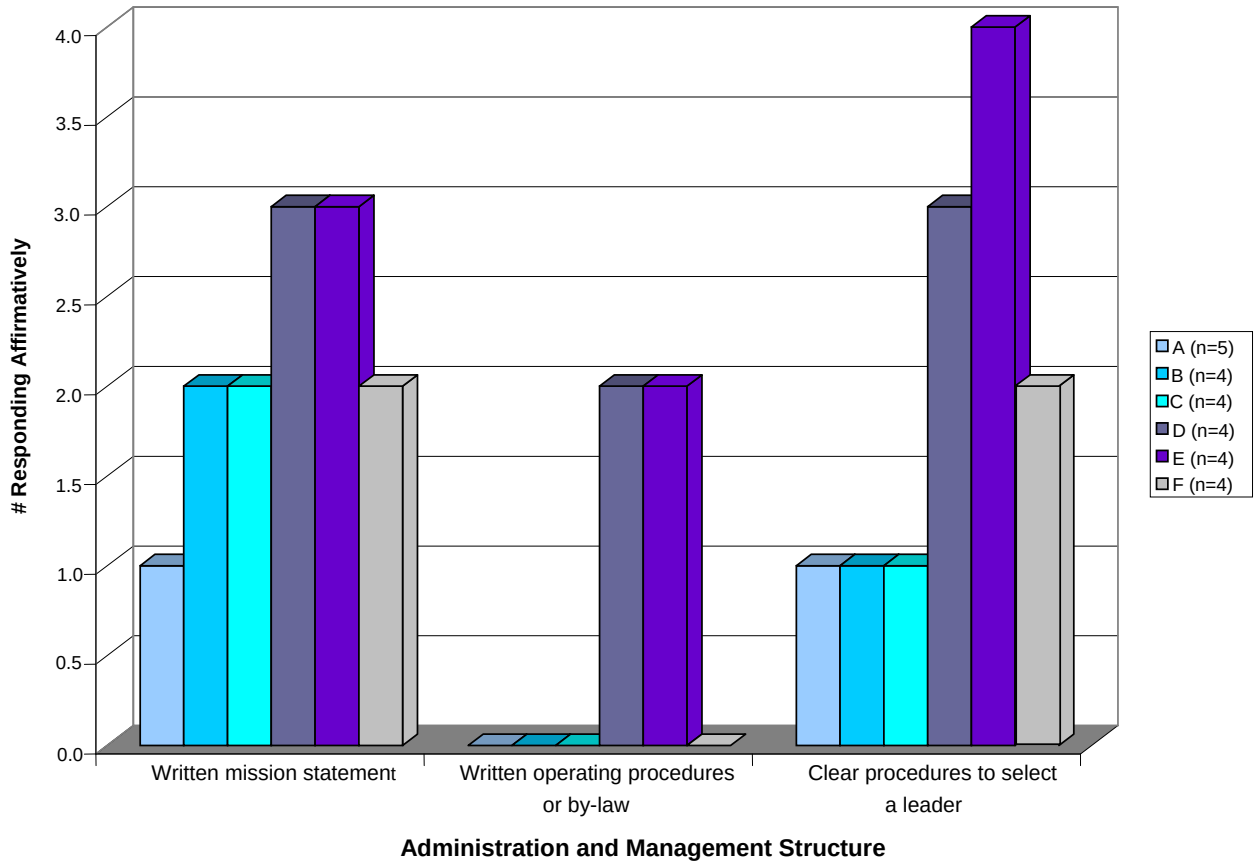


Figure 4-3b. Team Up state partnerships' perception of the presence of management structures (continued)

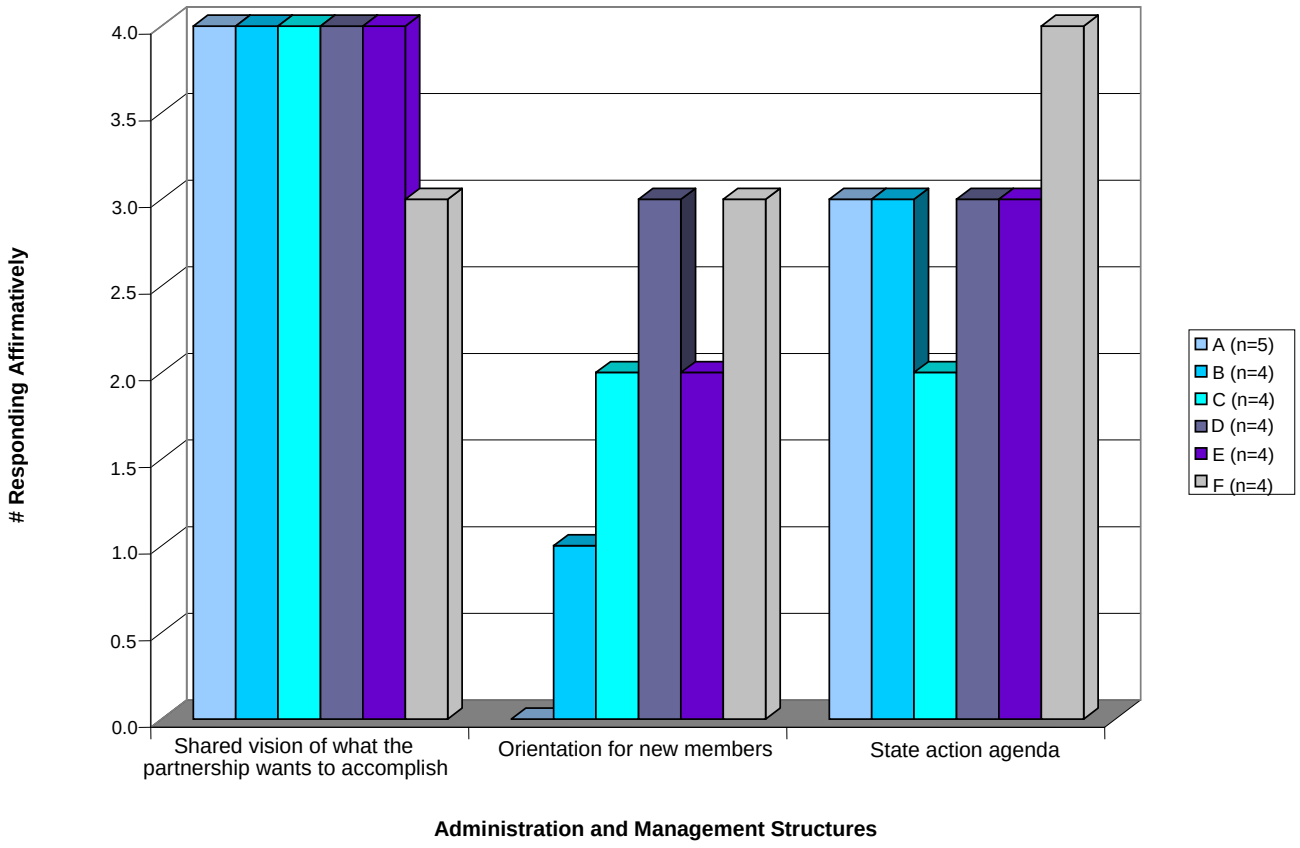
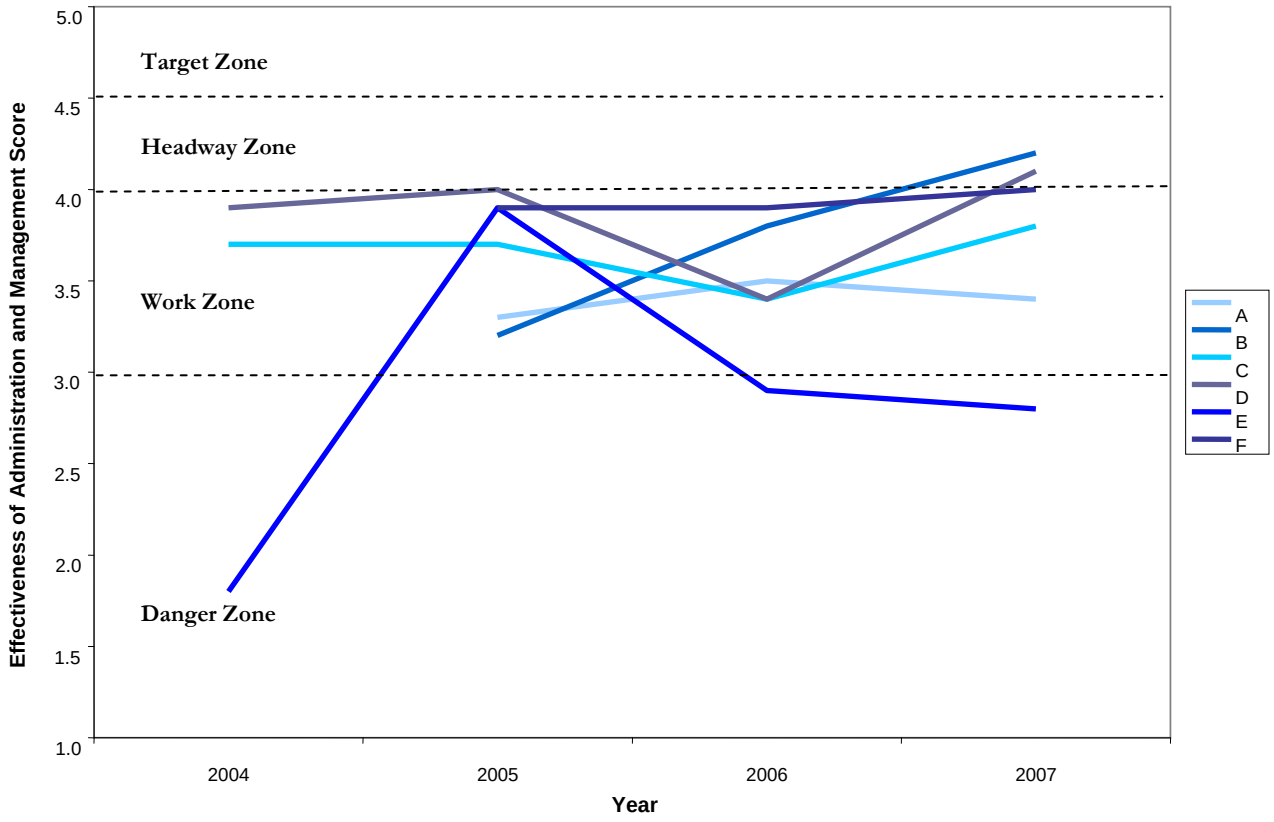


Figure 4-4 illustrates how the effectiveness of administration and management scores changed from 2004 to 2007. The score changes mirror those of the leadership effectiveness scores discussed in Section 4.2.2. Although State E reported having many management structures in place, it unexpectedly had the lowest scores for effectiveness of administration and management in all but one assessment year (2005). Even though State E had key structures in place, the Lasker and Weiss PSAT scores suggested low levels of effectiveness. In 2005, the State E PATH visit gave partners a chance to talk in person with individual team members, share personal stories, and problem solve as a group. Shortly after the PATH visit, the State E chair arranged leadership training for the four core partners. It is likely that the PATH visit, along with the leadership training and input from the coaches, increased the effectiveness of administration and management for State E, thereby explaining the striking increase in scores from 2004 (movement from low in the danger zone to the top of the work zone) to 2005. State D had in place a similar administrative and management structure to State E. However, State D focused on establishing administrative structures as a priority from the beginning of the partnership. Shortly after July 2003, State D created a Memorandum of

Figure 4-4. Lasker and Weiss PSAT effectiveness of administration and management scores over time



Target Zone: 4.6-5.0; Headway Zone: 4.0-4.5; Work Zone: 3.0-3.9; Danger Zone: 1.0-2.9

Understanding (MOU) outlining the working relationships of all partners. The data for this team suggest a high level of effectiveness that remained high in the work zone.

4.2.2.3 Efficiency

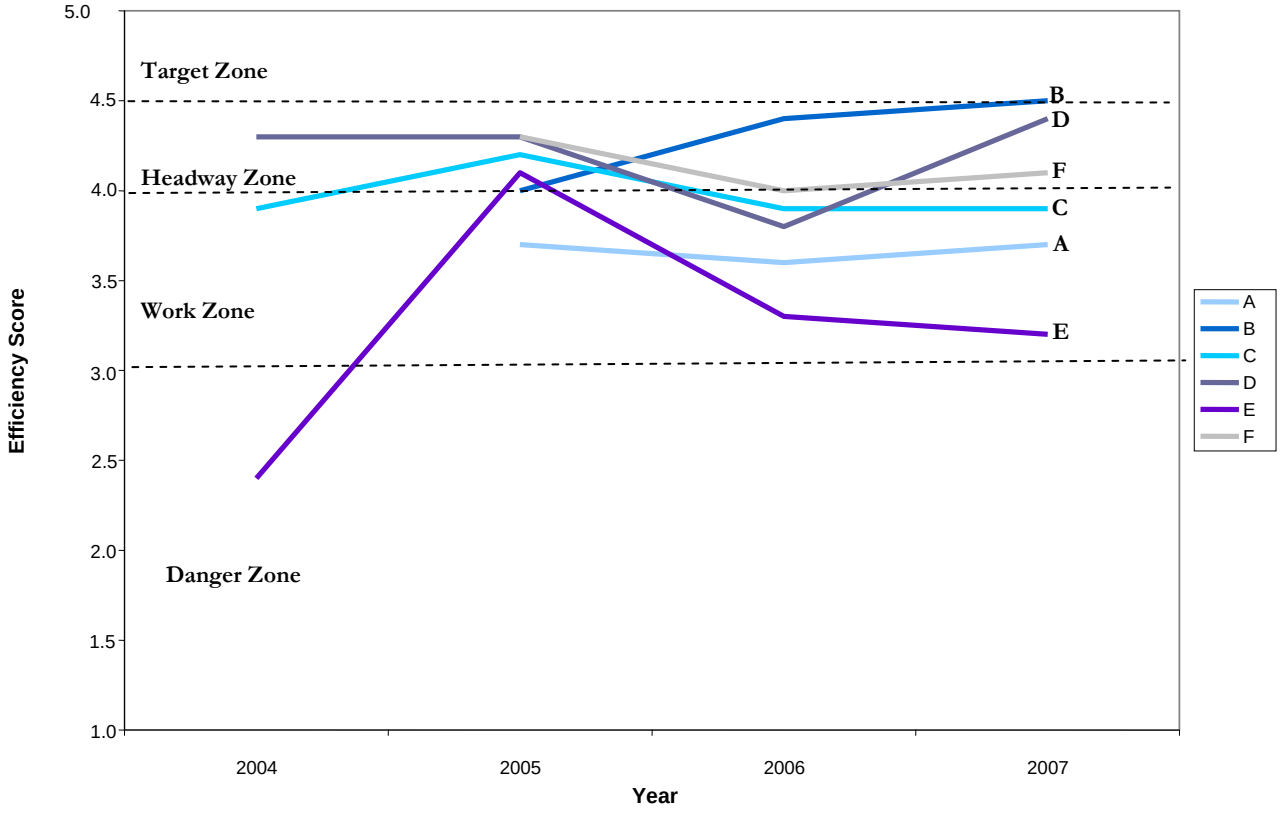
Efficiency refers to how well a partnership optimizes the involvement of its partners. The efficiency score of the Lasker and Weiss PSAT encompasses the following items:

- Financial Resources;
- In-kind resources; and
- Time.

Figure 4-5 illustrates how the efficiency scores changed over time. The changes in the efficiency scores again are similar to the changes in the leadership effectiveness and effectiveness of administration and management scores. Initially, three states began in the efficiency headway zone (States B, D, and F); however State B's score continued to improve over time and its 2007 score was at the high end of the headway zone suggesting that the partnership became increasingly efficient as it matured. On the other hand, State D's efficiency score dropped in 2005 and 2006, but by 2007 its score had risen from the work zone to the high end of the headway zone. The drop in State D's score was likely due to difficulty getting the state's intervention off the ground. There were several unexpected setbacks along the way (e.g., Institutional Review Board delays), which impacted being able to implement their chosen intervention (May 2007). States A and C both had efficiency scores in the work zone that remained relatively consistent, except when the State C score improved to the headway zone in 2005. Subsequently, State C's score decreased slightly and relapsed into the work zone. A similar oscillation in efficiency scores was seen with State E, which began in the danger zone, rose into the headway zone in 2005, and then dropped back into the work zone in 2006 and 2007. Unlike its leadership effectiveness and effectiveness of administration and management scores, the efficiency score for State E did not fall back into the danger zone after the 2005 improvement (although the score did drop slightly).

A key factor that affects the efficiency of a partnership was the ability to retain partners. Across states, 7 of the 25 respondents (to the spring 2006 telephone interviews) reported that their partnership experienced challenges in retaining partners in Team Up. Four of those respondents, two each from States A and D, mentioned that the challenge involved staff turnover. In State A, respondents thought that turnover was out of the partnership's control and was not uncommon for organizations working at a local level. For example, since the beginning of Team Up, State A had five different NBCCEDP directors. In State D, one respondent said, "The biggest issue is not at the organizational level, but at the individual level. There is turnover due to switching jobs, being reassigned duties, or retiring." Respondents in State D thought it was important to have an orientation with new members as they joined Team Up, and to be cognizant to keep the lines of communication open at all management levels. A new staff member could then be assigned to Team Up and not disrupt the workflow if another designee could no longer participate. Other challenges to retaining individual partners included lack of time to dedicate to Team Up duties (reported in States B and E) and lack of resources (reported in States C and E). Time and resources were both vital components of efficiency, according to the Lasker and Weiss Partnership Framework. Since State E reported problems in both areas, it follows that the partnership would experience difficulty with efficiency.

Figure 4-5. Lasker and Weiss PSAT efficiency scores over time



Target Zone: 4.6-5.0; Headway Zone: 4.0-4.5; Work Zone: 3.0-3.9; Danger Zone: 1.0-2.9

Three of four partnerships with the top efficiency scores in the 2006 and 2007 administrations of the Lasker and Weiss PSAT (States C, D, and F), also had the highest partnership effective score as measured by the spring 2006 telephone interviews. Respondents were asked to rate how effective their partnerships were in: (1) communicating between and among partners; (2) planning Team Up activities; and (3) making decisions related to Team Up (Table 4-2). A mean score was tabulated to note partnership effectiveness in moving partnership efforts along throughout the pilot program. Scores for all six partnerships were similar and almost indistinguishable, at the "somewhat effective" level (2.3 to 2.5). The State D score had more variability, suggesting less agreement among its partners than among other state partnerships. However, State E had relatively high agreement (SD=0.3) compared to other partnerships.

Table 4-2. State partnerships' rating of partnership effectiveness

Team up state partnership	n	Mean[a]	SD
A	5	2.3	0.5
B	4	2.3	0.9
C	4	2.5	0.4
D	4	2.5	0.6
E	4	2.3	0.3
F	4	2.5	0.6
Total	25	2.4	0.5

[a] A mean score was developed by averaging the responses to the three questions. The maximum possible score was 4 (strongly agree=4; somewhat agree=3; neither agree nor disagree/no opinion=2; somewhat disagree=1; strongly disagree=0).

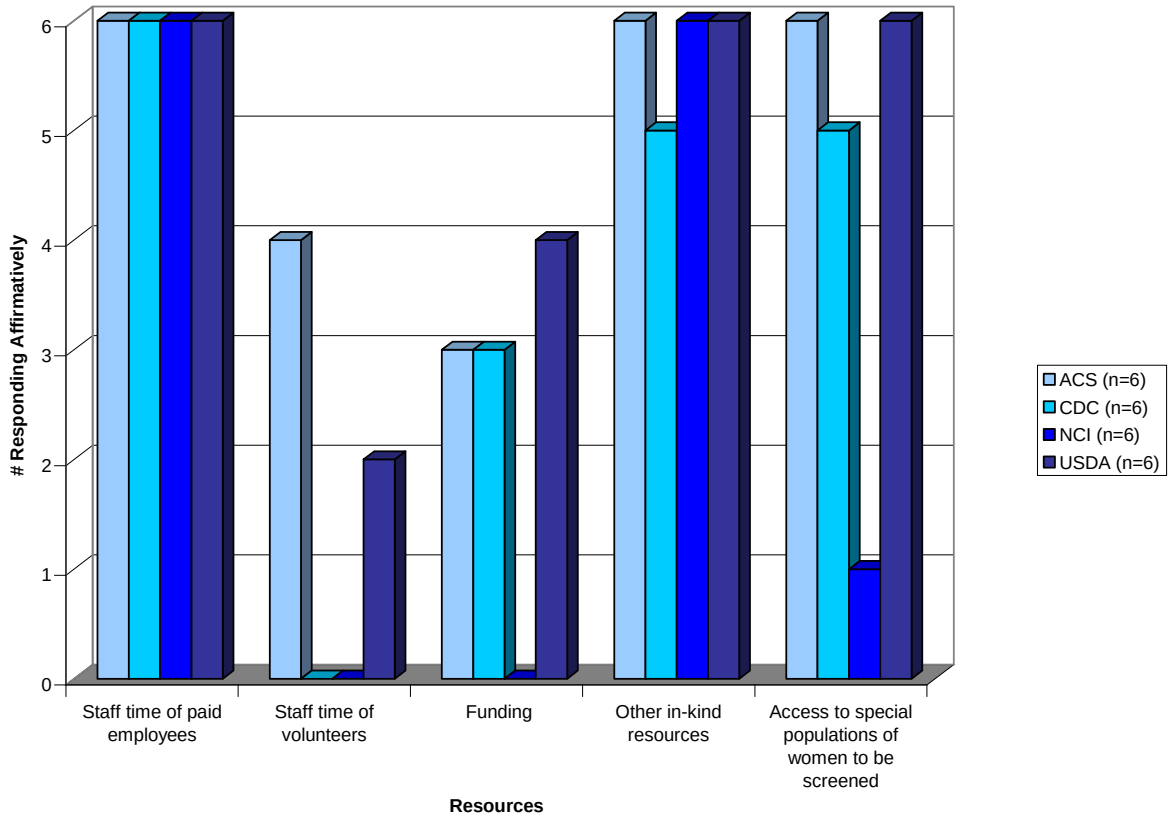
4.2.3 Partner Characteristics

Given the depth of understanding necessary to support a successful implementation project, it is the various types of partners that are the predominant resource of any project, especially Team Up. Consequently, it was important to have the right mix of partners to accomplish the project's goals. Each state partnership comprised four core organizations: ACS, CDC, NCI, and USDA. In addition to the core organizations, state partners were responsible for recruiting additional noncore members to fill gaps in the partnership, typically local community partners.

4.2.3.1 Core Partners

Each state partnership was responsible for staff time, obtaining access to special populations of women to be screened, and other in-kind resources to be contributed to the pilot. When respondents from core organizations were asked about the contributions their organization made to the state partnerships, responses reflected the overarching and unique goals of their national organization (Figure 4-6), suggesting that local state partners function in accordance with the stated national missions. Since each of the four core national partners committed to make Team Up a priority (both financially and nonfinancially), they encouraged field staff to do so as well. For example, state partners were encouraged to devote a portion of their staff's paid time to Team Up activities, if possible.

Figure 4-6. Material resources contributed by core organizations to Team Up



Accessing special populations of women reflected the activities of ACS and CDC, which are more closely aligned with the NBCCEDP, and USDA, which have access to special population groups in general, but not those of NCI. The NCI does not work directly with populations of women at a state or regional level, but rather functions at an organizational level with designated partners tasked to reach these special populations of women.

Similarly, funding was determined by the core national organizations. In the case of the ACS, CDC, and USDA, all three agencies had funds to work on specific projects at the state and local field levels that reach women in need of screening. However, because reaching women in need of screening is not a specific mission of NCI, its CIS contracting staff was unable to fund projects with contract dollars; it is not surprising, then, that this core organization did not report contributing funds to Team Up.

Each core organization had a distinct role in the Team Up partnership. This was one of the unique aspects of these four organizations collaborating at the field level. A main contribution of NCI at the state level was providing data, information, fact sheets, etc., activities that fall under the "other in-

kind resources" or "nonfinancial" category. CDC was the main provider of screening services for women through the NBCCEDP program. USDA had cooperative extension agents who worked on a day-to-day basis with the target population and already had a presence in the Team Up communities. In many state partnerships, the cooperative extension agents were the ones implementing the evidence-based intervention in the field. ACS provided information and data, and also had a presence in communities and worked closely with CDC, so its presence brought credibility to the project. The success of each state partnership relied on this particular mix of resources that each organization brought to Team Up.

Because Team Up comprised a distinct mix of field and state partners who may not usually work together, respondents were asked how much they agreed or disagreed with the following statements about nonmaterial contributions:

- My organization contributes to the strength of our partnership; and
- My organization's contribution to the strength of our partnership is clear.

As Table 4-3 shows, most respondents felt as though their organization's role in the Team Up partnership was clear and that their organization added to the overall strength of the partnership. State F, which rated itself lowest, had the most variability (SD: 1.0), suggesting that some respondents felt that their state partnership had clearly defined roles and made contributions, while others did not.

Respondents were also asked whether their organization was involved in the following activities:

- Preparing for partnership meetings and activities;
- Attending regular partnership meetings;
- Participating in committee work;
- Carrying out partnership-sponsored activities;
- Delivering educational sessions on screening; and
- Identifying women rarely or never screened.

Table 4-3. State partnerships' ratings of nonmaterial contributions

Team Up state partnership	n	Mean[a]	SD
A	5	3.8	0.3
B	4	3.8	0.5
C	4	4.0	0.0
D	4	4.0	0.0
E	4	3.8	0.3
F	4	3.4	1.0
Total	25	3.8	0.5

[a] A mean score was developed by averaging the responses to the two statements. The maximum possible score was 4 (strongly agree=4; somewhat agree=3; neither agree nor disagree/no opinion=2; somewhat disagree=1; strongly disagree=0).

Table 4-4 presents the average responses to questions about participation in Team Up activities. According to the spring 2006 telephone interviews, USDA was involved in the most of these partnership organizational activities, and NCI was involved in the fewest. While the roles of each core partner (described in detail above) varied, involvement in the listed activities was similarly expected to vary based on these roles.

Table 4-4. Core organization perceived participation in Team Up

Team Up core organization	n	Number of affirmative responses	Potential affirmative responses	% of affirmative responses[a]
ACS	6	32	36	88.9
CDC	6	30	36	83.3
NCI	6	27	36	75.0
USDA	6	34	36	94.4
Total	24	123	144	85.4

[a] A percentage was calculated by averaging the # of individuals responding affirmatively to the six questions about involvement in partnership activities/functions.

A majority of respondents from all organizations were involved in preparing for partnership meetings and activities, attending regular partnership meetings, and participating in committee work. The majority of respondents from ACS, CDC, and USDA also carried out partnership-sponsored activities and identified women rarely or never screened; for NCI, only half of the respondents were involved in these activities. All respondents from the USDA reported delivering educational sessions on screening, whereas only about half of respondents from the other three organizations reported this activity. Because USDA extension agents were the ones fielding the intervention in many states, it was expected that the USDA would deliver education sessions more often than other organizations.

4.2.3.2 Noncore Partners

All respondents, except for two from State B, indicated that they recruited noncore members into their state partnership (according to the findings from the spring 2006 telephone interviews). Respondents recruited organizations with which they had existing relationships. Respondents in all partnerships noted knowledge of and/or access to the community as the main contribution of new partners. One respondent in State A said, "[One noncore organization] is the key to giving us [Team Up] credibility in intervention counties. They also recruited community leaders to be lay health advisors." Another Team Up state partner in State C said, "We needed access in those counties in eastern [State C]. Most of the core partners…do [not] have an office where we were trying to implement the evidence-based strategy." Other contributions that noncore partners provided included guidance in selecting the evidence-based intervention, data, funding and/or other resources, assistance in writing the proposal or evaluation, and assistance with the adaptation process.

Five of the 23 respondents who stated that their partnership recruited new members identified challenges that their partnership faced in recruiting new members. Two respondents stated that potential partners did not have the time to dedicate to Team Up activities; other challenges included difficulty explaining the partnership mission and objectives, too many meetings, and inconvenient meeting locations.

4.2.4 Relationships Among Partners

All but one respondent had previously worked with someone from a core partner's field staff prior to the July 2003 pilot training. Relationships prior to Team Up included: participating in coalitions, such as the Comprehensive Cancer Control Coalition (CCC); providing referrals to the CDC's NBCCEDP; providing recommendations for speakers; collaborating on educational programs; distributing materials; and working on grants or other cancer-related activities together. Although some respondents had worked in various ways with most of the other core partners prior to Team Up, no respondent had collaborated with all organizations on a single project.

In some states, NBCCEDP and ACS had a unique relationship. ACS has a contractual agreement with CDC to implement certain components of the NBCCEDP program while other states provide office space for an ACS employee, so they had a well-established relationship. In half of the

partnerships, the NCI CIS and NBCCEDP had frequent relationships dealing with different cancer programs. USDA was the organization that the least number of respondents had worked with prior to Team Up. Those who had worked with USDA prior to Team Up were more likely to describe their relationship as rare or occasional. Because of USDA's access and established relationships within the intervention counties, their perspective was vital to the overall partnership. One respondent from State D stated, "We have a better understanding of the USDA resources, which informs the way we are working in [State D]. As we bring people to the table for Comprehensive Cancer or other programs, we think of nontraditional partners who might be part of a coalition. Being aware that the USDA resources exist and how to work within that structure has enhanced our [Team Up] activities as well."

In the 12 months preceding the spring 2006 telephone interviews, all respondents had collaborated in some way with other partners. Respondents were asked if their organization had been involved with the following collaborative activities in the past 12 months:

- Represented the partnership to other groups;
- Shared information between partners on evidence-based interventions; and
- Collaborated with other partners.

Although all respondents were involved in some collaborative efforts, the percentages were higher for States C, E, and F (Table 4-5).

Table 4-5. Collaboration among Team Up partnerships

Team Up core organization	n	Number of affirmative responses	Potential affirmative response	% of affirmative responses[a]
A	5	11	15	73.3
B	4	11	12	91.7
C	4	12	12	100.0
D	4	9	12	75.0
E	4	12	12	100.0
F	4	12	12	100.0
Total	25	67	75	89.3

[a] A percentage was calculated by averaging the # of individuals responding affirmatively to the three questions about collaboration.

Strong working relationships among formal partnerships was critical for achieving high levels of synergy. Respondents were asked how much they agreed or disagreed with the following statements:

- Our partnership has worked at building trust and respect among partners;
- Our partnership values differences and disagreements; and
- Our partnership handles conflict effectively.

A mean score was tabulated to rate the working relationship between partners (Table 4-6); State D had the highest score and State E the lowest. Tellingly, half of the respondents in State E (two out of four) somewhat disagreed with the statement, "Our partnership handles conflict effectively," and one respondent somewhat disagreed with the statement, "Our partnership values differences and disagreements."

Table 4-6. State partnerships' ratings of partnership functioning

Team Up state partnership	n	Mean[a]	SD
A	5	3.3	0.5
B	4	3.3	1.1
C	4	3.5	0.2
D	4	3.8	0.3
E	4	2.6	0.7
F	4	3.7	0.7
Total	25	3.4	0.7

[a] A mean score was developed by averaging the responses to the three statements about partnership functioning. The maximum possible score was 4 (strongly agree=4; somewhat agree=3; neither agree nor disagree/no opinion=2; somewhat disagree=1; strongly disagree=0).

When asked if the respondents had anything else to share about their experience in the partnership, a respondent from State F said, "State F has made pleasing progress. There was a lot of trust among partners now…," signifying a positive working relationship among State F partners.

4.2.5 Resources

According to the spring 2006 telephone interviews, approximately half of the respondents felt their state partnership did not have sufficient financial resources to successfully implement their intervention activities. State B was the only partnership in which the majority of respondents felt they had sufficient resources. In State D, no respondent reported having sufficient resources.

Respondents identified a need for external resources (both financial and nonfinancial), in addition to the existing resources, as an important component missing from their partnerships (Figures 4-7a and 4-7b). The majority of respondents had tried, or was continuing, to obtain external funding, materials, or staff with appropriate expertise. Partnerships also requested specific technical information from the coaches as well as the national partners to be able to conduct Team Up activities. However, only a few respondents tried to obtain additional space or equipment.

In four of the state partnerships, the majority of respondents reported trying to obtain external funding. Of those who had, all reported their partnership had been either completely or partly successful in obtaining outside funding. For example, in State F, three (out of four) respondents stated that their partnership had been successful in obtaining external funding for implementation of evidence-based interventions. Sixty-four percent of respondents said that their partnership had a viable plan for obtaining additional resources. In States B and C, all respondents reported having a plan for obtaining additional resources. In State A, only one respondent reported the partnership having a plan for obtaining additional resources in their partnership.

Figure 4-7a. Additional resources needed as identified by state partners

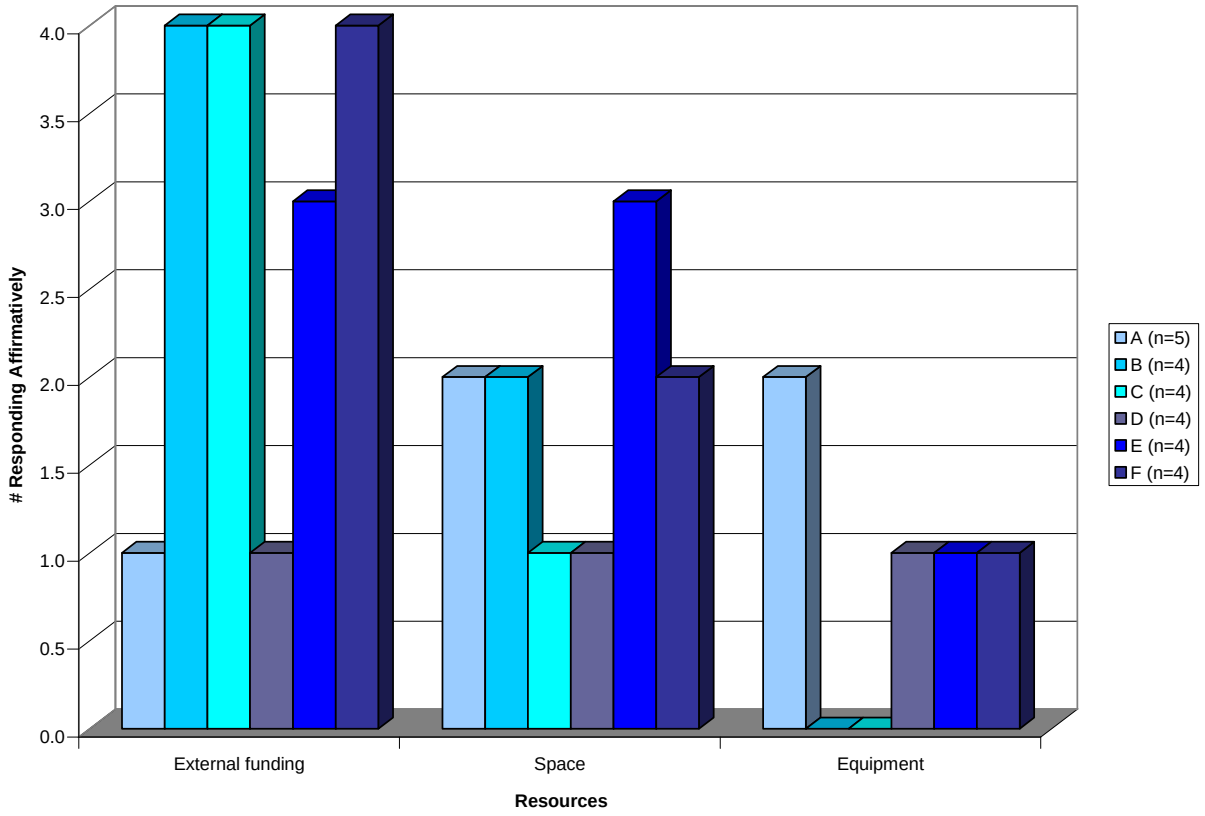
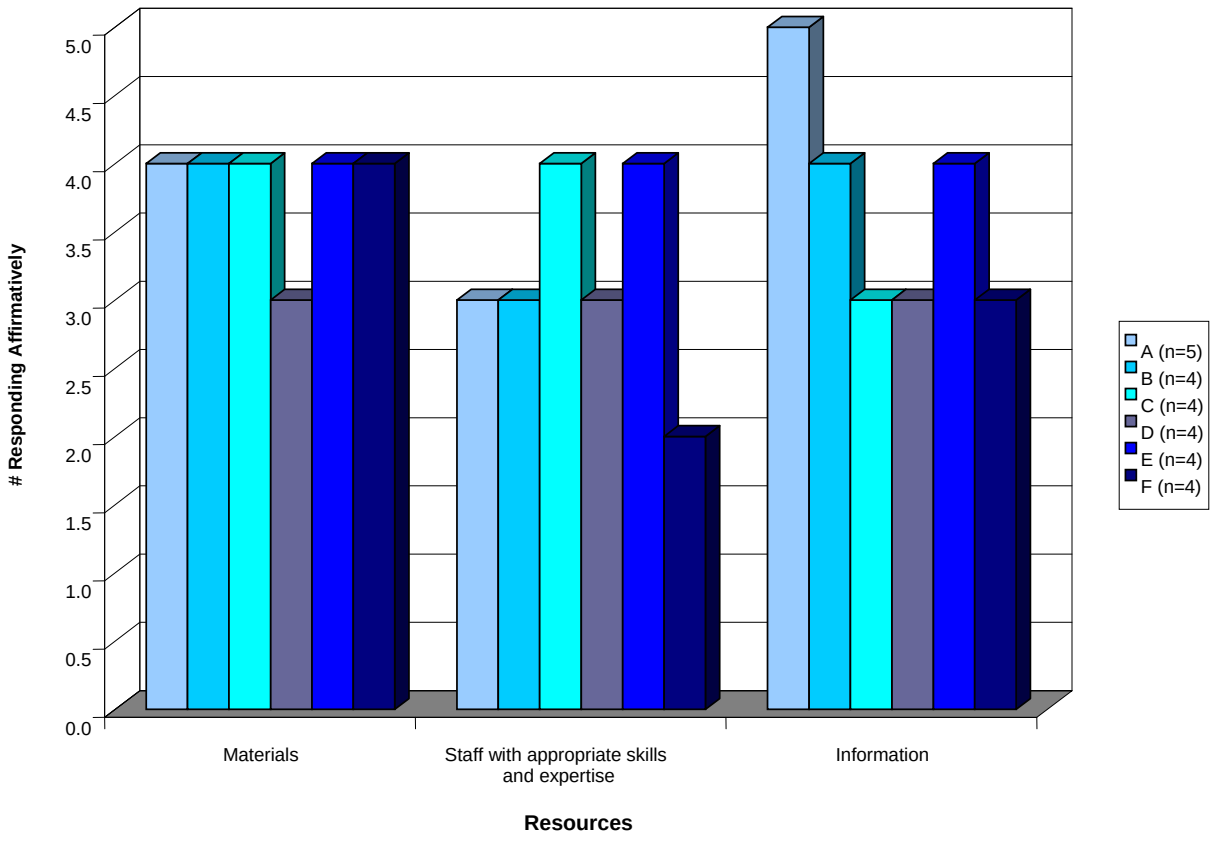


Figure 4-7b. Additional resources needed as identified by state partners (continued)



4.2.5.1 Sufficiency of Financial and Other Resources

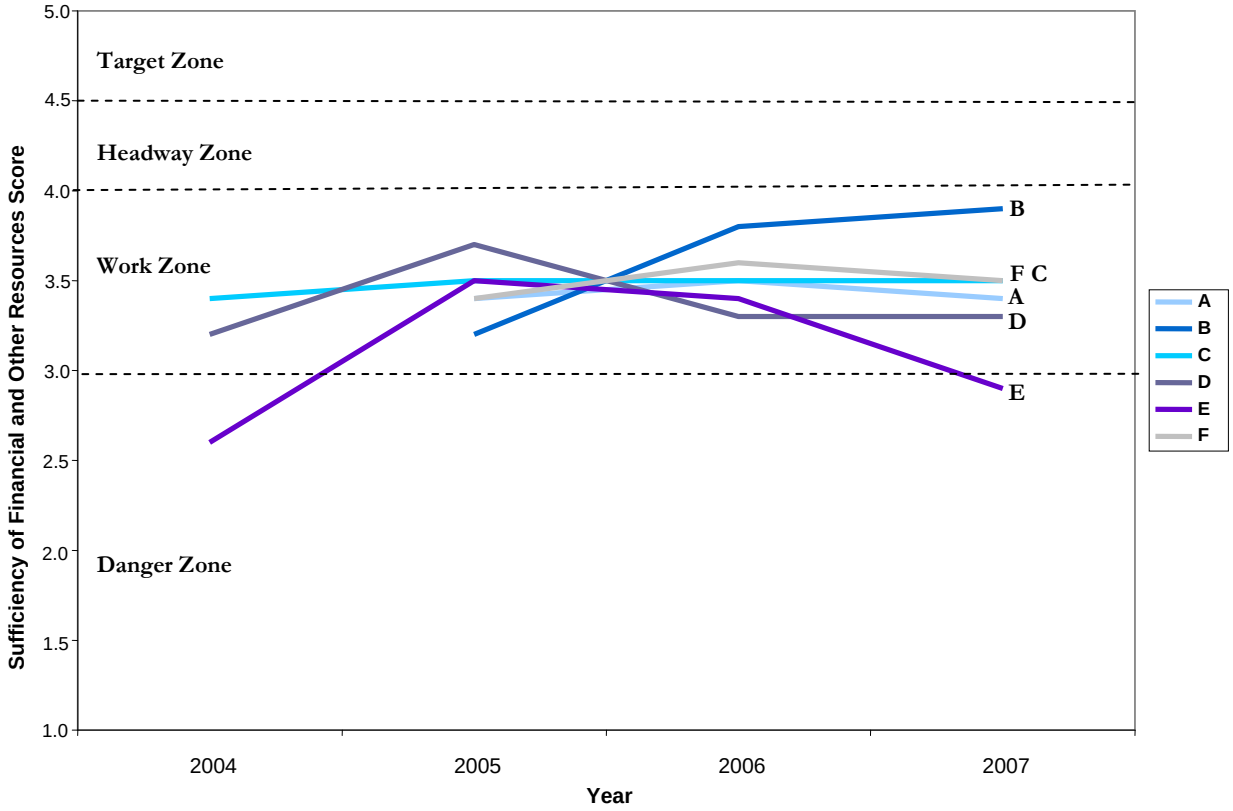
The Lasker and Weiss PSAT measures perceived sufficiency of financial resources. The sufficiency of financial and other resources score encompasses the following items:

- Money;
- Space; and
- Equipment and Goods.

Figure 4-8 illustrates how the perception of sufficiency of financial and other resources score changed over time from 2004 to 2007. Five state partnerships began in the work zone for this score; State E began in the danger zone. The partnerships that began in the work zone remained in the work zone, though State B's score improved. This is consistent with the findings from the spring 2006 process evaluation telephone interviews, in which the majority of respondents from State B felt that they had sufficient resources and a plan for obtaining additional resources. The increasing score

for State B can likely be attributed to the external funding they secured. However, although the State B score improved over time it never progressed beyond the work zone.

Figure 4-8. Lasker and Weiss PSAT sufficiency of financial and other resources scores over time



Target Zone: 4.6-5.0; Headway Zone: 4.0-4.5; Work Zone: 3.0-3.9; Danger Zone: 1.0-2.9

Perceptions of sufficiency of financial and other resources for other states both fell and rose over the 4 years, but remained relatively stable. The exception was the State E partnership. While State E perceptions moved into the work zone for both 2005 and 2006, they dipped into the danger zone in 2007. In general, these findings were anticipated; in almost all partnerships a majority of respondents reported that the partnership did not have sufficient financial or nonfinancial resources to conduct the Team Up pilot as desired (according to the spring 2006 telephone interviews). Interestingly, only two partnerships created a plan for actively pursuing additional fiscal resources. It is understandable, then, that as the Team Up pilot drew to a close, the sufficiency of financial resources scores declined for state partnerships with no additional plans to obtain resources.

None of the partnerships progressed past the work zone for their sufficiency of financial and other resources score. Many respondents felt that the national partners could, and should, have done more to financially support the pilot program at the state and county level. Although the state partnerships received funds ($15,000) to assist in the evaluation of their interventions, they did not receive implementation funds. The state partners most wanted financial assistance for this particular focus. One partner from State C said, "We need some seed money for the county level, even enough for refreshments and meetings." Another from State D said, "If [national partners] want Team Up to be successful, they have to put money on the table. In [State D] no one person is the 'go to' person. The leaders are there, but money is needed for people and time; even a .25 full-time employee (FTE) for leadership would bring about more success. Every partner has other projects to focus on [besides Team Up]."

Despite a perceived lack of financial resources, several states were creative and successful in obtaining external funding to augment the implementation of their evidence-based interventions. State B received $10,000 from their local ACS chapter to fund implementation activities associated with their evidence-based intervention. State F had a staff person dedicated to Team Up paid for by both the NBCCEDP and USDA. A State F respondent noted, "We do have a paid staff person that is paid for by the NBCCEDP and Extension [the position] will be filled until there are no more resources. Having a paid and dedicated staff person is extremely beneficial…." The funding for the State F Team Up coordinator ended June 30, 2007, and although there was concern about the impact on sustainability plans, four of the Team Up counties in State F obtained funding from the Susan G. Komen Foundation to sustain their interventions. The State C partnership also received funds from the Susan G. Komen Foundation, designated to develop and disseminate educational materials, not to sustain the intervention.

4.2.5.2 Sufficiency of Nonfinancial Resources

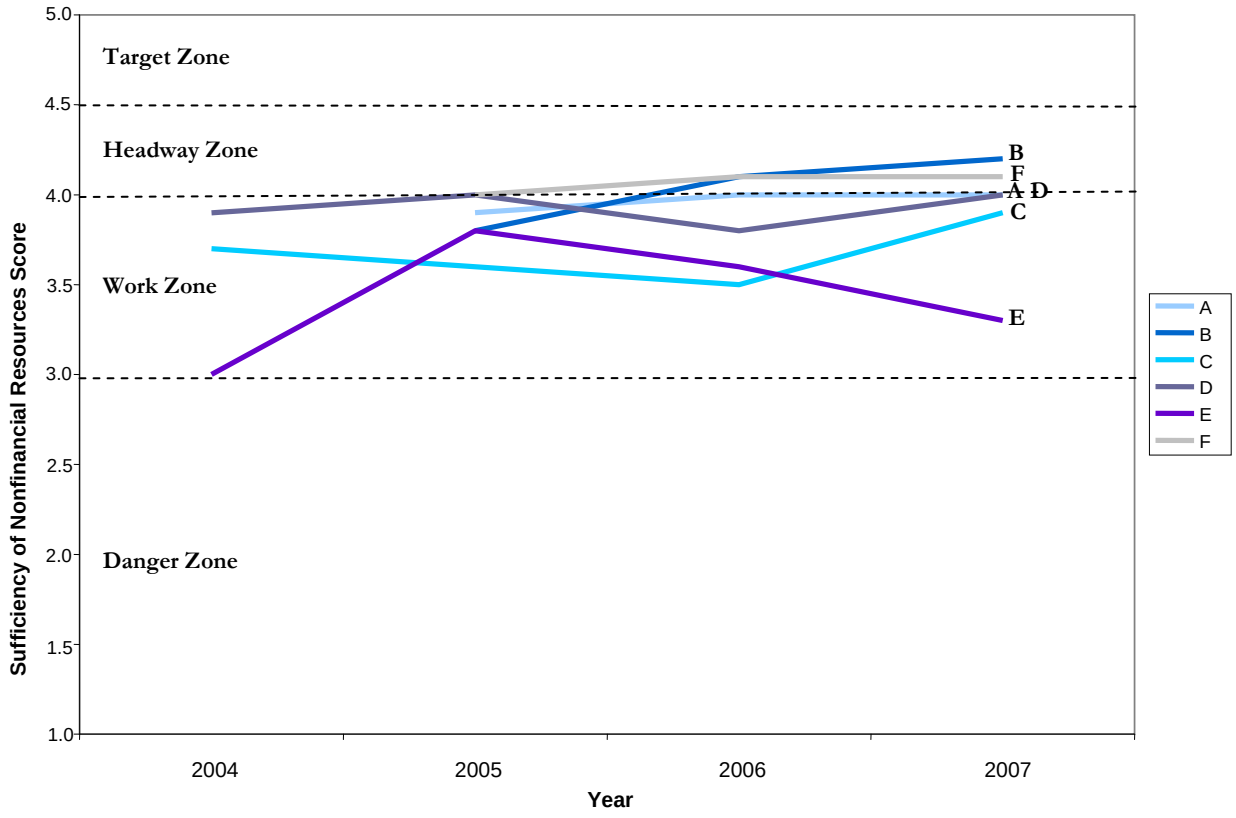
The Lasker and Weiss PSAT measures the sufficiency of nonfinancial resources. The sufficiency of nonfinancial resources score encompasses the following items:

- Skills and expertise;
- Data and information;
- Connections to target populations;

- Connections to political decisionmakers, government agencies, and other organizations/groups;
- Legitimacy and credibility; and
- Influence/ability to bring people together for meetings and activities.

Figure 4-9 illustrates how the sufficiency of nonfinancial resources scores changed from 2004 to 2007. Similarly to the sufficiency of financial and other resources, five partnerships' scores began in the work zone. State F's score began in the low end of the headway zone. However, by 2007, scores for four partnerships were in the headway zone (States A, B, D, and F), and the remaining two (States C and E) were in the work zone.

Figure 4-9. Lasker and Weiss PSAT sufficiency of nonfinancial resources score over time



Target Zone: 4.6-5.0; Headway Zone: 4.0-4.5; Work Zone: 3.0-3.9; Danger Zone: 1.0-2.9

In general, states were more successful obtaining nonfinancial resources than they were in obtaining financial resources. The majority of partners in all state partnerships reported trying to obtain materials (92.0 percent; 23 out of 25), staff with appropriate skills and expertise (76.0 percent; 19 out

of 25), and information (88.0 percent; 22 out of 25), according to the spring 2006 telephone interviews. Of those who said they tried to obtain additional resources, 100 percent responded that they had been either completely or partly successful in obtaining materials and staff with appropriate skills and expertise (23 out of 23 and 19 out of 19, respectively), and 95.5 percent in obtaining information (21 out of 22). In addition to these resources, state partnerships also obtained other nonfinancial resources, namely connections to target populations and legitimacy and credibility, by including noncore partners in the partnerships and by using the connections that the USDA had already established in intervention counties.

4.2.6 External Environment

Respondents to the spring 2006 telephone interviews were asked which community characteristics facilitated their Team Up partnership and which were barriers to building the partnership. Most respondents stated that community trust, recognition, and respect from other organizations or individuals in the community were vital to the partnership. The most noted barriers were competition for community resources and lack of community resources, if they were available. States A and C reported more community barriers than the other partnerships. Lack of community trust was also mentioned as a barrier to partnership.

Respondents had various ways of working with communities to help alleviate the lack of resources. One respondent from State A stated, "The rural areas we work with do [not] have a lot of resources. We try to build incentives for participation into our program. We also focus on making the [Team Up] program accessible and as close to them as we can, even if it's on a one-on-one basis, since transportation is a barrier." Another respondent from State B said, "Our group has tried to find ways to fill gaps because the communities we are working in have limited [financial] means. We are working with the communities to get the resources they need. Sustainability is important for us. We don't want the project to end when to evaluation is completed in 2007."

Respondents discussed how they dealt with lack of community trust. One respondent in State C felt that they were successful in dealing with this issue in some, but not all, counties. "It's hard being the new kid on the block and establishing the need and getting the community to accept us…We tried to encourage our coalitions that are working in those communities to work more closely with the [local] community and invite community members to participate [in Team Up]." Others noted that building community trust was a long process, and developed over time as community members

became familiar with Team Up. As noted above, noncore members from the field were essential in getting community members to accept Team Up since they already had established relationships with the communities.

4.3 National Partner Role in Supporting State Partnerships

Respondents to the spring 2006 telephone interviews were asked to rate how helpful various national partner activities were in building or sustaining the Team Up state partnerships (Table 4-7). Overall, the State E partnership found the national partner activities most helpful, and State F found the national partners activities least helpful.

The coaches received the highest rating of all activities in half of the partnerships. Four state partnerships rated the July 2003 training lower than any of the other activities. This is consistent with findings that the state respondents were not clear on the purpose or expectations of Team Up after the initial training. One respondent said, "After the July 2003 meeting, we were confused because we did [not] have clear expectations [for us or our teams]. When we reconvened 3 months later we had to take three steps back to figure out what the training was about and what the expectations were. During the 2005 training [Regional Meeting] the focus on evidence-based interventions became clear." In spite of these views, respondents in State D rated the July 2003 training higher than any of the other activities.

Respondents were also asked which of the national partner technical assistance and communication activities were most helpful in preparing states to undertake their expected partnership functions (Table 4-8). The ongoing assistance from the coaches and the regional meetings received the highest ratings for most functions; both activities took advantage of the pervasive, underlying problems identified by state partners and clarifying issues surrounding adoption and implementation of evidence-based interventions. In particular, state partners were having difficulty understanding the practicalities of the dissemination process from adoption to implementation and how their partnership could devise strategies that would work for them in the field. While the coaches provided ongoing one-on-one state team support, the regional meetings provided expert-led group support and instruction on issues relevant to the adaptation and implementation process. The regional meetings also provided experts who led group instruction on what was involved in collecting data to monitor and report on their work to the national partners.

Table 4-7. Usefulness of national partner activities in building or sustaining partnership

Which of the following activities sponsored by the national partners have been helpful in building or sustaining your partnership?	Team Up state partnership	Mean[a]	SD
Overall the activities have been helpful	A (n=5)	2.8	0.5
The July 2003 training was helpful		2.6	0.6
The Coaches have been helpful		3.0	0.7
The PATH visits were helpful		3.2	1.1
The Regional Meetings were helpful		3.0	1.0
Overall the activities have been helpful	B (n=4)	2.8	1.3
The July 2003 training was helpful		2.0	0.8
The Coaches have been helpful		3.3	1.5
The PATH visits were helpful		3.3	1.0
The Regional Meetings were helpful		4.0	0.0
Overall the activities have been helpful	C (n=4)	2.5	1.3
The July 2003 training was helpful		2.3	1.5
The Coaches have been helpful		2.8	0.5
The PATH visits were helpful		2.3	1.5
The Regional Meetings were helpful		2.8	1.0
Overall the activities have been helpful	D (n=4)	3.3	0.5
The July 2003 training was helpful		3.3	1.0
The Coaches have been helpful		2.5	1.3
The PATH visits were helpful		3.0	0.8
The Regional Meetings were helpful		2.8	0.5
Overall the activities have been helpful	E (n=4)	3.8	0.5
The July 2003 training was helpful		2.5	0.6
The Coaches have been helpful		3.8	0.5
The PATH visits were helpful		3.5	0.6
The Regional Meetings were helpful		3.3	0.5
Overall the activities have been helpful	F (n=4)	1.5	1.7
The July 2003 training was helpful		2.5	1.9
The Coaches have been helpful		2.7	1.5
The PATH visits were helpful		1.3	1.5
The Regional Meetings were helpful		1.8	1.3

[a] A mean score was developed by averaging responses to individual questions. The maximum possible score was 4 (strongly agree=4; somewhat agree=3; neither agree nor disagree/no opinion=2; somewhat disagree=1; strongly disagree=0).

Table 4-8. Helpfulness of national partner activities for partnership functions

Which Core-sponsored activities were helpful for the following partnership functions?	July 2003 training	Coaches	PATH visits	Regional meetings	Newsletters	Webinars
	% indicating activity was helpful (n=25)					
Getting ideas for recruiting new people or partners	32.0	40.0	16.0	40.0	24.0	12.0
Retaining partners	8.0	36.0	32.0	28.0	24.0	4.0
Building strong working relationships among partners	36.0	64.0	44.0	60.0	28.0	12.0
Managing and staffing the partnership	24.0	56.0	28.0	20.0	12.0	4.0
Securing resources for the partnership	8.0	40.0	32.0	52.0	24.0	40.0
Determining what interventions to implement	20.0	44.0	40.0	60.0	12.0	48.0
Determining evidence based methods for reaching rarely or never screened women	20.0	28.0	36.0	60.0	20.0	52.0

The PATH visits (also group activities) received high scores, most notably in the area of building strong working relationships among partners. Since the PATH visits were tailored to state needs, they were intended to facilitate training that would directly influence partnership relationships and were designed to help states focus on understanding the entire implementation process. In a separate evaluation of the PATH visits, the majority of respondents in all states felt that the primary objective of the PATH visits (to enhance relationships among state partners) had been met. The PATH visits were also found to be helpful in identifying how to secure resources for partnerships. Methods for obtaining outside funding for each state partnership was an action item included in the technical assistance plan that all state partnerships followed up with after the PATH visits.

Webinars were an inexpensive communication medium to tailor information, and was a useful vehicle for states to learn about essential processes and methodology needed to implement their evidence-based interventions. In particular, Webinars served as a channel to increase discussions around evidence-based interventions among individuals. Since the nature of Webinars is interactive, the medium provided yet another forum for states to identify and become skilled in how to adapt an evidence-based intervention. For example, one of the Webinars was dedicated to the Forsythe County Cancer Screening (FoCaS) intervention that five states chose to use. Respondents to the FoCaS Webinar evaluation noted that they liked having the opportunity to ask questions directly to a

FoCaS implementer and to gain more insight into specific intervention components that could and could not be changed in practice, as they were concerned about intervention fidelity during the adaptation process. The Webinar was also used to communicate with states how to secure evaluation resources to assess their interventions. The Webinar devoted to evaluation discussed how to write an evaluation proposal and outlines what states could expect with the assessment of their grant applications.

Sponsored national partner activities that took place after the process evaluation telephone interviews (June 2006) included the national meetings (August 2006 and June 2007), and the ACS-sponsored retreats.

Planning for and participating in the retreats gave participating states the opportunity to meet face-to-face as a team and develop action steps to move forward as a team. Three states participated in the retreats (States B, D, and F). The other three states declined to participate since the timing of the retreats would have interfered with implementing their evidence-based interventions. When the three participating states held their retreats, each was in a different stage of implementation. State D had selected but not yet implemented their intervention; State B had selected and pilot tested their intervention, but had not fielded the final intervention; and State F had been implementing their intervention for over a year. While a primary purpose of the retreats was to understand and strengthen collaboration among partners, it was interesting to observe that States B and F had the two highest synergy scores during the 2006 and 2007 administration of the Lasker and Weiss PSAT. By the 2007 administration of the Lasker and Weiss PSAT, State D had had their Retreat and they then had the third highest synergy score.

4.4 Summary

The goal of the process evaluation was to identify the dimensions of partnership functioning directly related to partnership synergy, and thus related to each partnership's ability to effectively implement an evidence-based intervention in its community. The results supported the conceptualization of partnership synergy overall, and with specific constructs from the Lasker and Weiss PSAT. It is important to remember that not all dimensions of partnership functioning are equally significant for synergy, and it is to be expected that synergy levels will vary over time as state partnerships develop, mature and reach their own expectations, not only the expectations of the national partners.

Findings suggest that although the effectiveness and administration of partnerships are challenging for some partners, it was not so for others. For example, some partnerships showed diminished areas that did not improve over the life of the pilot, while others seemed to coalesce quickly. In all areas except for nonfinancial sufficiency**,** State E began with scores in the danger zone, and although there was a noticeable increase in 2005 (into either the work zone or headway zone, possibly due in part to the technical assistance provided by the national partners that year), the scores then dropped in 2006 and 2007 into the work zone or danger zone. By 2007, State E was the one partnership with the lowest scores in all areas; State E's synergy score in 2007 was actually lower than its score in 2004. Lasker and Weiss (2001) suggest that leadership effectiveness is the one dimension of functioning this is most closely related to partnership synergy. While strong leaders are able to bridge diverse cultures and different perspectives to empower partners, it was the turnover in leadership and persistent turnover in staff that inhibited this team's ability to move forward as a consistent collaboration.

On the other end of the spectrum, State B began with relatively high scores in every area in 2005 and the scores continued to improve in each subsequent year. By 2007, State B had the highest synergy score as well as the highest score in the other five areas identified as Lasker and Weiss partnership domains. State B was able to optimize its partner's time and in-kind resources, but more importantly the partnership successfully obtained additional resources. This supports the Lasker and Weiss (2001) finding that synergistic partners are dependent on partner contributions in areas affecting management and resources.

The national partners provided several practical approaches to guide states through the implementation process, and to ensure a vehicle for their questions to be answered. All the technical assistance approaches offered facilitated discussion among states with the coaches, and the key areas that remained problematic then became featured topics at the regional and national meetings. These multiple strategies provided an important role for state partners to participate and help solve their own problems. These various ongoing discussions increased opportunities to strengthen state partnerships through the pilot with ongoing and coordinated support and a continuing dialogue.

Impact Evaluation Findings 5

5.1 Introduction

This chapter presents the results from the impact evaluation, which focused on the success of Team Up state partnerships in adopting, adapting, and implementing evidence-based interventions. The data for this part of the evaluation came from a single Historical Assessment, three rounds of Six-Month Assessments, and an Endpoint Interview. In addition, there were other data sources that informed the impact evaluation, including a summary of state interventions developed by Team Up state program staff.

This chapter begins with a discussion of the activities participating partners were involved in prior to Team Up. It then presents the evidence-based interventions that were selected, how and why they were selected, and how the selected evidence-based interventions were adopted and adapted to meet the local needs, including the challenges encountered in adapting the intervention. Lastly, the chapter describes the challenges in implementing the intervention, resource availability, and the likelihood of sustainability.

5.2 Interventions Prior to Team Up

During the Historical Assessment telephone interview (May–June 2006), respondents were asked to report the cervical and/or breast cancer interventions their organizations used prior to Team Up. Twenty-three of 24 respondents reported at least one intervention that their organization employed prior to Team Up; the maximum number of cervical and/or breast cancer interventions respondents reported using was four, with an average of two. The 23 respondents reported 47 separate interventions. Among the 47, 14 were breast cancer only and 33 were combined cervical and breast cancer interventions. Five respondents reported implementing only breast cancer interventions, while the remaining 18 implemented both cervical and breast cancer interventions. No state reported using an intervention focused solely on cervical cancer. The types of interventions reported included community awareness or educational programs, church events, didactic presentations, lay health advisor or peer-to-peer programs, health fairs, media campaigns, and mobile mammography days. Table 5-1 lists the types of interventions conducted according to the Rimer Typology (Rimer,

1994). As shown, the majority of pre-Team Up interventions were either individual-directed strategies or social network systems.

Table 5-1. Rimer typology of pre-Team Up interventions

Rimer typology	Breast cancer (n=14)	Breast and cervical cancer (n=33)
Media campaigns[1]	2	5
Individual-directed strategies[2]	3	12
System-directed or physician-directed methods[3]	—	
Access-enhancing approaches for communities[4]	—	2
Social-network systems[5]	7	11
Policy-level methods[6]	—	
Multistrategy methods[7]	2	3

Source: Rimer, 1994. 1. Media campaigns include mass media channels – TV, radio, etc.; 2. Individual-directed strategies include letters, mailed reminders, telephone counseling, posters, and targeted health education print materials and videos; 3. System-directed or physician-directed methods include prompts and manuals or computer-directed reminders; 4. Access-enhancing approaches involve mobile vans and transport providing access to health centers; 5. Social-network systems use peer leaders and community organization techniques to change social norms with underserved women; 6. Policy-level methods reflect regulation changes to increase cancer screening and are necessary, but are not sufficient to increase the use of screening; and 7. Multistrategy methods are directed to the patient, provider, and health care system.

Respondents gave a variety of reasons for why they chose their particular intervention(s). Some of those reasons related directly to the objectives of the parent organization; other interventions were selected to raise awareness, expand outreach, and reach a particular population. Some respondents noted that their parent organization selected a particular intervention because it had previously been proven to work elsewhere.

Respondents were asked to identify the sources they consulted to select their interventions prior to Team Up; Table 5-2 lists the reported sources. The most common source mentioned was peer-reviewed publications, followed closely by professional organizations and personal experience. Cancer Control P.L.A.N.E.T. was consulted for four of the interventions prior to the Team Up pilot program.

Some respondents rated interventions they used prior to Team Up as being "effective" because they believed the interventions had resulted in increased screening and early detection rates. Others thought interventions were "effective" based on the intervention methodology used, but not based on the outcome. Methods for selecting an "effective" intervention included using trusted

community leaders, having interventions linked directly to cancer screening services such as the NBCCEDP, and collaborating with other organizations to increase the number of women reached.

Table 5-2. Sources state partners consulted to select evidence-based interventions

Source	Number of interventions (n=47)
Peer-reviewed publications	18
Professional organizations	17
Personal experience	16
Program evaluations	14
Systematic reviews	10
Other tested interventions	9
Untested interventions	9
Cancer Control P.L.A.N.E.T./RTIPs	4

Based on personal experience, respondents were asked to indicate how effective they thought each intervention they mentioned was in reaching women who had rarely or never been screened for cervical or breast cancer. In 21 out of 47 cases (44.7 percent), the respondent said the intervention was "somewhat effective." Less than one-fifth of the interventions were rated as "extremely effective" (17.0 percent; 8 out of 47). The effectiveness of nearly one-third of the interventions was unknown (29.8 percent "don't know"; 14 out of 47).

Respondents reported facing numerous intervention challenges prior to Team Up, including: (1) decreased effectiveness of the interventions due to the lack of accessibility to the target population; and (2) limited amount of resources to administer the intervention as planned.

5.3 Adoption of an Evidence-Based Intervention

Although state partners were tasked with identifying an evidence-based intervention at the July 2003 training, many noted that it was not apparent that the Team Up national partners were encouraging states to collaborate and to identify and implement an evidence-based intervention. Consequently, even though state partners developed an action plan and a vision for their state in July 2003, it was not until much later that they actually selected and adopted an evidence-based intervention.

Some state partners began conducting outreach and educational interventions that were not evidence-based following the July 2003 kickoff meeting. Many of these interventions selected had no

research backing (i.e., was not evidence-based and was not efficacious) due in part to the state's lack of understanding of Team Up's focus on evidence-based interventions. The national partners' themselves struggled with how to package the concept of dissemination and implementation as it related to evidence-based interventions. In many presentations, the national partners emphasized a wide range of choices that provided insight into how to identify and move scientific evidence into practice. Absent were implicit strategies that provided clear process directions. This lack of clarity served as a deterrent to the immediate adoption of the evidence-based intervention concept, which for most was a new and complicated idea. Furthermore, some states were resistant to any change because they felt that they knew what worked best in their communities. This lack of awareness is reflected in one respondent reporting that, "I think different partners realized at different times that we were supposed to be doing an evidence-based intervention" and that their approach was compounded because "it felt like we were being given a bucket of resources, but not a directive to use an evidence-based intervention."

After state partners recognized that they were to use an evidence-based intervention, discussions among members included exactly what an evidence-based intervention was. Different partner organizations within the same partnership had different interpretations, and the varying organizational and agenda perspectives took time to reconcile, as noted by this individual: "[My partnership] developed an agreement about what an evidence-based intervention meant over the course of a year" and what took so long was "reaching consensus about how performance and success was measured. This differed among the four partners."

The state partnerships were given different types of support and distinct steps to assist them in identifying an appropriate evidence-based intervention. First, as part of their action plans, state partners were asked to identify counties in their state with high cervical and breast cancer mortality, and were asked to consider if it was viable to intervene in one or more of these counties. Then, in October 2004 two coaches were hired to provide small group technical assistance, skills building, and opportunities to identify and problem solve around barriers to the adoption and implementation processes. Additionally, a Webinar in 2005 presented an interactive venue with experienced researchers that was designed to address core elements surrounding the adoption process. It was not until 2005 that most state partnerships began the process of distinguishing which evidence-based intervention might or might not be acceptable to their partnership team.

In all states, the process of selecting an evidence-based intervention was lengthy. It involved a collective and iterative review of existing evidence-based interventions by the full state partnership

or a designated subcommittee, and then a full group determination to decide that a particular evidence-based intervention was most appropriate for a specific partnership and locale. While time-consuming, this process provided valuable time for partnerships to learn about each organization's different cultures, priorities, expertise, and what each could contribute to the collective Team Up effort. As one partnership representative emphasized, "[A key part of this] start-up period was getting to know what each organization could bring to the table," and that it was ultimately a process that "strengthened the partnerships."

After months of discussion and planning, five partnerships (States A, B, C, E, and F) chose the Forsyth County Cancer Screening Program (FoCaS) and the remaining partnership (State D) chose Breast Cancer Screening Among Non-Adherent Women. In addition to FoCaS, State B chose the Filipino American Women's Health Project, meaning that this state's intervention incorporated a blend of components from two evidence-based interventions. Appendix W includes a summary of each of the three evidence-based interventions selected by the state partnerships. All three are listed as RTIPs on the Cancer Control P.L.A.N.E.T. web portal and were selected using this portal.

The evidence-based interventions that contained multiple components appealed to most state partnerships, primarily because they could select all or part of the intervention to adopt and implement. For example, the FoCaS intervention strategies included four clinic-based strategies (chart reminders, examination room prompts, in-service meetings, and patient-directed literature) and five community-based strategies (educational sessions, literature distribution, community events, media, and church programs). However, State D specifically chose Breast Cancer Screening Among Non-Adherent Women as their evidence-based intervention because it had fewer components (tailored telephone counseling and targeted print communications), so it could be adopted in its entirety. State B liked the group session approach used in the Filipino American Women's Health Project, which is why they selected this evidence-based intervention in addition to FoCaS. Table 5-3 outlines the evidence-based intervention selected, the specific components selected, and the selection date.

State C was the first Team Up partnership to select an evidence-based intervention (2004), and they presented their adoption and implementation plans at the 2005 regional meetings. Other partnerships did not select evidence-based interventions until after the 2005 regional meetings, or until after the 2005 Webinar mentioned above.

Table 5-3. Evidence-based intervention, components selected, and selection year

State	Intervention selected	Components selected	Selection year
A	FoCaS	Media campaign, educational classes, one-on-one sessions, inclusion of church/religion	2005
B	FoCaS, Filipino American Women's Health Project	Educational classes, inclusion of church/religion	2005
C	FoCaS	Media campaign, educational classes, one-on-one sessions, inclusion of church/religion, educational games to teach examination skills, distribution of literature in the waiting room	2004
D	Breast Cancer Screening Among Non-Adherent Women	Tailored telephone counseling, tailored print communications	2005
E	FoCaS	Educational classes, inclusion of church/religion, in-service and primary care conference training for providers	2005
F	FoCaS	Media campaigns, educational classes, one-on-one sessions, direct mail, inclusion of church/religion, community events, in-service and primary care conference trainings for providers, distribution of literature, one-on-one counseling sessions and personalized followup letters for women with abnormal test results	2005

5.3.1 Factors Influencing Adoption

During all three rounds of the Six-Month Assessment and the qualitative telephone interviews (February to April 2008), respondents were asked to identify factors that influenced adoption of their evidence-based intervention. During the first and second round (June 2006 and December 2006), respondents were asked to identify factors that influenced the adoption of their chosen evidence-based intervention from a list of factors based on the 10 critical attributes of an innovation from the Roger's Diffusions of Innovation theory (Table 3-2). During the first round they were able to select all factors that applied, while during the second round they were limited to selecting three factors. During the third round and the qualitative interviews, respondents were asked to identify the top two factors that influenced their decision to select the evidence-based intervention in an open-ended format.

Figures 5-1a and 5-1b show the percent of respondents that identified each factor as influencing adoption during the first and seconds rounds of the Six-Month Assessment. During the first round, "easily adapted" was the top choice and influenced the adoption of all interventions. It should be noted that the response rate for the first round was very low (28.0 percent; 7 out of 25 respondents representing five of the six partnerships). During the second round, in which respondents were

limited to three choices, "demonstrated effectiveness" was the top factor influencing the decision to adopt a particular evidence-based intervention (65.2 percent; 15 out of 23 respondents).

Figure 5-1a. Factors from the Diffusion of Innovations theory that influenced the decision to adopt an evidence-based intervention

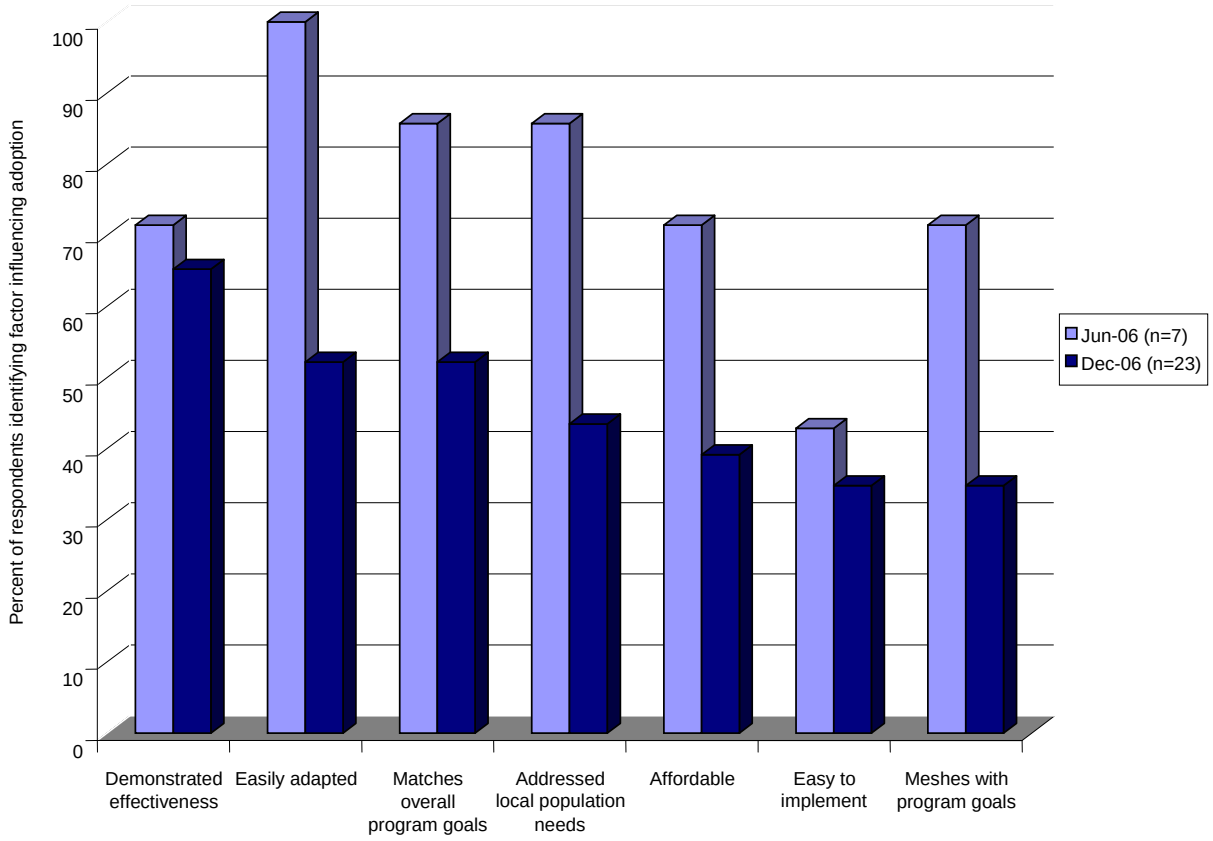
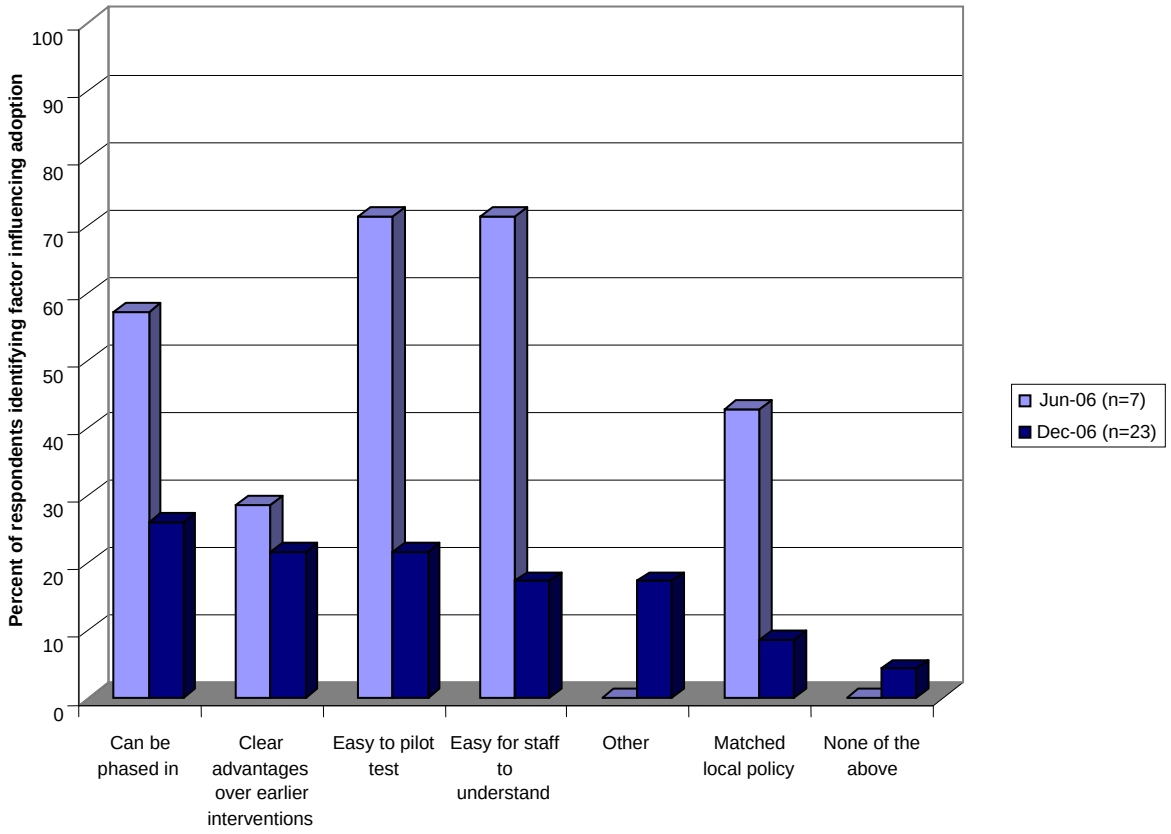


Figure 5-1b. Factors from the Diffusion of Innovations theory that influenced the decision to adopt an evidence-based intervention



During the third round of the Six-Month Assessment (May 2007), respondents were asked in an open-ended format to list the two most influential factors in their decision to adopt their chosen evidence-based intervention. Reasons respondents gave for choosing the intervention included: feasible to implement the intervention given the limited resources available; intervention applicable and adaptable to target population; and intervention fit well into the activities that the partners were already conducting. One respondent stated, "The team knew some of the limited resources we would have with staffing, and the evidence-based intervention we chose seemed like a good feasible fit." Another respondent noted that interventions were "based on the practicality of what would work in our community," a decision that was based on feedback from the community and USDA CES agents. Four respondents each from different partnerships noted that the main factor influencing their decision was that they felt limited to choosing an intervention from the Cancer Control P.L.A.N.E.T. web portal. One respondent stated, "Of the programs available on P.L.A.N.E.T., this program [Breast Cancer Screening Among Non-Adherent Women] best addressed the needs of [our] intended audience."

Overall, selecting an intervention from the Cancer Control P.L.A.N.E.T. web portal was seen as a major stimulus to the evidence-based intervention selection process, even though other resources were recommended. Using the Cancer Control P.L.A.N.E.T. web portal, state partnerships tried to identify evidence-based interventions that were both feasible (i.e., including considerations such as state resource availability and availability of state partners to conduct the intervention) and applicable to the target population.

5.3.2 Involvement in Decisionmaking (Change Agent)

During all three rounds of the Six-Month Assessments (June 2006, December 2006, and May 2007), respondents were asked to identify individuals or groups that were involved in the decisionmaking process of adopting an evidence-based intervention for their partnership. All respondents believed that most decisions were made by the entire group, rather than by one individual. The selection process, described by respondents in May 2007 during the third round of the Six-Month Assessment, was similar for all state partnerships: (1) they downloaded information on evidence-based interventions from RTIPs from the Cancer Control P.L.A.N.E.T. web portal; (2) they reviewed each intervention and rated its applicability (in several states, each partner was assigned one or two interventions to review and summarize for the group); and (3) the group rated the interventions and selected the intervention(s) that best suited their target population of women.

One respondent described the decisionmaking process stating, "We picked our intervention as follows: different folk were asked to look at an intervention and then we discussed the pros and cons of each evidence-based intervention—what was feasible [in our state] and with the partnership. We had very thorough discussions about what resources were available. After a while we came to a consensus about what evidence-based intervention we wanted to use."

In all state partnerships, the entire team participated in the decisionmaking process. However, States A and E went beyond the immediate core partnership structure and solicited community input to assist in the decisionmaking process. State A selected FoCaS and then held a town hall meeting where community representatives helped choose the specific intervention components to be implemented. State E held a community interest meeting prior to selecting its evidence-based intervention. They gathered information on community needs during this meeting and used that information to decide which evidence-based intervention (FoCaS) best suited the community they

were to work with. One respondent noted, "In terms of ultimately making a decision about the evidence-based intervention, most of the components we selected were based on feedback from the community. Also we considered what was feasible and practical based on our distance from [the selected target county] and the amount of time we had [to devote to implementing an intervention]." Along these lines, another respondent stated, "We found it difficult to decide on which intervention to choose and which one was most likely to be successful in the designated county. We did have some input from the community in terms of selecting the evidence-based intervention, but not to do the planning of replicating the intervention."

During the last round of the assessments (May 2007), respondents were asked to rate the level of involvement that each of the state-level core partners (ACS, CDC, NCI, and USDA) had in the decisionmaking process. Table 5-4 shows rankings given to each organization on a scale from one to five, with one being "not involved" and five being "extremely involved." All core partners received high rankings on average, with involvement ranging near the highest level.

Table 5-4. Level of organizational involvement in the intervention adoption and decisionmaking process across state partnerships

	A (n=4)	B (n=3)	C (n=4)	D (n=3)	E (n=3)	F (n=4)	Average
ACS	3.5	5.0	4.0	5.0	5.0	5.0	4.6
CDC	4.0	5.0	3.0	5.0	3.5	5.0	4.3
NCI	4.3	5.0	4.7	4.7	5.0	5.0	4.8
USDA	4.0	5.0	5.0	5.0	4.5	5.0	4.8

Respondents were also asked to describe the role, if any, that the national partners played in their decisionmaking process. In the first round of the Six-Month Assessment (June 2006), five of seven respondents thought the national partners played an active role in the adoption of their intervention. This role was described as guiding the state partnerships to choose an intervention from the Cancer Control P.L.A.N.E.T. web portal. During the second round (December 2006), 13 of 23 respondents (57 percent) reported that the national partners played a dynamic role in the selection of an evidence-based intervention. This role was providing educational information and additional resources on where to find the components of the evidence-based intervention (i.e., Cancer Control P.L.A.N.E.T.) and providing advice and feedback on specific interventions. One respondent noted, "It was actually the national partners who told us that we had to add in breast cancer. That happened pretty early on within several months of the initial (July 2003 kickoff) meeting. While this was not a problem, it did change which counties we were planning to work with and sent us back to

the drawing board to some degree. We thought we had made a decision about which evidence-based intervention we would use, but then we had to regroup and had to add new intervention components. This added a couple of steps for us."

5.4 Adaptation of an Evidence-Based Intervention

Although all of the partnerships adopted evidence-based interventions, no partnership implemented the intervention exactly as the original implementer had intended. During the replication process, each partnership had to adapt the intervention to fit their circumstances (i.e., target population, location, limited resources, revising or reducing the number and type of materials, etc.). Respondents were asked to describe the types of adaptations that were made to the selected evidence-based interventions. Consistent among their responses were the following:

- The intervention materials were made more understandable by lowering the reading level, updating screening information, and/or including contact information for local resources. One respondent said, "Because of the age of the FoCaS evidence-based intervention, we did end up having to update some of the materials because some of the information was now outdated. After all, the original FoCaS happened 15 to 20 years ago!"

- The number of intervention components used in the original intervention (i.e., select only some of the FoCaS components) was reduced or the intervention components were changed (i.e., one class instead of a series) due to limited resources. One respondent said, "It would have been helpful to know how the different components of FoCaS compared in terms of their effectiveness. There wasn't a way to gauge which parts of the intervention would have been most effective given our resources. If we had unlimited resources, we could have done all components."

- The intervention was tailored to appeal to the intended population, including adapting the location. For example, the intervention was held in multiple locations instead of a central housing unit since the population in the original intervention (FoCaS) was urban and the populations in many of the Team Up counties were rural.

- A cervical cancer component was added because the original intervention only focused on breast cancer.

- Strategies not included in the original intervention were added. For example, State C added an emergency room (ER) component, where uninsured women obtaining services in a county hospital ER were sent to a lay health advisor stationed at the hospital. The lay health advisor offered women cervical and breast cancer screening and connected them with a provider home via *HomePlace* navigators. State B used the educational session strategy, but adding a cooking demonstration to each class.

In the qualitative interview (February to April, 2008), others expressed that it would have been helpful to have had more guidance about the adaptation process from the national partners. For example, one respondent commented, "I think the national partners tried not to impose on the (state) partnership, but yet at the same time (they) had to be very clear about what they wanted the partnership to do. It would have been better if we had been given a clearer outline." Similarly, another reflected, "If you were a purist, then one could argue that it was difficult to adapt the intervention…and we didn't know if what we were doing was right."

5.4.1 Challenges in the Adaptation of an Evidence-Based Intervention

Respondents identified challenges faced in adapting their intervention from a list of challenges based on critical attributes of an innovation from the Diffusion of Innovations theory. During the first round of the Six-Month Assessment (June 2006), the most common challenge reported was that the instructions for implementing the intervention from the original principal investigator were incomplete (57.1 percent; 4 out of 7 respondents), meaning that the researcher did not provide enough information on how to implement the intervention, or that the partnership had questions that remained unanswered. During the second round (December 2006), the most common challenge reported was that it took longer to adapt the evidence-based intervention than was anticipated (39.1 percent; 9 out of 23 respondents). Five out of 23 respondents (21.7 percent) did not report facing any challenges in adapting their evidence-based intervention. Figure 5-2 shows the percentage of respondents reporting each listed challenge.

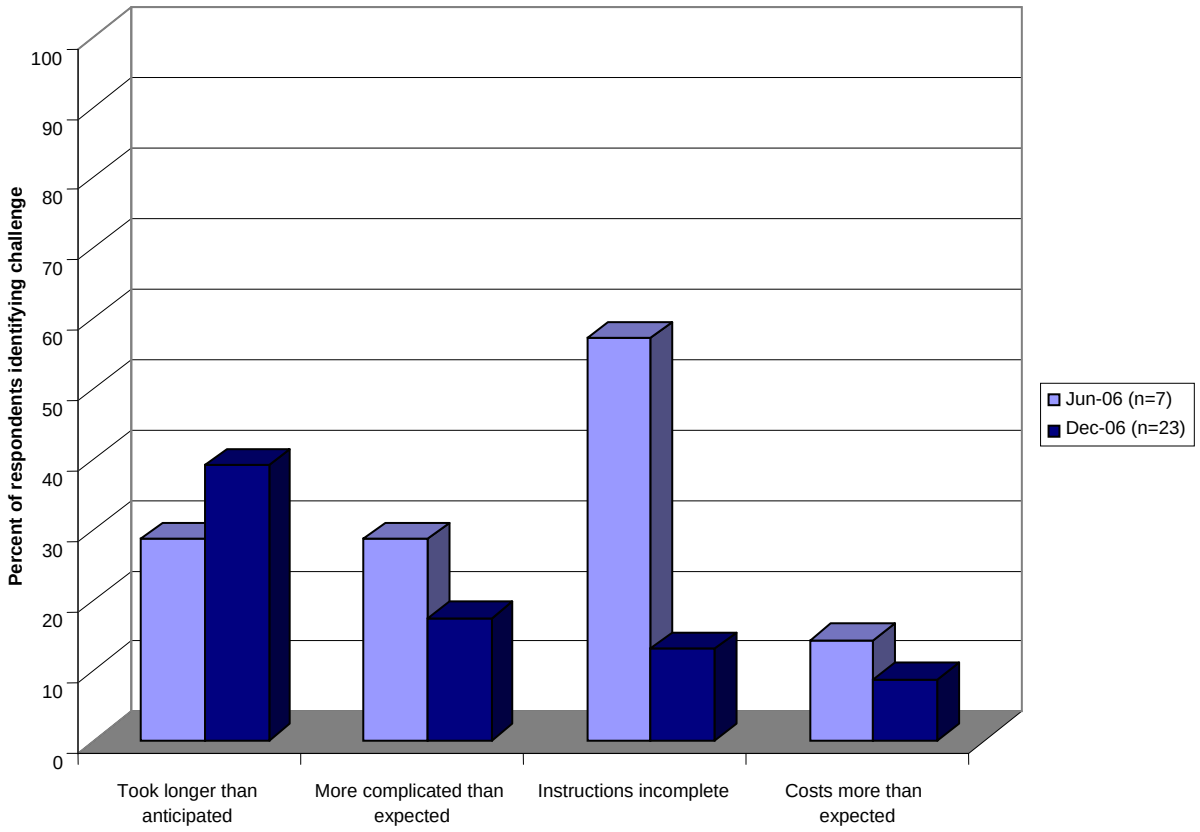
Additional challenges mentioned included difficulty getting involvement from the target population, not having full-time staff, remaining Health Insurance Portability and Accountability Act (HIPAA) compliant, and maintaining fidelity to the original intervention.

Respondents were asked to identify challenges in an open-ended format during the third administration of the Six-Month Assessment (May 2007). Challenges included:

- Converting an intervention setting from urban to rural;
- Lack of time or involvement from certain partners. One respondent from State A said, "None of the partners were located in our selected county, and everyone covered a multicounty area or the entire state;"

- Determining how much one could change an evidence-based intervention before it become a new intervention influenced by another intervention, rather than a true "evidence-based" intervention (issues of fidelity);
- Having partners agree on decisions, such as screening guidelines; and
- Finding evaluation materials.

Figure 5-2. Challenges in adapting the evidence-based interventions identified during the first and second rounds of the six-month assessment



Regarding challenges to the overall adaptation, another respondent stated, "We needed much more time to make it [the intervention] fit because we needed to get the buy-in of the community. We did not have the community involved in the planning because of the time constraints. Instead we met as a group and then presented something to them and they agreed, but I don't know if they really bought in."

5.5 Implementation of an Evidence-Based Intervention

Table 5-5 lists the dates that each state partnership began the implementation of their evidence-based intervention. Implementation dates varied across and within partnerships, from 2004 when State C began implementing its evidence-based intervention, to 2007 when State D implemented its evidence-based intervention. Although State C began its evidence-based intervention in 2004, over time the intervention became more robust as new components were added. For example, the media component did not begin until 2005 and the clinic-based component, where emergency room physicians referred women to lay health advisors (who refer women to the appropriate medical clinics for cervical cancer screening), did not start until 2006. State D, on the other hand, planned to begin its intervention earlier than 2007; however, it took longer than anticipated to adapt the evidence-based intervention and to gain Institutional Review Board (IRB) approval.

Table 5-5. Start date of implementation for each state partnership

States	Selection year	Implementation date
A	2005	Fall 2006
B	2005	Summer 2006
C	2004	Fall 2004
D[a]	2005	Spring 2007
E	2005	Summer 2006
F	2005	Fall 2005

[a] The process for obtaining IRB approval was longer than expected and caused a delay in the implementation of State D's intervention.

In general one respondent stated, "Our partnership's plan for implementation tended to unfold at meetings—namely, at each meeting we would plan out the tasks and activities for the next month." This member noted that although "evidence has to guide the partnership, being flexible is important when so many partners are involved since partners and perspectives change over time; you can't be too locked into a plan." It was clear that even though partnerships developed a written implementation plan and curricula at the state level, over time counties were given flexibility in how they implemented the intervention. This was because states recognized that they needed to accommodate different intra-state demographics and landscapes and that a one-size-fits-all model would be inappropriate, so a loose adaptation and implementation framework was needed. One respondent from State C stated, "Even though the partnership did develop a written plan, we didn't plan for the community. The communities were developing how they would implement the materials, and it was different in each community. We gave local people a menu of options and they made the decisions. Really, our role was more of a nurturing, supportive role rather than an implementation role." Another respondent from State F emphasized, "We came up with some core

activities within the evidence-based intervention that had to be done, but we gave the counties some flexibility to implement according to the resources that they had." Another representative from another partnership described the same organic phenomenon: "Once the intervention reached the county level, I think some of the [Cooperative Extension] agents altered [the program] even more. I don't know if the rest of the partnership was really aware of this until after the fact when they reported back to the group." One partnership (State B) representative doubted that their partnership would have succeeded at all if uniform implementation had been enforced: "If they [the national and state partners] had tried to impose one version of (an evidence-based intervention) implementation in all areas, it would not have worked."

5.5.1 Components of an Evidence-Based Intervention Implemented

During the third round of the Six-Month Assessment (May 2007), respondents were asked to identify the components of the evidence-based intervention that were implemented. Table 5-6 shows all of the components of FoCaS and the specific components state partnerships implemented. When there was a lack of consensus from partnerships surrounding whether an intervention component was implemented or not, other data sources, such as the 2007 State Team Profiles, were consulted to verify the presence of intervention components.

Table 5-6. FoCaS components selected for implementation

FoCaS component	A	B	C	E	F
Media campaigns	✓		✓		✓
Educational classes	✓	✓	✓	✓	✓
One-on-one sessions	✓		✓		✓
Direct mail					✓
Inclusion of church/religion	✓	✓	✓	✓	✓
Informational centers					
Community events					✓
In-service and primary care conference trainings for providers					✓
Educational games to teach exam skills			✓		
Distribution of literature in the waiting rooms			✓		✓
One-on-one counseling sessions and personalized followup letters for women with abnormal test results					✓

The five state partnerships that selected FoCaS chose community-based strategies more frequently than clinic or provider strategies because they were accustomed to working within communities and did not have easy clinic access. One respondent noted, "I think the other part of the FoCaS clinic-based 'tie-ins' did not really work in our project in the way that it did in the original FoCaS. It is not like we had clinic days set up, or had vouchers, or anything where we could make direct referrals to the clinics and then track the data."

All five partnerships decided to implement educational classes and included church/religiosity (i.e., the church was either used as the intervention site, or as a location for recruiting participants) in the implementation strategy. Three partnerships also selected media campaigns and one-on-one sessions. Only two state partnerships implemented any clinic or provider strategies; the most common approach being the distribution of literature in the waiting rooms. State E had planned to host a provider in-service training and had even identified a trainer and developed the training presentation; however, the training never came to fruition.

State B adapted and implemented the educational classes that were included in the Filipino American Women's Health Project intervention, in addition to selecting FoCaS components. State B chose this second intervention because they considered components in both the FoCaS and the Filipino American Women's Health Project interventions to be important evidence to reach their population of women.

Some aspects of implementation went fairly smoothly as noted by a respondent from State B who stated, "We did evidence-informed activities too. Team Up letters were going into the Extension mailings, being included in presentations at farm shows, etc. All this was happening simultaneously with the protocol for our state. Once we saw what the other members of different state partnerships were working on we realized that we really did select an evidence-based intervention and then we did stick pretty close to it."

Other respondents from State A noted difficulties that arose: "We did educational sessions. We created our own educational curriculum that matched the FoCaS requirements. Also, we did a public service campaign. The difficult part might have come in our ability to followup with women; this was in part because none of us lived in the target intervention community," suggesting that the rural nature of where women reside continued to be a barrier to reaching them.

In some cases, county-level adaptation resulted in successful innovations. One representative from State C stated, "The core process was planned, but once each county started going out and doing the work, different areas started doing their own thing (for example, one area. . . put together an educational DVD that they had raised money for)." Also, materials that had been developed at the local level had proven popular beyond the duration of the pilot study. State C reported, "We have found that there were some faith-based pieces that were (and still are) very popular…We had a template that had the messages that we wanted people to get regarding encouraging screening, and then people from churches could add their own church-related information, verses, etc., in it and then run it off on their church copier. The bookmarks were really popular."

State D, which did not use FoCaS, chose Breast Cancer Screening Among Non-Adherent Women and implemented both components of this intervention: tailored telephone counseling and tailored print communications. One respondent in this state noted, "We actually did 'targeted' mailings, not 'tailored' mailings, which were different from the evidence-based intervention. Also, we had to change a number of things with the evidence-based intervention (for example we had to change the script) and this created some struggles within our team; many people felt that they were not equipped to do this type of intervention work."

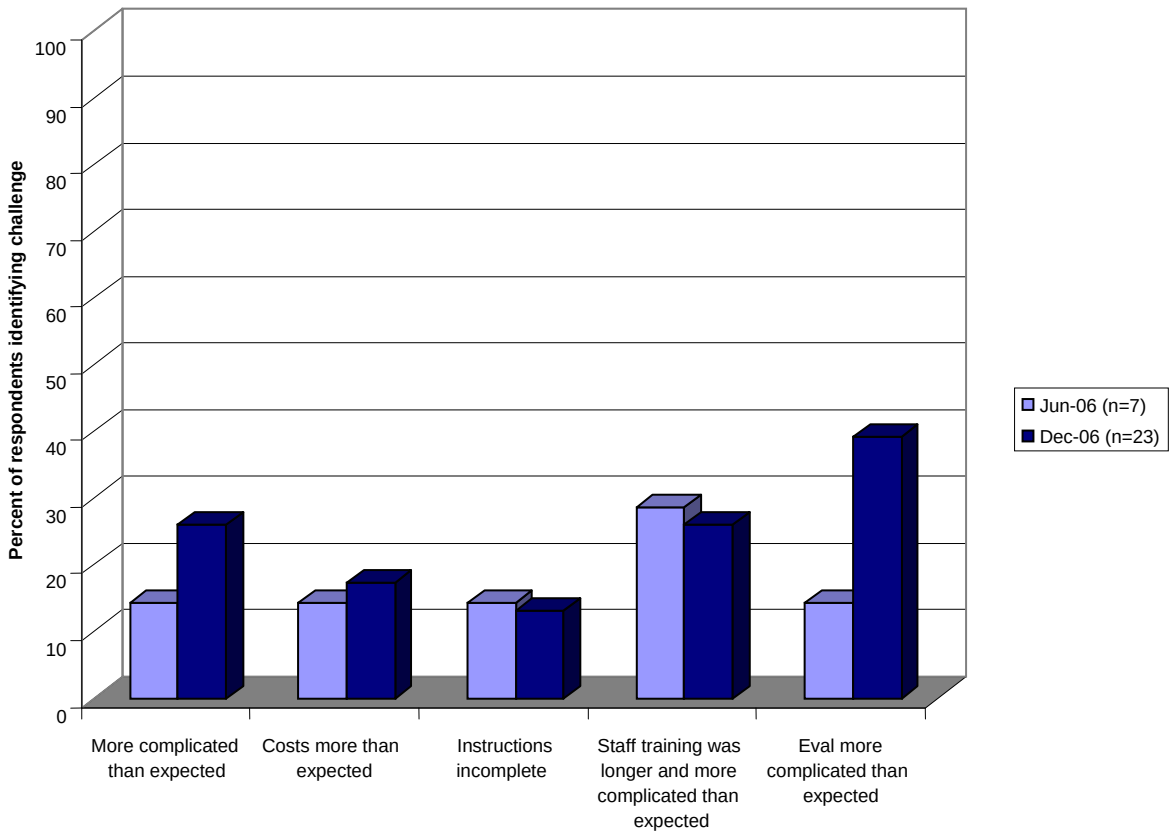
For many intervention components, there was little or no consensus within state partnerships as to whether or not it had been implemented. This suggests that although state partnership interventions were influenced by evidence-based intervention, there may have been significant enough changes during the adaptation process that the new intervention components did not easily match those of the original intervention. Also, in more remote communities individualized adaptation and implementation took place. Thus, fidelity to the original intervention is possibly a problem. Also, when asked, respondents may have identified intervention components differently. Similarly, the disagreement could have been due to a lack of knowledge or understanding about the evidence-based intervention, and thus not a clear recognition of specific components.

5.5.2 Challenges to the Implementation of an Evidence-Based Intervention

Respondents were asked to identify the challenges their partnership faced in implementing their intervention during all three rounds of the Six-Month Assessment (based on a list of factors related to the critical attributes of innovations). Some respondents did not answer this question because

they were not yet in implementation (3 out of 7 in the first round; and 2 out of 23 in the second). Figure 5-3 lists the challenges identified during the first and second administration of the Six Month-Assessment (June 2006 and December 2006). It should be noted that the sample size for the first round (n=7) was extremely small and almost half of those respondents did not answer this question in spite of prompting because they were not yet in the implementation phase. The most common challenges reported during the first round of the Six-Month Assessment were that staff training took longer and was more complicated than expected (28.5 percent; 2 out of 7 respondents). During the second round, the most reported challenge was that the evaluation was more complicated than expected (39.1 percent; 9 out of 23 respondents). Additional challenges mentioned included the target population being difficult to reach (17.4 percent; 4 out of 23 respondents), difficulty adhering to the implementation timeline (13.0 percent; 3 out of 23 respondents), difficulty with the process of referring women to services (4.3 percent; 1 out of 23 respondents), and issues with the accountability of volunteer staff (4.3 percent; 1 out of 23 respondents).

Figure 5-3. Challenges in implementing an evidence-based intervention



During the third administration (May 2007), 23 out of 25 respondents were asked about challenges in an open-ended format. The challenges that were reported included:

- Difficulty recruiting and reaching the target population;
- Time constraints – not having enough time to gain community buy-in or not having staff dedicated to the intervention;
- Keeping the momentum up – one respondent from State C said, "It takes a lot of man hours to keep up the momentum of having meetings and [maintaining the] structure around a project such as this. This will be a challenge in months ahead;"
- Staff turnover – one respondent stated, "It became hard for people who had not been at the table from the beginning to follow what our partnership's path was. For each new person who came on board to the partnership, the [overall] picture became that much more fuzzy." So, continuity of staff had ramifications on how the evidence-based intervention was carried out over time;
- Limited funding for the CDC's NBCCEDP – one respondent from State D said, "The breast and cervical cancer program is limited in funding at this time of the year, which impacts our ability to screen additional women;"
- Lack of funding to implement the intervention; and
- Difficulty collecting evaluation information.

Additional challenges respondents observed had to do with "Those partnerships that worked in more than one county. Here there were some questions as to how similar the intervention was from county to county. Some counties started doing their own thing."

The Endpoint Interviews (February to April, 2008) suggested that not involving local residents and USDA CES agents in the planning process was a substantial mistake since local people had a lot to offer. "If I were to do this again, I would say that it is absolutely necessary to involve the community [we are to reach] from the beginning," commented a State E representative. One partner from State C agreed that local community partners should have been welcomed more in the beginning: "I feel that the local level people felt dictated to at first; they didn't feel ownership over the [Team Up] project. If we could have spent a little more time at the very beginning getting people to the table who should be involved in this, and having these people go to the initial meetings, that would have solved a lot of the issues we had." While State C included the community in the selection process, they did not involve them in planning and the implementation phases and as a result this state was not sure that the community had "really bought in [to the Team Up goals]."

Other local contextual challenges emerged due to geographic disbursement. USDA CES agents were relied on heavily for program delivery and this entailed both time and cost. In more rural states, travel to multiple counties was necessary to implement interventions and to attend Team Up meetings. State E noted that both distance and manpower constraints prohibited this state from casting a wider net and reaching more women. State C reported that there were boundary-related conflicts between USDA CES agents: "In some counties, I think that coordination of extension activities with other organizations worked better than in others. Some counties have 'turf war' type relationships."

Other contextual impediments consisted of physicians and clinics who demonstrated very little buy-in for the intervention, which resulted in a paucity of support for the clinic-focused activities. A State C individual reported, "The other thing was that the physician understanding of how our screening program works wasn't very good." Another State C representative commented that this state "struggled with getting the message to the physicians and training them" due to a lack of connections to the Area Health Education Centers. Similarly, a respondent in a State E offered: "The hospital we were going to work with was having some transitional issues with their employees, and so the provider component of FoCaS never really got off the ground. I see now why FoCaS was a long-term program; it really takes a long time to develop those relationships, especially with providers. We also had issues getting a venue to do the training. We really needed some providers on the committee, but that didn't happen. If we had, it probably would have been easier to work out some of the logistics."

A major concern surrounds the degree of adaptation necessary for an evidence-based intervention in a new environment. Several states reported feeling confused and unsure of the authenticity of their adapted evidence-based interventions. A representative from State B noted that with respect to the extent that what they ultimately ended up doing resembled one of the evidence-based interventions; however, this individual continued to be "not sure." This individual said that they "just pulled out aspects [of the intervention] that we could adapt with [our current capacities and activities]." Another group of respondents from State F echoed this uncertainty: "We had to adapt, but I think that with the adapting, the 'evidence' part goes out the window." State A mentioned that time and resources also limited the extent to which an evidence-based intervention could be implemented with fidelity to the original intervention: "There was absolutely no way that we could possibly have done all the parts of the evidence-based intervention [with the Team Up pilot timeline], and the evidence shows that these evidence-based interventions only work if you implement all the parts." Similarly, State F stated, "We never could get a clear sense of at what point of changing the

evidence-based intervention it was no longer in line with the science." A representative from State C summed it up: "This work is evidence-based meets reality."

Challenges to adaptation and retaining fidelity had to do not only with limitations of resources and time, but also differences in demographics between the original evidence-based intervention target groups and the Team Up target communities with respect to ethnicity and environment (urban versus rural). This was apparent with the liberty a number of states took with redesigning materials and curricula for different populations and adding cooking classes.

Overall, the most common challenges were difficulty in reaching the target population and the contextual aspects of the implementation process, which were more complicated than expected. This was due to various factors such as the extent of adaptation, involvement of the local community, lack of resources, and staff turnover in multiple areas of the program.

5.6 Availability of Resources

During the first and second rounds of the Six-Month Assessment (June 2006 and December 2006), respondents were asked if they had adequate amounts of the following resources for implementing their evidence-based interventions: Team Up state partner support, adequate direct costs, staff time, volunteers, and office space. During the first round, three of the five participating states were in the implementation phase, and those states not yet in the implementation phase did not respond to this question. By the second round, all states except for State D were in the implementation phase; all responded to this question. Since almost all states were in implementation by the second round, results from that administration are presented.

The majority of respondents in all state partnerships reported that Team Up state partner support was adequate for implementing their interventions, even though some respondents noted difficulty getting all partners to participate in the adaptation and implementation of the evidence-based intervention. States B and F were the only states in which the majority of respondents (75.0 percent, 3 out of 4; and 66.6 percent, 2 out of 3, respectively) indicated that they had adequate direct costs for implementing their intervention. Respondents in these states also thought they had adequate staff time, volunteers, and office space for implementing their interventions. Most of the respondents in the other four states did not feel that they had adequate resources, other than Team Up state partner support.

In the qualitative interviews (February to April, 2008), all partnerships noted, to greater and lesser degrees, that money shortages were a barrier in the Team Up project. One respondent stated, "I felt that resources were not an issue during the implementation phase, but I do feel that if we had more resources available to us from the beginning of the Team Up pilot we would have been able to plan to do more than we did. For example, we could have cast a wider net, meaning that we could have used more agencies and Extension agents in other parts of the state beyond the areas that we worked with." This was not the case for another respondent who stated, "Once we learned that we were doing an evidence-based intervention we realized that we also did not have much money. This was definitely a challenge." Others pointed out that the lack of implementation funds simply forced them to be more resourceful and to make the most out of their partner organizations. "There wasn't any money that came with this, so choosing what to do involved really taking stock of what each partner organization could bring to the table; what our capacities were without having to pay extra," said an individual from State F.

Some of the Team Up state partnerships were successful in obtaining outside funds to implement their intervention. For example, State C obtained funding from a number of outside sources, including the state Women's Cancer Screening Program, the Susan G. Komen Foundation, and a state cancer center.

5.7 Sustainability of an Evidence-Based Intervention

Respondents' views on whether the evidence-based intervention would continue after Team Up ended changed over time. From the beginning, respondents thought that there was a possibility that their evidence-based intervention would be sustainable within their state. During the first round of the Six-Month Assessment (June 2006), two respondents from State F thought sustainability was "very likely," and four (representing States A, B, C, and D) thought it was "somewhat likely."

By the second round (December 2006), respondents in all six states thought it was "very likely" that the chosen intervention(s) would continue after the pilot ended. In two states (A and F), the majority of respondents (80.0 percent, 4 out of 5; and 100.0 percent, 4 out of 4, respectively) thought that their partnership would continue the intervention with other populations; most respondents in the other four states "did not know" or "had not decided" whether they would expand the intervention to include new populations.

By the third round (May 2007), when respondents were asked whether the evidence-based intervention would continue after Team Up ended the answers varied by state.

- **State A.** Two of four respondents thought the intervention would continue.
- **State B.** All four respondents thought that the evidence-based intervention would continue in the current counties and would expand to include additional counties. State B also planned to create a Spanish version of the intervention curriculum, create stronger marketing tools and strategies to attract the target population, open the intervention to populations other than the original target population, and add messages about colorectal cancer.
- **State C.** Three of four respondents thought that the evidence-based intervention would continue in at least some of the existing counties. All four respondents thought the intervention would be used in different counties; and one respondent thought this expansion depended on resource availability. The Appalachian Cancer Community Network obtained funds to hire a lay health advisor to continue the Emergency Room intervention, so it is being sustained in location.
- **State D.** Two of three respondents thought that whether or not the evidence-based intervention continued would depend on whether the intervention was found to be effective. The other respondent did not think the intervention would continue.
- **State E.** One of three respondents thought that the evidence-based intervention would continue, depending on the level of interest of the state partners. The other two respondents thought the intervention would not continue after the Team Up pilot finished. However, State E was working to become part of the State Cancer Alliance as a way to sustain the work they have done as part of the Team Up pilot program.
- **State F.** Three of four respondents thought the evidence-based intervention would continue and would expand beyond the Team Up pilot counties to include other new counties. One respondent noted that an outcome of the project was that USDA Extension Services (in State F) decided to include cancer prevention education as one of the choices county workers could select in developing their annual work plan. Team Up materials and other information would be made available to them for this purpose. As stated earlier, several counties were successful in obtaining funding from The Susan G. Komen Foundation and State F has encouraged other counties to apply for funding as well to sustain their intervention.

5.8 Summary

The Team Up state partners' experience of adopting, adapting, and implementing an evidence-based intervention varied greatly. Once state partners understood what was expected of them, some

respondents thought it was a great process and that their partnership became stronger as a result of the Team Up. One respondent from State C stated, "The Team Up partnership and implementation processes were very valuable and the outcomes rewarding. We have built great relationships as a state team that will make it easier to work on future interventions with greater ease and in a more timely fashion because we have the [implementation] process refined." Another respondent from State B said, "We are very proud to have the partnership that we have formed. We have found in each other wonderful partners and great resource." Another consequence of Team Up was the creation of important relationships between individuals and organizations who had not worked together before, especially USDA CES agents, and who now felt that they could tackle cancer screening and other health disparity problems together. A State F individual noted, "At least from [my organization's] perspective, Team Up has helped us strengthen our relationship with the national partner organizations involved in the partnership. Prior to this, [we] didn't really have a relationship with the Extension Agents in our state, and now we do." Finally, a State E partner emphasized that relationship building was as important to them as the increase in screening uptake: "For me, it's as much about what the partner organizations learned about each other and what it takes to adapt an evidence-based intervention as it is about getting women screened."

Other respondents did not feel the Team Up experience was as positive, or questioned whether they had actually implemented an evidence-based intervention. A respondent from State E wrote, "I do not feel like we were successful in implementing an evidence-based program (FoCaS). We only attempted to use two components of the [FoCaS] program, which was an extreme adaptation from the original [research] initiative. Funding and staff limitations also made our efforts difficult, especially since our chosen intervention lacked substantial funding." Another respondent from State F wrote, "The [Team Up] concept did [not] work since none of them [evidence-based interventions] applied to rural Appalachian women, plus all the interventions listed had research funding [to put them in the field in ideal conditions]. The [Team Up] programs ended when the [Team Up] funding ended. We had to explore strategies that could be implemented without significant funding [that] would [enable them to be] sustain[able] over time."

All state partners were involved in implementing evidence-based interventions, but their experiences varied with regard to their involvement in adopting, adapting, and implementing the evidence-based intervention. Because few guidelines were available at the beginning of Team Up to offer effective strategies to prepare interventions for dissemination and then to conduct the translation process itself, it is not surprising that all state partners struggled with how to close the research-to-practice gap. Since all of the interventions selected had only been implemented in research settings in which

they were initially developed, the process of successfully disseminating them into nonacademic community settings leaves much to be considered. For example, the impact evaluation itself did not inquire sufficiently about the balance of adequate fidelity to the original intervention and did not consider how to accommodate differences in replication across practice organizations in order to maximize the effectiveness of the intervention in the new environment (Kilbourne, Neumann, Pincus, Bauer & Stall, 2007). These and other questions remain unanswered. However, state partners were incredibly creative with their use of limited funds and other resources, and certainly maximized available expertise within their own partnership in an effort to achieve one of the Team Up goals—implementation of evidence-based interventions.

Outcome Evaluation Findings 6

6.1 Introduction

This chapter presents findings from the outcome evaluation. The Team Up national partners intervened with eight states having high incidence of cervical and breast cancers by providing training and technical assistance to help them: (1) form partnerships among key stakeholders and other partners; and (2) implement evidence-based interventions to increase cervical and breast cancer screening rates. The original purpose of the outcome evaluation was to determine whether the state partnerships were able to increase screening rates in the short term (in the year immediately following implementation) among women who have rarely or never been screened for cervical and breast cancer in targeted localities. Two of the eight states dropped out of the study after 2½ to 3 years of participation for reasons discussed earlier. With continued support from the national partners, each of the remaining six states adopted, adapted, and implemented an evidence-based intervention in one or more targeted counties in their state.

A decision was made mid-way through the evaluation by the Team Up evaluation team to modify the primary outcome objective. A more realistic objective was to assess the baseline cervical and breast cancer screening rates within each of the targeted implementation counties, rather than examine short-term screening impacts. The baseline screening rates would provide states with an assessment of county-level trends in Pap test and mammography use prior to the Team Up implementation phase, a valuable insight for the pilot program. The future intention is to examine short-term to mid-term screening rates within the target counties for the six states. The short- to mid-term outcome data, when it eventually becomes available, will be of substantial value in determining the success of the evidence-based intervention implementations in the six states.

A secondary purpose of the outcome evaluation was to determine the feasibility and approach of conducting Team Up to decide whether the program should move beyond a pilot phase. The Team Up national steering committee recognized that while Team Up was an exemplar pilot program, the likelihood that it would have a marginal effect on screening outcomes would be small, especially in the near-term. Team Up, then, also helped to explore the feasibility of conducting this type of outcome evaluation by defining the data needed to measure the outcomes for similar projects, and ascertaining the ease of gathering these data for future service-oriented community programs.

Finally, the experience drawn from this evaluation will yield new insights regarding previously understudied populations by identifying study design challenges and efforts to overcome them.

This chapter presents findings from the baseline analysis of the BRFSS county-level data as well as from the state reports. The BRFSS analysis provided a sense of the screening rates pre-Team Up, while the state reports gave insight into the effectiveness of the evidence-based interventions in increasing screening rates among rarely or never screened women.

6.1.1 Definition of Rarely and Never Screened Women

Since the terms "rarely screened" and "never screened" were identified for cervical and breast cancer for Team Up, the following definitions and associated survey items from BRFSS were used:

Cervical cancer *rarely* screened	No reported history of Pap test in past 3 years (If so, was it in the past 3 years?)
Cervical cancer *never* screened	No reported history of a Pap test prior to baseline (Ever had a Pap smear/test?)
Breast cancer *rarely* screened	No reported history of mammogram in past 2 years (If so, was it in the past 2 years?)
Breast cancer *never* screened	No reported history of a mammogram prior to baseline (Ever had a mammogram?)

The principal source of data used to examine screening rates in the intervention and control counties was the population-based cross-sectional BRFSS data. At the time the evaluation report was being prepared, BRFSS county-level data were available for 2000, 2002, and 2004. County-level data for 2006 will be released later in 2008. Since none of the state partnerships implemented an intervention program prior to 2004, it was unlikely that screening differences would be seen in the baseline analysis. As mentioned above, the Team Up evaluation team intends to repeat the BRFSS analysis at a later time with intervention and control counties; this will help determine if the interventions had any short-term impact on improving cervical and breast screening rates.

6.2 Screening Rates for Team Up and Control Counties

6.2.1 Overview

Tables 6-1 through 6-4 provide the overall screening rates for the intervention and control counties in each state, for 2000, 2002, and 2004, as well as for all years combined and all states combined. The tables present screening rates for any previous Pap test and Pap test in previous 3 years, any previous mammogram, and mammogram in the previous 2 years.

6.2.2 Papanicolaou (Pap) Screening

The screening rates for previous Pap tests were approximately 95 percent over all years and states in both intervention and control counties (Table 6-1), indicating about 5 percent of women were never screened for cervical cancer. Excluding State A, which had low numbers of survey respondents, all counties in all states had screening rates for previous Pap tests of at least 90 percent in all years shown in Table 6-1. In most cases, these screening rates were in the low- to mid-90 percent range. (Analysis of differences due to intervention, year, and states is given in Section 6.3.)

Table 6-1. Screening rates for previous Pap tests in Team Up and control counties

		Intervention counties		Control counties	
State	Year	Survey respondents	Screening rate (%)	Survey respondents	Screening rate (%)
Overall	2000	1,473	95.38	3,072	95.02
	2002	1,723	96.46	3,461	94.34
	2004	1,594	94.98	4,381	95.50
	Total	**4,790**	**95.64**	**1,914**	**95.00**
A	2000	4	100.0	11	100.0
	2002	2	100.0	17	82.35
	2004	7	100.0	21	95.24
	Total	**13**	**100.0**	**49**	**91.84**
B	2000	787	97.08	1,058	96.98
	2002	937	97.44	1,285	96.11
	2004	823	96.72	1,883	96.28
	Total	**2,547**	**97.09**	**4,226**	**96.40**
C	2000	219	91.32	821	91.84
	2002	245	95.10	999	91.99
	2004	237	90.72	945	94.07
	Total	**701**	**92.44**	**2,765**	**92.66**

Table 6-1. Screening rates for previous Pap tests in Team Up and control counties (continued)

State	Year	Intervention counties: Survey respondents	Intervention counties: Screening rate (%)	Control counties: Survey respondents	Control counties: Screening rate (%)
D	2000	304	95.39	739	95.94
	2002	321	95.95	773	95.47
	2004	277	94.95	881	96.37
	Total	**902**	**95.45**	**2,393**	**95.95**
E	2000	41	97.56	37	94.59
	2002	51	98.04	36	100.0
	2004	86	97.67	90	94.44
	Total	**178**	**97.75**	**163**	**95.71**
F	2000	118	90.68	406	94.58
	2002	167	93.41	351	92.02
	2004	164	90.85	561	94.12
	Total	**449**	**91.76**	**1,318**	**93.70**

The screening rates for Pap test in the previous 3 years (rarely screened) were roughly 10 percentage points lower (Table 6-2). Overall, about 12.1 percent of women in the intervention counties and 12.6 percent of women in the control counties (combining all states and all years) were rarely screened. Excluding State A (due to the small numbers of respondents), States B and E have somewhat higher screening rates overall, while States C and D have somewhat lower overall screening rates for Pap test in the previous 3 years. (Detailed analysis of differences due to intervention, year, and states is given in Section 6.3.)

Table 6-2. Screening rates for a Pap test in the past 3 years (rarely screened) in Team Up intervention and control counties

State	Year	Intervention counties: Survey respondents	Intervention counties: Screening rate (%)	Control counties: Survey respondents	Control counties: Screening rate (%)
Overall	2000	1,393	87.58	2,889	87.68
	2002	1,631	89.52	3,212	88.45
	2004	1,487	86.48	4111	86.45
	2004	1,487	86.48	4,111	86.45
	Total	**4,511**	**87.92**	**10,212**	**87.43**
A	2000	4	75.00	11	81.82
	2002	2	100.0	14	78.57
	2004	6	100.0	19	100.0
	Total	**12**	**91.67**	**44**	**88.64**
B	2000	756	89.42	1,011	91.69
	2002	895	92.96	1,217	91.45
	2004	788	90.36	1,783	90.19
	Total	**2,439**	**91.02**	**4,011**	**90.95**

Table 6-2. Screening rates for a Pap test in the past 3 years (rarely screened) in Team Up intervention and control counties (continued)

		Intervention counties		Control counties	
State	Year	Survey respondents	Screening rate (%)	Survey respondents	Screening rate (%)
C	2000	200	84.00	746	84.85
	2002	226	85.84	893	86.45
	2004	203	81.77	864	81.94
	Total	**629**	**83.94**	**2,503**	**84.42**
D	2000	289	85.12	705	85.25
	2002	305	83.61	735	85.03
	2004	260	80.38	840	83.21
	Total	**854**	**83.14**	**2,280**	**84.43**
E	2000	40	95.00	34	94.12
	2002	49	87.76	35	85.71
	2004	84	88.10	85	87.06
	Total	**173**	**89.60**	**154**	**88.31**
F	2000	104	85.58	382	86.65
	2002	154	87.01	318	91.19
	2004	146	81.51	520	85.77
	Total	**404**	**84.65**	**1,220**	**87.46**

6.2.3 Mammography Screening

For previous mammograms, the overall screening rates were approximately 67 percent in intervention counties over all years and 68 percent in control counties over all years (Table 6-3). States E and F had somewhat higher screening rates for any previous mammogram, ranging from 71 to 78 percent (over all years).

Table 6-3. Screening rates for previous mammograms in Team Up intervention and control counties

		Intervention counties		Control counties	
State	Year	Survey respondents	Screening rate (%)	Survey respondents	Screening rate (%)
Overall	2000	1,475	62.98	3,077	64.38
	2002	1,723	66.80	3,463	68.78
	2004	1,600	71.06	4,392	70.81
	Total	**4,798**	**67.05**	**10,932**	**68.36**
A	2000	4	50.00	11	90.91
	2002	2	100.0	17	58.82
	2004	7	42.86	21	71.43
	Total	**13**	**53.85**	**49**	**71.43**

Table 6-3. Screening rates for previous mammograms in Team Up intervention and control counties (continued)

		Intervention counties		Control counties	
State	Year	Survey respondents	Screening rate (%)	Survey respondents	Screening rate (%)
B	2000	788	62.94	1,061	65.32
	2002	940	67.02	1,285	67.24
	2004	826	71.31	1,887	69.48
	Total	**2,554**	**67.15**	**4,233**	**67.75**
C	2000	221	64.71	823	63.91
	2002	244	64.75	1,003	68.79
	2004	239	72.80	948	69.51
	Total	**704**	**67.47**	**2,774**	**67.59**
D	2000	303	58.75	738	63.01
	2002	320	64.38	772	68.91
	2004	277	65.70	884	71.27
	Total	**900**	**62.89**	**2,394**	**67.96**
E	2000	41	73.17	37	78.38
	2002	51	72.55	35	71.43
	2004	86	73.26	92	81.52
	Total	**178**	**73.03**	**164**	**78.66**
F	2000	118	67.80	407	63.39
	2002	166	71.08	351	74.36
	2004	165	76.36	560	75.00
	Total	**449**	**72.16**	**1,318**	**71.24**

Mammogram use in the past 2 years (rarely screened) was somewhat higher; overall, about 82.5 percent of women in all states, over all years, reported having had a mammogram in the previous 2 years (Table 6-4). All states except A and E had similar screening rates.

Table 6-4. Screening rates for a mammogram in the past 2 years (rarely screened) in Team Up intervention and control counties

		Intervention counties		Control counties	
State	Year	Survey respondents	Screening rate (%)	Survey respondents	Screening rate (%)
Overall	2000	915	84.70	1,960	83.42
	2002	1,145	81.75	2,350	83.70
	2004	1,121	81.53	3,070	80.94
	Total	**3,181**	**82.52**	**7,380**	**82.48**
A	2000	2	50.00	10	90.00
	2002	2	100.0	10	100.0
	2004	3	100.0	15	80.00
	Total	**7**	**85.71**	**35**	**88.57**

Table 6-4. Screening rates for a mammogram in the past 2 years (rarely screened) in Team Up intervention and control counties (continued)

		Intervention counties		Control counties	
State	Year	Survey respondents	Screening rate (%)	Survey respondents	Screening rate (%)
B	2000	485	86.60	686	84.69
	2002	629	80.76	853	85.70
	2004	584	82.36	1,296	83.26
	Total	**1,698**	**82.98**	**2,835**	**84.34**
C	2000	142	75.35	518	80.89
	2002	153	81.70	673	81.43
	2004	166	84.94	645	78.29
	Total	**461**	**80.91**	**1,836**	**80.17**
D	2000	177	88.14	462	84.63
	2002	207	82.61	529	83.55
	2004	180	73.89	623	79.29
	Total	**564**	**81.56**	**1,614**	**82.22**
E	2000	30	93.33	29	82.76
	2002	37	83.78	25	88.00
	2004	63	87.30	75	85.33
	Total	**130**	**87.69**	**129**	**85.27**
F	2000	79	79.75	255	82.75
	2002	117	84.62	260	82.31
	2004	125	80.80	416	79.57
	Total	**321**	**81.93**	**931**	**81.20**

6.2.4 Summary

Comparing overall screening rates for control and intervention counties, there was no more than a few percentage points difference in screening rates for Pap test or mammogram use, either for any previous tests or for tests in the past 2 to 3 years (rarely screened). There is slightly more variation among screening rates for cervical cancer using a Pap test in the prior 3 years (rarely screened) as shown in Table 6-2, but no consistent patterns over years or between intervention and control arms was seen. For previous mammograms (Table 6-3), the screening rates increased from 2000 to 2004 by about 8 percent in intervention counties and 6.4 percent in the control counties. Over the same period, mammograms in the past 2 years (rarely screened) increased by about 3 percent in intervention counties versus 2.5 percent in control counties (Table 6-4). This pattern was replicated in the four states with sufficient data to analyze separately (States B, C, D, and F), with parallel increases in both intervention and control arms for previous mammograms (Table 6-3) and with parallel decreases for mammography use in the previous 2 years (Table 6-4). The only exception to this pattern was an increase of almost 10 percent in mammography use in the previous 2 years for the intervention group in State C.

6.3 Logistic Regression Analysis

The purpose of the logistic regression was to provide a more rigorous analysis of the screening rates presented in Section 6.2, evaluating the variation in screening rates by intervention, year, and state. Section 6.3.1 presents analysis of screening for cervical cancer, while Section 6.3.2 gives results for breast cancer screening.

In all the analyses presented here, the unit of response is the individual BRFSS respondent, with the outcome of having been screened or of never having been screened, with the relevant test and over the relevant time period. All logistic regression models contained the same predictor variables: intervention versus control, year of survey, year × treatment intervention, and state. In all models, the control group was used as the reference for treatment effects, the year 2000 was used as the reference for year, and State F was used as the reference for state. In all cases, the choice of reference groups was arbitrary.

Treatment and year of survey were the critical variables for showing effectiveness of the intervention. Ideally, one would expect to see the intervention groups have similar screening rates prior to the actual time of the intervention, with rates increasing over time in the intervention group. Parameters for state differences were included in the models to control for state-to-state variation in screening rates.

6.3.1 Papanicolaou (Pap) Test Screening

The first logistic regression analyses evaluated whether Pap test screening varied by treatment group, time period, or treatment group within time period, controlling for variation between states.

Table 6-5 shows the results for previous Pap test screening. There were significant differences in screening rate variation depending on year, intervention arm (within year), and state. Overall, women were more likely to report having been screened in 2002 than in 2000 ($p = 0.0130$). However, women were significantly more likely to report having been screened in the control counties than in the intervention counties in 2002. In 2004, the control counties reported significantly less screening for previous year, as compared to intervention counties, a result consistent with a "Team-Up" effect ($p = 0.0477$). Finally, there were some significant differences between states, with States A, D, E,

and F reporting similar screening rates, but State B having a higher rate of previous Pap tests and State C having a lower rate.

Table 6-6 shows the model for Pap test in the past 3 years (rarely screened) among women who had had them previously. There were no significant differences by intervention arm or survey year, though there were differences among the states. State B showed a significantly higher rate of screening when compared to State F, while States C and D had significantly lower rates of screening. State A, E, and F had similar screening rates.

Table 6-5. Differences in screening rates for previous Pap tests

Effect	Treatment arm	Year	State	Estimate	Standard error	OR	95% CI			p-value
Intercept				2.9991	0.1780					<0.0001
Treatment arm	Intervention			-0.0254	0.0853	0.97	0.82	–	1.15	0.7658
	Control			(reference)						
Year		2000		(reference)						
		2002		0.5386	0.2167	1.71	1.12	–	2.62	0.0130
		2004		-0.3722	0.2046	0.69	0.46	–	1.03	0.0689
Treatment × year Interaction		2000		(reference)						
		2002		-0.3262	0.1208	0.72	0.57	–	0.91	0.0069
		2004		0.2283	0.1153	1.26	1.00	–	1.58	0.0477
State			F	(reference)						
			A	-0.2641	0.4349	0.77	0.33	–	1.80	0.5436
			B	0.4044	0.1176	1.50	1.19	–	1.89	0.0006
			C	-0.4180	0.1169	0.66	0.52	–	0.83	0.0004
			D	0.1755	0.1258	1.19	0.93	–	1.53	0.1630
			E	0.4460	0.2718	1.56	0.92	–	2.66	0.1008

Table 6-6. Differences in screening rates for a Pap test in the past 3 years (rarely screened)

Effect	Treatment arm	Year	State	Estimate	Standard error	OR	95% CI			p-value
Intercept				1.86	0.1236					<0.0001
Treatment arm	Intervention			0.0688	0.0562	1.0	0.9	–	1.20	0.2202
	Control			(reference)						
Year		2000		(reference)						
		2002		0.2209	0.1387	1.25	0.95	–	1.64	0.1113
		2004		-0.1384	0.1338	0.87	0.67	–	1.13	0.3010
Treatment × year Interaction		2000		(reference)						
		2002		-0.0613	0.0793	0.94	0.81	–	1.10	0.4393
		2004		0.003	0.0755	1.00	0.87	–	1.16	0.9683

Table 6-6. Differences in screening rates for a Pap test in the past 3 years (rarely screened) (continued)

Effect	Treatment arm	Year	State	Estimate	Standard error	OR	95% CI			p-value
State			F	(reference)						
			A	0.1664	0.3620	1.18	0.58	–	2.40	0.6457
			B	0.3544	0.0876	1.43	1.20	–	1.69	<0.0001
			C	-0.2982	0.0898	0.74	0.62	–	0.88	0.0009
			D	-0.3081	0.0895	0.73	0.62	–	0.88	0.0006
			E	0.168	0.1657	1.18	0.85	–	1.64	0.3104

6.3.2 Mammography Screening

The next two logistic regression analyses assessed whether mammography screening varied by intervention group, survey year, or intervention group within survey year, after adjusting for differences between states.

Table 6-7 gives the results for whether respondents previously had mammogram screening. There were no significant coefficients for either intervention or intervention within year, indicating that there was no intervention effect on mammogram screening. There was a slightly higher likelihood of screening in 2004 as compared with 2000. Among states, States A, B, C, and F had similar screening rates; State D had significantly lower screening rates than State F, while State E had higher rates.

Table 6-7. Differences in screening rates for a previous mammogram

Effect	Treatment arm	Year	State	Estimate	Standard error	OR	95% CI			*p*-value
Intercept				0.7229	0.0820					<.0001
Treatment arm	Intervention			0.0506	0.0378	1.05	0.98	–	1.13	0.1799
	Control			(reference)						
Year		2000		(reference)						
		2002		-0.0559	0.0905	0.95	0.79	–	1.13	0.5370
		2004		0.2352	0.0932	1.27	1.05	–	1.52	0.0116
Treatment × year interaction		2000		(reference)						
		2002		0.0474	0.0521	1.05	0.95	–	1.16	0.3623
		2004		-0.0546	0.0527	0.95	0.85	–	1.05	0.2999

Table 6-7. Differences in screening rates for a previous mammogram (continued)

Effect	Treatment arm	Year	State	Estimate	Standard error	OR	95% CI			*p*-value
State			F	(reference)						
			A	-0.1021	0.2282	0.90	0.58	–	1.41	0.6545
			B	-0.0876	0.0560	0.92	0.82	–	1.02	0.1177
			C	-0.0847	0.0598	0.92	0.82	–	1.03	0.1565
			D	-0.1231	0.0599	0.88	0.79	–	0.99	0.0400
			E	0.3008	0.1158	1.35	1.08	–	1.70	0.0094

Among women who had mammograms, Table 6-8 gives the model for whether they had them in the past 2 years (rarely screened). There were no significant differences by intervention arm or survey year. Among the states, the only significant difference was between States C and F: State C had significantly fewer mammogram screenings in the prior 2 years, while all other states had similar screening rates.

Table 6-8. Differences in screening rates for a mammogram in the past 3 years (rarely screened)

Effect	Treatment arm	Year	State	Estimate	Standard error	OR	95% CI			*p*-value
Intercept				1.5961	0.1313					<.0001
Treatment arm	Intervention			0.0444	0.0578	1.05	0.93	–	1.17	0.4422
	Control			(reference)						
Year		2000		(reference)						
		2002		-0.2119	0.1374	0.81	0.62	–	1.06	0.123
		2004		-0.033	0.1366	0.97	0.74	–	1.26	0.8088
Treatment × year interaction		2000		(reference)						
		2002		0.1451	0.0791	1.16	0.99	–	1.35	0.0664
		2004		-0.0504	0.0771	0.95	0.82	–	1.11	0.5129
State			F	(reference)						
			A	0.3441	0.3987	1.41	0.65	–	3.08	0.3881
			B	-0.00012	0.0932	1.00	0.83	–	1.20	0.999
			C	-0.2632	0.0973	0.77	0.64	–	0.93	0.0068
			D	-0.1421	0.0984	0.87	0.72	–	1.05	0.1486
			E	0.2341	0.1727	1.26	0.90	–	1.77	0.1751

6.3.3 Summary

In summary, the analysis of cervical and breast screening rates does not give strong indications of differences between intervention and control counties. In most cases, the screening rates were very

similar. The analysis of previously screened with Pap tests showed a decrease in screening in the control counties as compared with the Team Up counties. However, the significance level was marginal ($p = 0.0477$) and the result was not supported by analysis, such as screening within the past 2 years (rarely screened). Moreover, since no state had substantially implemented an intervention strategy prior to the years for the available BRFSS survey data, one would not expect to find differences in these data. Nonetheless, collecting and analyzing these baseline data will provide a basis for future Team Up program evaluation.

6.4 State Reports

In addition to the national partner outcome evaluation that was conducted, state partners carried out individual evaluations of their evidence-based interventions. All six Team Up state partnerships summarized and reported on their evaluation. Since the states did not conduct parallel evaluations, the data from the state evaluations are not comparable across states. States A and B collected data on the number of women screened as a direct result of their intervention. States C and F both analyzed NBCCEDP county-level data to compare screening rates in Team Up intervention counties to control counties (selected by the state partnerships). State D tracked the number of telephone calls to the 1-800-4-Cancer toll-free number in the intervention counties, and will be assessing the number of women who received screenings as a result of the intervention. State E's report focused on the collaborative process of the partnership and obtained limited information on post-intervention screening behaviors.

6.4.1 State A

State A adapted the FoCaS Program. Their intervention consisted of community-based educational sessions and a media campaign. The educational session focused on prevention and early detection. There were a series of two 1- to 2-hour sessions, in four different target areas for a total of eight sessions. The media awareness campaign consisted of church bulletin inserts and flyers, radio public service announcements (PSAs), and news articles.

The target population was low-income, African American women aged 40 and older who were rarely or never screened. The intervention county was selected because of the high rate of cervical and breast cancer mortality rates as well as the existing presence of partner organizations in the county.

A total of 125 women participated in the educational sessions. Baseline surveys were completed prior to the first educational session in each target area and included questions about cervical and breast cancer screening practices. Table 6-9 shows baseline and post-intervention screening rates.

Table 6-9. State A baseline and post intervention screening behaviors

Baseline	Pap test (n=58)		Mammogram (n=59)	
	n	%	n	%
Number of women ever screened at baseline	56	96.8	46	78.0
Number of women screened within the past 2 years	54	93.1	42	71.2
Post-Intervention[a]	**Pap test (n=4)**		**Mammogram (n=6)**	
	n	%	n	%
Number of women screened following the intervention	1	25.0	1	16.7

[a] Women who did not receive a Pap test within the last 3 years and women over the age of 40 who had never had a mammogram were followed up with post-intervention.

A total of 58 women responded to the questions about a Pap test, with 96.8 percent of the women (56) reporting previously having a Pap test. One woman reported she did not have a test and another was unsure. For the 56 women who previously had a Pap test, 70.7 percent (41 women) had the test within the past year, 22.4 percent (13 women) had the test within the past 2 years, 3.4 percent (two women) had the test within the last 5 years, and 3.4 percent (two women) had the test more than 5 years ago. The women who had never been screened or had been screened 5 or more years ago were followed up with. Of these four women, one could not be reached by telephone, one was unsure if she was screened since participating in the intervention, and the other two reported that they had not been screened. One of these women made an appointment, but did not keep the appointment and the other had not yet made the appointment due to lack of time.

A total of 59 women responded to the question, "Have you ever had a mammogram?" Seventy-eight percent (46 women) responded affirmatively, while 22 percent (13 women) had not had a mammogram. Of the 13, six of those were over the age of 40. Of the 48 women who answered the followup question, "When was your last mammogram?" 78.35 (36 women) had one within the past year, 13.1 percent (6 women) within the past 2 years, 4.3 percent (2 women) within the past 3 years, and 4.3 percent (2 women) 5 years or more. Of the six women who have *never* had a mammogram, one obtained a mammogram following the educational session, two women could not be reached, and three women reported not having a mammogram. The rarely screened women were not followed up with.

State A learned several lessons from conducting this evaluation.

- Literacy was an issue for some women, which had not been anticipated. They emphasized the importance of using strategies to ensure that the information presented was understandable for their population.
- Community liaisons were key to the success of the project. State A noted the importance of training community liaisons in the content area of cancer screening so that they were prepared to work in the community.
- State A did not have a clinic partner for this project. They thought that having a clinic partner would help address the barriers women face in receiving screening as well as serve as a mechanism to better track whether women were screened following the intervention, since self-report was unreliable.

6.4.2 State B

State B adapted components from both FoCaS and the Filipino American Women's Health Project. The resulting intervention, Cooking for a Life Time Cancer School, consisted of 17 two-lesson cancer prevention cooking school programs conducted through the University of Georgia's Family and Consumer Sciences Cooperative Extension. The two-session program sought to encourage healthier behaviors, such as eating healthy, exercising regularly, and encouraging regular cervical and breast cancer screenings, particularly in older African American women. Both sessions also included a food demonstration and tasting.

The target population for this intervention was low-income, African American women rarely or never screened for breast and cervical cancer eligible for the NBCCEDP. Participants who attended the training program and who had no health insurance coverage were eligible to receive a coupon to obtain a free breast and cervical cancer screening from their local health department. The intervention counties were selected because they had high rates of cervical cancer incidence and mortality, and a USDA extension agent who could deliver the intervention.

Before and after each session, participating women were asked to complete evaluation forms. A total of 442 women completed the evaluation questionnaires. Of these, 76 percent were African American, 16 percent were White, 2 percent were Asian/Pacific Islander, 2 percent were Hispanic, and 2 percent were multiracial. Their ages ranged from 9 to 93, with a mean age of 52.

Participants were asked questions about their satisfaction with the education session, as well as a series of true/false questions testing their knowledge. The first session focused on nutrition and cancer. Of the 339 women who completed both the pre- and posttest, the mean knowledge test score significantly increased from 80 percent before the session to 87 percent after the session. The second session focused on health habits to promote prevention and early detection, such as eating less read meat, reducing fat, and getting regular health screenings. For the true/false series of questions for this session, there was a significant increase from 53 percent before the session to 66 percent after. At the end of each session, women were asked about their intention to follow recommended health-related practices. After both sessions, the majority of participants reported either already engaging in the behaviors or planning to do so. Table 6-10 shows the outcome for women who were given NBCCEDP coupons.

Table 6-10. NBCCEDP screenings reported due to cancer cooking schools

	Number of women screened of the women who received coupons (n=66)	% of women[a]
Pap test	19	35.2
Mammogram	26	48.1
Clinical breast exam	26	48.1

[a] Based on denominator of 54, because 12 women who received coupons were found to be ineligible.

NBCCEDP coupons were given to the 66 women who self-reported that they might be eligible for the NBCCEDP program. Of the 66 women, 26 women received mammograms and 19 women received Pap tests. Nineteen women are pending referrals, 2 women have pending appointments, 2 women were already up-to-date with screening, 12 women were found to not be eligible for NBCCEDP, and 8 women could not be contacted.

This data was provided 1 month after the end of the final cooking school, and reporting for the NBCCEDP data is 3 months behind actual screening. Therefore, State B had to rely on NBCCEDP staff to provide the most up-to-date screening information. There was a staff shortage at NBCCEDP, which made it difficult to get data back from NBCCEDP staff. The shortage of staff also resulted in some women having difficulty reaching the NBCCEDP program and having screenings scheduled for several weeks after the intervention had ended.

State B emphasized the importance of outside funding in the success of their program. They noted that they would not have been able to conduct as many cooking schools as they did had they not received implementation funding from their local ACS.

6.4.3 State C

State C adapted FoCaS. State C used both clinic-based strategies (placing cancer screening guideline posters in doctors offices, provider education, and mobile mammography van days) and community-based strategies (developed a curriculum guide for extension agents to present to community groups; hosted a local birthday event as part of the statewide 'birthday card' effort (cards were sent to all women aged 65 to 69 encouraging them to get a mammogram); sent birthday cards to female Medicaid beneficiaries aged 40 to 64 living in Team Up counties, encouraging them to receive a Pap test and mammogram; built and/or strengthened county cancer coalitions; conducted "train the trainer workshops" using educational flipcharts; developed materials, including bookmarks, fliers, brochures, church bulletins, and PSAs; and developed a media toolkit, advertised in local newspapers, secured radio spots, and produced television (TV) commercials.

In addition to the strategies adapted from FoCaS, State C also implemented a novel strategy; in one of their counties they targeted patients leaving a hospital's emergency room. The patients were counseled on age- and gender-appropriate cancer screening guidelines, smoking, and other health concerns and were referred to a lay health navigator if they expressed interested in receiving followup assistance to receive either a Pap test or mammogram.

Their target population was all women aged 21 and over eligible to receive cervical cancer screening and all women aged 40 and over eligible for mammograms, with an emphasis on rarely or never-screened women. State C selected their intervention counties using data for the incidence and mortality rates from the state cancer registry. They intervened in multiple counties and the specific intervention components implemented varied by county.

State C faced a number of barriers in data collection. Baseline screening rates were collected from the state NBCCEDP and the Anthem Health Insurance Plan (using 2003-2004 data). However, the Anthem Health Insurance Plan was dropped as a data source because the number of women enrolled was too low. The data collection methods for NBCCEDP changed during this time as well, so although they obtained screening rates for 2005 and 2006, they were not comparable to the 2003 rates. The Medicare program also provided data on screening rates. In addition, USDA CES agents were asked to fill out and return monthly tracking forms regarding outreach activities to get a sense of the number of women reached by intervention activities. However, the CES agents reported difficulty in accurately tracking their outreach activities and number of women served.

NBCCEDP data shows that in 2005, the percentage of rarely or never screened women receiving a Pap test was 30.2 percent in intervention counties compared to 25.4 percent in control counties. Mammography rates for the Medicare population were compared pre-intervention and during/post-intervention. Six of the nine intervention counties increased mammography rates for the Medicare population from July 2004 through June 2006 compared to the time period of April 2002 through March 2004.

State C worked in a large number of counties and had various intervention activities implemented in each county. Therefore, increases in screening cannot be linked to specific intervention components. For some of the intervention activities they were able to track the number of women served. For example, three counties had mobile mammography days, and more than 60 women were screened as a result. Another success was that State C helped build and/or strengthen county-level cancer community coalitions in six counties.

Partners from State C noted that one difficulty in working with multiple local coalitions was that they did not have the final say on materials that were distributed, and therefore all intervention materials were not "evidence-based." Another factor that impeded implementation was that the CES agents developed their work plan during an annual meeting. Since the emergence of Team Up did not coincide with the meeting, it was hard to get support for the project and many of the USDA CES agents did not use a curriculum that was developed by the State C partnership. However, as discussed previously, State C was successful in obtaining funds to continue their efforts. Similarly, USDA CES agents were also able to apply for $5,000 grants to sustain Team Up screening efforts.

6.4.4 State D

State D adapted Breast Cancer Screening for Non-Adherent Women. The program provided tailored mailings and tailored telephone counseling calls using information from NCI's Consumer Health Profiles (CHPs) and Medstat, respectively. CHPs provided information on cancer statistics as well as social marketing data to help tailor the mailing, while Medstat provided a telephone list of randomly selected women identified as high risk for cervical and breast cancer.

The target population was women aged 40 to 64 years who were rarely or never screened for cervical cancer with an emphasis on minority women. They chose their counties because of the high cervical and breast cancer mortality rates and the availability of treatment options in those counties.

State D tracked the number of women per county who were mailed tailored print communications and the number of women per county who participated in tailored telephone counseling sessions. State D tracked the number of women per county who contacted NCI's 1-800-4-CANCER number to be transferred to NBCCEDP, and who requested a referral for cervical or breast cancer screening from the telephone counselor. For the tailored counseling group, State D also assessed the number of women who intended to obtain cervical and breast cancer screenings in the next 3 months as a result of the intervention. The final outcome measure will be the number of women who obtain cervical and breast cancer screenings through NBCCEDP in the intervention counties as compared to control counties. The number of women who had a definite screening date for a mammogram was 175 out of 1,771 women or about 10 percent of women.

As shown in Table 6-11, State D sent 1,000 target mailings and conducted 60 tailored telephone counseling calls (participants were randomly selected from Medstat labels). Table 6-12 describes the telephone calls received by the NCI 1-800-4-Cancer (CIS) and shows the type of information provided to the caller. Note that 18 callers identified the USDA CES agents as the source for finding out about the NCI 1-800-4-Cancer (CIS). These individuals were seeking health information about screening for cervical and breast cancer. This information suggests a favorable relationship between CDC, NCI, and USDA partners.

Table 6-11. Number of intervention telephone counseling contacts

Counties	April–May 2007	November 2007	Total
Telephone Counseling[a]			
Intervention Counties	60	0	60
Targeted Mailings			
Intervention Counties	1,000	2,711	3,711
Total			3,711

[a] Additional data available regarding call attempts.

Table 6-12. Number of calls NCI 1-800-4-Cancer (CIS) from State D (USDA CES) with CDC (NBCCEDP) as one type of information provided to the caller

	April–May 2007	June–July 2007	November 2007	January–December 2007
State D	57	41	30	338
Organization/Community Group	4	8	4	44
Extension	2	4	0	18
Direct Mail	2	0	0	2

Implementation of the intervention began April 2007. From April 2007 through July 2007, 16 individuals from counties who received targeted mailings and 10 individuals from counties who received tailored telephone contacts called the 1-800-4-CANCER regarding cervical and/or breast cancer screening. None of these individuals identified an "organization or community group" or "Extension" as how they found out about the service. The number of women who had a definite screening date for a mammogram was 175 out of 1,771 women or about 10 percent of women. On the other hand, the number of women who received a Pap test will be available in late 2008.

6.4.5 State E

State E adapted FoCaS. The participating counties were chosen because they had high cervical and breast cancer incidence and mortality rates, and available resources. State E's intervention consisted of a five-session cervical and breast cancer program designed to increase screening in five churches. Session topics included cancer education, screening, nutrition, family health histories, resiliencies, and nutrition.

The target population was rarely or never screened women aged 40 and over in their intervention counties. The intervention county was chosen because of high cervical and breast cancer mortality rates.

Three of the five churches completed all five sessions of the intervention, two within 3 months (which was the timeframe recommended by the State E partnership). Across all churches, 75 individuals attended at least one session. Of these, all were African American.

Pre- and posttests were given, but since only four individuals (who completed the pretest) properly completed the posttest, no pre-/postanalyses were conducted. At baseline, 85 percent of participants

reported having a Pap smear within the past 5 years and 84 percent reporting having a mammogram within the past 2 years.

Only three participants attended all five sessions. Participants who attended at least two of the Team Up sessions (23 of 75 individuals) were asked to participate in a followup call on screening behavior. Twelve of the 23 individuals participated in the followup call. All 12 women reported having a Pap test and a mammogram within the last 5 years. Nine of the 12 women had a Pap test in the last 2 years, and 7 of the 12 women had a mammogram in the last 2 years. Ninety-two percent of the women and 83 percent of the women planned on getting Pap tests and mammograms, respectively, within the next year. Many indicated that getting screened was a regular part of their health care routine.

State E felt as though they were "preaching to the choir," since participants had high levels of knowledge, expressed disagreement with cancer myths, and were already practicing the desired screening behaviors.

The majority of State E's evaluation focused on the partnership. Major themes that resulted were that members felt that Team Up was a team without team involvement, that the biggest benefit of Team Up was involving USDA as a partner, and that community buy-in at all levels was a barrier.

6.4.6 State F

State F's Team Up adapted FoCaS. Their intervention consisted of both community- and clinic-based strategies. All intervention counties implemented the following activities: distribution of educational materials, mass media activities, and educational presentations, training of health professionals, education (visual prompts in examination rooms, exhibits, and information in the waiting rooms), abnormal test protocols, and counseling/letters for abnormal test result followup. Some counties also chose to implement additional strategies, including free screening days.

The target population was rural Appalachian women aged 50 to 64 rarely or never screened for breast and cervical cancer who were eligible for the NBCCEDP. The intervention counties were selected because they had high cervical and breast cancer mortality rates and USDA CES agents who were interested in implementing such an intervention.

Baseline breast and cervical cancer screening data was obtained using 2003 data from the state NBCCEDP program for both intervention and (state-selected) control counties. All intervention counties experienced an increase in screenings through the NBCCEDP.

In addition, evaluation questionnaires completed after the educational programs assessed knowledge, attitudes, and intended behavior change of participants. Eighty-three percent of women (out of 219) planned to get a Pap test, and 96 percent (out of 247) planned to schedule a yearly mammogram.

6.5 Summary

The results from this outcome evaluation suggest that the objective of identifying whether Team Up state teams increased screening rates in the short term proved to be more challenging than anticipated. Although analyses from the cross-sectional BRFSS data did not show significant differences between intervention and control counties overall, there were differences by survey year that showed minimal breast and cervical screening increases. More than likely, these increases were due to ongoing national and local efforts to improve screening among underserved women. Given that states did not begin to field their interventions until 2004, and others continued to field interventions throughout 2007, baseline screening rates for cervical and breast cancer were collected rather than make short- to mid-term outcome judgments of changes in screening.

Having states appraise their own interventions provided additional insight into understanding the active process of and numerous factors involved in the uptake of screening from their perspective. One key point was that few states reported on the actual number of women screened by their program; they provided extremely valuable information about the methods and context of their interventions, and whether they perceived success at having undergone the implementation process. There is much to be learned from the state partner's experience, especially when it is difficult to demonstrate a desired outcome with available data sources.

Discussion 7

7.1 Introduction

The overall purpose of the Team Up evaluation was to examine the use of evidence-based cancer screening interventions at the community level by employing the Team Up partnership approach. The three-tiered evaluation sought to answer six research questions to assess the extent to which Team Up was able to achieve its goals. The chapter presents a discussion of those questions.

7.2 Building and Sustaining State Partnerships

7.2.1 Question 1: How successful have the state partnerships been in building and sustaining partnerships?

The states had varying levels of success in building and sustaining their state partnerships throughout the pilot program. Six of the eight state teams were able to sustain their partnerships for the duration of the pilot program (from July 2003 through December 2007). The other two (Illinois and Mississippi) terminated their involvement in Team Up by 2006. Illinois was able to initially build their partnership, but could not sustain it, while Mississippi had difficulty building their partnership. Overall, the partnerships that were most successful had the full participation of all (or most) members, obtained external resources, and were committed to achieving the objective of Team Up, implementing an evidence-based intervention. The partnerships that were not as successful were less likely to have the full commitment of all partners. Since each partner brought a unique perspective, expertise, and resources to the partnership, those that did not have involvement from all partners had a harder time achieving the goals of Team Up.

The success of the six state teams in building and sustaining their partnerships was measured by the state's synergy level, as rated by the Lasker and Weiss PSAT. A partnership's level of synergy is "the extent to which the perspectives, resources, and skills of its participating individuals and organizations contribute to and strengthen the work of the group," resulting in a whole that is greater than the sum of its parts. Partnerships with higher levels of synergy are more likely to be effective in accomplishing their goals. Unfortunately, no state partnership made it to the desired

target zone. By the 2007 administration of the Lasker and Weiss PSAT, however, the synergy scores for four state teams were in the headway zone; one state was in the work zone, and one state in the danger zone.

All states faced some initial difficulty in building a partnership. One reason often cited was partly because the comprehensive purpose of Team Up was not clear when the pilot was launched in 2003. Even State B (the state with the highest synergy score) did not clearly understand the entire purpose of Team Up. It was not until after the 2005 Regional Meetings (2 years later) that the state partnerships clearly understood that in addition to partnership building another important purpose of Team Up was to use the partnerships to implement an evidence-based intervention. Once states grasped this second purpose, they began to move forward. Some members of each partnership were resistant to implementing evidence-based interventions (a core element of Team Up), either because they did not think that using an evidence-based intervention was the best method for reaching rarely or never screened women in their state, or because they saw implementing an evidence-based intervention as a time- and resource-intensive undertaking. However, by the end of the pilot, all six partnerships had achieved the goal of implementing an evidence-based intervention.

Two overarching issues across all partnerships were that they had neither the financial resources nor adequate personnel time necessary to dedicate to Team Up. The state partners had to balance their Team Up responsibilities with their funded job responsibilities, and the funded responsibilities took precedence. Lack of time and lack of resources went hand in hand. State partners felt that if they were given implementation funds they would have been in a better position to defend the time they spent on Team Up activities. However, it was true that some states were more effective in addressing these issues than others.

The partnerships with higher levels of synergy had different strategies for helping achieving partnership goals. States B and C both obtained external funds for implementation. State B in particular noted that they would have been less successful in implementing their evidence-based intervention had they not received these funds. State F hired a full-time project coordinator dedicated to Team Up. Participants perceived this position as vital to the organizational success of the partnership, especially since their intervention spanned numerous counties. This position served as the partnership infrastructure.

Partnerships with lower levels of synergy were more likely to have problems obtaining the full participation of all members. State E's chair resigned in 2006, and, after that, the partnership was unsuccessful in identifying a new leader. Instead of continuing the partnership post-Team Up, they

decided to join another statewide initiative with similar goals to Team Up. State A had ongoing problems with staff turnover. The state NBCCEDP director for State A changed five times during the duration of Team Up. This made it difficult for this particular partnership to move forward because they were continually orienting key new members to the Team Up pilot.

Partnership building is complicated and time-intensive. Given that most state partnerships did not effectively get underway until 2005, it is an accomplishment in itself that the majority of the partnerships (six out of eight) were able to sustain their work for the duration of the pilot and implement an evidence-based intervention. Most partners were dedicated to Team Up and worked hard to realize their goals.

Five of the original eight state partnerships planned to continue Team Up activities in some capacity after the Team Up pilot ended. Two of the three Team Up partnerships decided not to proceed with Team Up activities, as noted elsewhere. They terminated their involvement as a Team Up partnership prior to implementing an intervention. The other state partnership completed a pilot intervention, but decided to forego the Team Up effort in favor of combining their efforts with another entity. In this new capacity, the partnership that reconvened will continue their prevention efforts.

7.2.2 Question 2: How has the national partnership been helpful to the states in building and sustaining their partnerships among the four core organizations (ACS, CDC, NCI, and USDA)?

The national partners implemented a series of activities aimed at building and sustaining viable partnerships among the collaborators in each of the Team Up states. Among the activities were team building exercises through PATH visits, regional meetings and ongoing technical assistance from coaches.

The national partners were the impetus for developing the partnerships among these six states. The July 2003 kickoff meeting, sponsored by the national partners, provided an opportunity for participating states: (1) to develop, create, or strengthen a partnership at the state and local level; and (2) to understand how to access and adapt evidence-based screening interventions for use in high mortality regions. However, as discussed above, many of the state partnerships were not clear on how to proceed with the two objectives following the July 2003 meeting, even though they created state agendas (plans of action), which were intended to guide them through the startup.

Following the July 2003 meeting, national partner-sponsored activities did not resume until October 2004, more than a year after the kickoff meeting. State partners were contacted 3- and 6-months post the July 2003 training to track their progress, and states had different levels of success moving their state level efforts along during this period. However, it was clear that not all states were moving at the same pace, nor did they have clear expectations of the purpose of Team Up.

The addition of the coaches in October 2004 provided an opportunity for states to reexamine their progress and develop a revised plan of action to move forward. State partners found the coaches to be helpful in numerous partnership-building activities, such as identifying methods for retaining partners, building strong working relationships, managing and staffing the partnership, and securing resources for the partnerships.

Most state partnerships really starting making progress after the national partner-sponsored PATH visits and regional meetings in 2005. These face-to-face meetings were a source of tailored exercises, educational sessions, and lectures that helped state partnerships with capacity building as well as reaching their goal of adopting, adapting, and implementing evidence-based interventions.

As the pilot came to an end, the national partners tried to obtain resources (from the Susan G. Komen foundation) to help with the sustainability of the state partnerships; however, they were not successful in obtaining these funds. While they worked with state partnerships to try to determine ways to sustain the partnerships, the national partners were not able to provide financial support, which states believed was the key determinant of whether they would be able to continue their efforts or not.

In summary, the national partners were the guiding force in developing the state partnerships. Unfortunately, the momentum from the July 2003 meeting was muted by the lack of a clear singular Team Up objective. By late 2004, it became clear that the state partnerships needed assistance from the national partners to move their efforts forward. The national partners listened to the states' request for more focused support and introduced the coaches at this time as a technical assistance resource. The 2005 regional meetings acted as a second beginning for Team Up. States had an apparent understanding of the Team Up expectations, and national partners provided continuous technical assistance for team building for the remainder of the pilot. The national partners encouraged the sustainability of the state partnerships post-pilot; however, they did not have the means to support financially support sustainability.

7.3 Adoption, Adaptation, and Implementation of an Evidence-Based Intervention

7.3.1 Question 3: To what extent has an evidence-based intervention been adopted, adapted, and implemented by state and local partners in the target counties?

Initially, five partnerships began implementing 'evidence-influenced' interventions before fully understanding that they were being encouraged to choose an evidence-based intervention. This initial trajectory was based partly on not understanding the expectation of implementing an evidence-based intervention, and partly on a familiarity with community needs. As field workers, many members of the state partnerships felt that they knew what worked best in their communities (even if it was not an evidence-based intervention), and wanted to continue using the intervention activities that had worked in the past rather than change. After learning about the requirement to use an evidence-based intervention, one respondent from State F said, "We did our best to retrofit our work, and to allow each county to continue their work and to have input about what they felt were appropriate strategies specific to their counties."

Part of the state partnerships' initial resistance and uncertainty was the perception that the national partners wanted the interventions chosen from the Cancer Control P.L.A.N.E.T. web portal (http://www.cancercontrolplanet.com/). Several respondents did not believe there was an intervention on Cancer Control P.L.A.N.E.T. that fit their community's needs, either because the target population in a particular state was different from those of the interventions identified on Cancer Control P.L.A.N.E.T., or because states did not have access to the implementation funding, and administrative and personnel resources necessary to carry out an evidence-based intervention. All state partnerships ended up selecting evidence-based interventions from the Cancer Control P.L.A.N.E.T. web portal even though other venues to identify an evidence-based intervention were provided. Five partnerships chose the FoCaS Program, one chose the Breast Cancer Screening Among Non-Adherent Women, and one chose the Filipino Women's Health Project (to be used in conjunction with FoCaS).

Each state partnership adapted their chosen intervention despite limited fiscal and personnel resources, and despite the uncertainties in the growing field of research dissemination. One issue of concern was fidelity to the original intervention. State D was the only state that adapted and

implemented all components of its intervention (Breast Cancer Screening Among Non-Adherent Women). FoCaS contained many different components and no one state partnership attempted to adapt or implement all components of this intervention. State F adapted the most components, implementing all but two components of FoCaS, while States B and E implemented the fewest components. Both states only selected educational classes and the inclusion of faith.

Currently, there is no universal recommended process or set of agreed-on best practices for adapting evidence-based interventions to conditions different from those present in the original research (McKleroy et al., 2006). While adaptation is necessary to make the intervention more relevant for a new target population, the more intervention components are altered the less fidelity to the original intervention exists. On the other hand, it can also be a facilitator for those who are adopting the evidence-based intervention to gain ownership of the new intervention. The more involved partners are in the adaptation process, the more likely the intervention will be institutionalized and subsequently sustained within the community.

The adaptation of some, but not all, intervention components brought up the question raised by the state partners: "How much can an evidence-based intervention change before it becomes a completely different intervention?" Each of the states dealt with adaptation distinctly. State D specifically did not choose FoCaS because they did not have the resources to implement all the components, and they felt they had to implement an entire intervention; consequently this team's chosen intervention was adapted and implemented in its entirety. In contrast, respondents from other partnerships who selected FoCaS expressed concerns about the extent of their adaptation process. Since five states adapted a few FoCaS components, expanded the intervention, or added new materials or activities entirely, fidelity was certainly an issue they considered. To fit its needs, the sixth state, State B, selected and integrated intervention strategies from two distinct evidence-based interventions and created its own hybrid intervention. Consequently, some components of the hybrid intervention bore no resemblance to the original intervention. While the State B strategy cannot be described as a replication of a single, or even two, evidence-based interventions, this adaptation strategy raised another set of valid questions about implementation methods that need further clarification.

Five of the six partnerships planned to continue their intervention in some capacity. Most partnerships felt that the future of their interventions depended on the available resources and partner interest. Some Team Up partnerships expanded their interventions to include different target populations and cancer sites. Team Up also resulted in changes at the state organizational level. For example, in State F the USDA CES decided to include cancer prevention education as one of the

choices county extension workers are able to select in developing an annual work plan. The Team Up materials developed by both national and state partners as well as other information will be made available to county workers who choose to focus on partnerships, evidence-based strategies, and increase cervical and breast cancer screening.

7.3.2 Question 4: What factors (e.g., characteristics of the selected innovation) influenced the adoption, adaptation, and implementation of an evidence-based intervention by individual partnerships?

Most of the partnerships (five out of six) did not begin to identify and select evidence-based interventions until after the 2005 regional meeting, almost 2 years after the Team Up pilot began (State C was the only partnership to select an evidence-based intervention prior to the 2005 regional meetings, in 2004). This delay in adoption was primarily due to a lack of understanding by state partners that a core goal of Team Up was to implement evidence-based interventions. Once the pilot objectives were clarified, all partnerships selected evidence-based interventions from the Cancer Control P.L.A.N.E.T. web portal.

Each state partnership went through a comprehensive process of reviewing all of the possible evidence-based interventions prior to reaching a decision to select the most appropriate and feasible one (or two, in the case of State B) for that state. The top considerations for selecting an evidence-based intervention included: the demonstrated effectiveness of the intervention; how easily the intervention could be adapted; how well the intervention addressed local population needs and fit the target population; and how affordable the intervention was.

Once the evidence-based intervention was adopted, states needed to adapt the intervention to fit their target population. The main types of adaptation strategies considered were: scaling down the original interventions components, alternative activities and delivery modalities due to limited resources; altering materials to better fit the target population; updating materials to include the most recent screening recommendations; and including local contact information on printed materials. Many partners confirmed that the adaptation process took longer than expected. For example, one respondent from State D said, "We gained a more realistic understanding of the amount of time it takes to adapt a research-tested intervention [which also includes completing] the Institutional Review Board (IRB) process." In addition to modifying the original intervention components and

materials, which were not available on the Cancer Control P.L.A.N.E.T. web portal, items like class curriculums had to be developed de novo, because key intervention characteristics were not retained.

Since the adaptation process was more involved and more extensive than anticipated, the majority of states did not implement an intervention until the latter half of 2006 or later. States that implemented their evidence-based intervention prior to 2006 were State C (2004) and State F (2005). Although State C began implementing its evidence-based intervention in 2004, the partnership continued to add new components over time so the intervention became increasingly more comprehensive and robust. State D, the last partnership to implement its intervention (May 2007), was delayed because of the unexpected amount of time involved in obtaining an IRB approval from the state's affiliated university.

7.3.3 Question 5: How and to what extent has the Team Up national partnership assisted in the process of adopting, adapting, and implementing an evidence-based intervention?

The national partners strived to develop opportunities that would make it easier for states to identify different types of evidence. State partners were instructed in how to find state epidemiological cancer data, to identify evidence-based intervention sources, and access evidence-based interventions, and then encouraged to adopt such interventions. Beginning with the initial training (July 2003), state partners were instructed on how to access an evidence-based intervention during a demonstration of the Cancer Control P.L.A.N.E.T. web portal. They were also familiarized with the CDC's *Guide to Community Service*. Subsequent regular communication and specific opportunities to learn about implementation and practical evaluation strategies led to a series of Webinars. The Webinar on the FoCaS intervention influenced states to adopt this intervention.

In addition to Webinars, the national partners were receptive to the request for technical assistance through: (1) the use of the coaches, who worked directly with the Team Up state partnerships to provide ongoing guidance and assistance as needed throughout the implementation process; and (2) the use of teleconference and in-person meetings, retreats, and trainings, all of which included an emphasis on partnership capacity building in the area of adapting and implementing evidence-based interventions.

Overall, the national partners were resourceful in linking the state partners to sources that housed evidence-based interventions. However, even though available and offered, states reiterated that they

would have preferred to have sources besides the Cancer Control P.L.A.N.E.T. web portal to select from. Also, states had numerous questions about the process of adapting evidence-based interventions that remain unanswered. Participants would have liked the national partners to provide more guidance on how to appropriately adapt an evidence-based intervention. Toward the end of the pilot, most of the questions from states were concerned with the fidelity of the intervention and whether their intervention could be classified as evidence-based despite the major modifications being made. This was interesting because it revealed that an education effect took place through the pilot's technical assistance efforts. States had no concerns with fidelity at the outset of the pilot. Finally, as mentioned repeatedly was a needed fiscal contribution from the national partners for implementation support.

7.3.4 Question 6: To what extent did the state partnerships increase screening rates in the targeted areas among women who have rarely or never been screened for cervical or breast cancer?

In the absence of post-intervention data this question cannot be answered at this time. Future work will focus on the short- to mid-term outcomes that address the influence of state interventions on the cervical and breast cancer screening rates. Partnerships offered considerable promise as an approach to problem-solve and to address complex and dynamic problems such as reaching rarely or never screened women.

Team Up Evaluation Key Findings and Recommendations 8

State teams were selected for Team Up primarily due to increasing attention being given to counties with high mortality and low screening rates for breast and cervical cancer (National Center for Health Statistics, 2002). Direct funds were not made available to initiate or support the state teams, so the individual state programs were built entirely from organizational commitments made by the four public and private health entities—ACS, NCI, CDC, and USDA—typically tasked with the design and implementation of screening programs. The primary objectives of the state teams were to build a sustainable partnership (the process evaluation), then select and implement an evidence-based screening program in one or more community settings with low cervical and breast cancer screening rates (the impact evaluation) with the goal of increasing the screening rates of rarely or never screened women (the outcome evaluation). The long-term outcome expected of Team Up was to reduce cancer mortality. However, that objective was out of the scope of the evaluation and is not addressed at this time.

This chapter presents conclusions associated with each primary objective of Team Up and a set of recommendations based on the conclusions.

8.1 Build Viable State Partnerships

The state team partnerships occupied a central position in Team Up, and their success was conceptualized from both a process perspective and an outcome perspective. First, from the point of view of process, the state teams were assessed by their success in working together to form a sustainable partnership, including how well the partners worked together to address the joint objective of improving screening rates and the sustainability of their partnership efforts as a result of the Team Up collaboration. The context in which Team Up states operated provides important information about the program. From the outcome point of view, the focus was on increasing cervical and breast cancer screening rates for rarely or never screened women. The key conclusions that can be drawn from the Team Up evaluation include the following:

Key Findings

- Several state teams were able to create viable state partnerships with some combination of 'top-down' and 'bottom-up' approach. Six of the original eight Team Up state partnerships created partnerships incorporating ACS, NCI, CDC, and USDA. All of these six partnerships implemented evidence-based interventions designed to increase cervical and breast cancer screening rates among rarely or never screened women in their targeted counties.

- Without seed money, a cohesive partnership may take longer to develop and grow, and may also dissolve more readily than those having money to support participation. One of the most persistent concerns raised by members of the state partnerships was lack of funds to help move the implementation of evidence-based objectives of Team Up along. Members were constrained by their 'real job' commitments and limited resources. Many partners noted that having a staff person dedicated to Team Up (even if part time) would have helped sustain the infrastructure of the partnership. Only one state had a staff person dedicated to Team Up. Interestingly, this team was one of the first states to implement an evidence-based intervention. Unfortunately, in June 2007 the funding for this individual ended, leaving the partnership without its lead. Even though finances were a limitation for some partners, it was clear that the levels of engagement and commitment of partners overall in most states suggested harmonious and healthy partnerships. In general, part of Team Up's success in achieving synergy can be reflected in the strong leadership and management structures in place that enhanced collaboration at the local level.

- Synergy among the federal and national agencies, a key measure of partnership success, did not grow evenly or steadily over the life of the pilot. Instead, synergy appeared to oscillate, moving up and down in small increments over time. Only in those states where major events occurred did the synergy of team partnership seem to vacillate greatly up or down. For example, in one state where the project leadership changed, the partnership synergy seriously dissipated for a period of time.

- Without a strong commitment by the participating federal agencies and national organizations in the state, it is not clear how the Team Up state partnerships will maintain—or improve—their level of synergy and remain a viable entity over time. In general, some state partner agencies did not view the Team Up effort as a central concern or interest. Team Up did not serve as a rallying point for coordinated screening efforts within or across some state-level organizations. Initially, implementing evidence-based programs was seen as a burden by some partners since there was no funding to go with the pilot. Following implementation, most partners felt as though Team Up was a worthwhile project, yet at the organizational level, Team Up was still not a central project since there were other funded projects that had priority.

- The involvement of the USDA CES in Team Up was one of its more creative and novel characteristics, and the partnerships uniformly felt that the involvement of this organization was critical to their accomplishments; at the same time, involving a new partner, with which most of the other partners were not familiar, created a learning

curve about what the USDA CES was, how it was structured (which is different state by state), and what its role in the project should be.

These process measures related to how well the state teams formed functioning partnerships during the Team Up pilot, rather than understanding their longer-term societal products. The theoretically driven assessment of partnerships sought to understand the contexts that led to the positive short-term outcomes, notwithstanding the sometimes conflicting results, as state teams worked across different community sectors to promote local health status change among women. Team Up, as a novel pilot project, succeeded in many respects. Public health partnerships were created that fostered lasting organizational and personal relationships, which have strengthened the cancer prevention and control infrastructure in the participating states; and cancer outreach and education programs have been institutionalized as part of ongoing programmatic USDA CES activities in some states, and in others as part of state-wide initiatives. And, true to the purpose of a pilot project, this effort yielded many informative lessons learned that can be applied to future initiatives.

8.2 Selection, Adoption, Adaptation, and Implementation of an Evidence-Based Screening Intervention

The impact evaluation described the short-term and intermediate success of the partnerships to select, adapt, and implement evidence-based interventions. There is a well-acknowledged gap in the understanding of the process of implementing evidence-based interventions in multilayered community contexts. Understanding the diffusion process, including the contextual factors associated with particular communities, adoption, and implementation of interventions, is essential to explaining the research to practice gap. Once adopted, there is immense variation in how an intervention is then dismantled, reassembled, and packaged for a particular community. To help guide future similar research, the Team Up evaluation also monitored the process of adoption, adaptation, and implementation in each state.

Key Findings

- The importance and value of using (selecting, adopting, adapting, and implementing) evidence-based screening programs were not inherently obvious or acceptable to all state partnerships. Some members of state partnerships felt as though there were screening programs that were not evidence-based more suitable for their communities than the evidence-based interventions from the Cancer Control P.L.A.N.E.T. web portal. Rather than starting fresh when selecting an evidence-based intervention, some

states initially tried to retrofit the work they were already doing to fit one of the evidence-based interventions. Reports from partner members indicated that many were unhappy about having to select from a limited set of intervention programs.

- While all state partnerships selected an evidence-based screening program (from the Cancer Control P.L.A.N.E.T. web portal), it was clearly open to interpretation whether or not these programs were implemented as intended (i.e., with fidelity to the original model). The majority of state partnerships selected FoCaS as their evidence-based intervention. FoCaS was a fully funded project that included 11 different community- and clinic-based intervention components. All Team Up state partnerships that chose FoCaS selected to implement the educational classes and the included church/religion strategies. However, implementation of the other nine components varied by state. No state implemented all components. For the components that were selected, states reported having difficulty finding materials and curriculums from the original intervention, and they needed to develop new materials. Many state partners questioned whether they had implemented an evidence-based intervention, since it varied so much from the original. One state selected to adapt components from two different evidence-based interventions; this intervention was not a replication of a single intervention. These concerns raise the issue about how much of an evidence-based program needs to be implemented before one can call the implementation "evidence-based"?

- Partnerships described an organic process of adaptation, that is, they needed to adapt the evidence-based intervention at the state level during their planning phase and then allow for further local adaptation at the county level when the intervention was implemented. It was clear that adaptation determinants were complex, varied between states, and were subject to individual and collective choices, the result of discrete decisions taken over several weeks and months.

- There appeared to be something in the translation and connection between how a partnership perceived what will work in their local communities and the potential evidence-based practice alternatives that were not disseminated or realized in practice. Partners indicated several times and in different ways that aspects of the evidence-based program "would not work," "could not be adapted," or that "other programs" (not necessarily evidence-based) were more appropriate to their community settings. Not all Team Up partners were convinced that evidence-based practices were the best strategies for new screening efforts in their local communities. Perhaps the expectation that an evidence-proven intervention could be replicated and scaled up for much wider use without losing fidelity to the original intervention required more skill than Team Up technical advisors provided.

- Implementation was relatively slow in all, but one state raised questions about the difficulty of implementing a research-tested intervention and the ability to implement new programs as a partnership. It is not clear which created the larger problem. However, time constraints and staff turnover were two issues that slowed down the process of adoption, adaptation, and implementation.

- Contextual challenges to implementation were minimized when community members and USDA CES agents were involved from the beginning in all facets of the project.

Those partnerships that extended beyond the immediate four partners and included local community residents before implementation recognized that involvement in decisionmaking was critical to their team's success, because it facilitated more precise intervention tailoring and provided additional insights into reaching the target population of rarely and never screened women.

- A prominent theme that surfaced was that partnerships viewed what Team Up was trying to accomplish with implementation very positively. Implementation itself led to the development of new and valuable organizational and personal relationships, the impact the partnerships made on heightening local awareness and increasing breast and cervical cancer screening rates among rarely or never screened women, and the institutionalization of partnership efforts within a partnering organization or as part of other established cancer control mechanisms or initiatives in specific states.

While Team Up as a whole learned to close a narrow portion of the gap between research and practice, much work remains to be done to understand this complex area as it applies to real world practice. Unfortunately, there were too many things going on around the adoption and adaptation process to understand the exact reasons for slow implementation, although speculation about some of the determinants has been made. However, it is clear that a major issue concerns understanding of what constitutes fidelity to an evidence-based practice. Nevertheless, Team Up represents an important milestone within the broad arena of applying evidence-based public health approaches within communities. As such, these efforts will contribute to the advancement of this scientific area.

8.3 Increase of Screening Among Rarely or Never Screened Women

The outcome evaluation assessed two short-term changes. First, the evaluation documented baseline cervical and breast cancer screening rates in targeted counties within each of the Team Up states with the goal of assessing change following implementation of the intervention. Second, the evaluation was designed to assess whether or not the Team Up partnerships approach should move beyond a pilot phase. Because this was a brief pilot program, it was not realistic to expect that the outcome evaluation measures changes in cervical and breast cancer screening rates, which would require examining screening rates 1 to 2 years post-intervention.

Key Findings

- States had difficultly obtaining data to determine the number of rarely or never screened women who received screening as a result of their Team Up intervention. The main screening provider for the Team Up interventions was the NBCCEDP. State partners reported problems in obtaining screening data from the NBCCEDP staff, due to staff shortages in the program. Even when states were able to obtain data from the NBCCEDP, they were often not able to link increased screening rates directly to Team Up interventions, since Team Up was not an option when women were asked how they were referred to NBCCEDP. Some state partnerships directly followed up with women who attended intervention activities and had varying levels of success in making contact.

- Reaching rarely or never screened women proved to be problematic for several state partnerships. Many of the women who attended intervention activities were not rarely or never screened women. For example, one Team Up partnership followed up with women who attended at least two of five educational sessions. All of those women (n=12) had received a Pap test within the last 5 years. Nine of the 12 women had a Pap test in the last 2 years and 7 of the 12 women had mammograms within the last 2 years.

- Even without screening data, partnerships reported that they were having an impact on cancer screening rates among rarely or never screened women in their target communities, or at the very least, they reported raising awareness in their communities of the importance of screening, which has become one of the priorities of the state's cancer control efforts.

While each of the six state partnerships differed in their approach to partnership engagement and the type of evidence-based intervention they implemented, it is difficult to ascertain if the Team Up pilot program had a short-term impact on changing cervical and breast cancer screening rates among the targeted population. The outcome objective proved more challenging than originally realized, and, consequently, further work is needed to answer lingering questions. For this reason it is premature to comment conclusively on the widespread effect of implementing evidence-based interventions.

8.4 Recommendations

Team Up sought to build state-level public-private partnerships with the goal of implementing evidence-based interventions. The following are recommendations for moving forward with such a model.

8.4.1 Process Evaluation

Recommendation 1: Building and Sustaining Partnerships

- **Interorganizational public health partnerships need to involve and listen to local residents and professionals in the planning phases.** In some partnerships, contextual challenges had an impact on their success, which could have been addressed and/or avoided in some measure with earlier input from local residents and those who work in the target communities. Consequently, both a 'top-down' and 'bottom-up' approach are appropriate to employ at different stages in the developmental trajectory of partnerships.

- **Membership continuity and experience is vital to complex partnerships.** Those who have experience working in the target communities and diverse constituents typically know what is feasible, realistic, and improves buy-in and participation in later phases of the project. Involving individuals who will carry out the intervention early during project planning will increase ownership, communication, commitment, and reduce turnover. Member satisfaction is correlated with increased commitment and involvement.

- **Synergistic collaborations thrive on partnership consensus.** Collaborations formed early in the partnership can be sustained throughout and beyond a project. Collaborations are able to overcome obstacles in successful and creative ways.

Recommendation 2: National Partnership Helping States Facilitate and Sustain Their Partnerships Among Core Organizations

- **Provide project participants with clear project expectations from the inception, and confirm that those expectations are understood.** Ongoing communication and technical assistance need to be consistent with and supportive of these expectations.

- **Maintain ongoing support throughout the entire project.** A favorable organizational environment supports tasks to be accomplished during planning and throughout the project. Programmatic support needs to include clarification of the organization's mission, recruitment of members, formalized roles and procedures, an outline of dissemination and implementation strategies, and incorporation of evaluation as part of the program.

- **Integrate researcher and practitioner experiences.** Foster collaboration during the planning phases (not the implementation phase) with original researchers and practitioners available to communicate. Dialogue will help narrow the research-to-practice chasm. Both have a common goal to solve a particular health problem. Both want to ensure the integration and use of evidence into practice.

8.4.2 Impact Evaluation

Recommendation 3: The Adoption, Adaptation, and Implementation of an Evidence-Based Intervention

- **When considering adoption, there should be some agreement as to what counts as evidence and in what circumstances.** Interventions that do not contain the entire 'suite' from the original research intervention may not be able to maximize effectiveness in the new practice environment.

- **Due to geographic and demographic diversity, adaptation of an intervention occurs at multiple levels and continuously evolves.** Key is tracking all of the adaptation through implementation processes systematically. Partners repeatedly expressed the idea that "one size does not fit all," and in their diverse states this translated into innovative county- and community-level adaptation, beyond what was planned by the state partnerships. Adaptation and implementation became an organic process by necessity rather than by design.

- **Practitioners will continue to experience implementation problems unless evidence-based interventions are repackaged for dissemination.** State partners need to continue to communicate with researchers and other state partners to exchange information and advice throughout implementation. The practice of combining, customizing, and piecing together intervention components in less-than-ideal field conditions is valuable information for researchers to know. Researchers need to understand what is involved when others translate research into practice.

Recommendation 4: Factors Influencing the Adoption, Adaptation, and Implementation of Evidence-Based Interventions

- **Match of state action agenda and dissemination and implementation processes.** State partners need to spend time during the planning phase to link state action agendas to implementation goals and processes. They also need to identify clear implementation strategies that collapse steps and document activities accomplished, describe processes, and determine whether goals have been accomplished.

- **A better understanding of implementation methodologies such as fidelity requirements (to the original intervention) for evidence-based interventions is necessary.** Once the appropriate adoption process is clearly defined, national partners should work closely with state partners to ensure that evidence-based approaches are adapted as intended, and to ensure that the new intervention becomes a faithful replication of what was proposed. Even though dissemination and implementation are

evolving efforts, it is essential that practical and replicable solutions be available to others who wish to build on this work and address a similar health disparity problem.

Recommendation 5: National Partnership Assistance in Adopting, Adapting, and Implementing an Evidence-Based Intervention

- **Seed money (at a minimum) is required for timely and effective partnership efforts.** For the Team Up state-level partnerships to achieve their goals, the national partners should provide financial resources to: (1) assist in developing partnerships (e.g., hiring a partnership coordinator); and (2) fund continued implementation of their evidence-based intervention.
- **Promotion of standardized ways to deliver programmatic capacity-building that supports partnerships to implement evidence-based approaches.** Promotion of consistent technical support across states will permit site-to-site and partnership-to-partnership comparisons and subsequent improvements on a larger scale.

8.4.3 Outcome Evaluation

Recommendation 6: State Partnerships Increase of Screening Rates Among Women Who Have Rarely or Never Been Screened for Cervical and/or Breast Cancer

- **More rigorous evaluation designs focused at the local level are required to evaluate the short- and mid-term outcomes of implemented screening programs.** The BRFSS data is not likely to provide the sensitivity needed to detect changes in screening rates for rarely or never screened women.
- **The BRFSS data analysis for assessing screening rates should be put on hold in favor of first examining fidelity to the evidence-based intervention in each locale.** In addition, national partners should work with state partners to develop a method for tracking the number of women who receive screening as a direct result of Team Up intervention.

8.5 Summary

The Team Up project broke new ground on several fronts. It provided an environment for several federal and national partners to create alliances to help establish upstream changes with the use of screening services for those populations of women who use them the least. Team Up also served as

a model for the use of evidence-based public health interventions within communities. The evaluation efforts also broke new ground in several areas. It began almost as soon as the partnership was formed and tracked performance on multiple levels. Following the introduction of the concept of evidence-based efforts, interim measures of program impact were applied to ensure that Team Up was functioning optimally, and that it moved towards the goal of reducing the burden of disease in the population. Because the reduction of mortality could not be realized with this evaluation, interim measures of program process and impact were used to determine whether the state-level screening programs delivered expected benefits.

Team Up was an important milestone in simultaneously measuring the influence of partnerships asked to implement evidence-based measures and to understand how viable state partners perceived the implementation process to be. The evaluation considered the concerns and tactics employed throughout the implementation with the purpose of distilling what was done at each of the six state practice sites. It uncovered the methods and procedures they employed and captured the effects of their work within their communities. Team Up looked at both the partnership and the implementation and considered how one influenced the success of the other. Future programs would do well to consider building in a cost assessment associated with implementing such a program in multiple states.

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Appendix A

Cervical Cancer Mortality Data

Table A-1. Counties with the top 20% cervical cancer mortality rate for White females: 1990-1998

Cervix cancer mortality by state and county: 1990-1998[a]			
White (sorted by state)	Top 20% counties		
State, county, and county population	Rate[b] White females	Count White females	Population White females
Alabama			
Winston County (01133)	6.2	7	105,367
Jackson County (01071)	5.5	12	215,449
Lawrence County (01079)	5.5	7	115,155
Elmore County (01051)	5.4	11	189,663
Georgia			
Baker County (13007)	15.6	6	39,089
Cherokee County (13057)	9.7	11	94,847
Columbia County (13073)	7.3	11	127,344
Toombs County (13279)	6.2	7	114,718
Ben Hill County (13017)	5.7	14	254,479
Jasper County (13159)	5.1	7	134,107
Illinois			
Pope County (17151)	8.7	9	101,531
St Clair County (17163)	7.5	6	78,553
Jo Daviess County (17085)	7.0	10	138,094
Logan County (17107)	6.9	14	199,594
Cook County (17031)	6.5	10	148,555
Alexander County (17003)	6.3	19	269,283
Johnson County (17087)	6.2	7	114,623
Rock Island County (17161)	6.1	7	89,548
Knox County (17095)	5.9	7	139,908
Massac County (17127)	5.7	10	181,589
Fulton County (17057)	5.6	6	89,756
Marion County (17121)	5.6	9	159,546
Greene County (17061)	5.5	19	315,017
Richland County (17159)	5.4	7	131,546
Vermilion County (17183)	5.3	7	114,844
Morgan County (17137)	5.2	6	117,339
De Witt County (17039)	5.1	10	195,335
Kentucky			
Pulaski County (21199)	12.8	6	55,162
Lincoln County (21137)	11.5	7	59,648
Boone County (21015)	11.2	15	137,832
Perry County (21193)	10.8	6	59,945
Casey County (21045)	9.8	12	117,398
Henderson County (21101)	9.2	7	68,386
Breckinridge County (21027)	8.9	6	69,758
Bullitt County (21029)	8.3	7	72,757
Livingston County (21139)	7.6	7	93,232
Ballard County (21007)	7.5	6	74,028
Franklin County (21073)	7.2	14	199,487

Table A-1. Counties with the top 20% cervical cancer mortality rate for White females: 1990-1998 (continued)

Cervix cancer mortality by state and county: 1990-1998[a]			
White (sorted by state)	Top 20% counties		
State, county, and county population	Rate[b] White females	Count White females	Population White females
Kentucky (continued)			
Kenton County (21117)	7.0	8	108,688
Lyon County (21143)	6.8	8	107,169
Martin County (21159)	6.7	16	273,848
Webster County (21233)	6.7	6	81,648
Lewis County (21135)	6.6	8	122,677
Simpson County (21213)	6.6	8	113,398
Larue County (21123)	6.3	9	141,650
Oldham County (21185)	6.1	6	98,823
Carlisle County (21039)	6.0	23	397,193
Boyle County (21021)	5.8	16	229,471
Knott County (21119)	5.7	36	648,835
Johnson County (21115)	5.3	7	148,063
Adair County (21001)	5.2	27	505,742
Clark County (21049)	5.2	10	216,928
Lawrence County (21127)	5.2	11	214,059
Missouri			
Montgomery County (29139)	8.7	6	65,985
Morgan County (29141)	7.0	6	77,817
Iron County (29093)	6.9	7	81,147
Nodaway County (29147)	6.2	7	89,823
Atchison County (29005)	5.8	9	133,406
Ralls County (29173)	5.2	7	101,010
South Carolina			
Newberry County (45071)	8.1	6	66,543
Dillon County (45033)	6.1	12	178,297
Calhoun County (45017)	5.6	18	431,065
Chester County (45023)	5.2	9	169,926
Tennessee			
Dickson County (47043)	12.5	9	69,559
Franklin County (47051)	9.2	7	70,206
Carter County (47019)	7.8	12	115,876
McMinn County (47107)	7.7	9	112,515
Lawrence County (47099)	7.6	6	74,275
Union County (47173)	7.2	7	78,936
McNairy County (47109)	7.0	8	100,280
Sequatchie County (47153)	6.7	6	88,206
Hawkins County (47073)	6.6	8	105,594
Perry County (47135)	6.3	6	83,897
Washington County (47179)	6.3	11	153,672
Roane County (47145)	6.2	8	118,396
White County (47185)	6.2	9	137,720

Table A-1. Counties with the top 20% cervical cancer mortality rate for White females: 1990-1998 (continued)

Cervix cancer mortality by state and county: 1990-1998[a]			
White (sorted by state)	Top 20% counties		
State, county, and county population	Rate[b] White females	Count White females	Population White females
Tennessee (continued)			
Clay County (47027)	5.6	8	126,947
Macon County (47111)	5.6	11	160,749
Trousdale County (47169)	5.6	8	143,406
Cannon County (47015)	5.5	11	169,884
Grundy County (47061)	5.3	16	261,164
Coffee County (47031)	5.1	8	138,256
Texas			
Crosby County (48107)	37.6	7	18,670
Dickens County (48125)	10.4	9	76,203
Williamson County (48491)	9.8	8	86,940
Limestone County (48293)	9.0	19	220,034
Tom Green County (48451)	8.6	9	95,700
Ector County (48135)	8.2	8	81,863
Knox County (48275)	7.6	9	130,995
Medina County (48325)	6.8	10	198,179
Bell County (48027)	6.5	6	108,545
Camp County (48063)	6.4	72	1,373,085
Montgomery County (48339)	6.1	7	82,585
McMullen County (48311)	5.9	7	141,322
Presidio County (48377)	5.9	25	414,758
Stephens County (48429)	5.9	9	223,247
Aransas County (48007)	5.5	16	279,601
Burleson County (48051)	5.5	11	154,641
Wilbarger County (48487)	5.5	28	497,161
Jeff Davis County (48243)	5.4	7	119,402
Hill County (48217)	5.3	88	2,106,235
Lamar County (48277)	5.2	10	174,842

[a] Underlying mortality data provided by NCHS (http://www.cdc.gov/nchs).

[b] Rates are per 100,000 and age-adjusted to the 2000 U.S. (5-year groups) standard.

Table A-2. Counties with the top 20% cervical cancer mortality rate for African American females: 1990-1998

Cervix cancer mortality by state and county: 1990-1998[a]			
African American (sorted by state)	Top 20% counties		
State, county, and county population	Rate[b] African American females	Count African American females	Population African American females
Alabama			
Wilcox County (01131)	20.3	8	45,928
Monroe County (01099)	14.7	6	45,788
Dallas County (01047)	14.2	16	139,364
Lee County (01081)	13.0	12	110,448
Macon County (01087)	12.7	13	101,003
Georgia			
Echols County (13101)	27.8	6	27,908
Ware County (13299)	17.1	6	44,894
Clinch County (13065)	14.8	11	236,285
Monroe County (13207)	14.7	6	50,930
Turner County (13287)	14.2	11	91,048
Jenkins County (13165)	14.0	7	50,736
Illinois			
Bureau County (17011)	12.2	12	156,942
Missouri			
Callaway County (29027)	22.2	10	56,330
Jackson County (29095)	14.9	9	79,272
Clinton County (29049)	14.7	18	165,906
Camden County (29029)	14.5	12	103,059
Lawrence County (29109)	14.5	9	75,982
Bates County (29013)	13.8	13	130,707
Henry County (29083)	13.6	7	76,321
Cape Girardeau County (29031)	13.4	7	69,181
South Carolina			
Dorchester County (45035)	17.3	9	63,780
Florence County (45041)	16.4	8	61,675
Williamsburg County (45089)	16.2	6	44,888
McCormick County (45065)	16.0	13	95,486
Oconee County (45073)	15.4	8	56,949
Colleton County (45029)	13.6	9	80,125
Georgetown County (45043)	12.4	22	232,772
Tennessee			
Giles County (47055)	17.1	8	47,200
Moore County (47127)	15.9	9	94,152
Texas			
Kendall County (48259)	30.8	11	40,375
Moore County (48341)	13.8	6	47,311
Franklin County (48159)	13.4	17	271,964
Grimes County (48185)	13.3	13	104,858

[a] Underlying mortality data provided by NCHS (http://www.cdc.gov/nchs).

[b] Rates are per 100,000 and age-adjusted to the 2000 U.S. (5-year groups) standard.

Appendix B

Concept Mapping Summary Report

CONCEPT SYSTEMS INC.

Partnership To Increase Cervical And Breast Cancer Screenings In High Mortality Counties

Concept mapping Summary Report

November, 2003

Prepared for:

Pilot Training Participants & Contributors
The American Cancer Society
The National Cancer Institute
Centers for Disease Control and Prevention
United States Department of Agriculture

By:

Daniel McLinden, Concept Systems, Incorporated

Partnership To Increase Cervical and Breast Cancer Screenings In High Mortality Counties

Concept Mapping Summary Report

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Partnership to Increase Cervical and Breast Cancer Screenings in High Mortality Counties

Project Summary Report

Executive Summary

The National Cancer Institute (NCI), Centers for Disease Control & Prevention (CDC), United States Department of Agriculture (USDA) and the American Cancer Society (ACS) partnered to pilot a project to use evidence-based strategies to increase the probability that women in high-mortality counties will get screened and/or get care for cervical and breast cancer.

For this project, staff from the above organizations collaborated with Concept Systems, Inc. (CSI) to work with a broad group of stakeholders from groups involved with this issue, using a Concept Mapping methodology to analyze and map this group's ideas and values, and then use that data facilitate the discussions and action planning. This methodology provided a quantitative basis for discussion and planning within a group setting.

This report is a summary of what the project participants identified as steps that should be taken to increase cervix and breast cancer screenings. The stakeholders invited to participate included advocates, medical personnel, community health leaders, and health department administrators on the local and state levels. The contributions of the stakeholder-participants in the project led to the wealth of information presented here. This project enabled us to capture the specific recommendations of all the individual participants, while also allowing us to capture themes and commonalities among all participants. The stakeholders' contributions have provided a foundation for their collaborative effort.

Project Design and Methodology

The purpose of this study was to gather, aggregate, confirm and integrate the specific knowledge and opinions of key members of communities of interest on the topic of increasing cervix and breast cancer screenings in high mortality counties. The desired outcomes of this effort were to craft and agree upon recommendations for strategies for encouraging underserved women in high-mortality counties to be screened for cervical and breast cancer and obtain care, as well as enhancing access to services for these populations.

To accomplish the desired results, planners utilized The Concept System® planning and facilitation methodology. Key components are concept mapping and action planning. Concept mapping is a mixed methods planning and evaluation approach that integrates familiar qualitative group processes (brainstorming, categorizing ideas, and assigning value ratings) with multivariate statistical analyses to help a group describe its ideas on any topic of interest and represent these ideas visually through a series of related maps.

The Concept Mapping approach we used had several key advantages for this study:

- It combined the ideas of diverse stakeholders in unique ways to understand how the entire group thinks about this issue.
- Given the diversity of opinions and stakeholders on this issue, we chose to have specific stakeholder groups analyze assigned clusters of ideas, to gain a deeper understanding of issues and action items. The data resulting from the Concept Mapping methodology greatly facilitated this approach.
- It produced a clear visual representation of how the group as a whole thinks about strategies for improving access to screening and care in high-mortality counties, as a basis for discussion and consensus.
- It assured that we had a well-informed, group-oriented process.

The Concept Mapping process typically requires the participants to brainstorm a set of statements relevant to the topic of interest, individually sort these statements into piles of similar ones, rate each statement on one or more dimensions, and generate a series of quantitative maps which reveal a topology of thought resulting from the analysis of this data. Participants can then use these maps as a basis for further discussion, and a framework for conclusions and action planning. The entire

process is driven by the stakeholders themselves, ranging from initial brainstorming, to the eventual identification and naming of clusters of thought, to interpretation and analysis of these maps.

This report is a summary of what a Core Group of project coordinators and an Extended Group of stakeholders identified as actions necessary to create a collaborative effort to increase cervix and breast cancer screenings, with assistance from consultants from Concept Systems, Inc. (CSI). The contributions of the stakeholder-participants in the project led to the wealth of information presented here. This project enabled us to capture the specific recommendations of all the individual participants, while also allowing us to capture themes and commonalities among all participants, as a basis for future collaborative effort.

The following steps were taken to achieve the goals of this study:

Establishing the Focus

To facilitate the collection of meaningful input, members of the Core Group, with guidance from Concept Systems, Inc., developed a focus prompt to which stakeholders responded:

"Steps we can take to increase screening among women who have rarely or never been screened for cervix and breast cancer are..."

Identify the Participants

Two groups were identified for the purpose of this task. The core group consisted of the planning team for this project as well as other identified stakeholders (N=29). The extended group consisted of a larger group of individuals who were targeted for attendance at a meeting to discuss the results and develop action plans to address the issue (N=75). Given the higher participation of the core group in decision-making, this group was asked to invest more time in the data collection effort. Consequently the extended group was asked for a lower investment of time in the data collection.

Idea Generation

During the period from March 27-April 23, 2003, stakeholders were asked separately to provide input on steps to increase screening among women who have never been screened for cervix and

breast cancer in high mortality counties, using the above prompt as the focus for the structured responses. Recognizing that the stakeholders' locations and access to technology varied, the project enabled multiple methods for submitting ideas. Stakeholders were contacted and provided with a web address for a project-specific website on which participants could submit their ideas online[1]. Additionally, participants could choose to submit ideas using a fax back form. Participants could also return forms by mail. Approximately 70 people participated[2] and contributed 199 ideas.

Statement Reduction

The preliminary statement set generated by stakeholders in response to this focus prompt numbered 199. At a meeting on April 28, 2003, the Core Group used the following criteria in reviewing these preliminary statements to produce a final set of 77 statements:

- Relevance to the stated focus question or within the scope of the question at hand;
- Redundancy or duplication;
- Clarity of meaning; and,
- Relative appropriateness for the sorting and rating tasks to be completed.

Appendix I shows the final list of 77 ideas that resulted from this process.

Structuring the Ideas

Following the completion of the idea generation or brainstorming phase, participants were contacted again and asked to participate in tasks to structure the information.

Sorting. In the sorting task, individuals are asked to organize or sort the entire database of ideas into groups or themes based on similarity of the ideas. Members of the Core Group were asked to complete this task, as well as the subsequent rating task below, between May 7-June 3, 2003.

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[1] The Concept System® computer software (Concept Systems, 2000) was used to perform all analyses and produce all of the maps and statistical results. Data was also collected over the Worldwide Web using the Concept System Global© software, to allow for participation from any location with access to the World Wide Web. Detailed references and articles on the Concept System can be obtained by calling 607-272-1206 or by emailing infodesk@conceptsystems.com.

[2] Participation in Idea Generation is anonymous. Estimates of participation were developed based on the number of visits to the website and faxes received.

Concept Systems, Inc.[1] provided consulting assistance and facilitation to this process, and again provided a dedicated website for those participants to complete the task online.

Rating. For the rating task, stakeholders who participated in the idea generation were again contacted and asked to evaluate or rate each of the final ideas on a Likert five point scale. Both the Core Group and the larger Extended Group participated in this process, which was completed by July 14, 2003. Participants were asked to rate along two dimensions: *Importance* and *Feasibility*. Stakeholders completed this task by using the dedicated website, or by faxing back a paper form that was sent to them.

Computing the Maps

The Concept System® [3] uses multi-dimensional scaling and hierarchical cluster analysis to integrate the sorting information from each individual and develop a series of easily readable concept maps and reports. These maps show the perspective of the entire group of participants as well as sub groups. In effect, The Concept System® represents the unique perspectives of a diverse group of individuals, preserves the best thinking of each individual and integrates the individual detail to construct and produce a coherent picture of the entire group.

The analysis uses the sort information to construct an NxN binary matrix of similarities, using the results of the sorting activity from all Core Group participants.

The total similarity matrix was analyzed using non-metric multi-dimensional scaling (MDS) analysis with a two-dimensional solution. The two-dimensional solution yields a configuration in which statements grouped together most often are located more closely in two-dimensional space than those grouped together less frequently. The x,y configuration resulting from the MDS analysis was the input for the hierarchical cluster analysis. To determine the best fitting cluster solution the analysts examined a range of possible cluster solutions suggested by the analysis, and took into account the fit of the contents within clusters as well as the specific desired uses of the results in planning and action development.

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[3] The Concept System® and Concept System Global© software are licensed through Concept Systems Incorporated, Ithaca, New York (http://www.conceptsystems.com).

Map Interpretation

The maps and reports produced by The Concept System® reflect and summarize the work of the stakeholders during the idea generation and structuring (sorting and rating) phases. The next step in the process required interpretation and discussion by the stakeholders in this project. Two tasks were undertaken in this step.

- First, the resulting data was reviewed with the Core Group and Project Advisors to ensure the reasonableness of the solution and name the clusters or concepts. This review also involved a preliminary discussion of the meaning, relevance and potential uses and implications of the results.

- Second, the results were presented to stakeholders at the Pilot Training to Increase Cervix and Breast Cancer Screenings in High Mortality Counties. At this meeting, participants interpreted the maps, discussed the broader themes suggested by the data and identified the actions that these maps suggest are necessary to create a collaborative effort to increase cervix and breast cancer screenings.

A more detailed description of the results appears in the following section.

Results

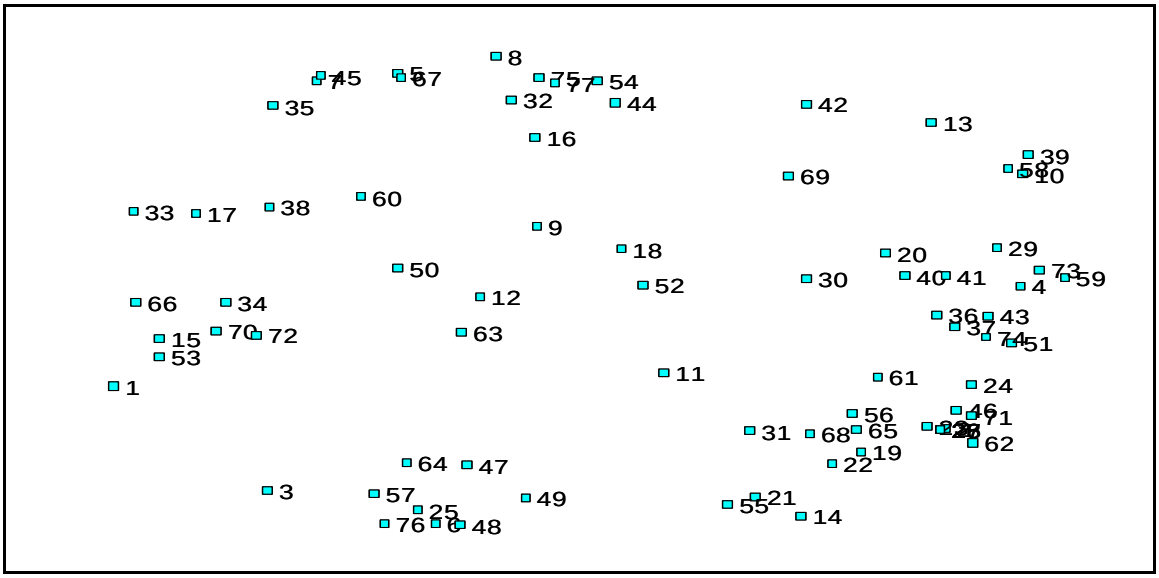
Concept Mapping combines a group process with computer technology that uses multivariate statistical techniques to develop maps to show what the group thinks. A single Concept Mapping project actually produces a number of interrelated maps – like different views of the same structure. In this case the group was a purposive sample of stakeholders who were asked to provide structured input on the topic of barriers and actions to overcome barriers. Overall, response rates were high. For the core group this was 19 out of a total of 29 who were asked to participate and for the extended group this was 52 out of a total of 75.

Concept Mapping Results

Concept maps were generated showing the relationships and importance ratings for the 77 distinct ideas generated as part of the brainstorming process.

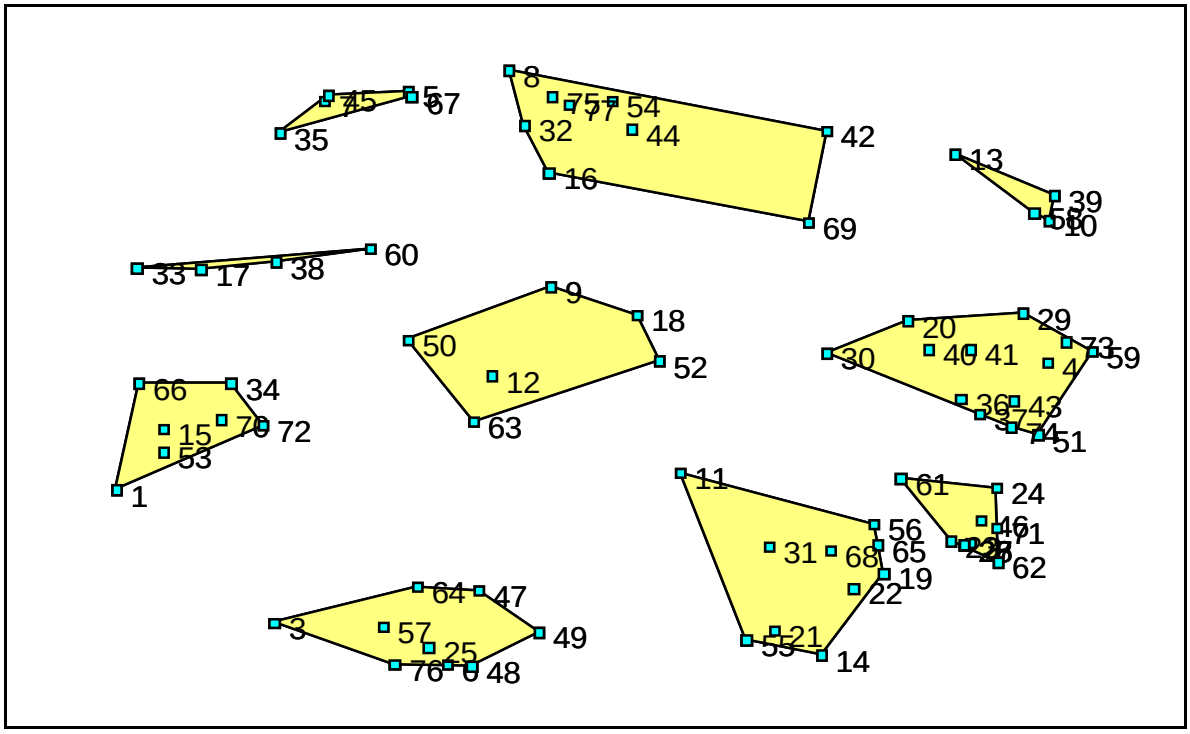
A point map shows each of the original brainstormed ideas as a point on the screen. Ideas that are closer together were sorted more frequently by participants into the same group. In this map you can see 77 points, each representing one of the distinct ideas brainstormed by the stakeholders from an original raw list of 199 statements.

Figure 1. Point map, indicating the array of all statements and their relationship to each other



A cluster point map shows all the points, just as the point map does. But it also shows the categories into which the points were sorted. The name given to each cluster will reflect the theme or topic expressed in the statements within that cluster. In this case the optimal solution was a ten-cluster solution, as indicated in Figure 2 below.

Figure 2. Point cluster map, showing point values groups within statement clusters

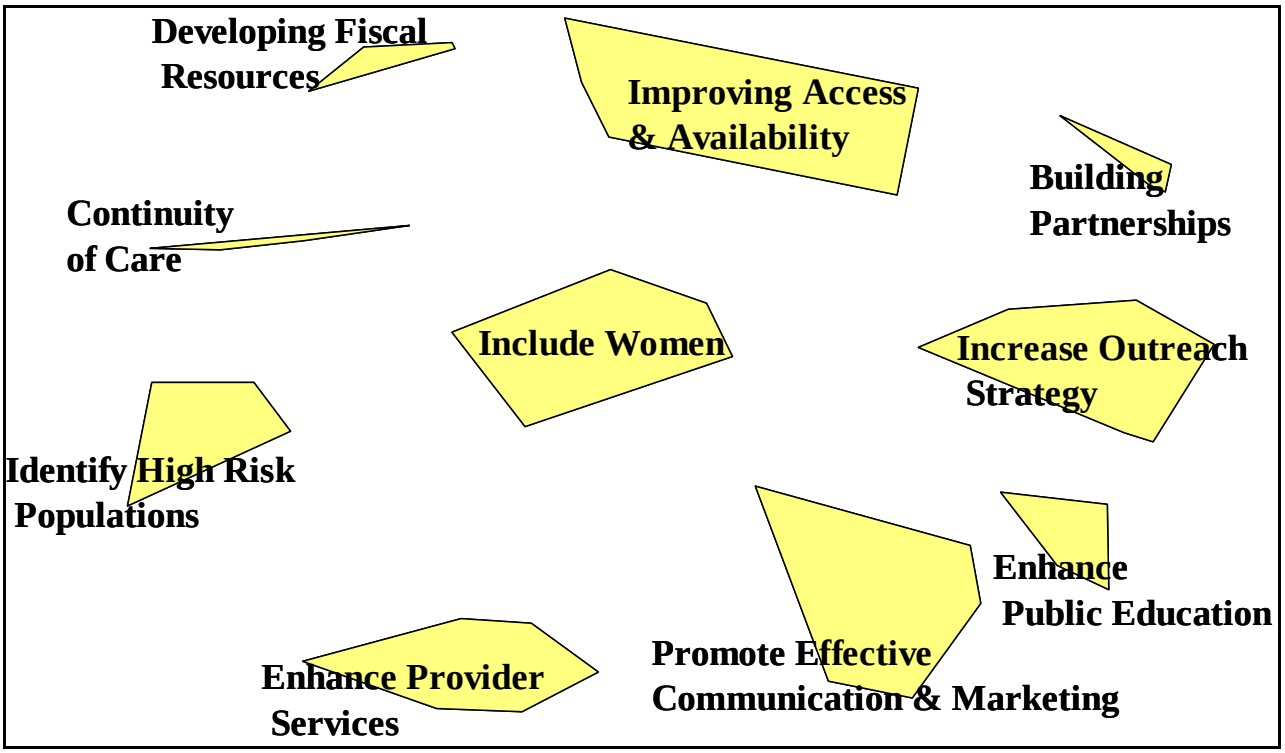


The data suggests that ten major issues should be considered when working to increase cervix and breast cancer screening among women who rarely or never get screened. The Labeled Cluster Map shows the clusters labeled with these categorical issues. The following are those categories, in no particular order:

- Developing Fiscal Resources
- Improving Access and Availability
- Building Partnerships
- Increase Outreach Strategy
- Enhance Public Education
- Promote Effective Communication and Marketing

- Enhance Provider Services
- Identify High Risk Populations
- Continuity of Care
- Include Women

Figure 3. Concept map. A ten-cluster concept map indicating the main topics, or concepts, that contain the 77 ideas that make up the content of the study results.



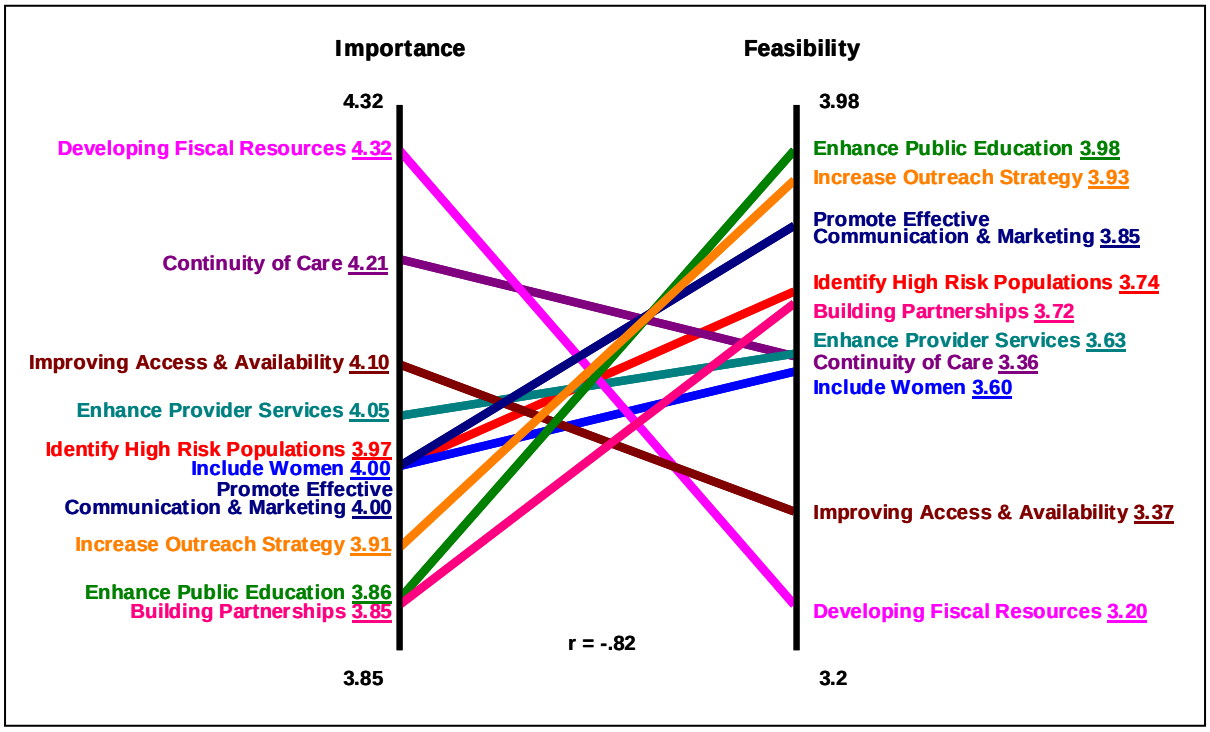
Pattern Matching Results

In order to compare the ratings of importance and feasibility that all project participants provided in advance of the pilot training, we created a Pattern Match, shown below. Keep in mind that we are referring to "relative" importance and feasibility. Because key informants generated all of these ideas, all ideas need to be considered as important.

The Pattern Match below shows the correlation between the average importance and feasibility ratings for each cluster. In this case, the correlation is strongly negative and indicates that, in general, clusters that were rated as high on importance were considered less feasible and vice versa for items low on importance. Visually this can be seen in the steep slop connecting concepts on the left

(importance) to same concept on the right (feasibility). On the other hand, the cluster of ideas relating to "Enhance Provider Services" and "Include Women" were thought to be nearly equal in importance and feasibility. It is also interesting to note that "Enhance Public Education" was rated relatively high in feasibility but had a lower importance rating. For clusters that show this pattern this may indicate that steps are already being taken in this area.

Figure 4. Importance and Feasibility Relative Pattern Match: All Participants.



Where participants rated specific clusters relatively high in importance and not quite as high in feasibility, this may mean that these clusters represent issues that, although, important are difficult to accomplish. "Developing Fiscal Resources" is an example of a cluster with that shows this pattern. It might be interesting to re-consider the feasibility ratings once the stakeholders have established their collaborations with various agencies and have worked to implement their action plans.

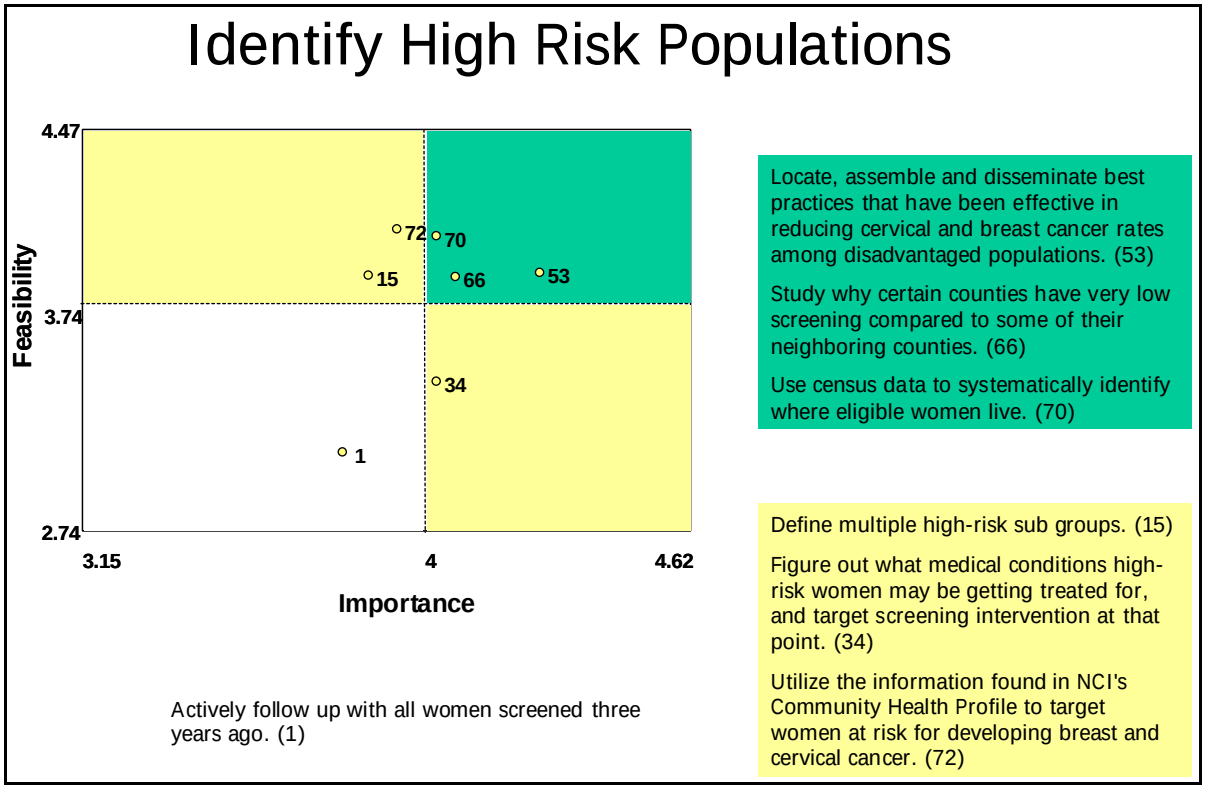
Go-Zone Analysis Results

Concept Systems also created Go-Zone analyses for this project, which are located on the following pages. These analyses are bivariate plots for each cluster that show the average importance and feasibility rating of each statement within a cluster. Just as the concept map cluster levels and the

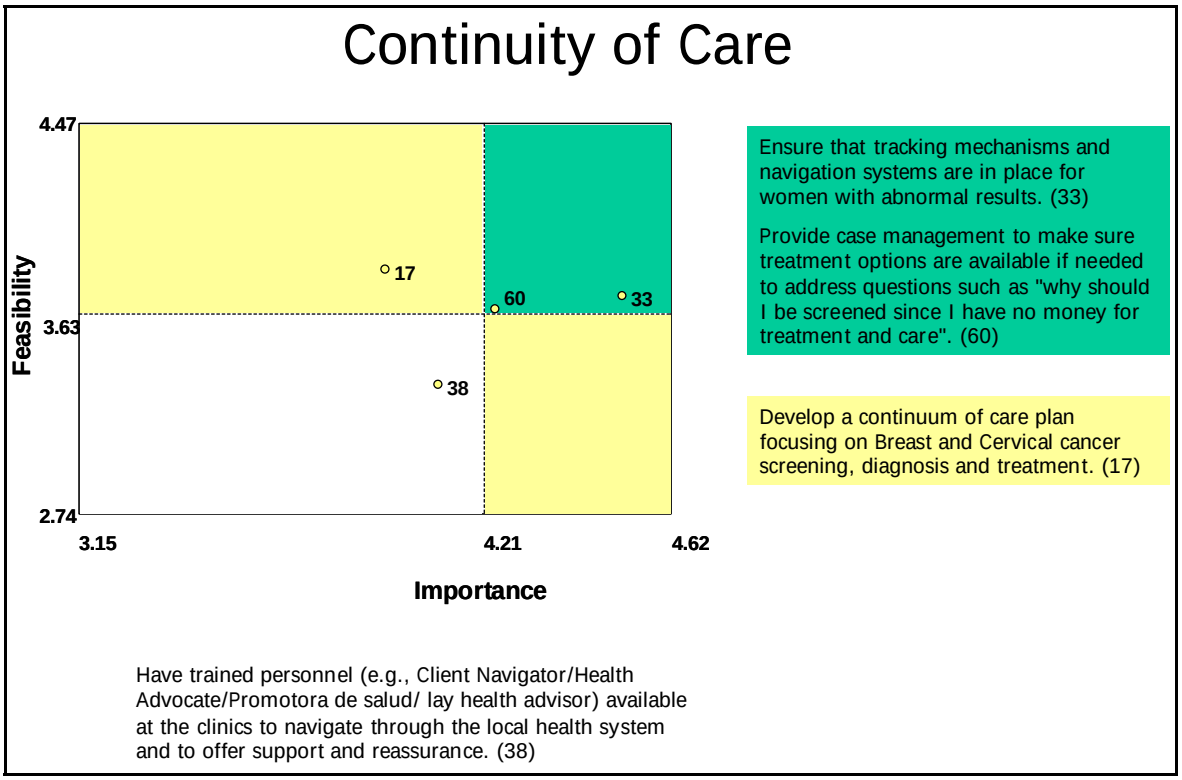
pattern match enable decision makers to observe, understand and agree upon the relationship and relative value of concepts, the Go-Zone analysis enables stakeholders to keep the larger conceptual view in mind, while returning to the detailed contents of each cluster.

Those items located in the upper right quadrant were rated higher than average on both importance and feasibility. We call this the "Go-Zone" because when ideas are rated high on both importance and feasibility, they are often the most logical ideas to act upon. However, this is not always the case. Sometimes ideas that are rated high on both importance and feasibility are indeed important ideas but are already being addressed sufficiently. Similarly, the items in the upper left (high feasibility and relatively low importance) and those in the lower right (high importance and relatively low feasibility) can be considered "gap" areas. These gap areas contain items for which value imbalance exists. However, sometimes ideas that are rated high in importance and low in feasibility have not yet been adequately tried or explored. In these cases, the feasibility may be unknown or underestimated. Certainly there are other interpretations that could be added to understand this graph. The key point is that this provides a way for all stakeholders to view the data and to then engage in assisted dialogue about implications.

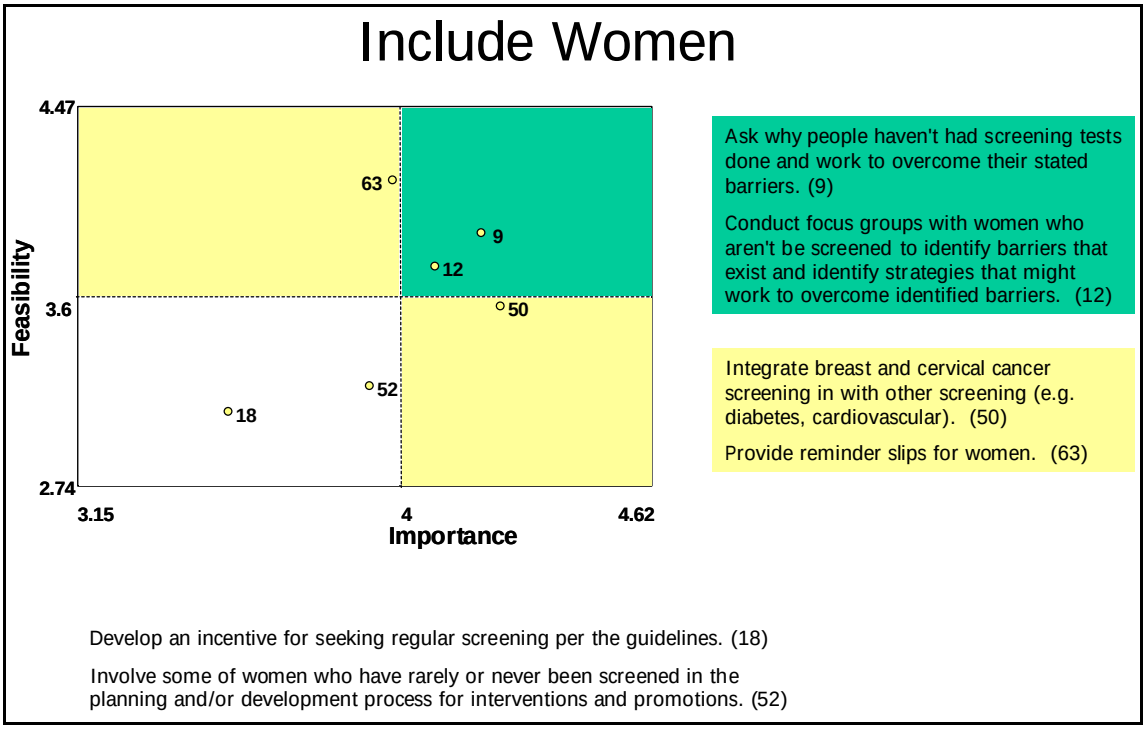
Cluster 1. Identify High-Risk Populations



Cluster 2. Continuity of Care

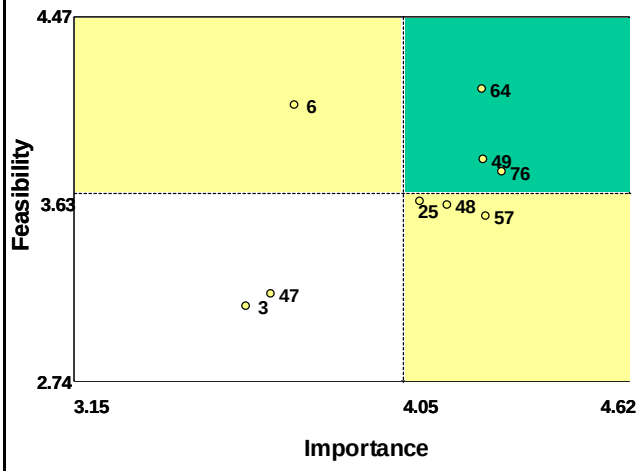


Cluster 3. Include Women



Cluster 4. Enhance Provider Services

Enhance Provider Services



Inform educators and providers about all the possibilities for having screening done at little or no cost. (49)

Set expectations for regular annual screenings, at first screening. (64)

Work with providers to increase understanding and compliance with screening guidelines and practices. (76)

Provide health care providers/professionals with NCI scientific information and CIS resources. (6)

Educate providers about underserved communities beliefs and attitudes toward the medical system and screening. (25)

Increase provider education to ensure referrals to free clinics. (48)

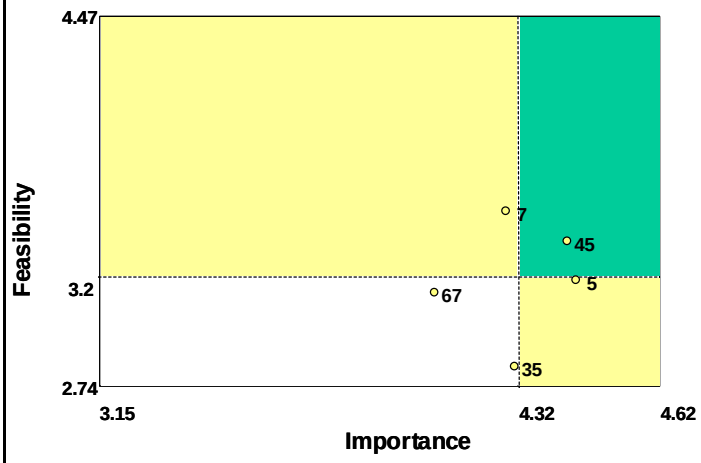
Partner with local primary care providers who will include the screening message in their patient counseling during sick visits. (57)

Ensure culturally competent staff by hiring providers who reflect the ethnicity of the community being served. (3)

Increase positive encounters with the medical system by bringing provider representatives into the community. (47)

Cluster 5. Developing Fiscal Resources

Developing Fiscal Resources



Increase and advocate for additional funding especially for underserved women (e.g. Breast and Cervical Cancer Early Detection program). (45)

Provide financial assistance for those without or in need (e.g. uninsured and underinsured) for screening and treatment. (5)

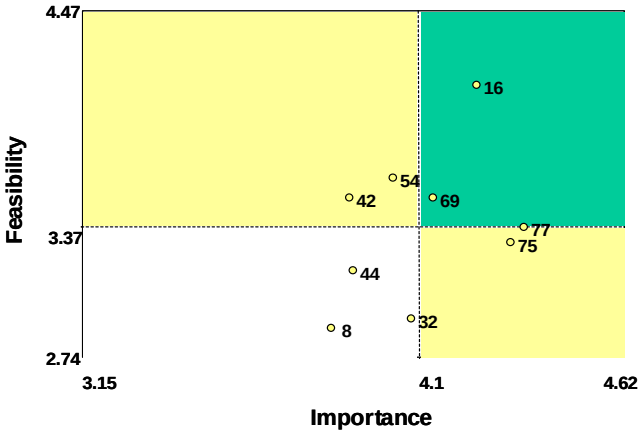
Advocate for screening to be paid for by insurance as a normal part of routine yearly check-ups, per the guidelines. (7)

Guarantee monetary assistance for follow-up, diagnosis, and treatment when problems are found. (35)

Support community clinics/organizations by providing grants to fund screening. (67)

Cluster 6. Improving Access & Availability

Improving Access & Availability



Determine the barriers to accessing screening (e.g., travel, facility availability, literacy, culture, fear, etc.). (16)

To go to the clients (mobile units to communities, places of work, etc.). (69)

Identify manufacturing centers known to have large numbers of employees at low wages and develop methods for convenient screenings (e.g., at shift changes). (42)

Make screening events more available for specific populations. (54)

Work to overcome financial, transportation, childcare and access issues. (75)

Work within the healthcare delivery system to ensure that the system does not present additional barriers once a woman decides to be screened. (77)

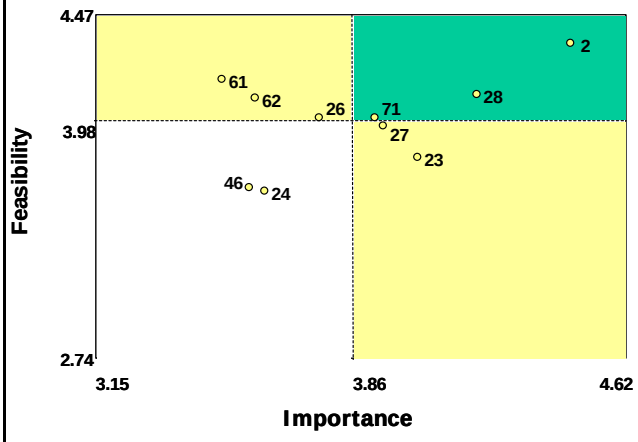
Advocate to have mammogram equipment placed in community clinics. (8)

Ensure that facilities are open at non-traditional hours (i.e., other than 8:00-5:00) and days (i.e., other than Monday through Friday). (32)

Increase access to HPV screening/vaccine. (44)

Cluster 7. Enhance Public Education

Enhance Public Education



Educate women that early detection and treatment increase survival rates. (2)

Educate women regarding the relationship between Human Papilloma virus (HPV) and cervical cancer. (28)

Use peer education to provide materials on the importance of breast and cervical cancer screenings. (71)

Dispel healthcare and cancer related myths (e.g., "You only have to worry about breast or cervical cancer if it 'runs' in your family" and "cancer is not a death sentence"). (23)

Educate women about the fact that screening may be uncomfortable and painful that it is essential. (26)

Educate women on the need for cervical cancer screening even they have had a hysterectomy. (27)

Provide displays at community health fairs and provide the opportunity to signup for appointments at the event. (61)

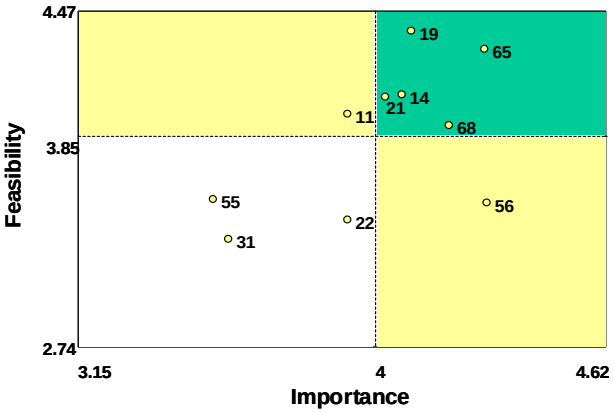
Provide educational materials and sessions at events for both men and women (e.g., educational sessions at college campuses, auctions, Farmer's Markets, restaurants, convenience stores, English as a Second Language classes). (62)

Educate church leaders to at the very least, be neutral, and not promote fatalistic attitudes. (24)

Increase one-on-one education through different venues such the American Cancer Societies Tell A Friend program. (46)

Cluster 8. Promote Effective Communication & Marketing

Promote Effective Communication & Marketing



Create culturally appropriate materials/media that can be delivered by community leaders to minorities and the medically underserved. (14)

Develop and distribute awareness materials that are printed at a low literacy level. (19)

Develop promotional strategies and screening opportunities that are social and that are culturally adapted. (21)

Stress that all women should be regularly screened, even if they are young, postmenopausal (not of childbearing age), if they are elderly and/or if they are not sexually active. (65)

Tailor messages to specific communities. (68)

Develop, fund, and implement effective marketing campaigns that include culturally competent materials, national spokespeople and appropriate media channels. (22)

Encourage use of more effective screening technologies at Breast Self-Exam teaching events. (31)

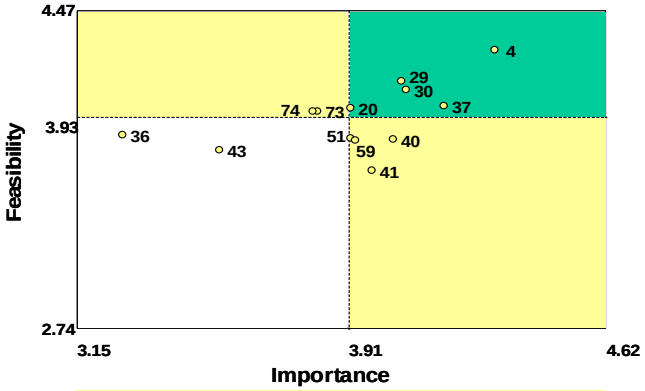
Make sure that all educators speak from experience and feel relaxed enough to share their personal knowledge. (55)

Conduct focus groups and individual interviews to determine the best approach for getting the key messages to the target population. (11)

Make sure that women understand why screening is important even when they are worried about fulfilling immediate survival needs (job, food, housing, single parenthood issues). (56)

Cluster 9. Increase Outreach Strategy

Increase Outreach Strategy



Partner with the community to develop outreach ideas and messages. (4)

Develop community profiles and use this information to educate and service the population. (20)

Encourage and conduct outreach and recruitment in public housing units, beauty shops, nail salons and churches. (29)

Encourage in-reach activities through local health departments and primary care offices. (30)

Have contact points in a county (e.g. health department reception, local ACS, etc.) provide a consistent message - where to get screened, how to qualify. (37)

Identify diverse populations and work with them to develop specific outreach strategies. (40)

Identify gatekeepers for each community and work with them to develop a plan for educating women. (41)

Involve cervical cancer survivors and peer leaders in outreach activities. (51)

Partner with school councils, unions, employers and parents to educate women on the importance of screening. (59)

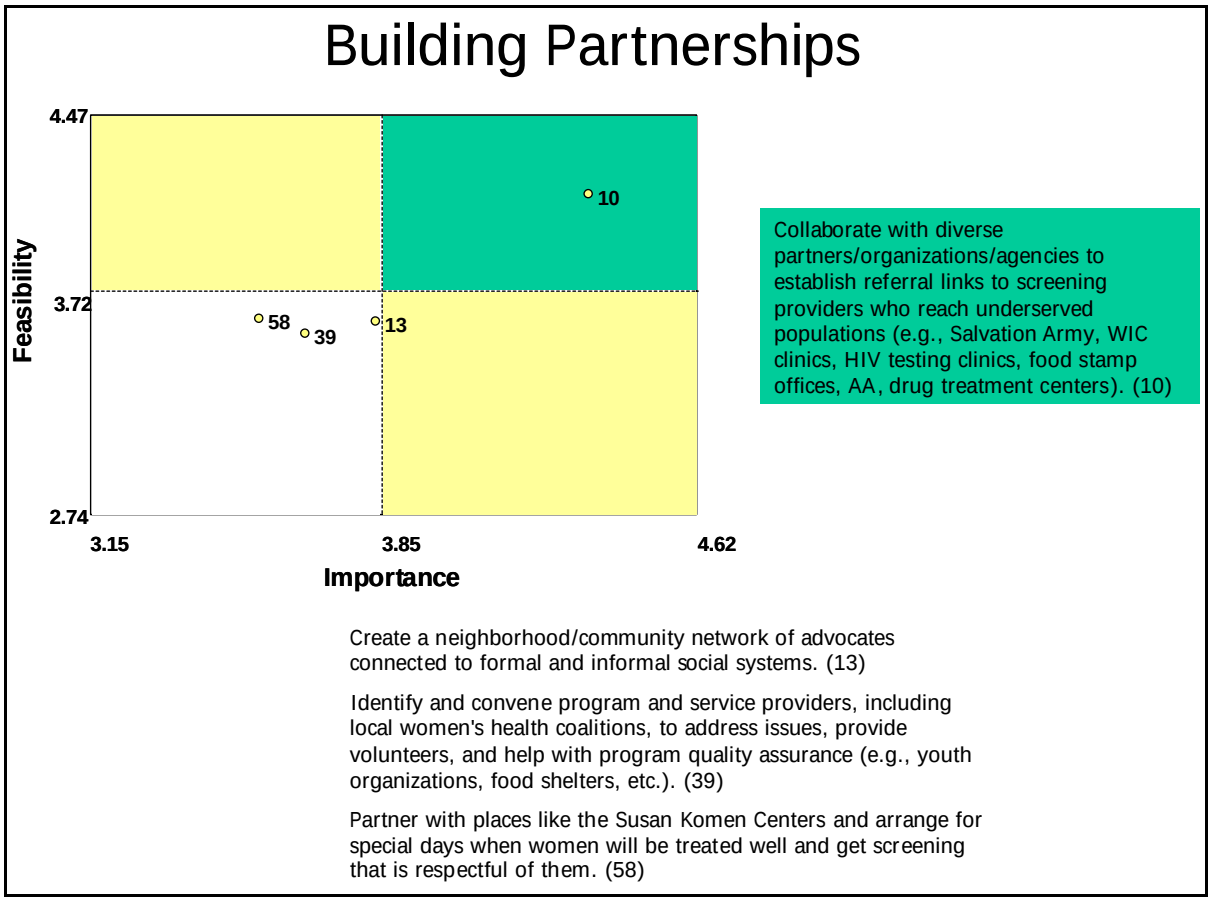
Work closely with faith-based organizations. (73)

Work through churches in targeted areas to get the message out about the importance of screening. (74)

Have a "Spring Into Wellness Day" with free refreshments and door prizes at the health department offering same day screenings to eligible women. (36)

Implement programs such as; "Come get screened and bring a friend". (43)

Cluster 10. Building Partnerships



Appendix

Appendix I: Statement List

The following is a list of statements used in the concept mapping project for the focus prompt "Steps we can take to increase screening among women who have rarely or never been screened for cervix and breast cancer are..."

#	Statement
1.	Actively follow up with all women screened three years ago.
2.	Educate women that early detection and treatment increase survival rates.
3.	Ensure culturally competent staff by hiring providers who reflect the ethnicity of the community being served.
4.	Partner with the community to develop outreach ideas and messages.
5.	Provide financial assistance for those without or in need (e.g. uninsured and underinsured) for screening and treatment.
6.	Provide health care providers/professionals with NCI scientific information and CIS resources.
7.	Advocate for screening to be paid for by insurance as a normal part of routine yearly check-ups, per the guidelines.
8.	Advocate to have mammogram equipment placed in community clinics.
9.	Ask why people haven't had screening tests done and work to overcome their stated barriers.
10.	Collaborate with diverse partners/organizations/agencies to establish referral links to screening providers who reach underserved populations (e.g., Salvation Army, WIC clinics, HIV testing clinics, food stamp offices, AA, drug treatment centers).
11.	Conduct focus groups and individual interviews to determine the best approach for getting the key messages to the target population.
12.	Conduct focus groups with women who aren't be screened to identify barriers that exist and identify strategies that might work to overcome identified barriers.
13.	Create a neighborhood/community network of advocates connected to formal and informal social systems.
14.	Create culturally appropriate materials/media that can be delivered by community leaders to minorities and the medically underserved.
15.	Define multiple high-risk sub groups.
16.	Determine the barriers to accessing screening (e.g., travel, facility availability, literacy, culture, fear, etc.).
17.	Develop a continuum of care plan focusing on Breast and Cervical cancer screening, diagnosis and treatment.
18.	Develop an incentive for seeking regular screening per the guidelines.
19.	Develop and distribute awareness materials that are printed at a low literacy level.
20.	Develop community profiles and use this information to educate and service the population.
21.	Develop promotional strategies and screening opportunities that are social and that are culturally adapted.
22.	Develop, fund, and implement effective marketing campaigns that include culturally competent materials, national spokespeople and appropriate media channels.

#	Statement
23.	Dispel healthcare and cancer related myths (e.g., "You only have to worry about breast or cervical cancer if it 'runs' in your family" and "cancer is not a death sentence").
24.	Educate church leaders to at the very least, be neutral, and not promote fatalistic attitudes.
25.	Educate providers about underserved communities beliefs and attitudes toward the medical system and screening.
26.	Educate women about the fact that screening may be uncomfortable and painful that it is essential.
27.	Educate women on the need for cervical cancer screening even they have had a hysterectomy.
28.	Educate women regarding the relationship between Human Papillomavirus (HPV) and cervical cancer.
29.	Encourage and conduct outreach and recruitment in public housing units, beauty shops, nail salons and churches.
30.	Encourage in-reach activities through local health departments and primary care offices.
31.	Encourage use of more effective screening technologies at Breast Self-Exam teaching events.
32.	Ensure that facilities are open at non-traditional hours (i.e., other than 8:00-5:00) and days (i.e., other than Monday through Friday).
33.	Ensure that tracking mechanisms and navigation systems are in place for women with abnormal results.
34.	Figure out what medical conditions high-risk women may be getting treated for, and target screening intervention at that point.
35.	Guarantee monetary assistance for follow-up, diagnosis, and treatment when problems are found.
36.	Have a "Spring Into Wellness Day" with free refreshments and door prizes at the health department offering same day screenings to eligible women.
37.	Have contact points in a county (e.g. health department reception, local ACS, etc.) provide a consistent message - where to get screened, how to qualify.
38.	Have trained personnel (e.g., Client Navigator/Health Advocate/Promotora de salud/ lay health advisor) available at the clinics to navigate through the local health system and to offer support and reassurance.
39.	Identify and convene program and service providers, including local women's health coalitions, to address issues, provide volunteers, and help with program quality assurance (e.g., youth organizations, food shelters, etc.).
40.	Identify diverse populations and work with them to develop specific outreach strategies.
41.	Identify gatekeepers for each community and work with them to develop a plan for educating women.
42.	Identify manufacturing centers known to have large numbers of employees at low wages and develop methods for convenient screenings (e.g., at shift changes).
43.	Implement programs such as; "Come get screened and bring a friend".
44.	Increase access to HPV screening/vaccine.
45.	Increase and advocate for additional funding especially for underserved women (e.g. Breast and Cervical Cancer Early Detection program).
46.	Increase one-on-one education through different venues such the American Cancer Societies Tell A Friend program.
47.	Increase positive encounters with the medical system by bringing provider representatives into the community.
48.	Increase provider education to ensure referrals to free clinics.
49.	Inform educators and providers about all the possibilities for having screening done at little or no cost.
50.	Integrate breast and cervical cancer screening in with other screening (e.g. diabetes, cardiovascular).
51.	Involve cervical cancer survivors and peer leaders in outreach activities.
52.	Involve some of women who have rarely or never been screened in the planning and/or development process for interventions and promotions.
53.	Locate, assemble and disseminate best practices that have been effective in reducing cervical and breast cancer rates among disadvantaged populations.

#	Statement
54.	Make screening events more available for specific populations.
55.	Make sure that all educators speak from experience and feel relaxed enough to share their personal knowledge.
56.	Make sure that women understand why screening is important even when they are worried about fulfilling immediate survival needs (job, food, housing, single parenthood issues).
57.	Partner with local primary care providers who will include the screening message in their patient counseling during sick visits.
58.	Partner with places like the Susan Komen Centers and arrange for special days when women will be treated well and get screening that is respectful of them.
59.	Partner with school councils, unions, employers and parents to educate women on the importance of screening.
60.	Provide case management to make sure treatment options are available if needed to address questions such as "why should I be screened since I have no money for treatment and care".
61.	Provide displays at community health fairs and provide the opportunity to signup for appointments at the event.
62.	Provide educational materials and sessions at events for both men and women (e.g., educational sessions at college campuses, auctions, Farmer's Markets, restaurants, convenience stores, English as a Second Language classes).
63.	Provide reminder slips for women.
64.	Set expectations for regular annual screenings, at first screening.
65.	Stress that all women should be regularly screened, even if they are young, postmenopausal (not of childbearing age), if they are elderly and/or if they are not sexually active.
66.	Study why certain counties have very low screening compared to some of their neighboring counties.
67.	Support community clinics/organizations by providing grants to fund screening.
68.	Tailor messages to specific communities.
69.	To go to the clients (mobile units to communities, places of work, etc.).
70.	Use census data to systematically identify where eligible women live.
71.	Use peer education to provide materials on the importance of breast and cervical cancer screenings.
72.	Utilize the information found in NCI's Community Health Profile to target women at risk for developing breast and cervical cancer.
73.	Work closely with faith-based organizations.
74.	Work through churches in targeted areas to get the message out about the importance of screening.
75.	Work to overcome financial, transportation, childcare and access issues.
76.	Work with providers to increase understanding and compliance with screening guidelines and practices.
77.	Work within the healthcare delivery system to ensure that the system does not present additional barriers once a woman decides to be screened.

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Appendix C

July 2003 Pilot Training Evaluation

MEETING EVALUATION RESULTS

PARTNERSHIP TO INCREASE CERVICAL AND BREAST CANCER SCREENING IN HIGH MORTALITY COUNTIES:

PILOT TRAINING CONDUCTED
JULY 30 – AUGUST 1, 2003

ATLANTA, GA

Ratings

Wednesday, July 30, 2003						
		Poor				Excellent
Question	Average	1	2	3	4	5
Opening Session: (Introduction/Purpose & Expectations/ Presentations on What Each Organization Does in Cervical and Breast Cancer						
The session was well structured.	**3.79**	6	6	7	29	22
I understood the objectives.	**3.81**	5	5	10	28	22
The objectives were accomplished.	**3.83**	3	6	14	23	23
The instructor(s) made effective presentations.	**3.84**	6	4	10	25	25
The content was covered in sufficient depth.	**3.77**	5	5	14	23	23
Overview of the Issue:						
The session was well structured.	3.95	3	5	7	21	23
I understood the objectives.	3.95	3	4	8	23	22
The objectives were accomplished.	3.82	5	4	8	24	20
The instructor(s) made effective presentations.	3.85	5	5	6	23	22
The content was covered in sufficient depth.	3.8	5	5	6	25	19
Cervical and Breast Cancer Screening in the Context of Comprehensive Cancer Control:						
The session was well structured.	3.87	3	6	7	24	20
I understood the objectives.	3.92	3	5	8	22	22
The objectives were accomplished.	3.88	4	5	6	24	21
The instructor(s) made effective presentations.	3.92	4	5	4	26	21
The content was covered in sufficient depth.	3.82	5	5	7	23	21

Wednesday, July 30, 2003						
		Poor				Excellent
Question	Average	1	2	3	4	5
State Team Activity One: Self-Assessing Capacity for Increasing Cervical and Breast Cancer Screening						
The session was well structured.	3.81	3	7	8	25	19
I understood the objectives.	3.76	5	3	14	20	20
The objectives were accomplished.	3.66	5	5	11	25	15
The instructor(s) made effective presentations.	3.76	5	4	11	23	19
The content was covered in sufficient depth.	3.72	6	3	9	27	16
Tour of Concept Mapping:						
The session was well structured.	3.81	4	3	14	21	20
I understood the objectives.	3.81	3	6	9	26	18
The objectives were accomplished.	3.79	4	6	9	23	20
The instructor(s) made effective presentations.	3.82	4	5	9	24	20
The content was covered in sufficient depth.	3.74	4	5	12	23	18
State Team Activity Two: Cluster Review						
The session was well structured.	3.73	3	6	11	27	15
I understood the objectives.	3.68	3	6	15	22	16
The objectives were accomplished.	3.61	3	7	15	23	14
The instructor(s) made effective presentations.	3.67	3	5	15	24	14
The content was covered in sufficient depth.	3.61	3	6	15	25	12
Global Perspectives of the Maps:						
The session was well structured.	3.65	5	6	15	17	20
I understood the objectives.	3.59	4	8	15	19	17
The objectives were accomplished.	3.56	5	7	15	18	17
The instructor(s) made effective presentations.	3.65	5	6	14	19	19
The content was covered in sufficient depth.	3.59	5	6	16	19	17

Comments

Wednesday, July 30, 2003

1. **Open Session: (Introduction/Purpose & Expectations on What Each Organization Does in Cervical and Breast Cancer). Please provide an assessment of the session indicating your agreement with each of the following statements:**

   What specific suggestions do you have for improving this session?

   - Good session.
   - A good overview of all the national partners.
   - Needed more time to discuss with our state for activity!
   - Write down the objectives and put them in the front of the binder.
   - More energy early on–i.e., NCI presentation.
   - None at the time.
   - State specific information regarding current activities brought to meeting by participants. Very well structured sessions! Great input and feedback.
   - Need to be clear upfront what really want from extension. Explain more why certain people invited.
   - Use of humor made the presentation easier to follow and understand.
   - Workgroups need to have more time than 30 minutes.
   - Concept mapping very confusing–I enjoyed more hearing from other state's feedback.
   - Sessions were held too long on day 1 due to traveling to the event.
   - Very nicely done. One suggestion, find a way to include national partners into the exercises.
   - Stay on time.

2. **Overview of the Issue: Please provide an assessment of the session indicating your agreement with the following statements:**

What specific suggestions do you have for improving this session?

- N/A.
- This day was very confusing/purpose…

3. **Cervical and Breast Cancer Screening in the Context of Comprehensive Cancer Control:**

What specific suggestions do you have for improving this session?

- N/A.
- Moderations/facilitators need to draw out responses from shy participants.
- Unclear about expectations, facilitation was unclear.

4. **State Team Activity One**:

What specific suggestions do you have for improving this session?

- The wording in the activity could be worded more clearly.
- Be more specific.
- Need more prompting from moderator.
- Longer time for team activities/brainstorming.
- Great opportunity to hear input from around the state.
- Too rushed. Did not complete fully.
- Need more time.
- Would have helped to make facilitator more familiar with the state.

5. **Tour of Concept Mapping**:

What specific suggestions do you have for improving this session?

- Explain the axes of the map in lay terms early.
- Insightful exercise.
- Great presentation, graphic presentation to concepts very helpful!

- Need to give from handouts so can follow better. Homework not realistic with coming activity.
- None of the suggestions in the April meeting were followed for all the sessions.
- A little hard to understand how was done–but understand the basic concepts.
- Excellent.

6. State Team Activity Two:

What specific suggestions do you have for improving this session?

- Facilitations need to direct more of the discussion, and also it would be helpful to have a facilitator, another person to take notes, another timekeeper. (Same for all state activities).
- The wording and instructions were not very clear.
- Needed more time.
- Too much detail, convaluate message needed for this exercise.

7. Global Perspectives of the Maps:

What specific suggestions do you have for improving this session?

- Concept mapping presentation should've been done differently.
- Suggestions should've been taken from state group meeting in June.
- Need to end break on time. Should discuss weaknesses of analyses, esp. fact that ratings were opinions not necessarily linked to data.
- Unclear facilitation.
- Same comments as "tour of concept mapping."
- Same as in April which we said should be presented differently!!
- Difficult topic but explained in a way easy to understand.

Ratings

Thursday, July 31, 2003						
		Poor				Excellent
Question	Average	1	2	3	4	5
The Big Picture: Who Do We Want To Reach, What Do We Want To Do?						
The session was well structured.	4.04	0	1	4	11	7
I understood the objectives.	4	1	0	3	13	6
The objectives were accomplished.	4	1	0	4	11	7
The instructor(s) made effective presentations.	4.22	1	0	1	12	9
The content was covered in sufficient depth.	4.04	1	0	2	14	6
State Team Activity Three: Where are we now and where do we want to go? Creating a "Big Picture" for your state						
The session was well structured.	3.87	1	2	1	14	5
I understood the objectives.	4	1	0	2	15	5
The objectives were accomplished.	3.91	2	0	1	15	5
The instructor(s) made effective presentations.	4	1	0	2	15	5
The content was covered in sufficient depth.	3.96	1	1	1	15	5
Building Partnerships/ Available Tools For Partnership Planning:						
The session was well structured.	3.83	1	0	6	12	5
I understood the objectives.	3.79	1	0	6	13	4
The objectives were accomplished.	3.79	1	0	6	13	4
The instructor(s) made effective presentations.	3.83	1	0	6	12	5
The content was covered in sufficient depth.	3.79	1	0	6	13	4
State Team Activity Four: Assessing Partnership Potential						
The session was well structured.	3.83	1	0	5	13	4
I understood the objectives.	3.91	1	0	3	15	4
The objectives were accomplished.	3.96	0	1	3	15	4
The instructor(s) made effective presentations.	3.91	1	0	3	15	4
The content was covered in sufficient depth.	3.91	1	0	3	15	4

Thursday, July 31, 2003						
		Poor				Excellent
Question	Average	1	2	3	4	5
Local Partnerships:						
The session was well structured.	3.86	0	1	7	8	6
I understood the objectives.	3.82	1	0	7	8	6
The objectives were accomplished.	3.82	1	0	7	8	6
The instructor(s) made effective presentations.	3.86	1	0	6	9	6
The content was covered in sufficient depth.	3.86	0	1	7	8	6
State Team Activity Five: How will we work together? Challenges and Solutions						
The session was well structured.	3.95	0	2	2	12	5
I understood the objectives.	4.05	0	2	1	12	6
The objectives were accomplished.	4	0	2	1	13	5
The instructor(s) made effective presentations.	4.05	0	2	1	12	6
The content was covered in sufficient depth.	4	0	2	2	11	6
Using Data To Inform Action:						
The session was well structured.	3.83	0	1	7	10	5
I understood the objectives.	3.78	0	1	7	11	4
The objectives were accomplished.	3.74	0	1	8	10	4
The instructor(s) made effective presentations.	3.7	0	2	7	10	4
The content was covered in sufficient depth.	3.74	0	1	8	10	4
State Team Activity Six: Why Did Joanne Die?						
The session was well structured.	4	0	2	1	14	5
I understood the objectives.	3.91	1	1	2	13	5
The objectives were accomplished.	3.86	1	2	1	13	5
The instructor(s) made effective presentations.	4	1	1	2	11	7
The content was covered in sufficient depth.	3.91	1	1	1	15	4

Thursday, July 31, 2003						
		Poor				Excellent
Question	Average	1	2	3	4	5
Evidence-based Cervical and Breast Cancer Screening Programs:						
The session was well structured.	3.95	0	0	5	12	4
I understood the objectives.	4.05	0	1	2	13	5
The objectives were accomplished.	3.95	0	0	5	12	4
The instructor(s) made effective presentations.	4	0	0	4	13	4
The content was covered in sufficient depth.	3.95	0	1	3	13	4
Building Local Resources:						
The session was well structured.	3.86	1	0	5	10	5
I understood the objectives.	3.9	1	0	4	11	5
The objectives were accomplished.	3.86	1	0	5	10	5
The instructor(s) made effective presentations.	3.81	1	1	4	10	5
The content was covered in sufficient depth.	3.86	1	0	5	10	5
Pulling Together a Meaningful Action Agenda:						
The session was well structured.	4	1	1	2	9	7
I understood the objectives.	4.05	0	2	2	9	7
The objectives were accomplished.	3.95	1	1	2	10	6
The instructor(s) made effective presentations.	3.95	1	1	2	10	6
The content was covered in sufficient depth.	4	1	1	2	9	7
State Team Activity Seven (Part 1): Developing an Action Agenda						
The session was well structured.	3.86	1	3	1	9	7
I understood the objectives.	4	1	2	1	9	8
The objectives were accomplished.	3.9	1	3	1	8	8
The instructor(s) made effective presentations.	3.95	1	1	3	8	7
The content was covered in sufficient depth.	3.85	1	3	1	8	7

Comments

Thursday, July 31, 2003

1. **The Big Picture: Who Do We Want To Reach, What Do We Want To Do? Please provide an assessment of the session indicating your agreement with each of the following statements:**

   What specific suggestions do you have for improving this session?

   - Great Presentation!!
   - Objectives for each session were not given, only an overview of the agenda.
   - State Objectives.
   - While well structured, the activity and information is beginning to be redundant.
   - The Statistics are fine, but all the mapping is getting to be a burden and it is redundant, also.
   - I enjoyed the facilitation of our discussion, we were able to think outside of the box.
   - Difficult to network with partners at the table due to noise during activity sessions can not hear input around the table. Recommend activities be conducted in smaller rooms with limited noise.
   - Are clients turned off by the medical system or not threatened by a second breast cancer threat?
   - The facilitator was much improved.
   - N/A Absent.

2. **State Team Activity Three:**

   What specific suggestions do you have for improving this session?

   - Our group (ky) was large and difficult to manage facilitator had to work to keep people on track.
   - N/A.
   - Cannot hear fellow people at table.
   - N/A Absent.

3. **Building Partnerships/Available Tools For Partnership Planning:**

What specific suggestions do you have for improving this session?

- Was not real clear on what they were talking about.
- N/A.

4. **State Team Activity Four:**

What specific suggestions do you have for improving this session?

- No need to talk about partnerships this is a common concepts old hat!
- N/A.
- Content is covered more than sufficiently.
- Difficulty hearing people's comments at the table.
- N/A.

5. **Local Partnerships:**

What specific suggestions do you have for improving this session?

- N/A.
- Should have made clear how USDA Extension staff participated.
- N/A.

6. **State Team Activity Five:**

What specific suggestions do you have for improving this session?

- Cut the partnership section.
- N/A.
- Too diffused.
- Most of these activities could be condensed and completed sufficiently.
- Good activity.

7. Using Data To Inform Action:

What specific suggestions do you have for improving this session?

- N/A.
- Political comments were not appreciated. Democrats are not the only people concerned with well being of others. In our area, the movers and shakers are not Democrats.
- If felt that Jon Kerner's political remark made the rest of the presentation hard to focus on. Leave political remarks out.
- Well presented presentation.

8. State Team Activity Six:

What specific suggestions do you have for improving this session?

- N/A.
- Redundant. Focus seems to have moved from prevention and early detection to treatment.

9. Evidence-Based Cervical and Breast Cancer Screening Programs:

What specific suggestions do you have for improving this session?

- N/A.
- Web site Resources – GREAT!

10. Building Local Resources:

What specific suggestions do you have for improving this session?

- Great Activity!
- Did not happen–did a poorly focused, overly long exercise analyzing yellow pages.
- Most of these activities could have been confined.

11. Pulling Together a Meaningful Action Agenda:

What specific suggestions do you have for improving this session?

- Make sure all members understand their purpose for being present.
- Redundant, focus seems to have moved from prevention and early detection to treatment.

- Great opportunity to meet as a state to concentrate on state planning.

12. State Team Activity Seven (Part 1):

What specific suggestions do you have for improving this session?

- This did not need to be at 4:00 in the afternoon. Creative juices flow better in the A.M. After a long info packed day, folks threshold reached tempers short, patience even shorter!

- General Observation:

  - Time tested for activity and actual time given incongruent.

  - TMI–too much information in one day's by action? Everyone was tired and bored.

- The training was a lengthy training. Please consider holding training for 8:30 – 3 with a 45 min. lunch. 5:00 p.m. meetings are too long.

- N/A.

- Leaving this to end of day left us too tired to focus effectively.

- Most productive of all sessions.

- Need more time like this with state table to discuss unique program specifics of all Minorities programs.

Ratings

Friday, August 1, 2003						
		Poor				Excellent
Question	Average	1	2	3	4	5
State Team Activity Seven (Part 2): How to prioritize actions						
The session was well structured.	4.33	0	0	0	2	1
I understood the objectives.	4	0	0	1	1	1
The objectives were accomplished.	4	0	0	1	1	1
The instructor(s) made effective presentations.	4.33	0	0	0	2	1
The content was covered in sufficient depth.	4.33	0	0	0	2	1
State Team Activity Eight: Articulating a vision for increasing cervical and breast cancer screening purpose						
The session was well structured.	4.15	3	0	2	17	17
I understood the objectives.	4.28	2	0	2	16	19
The objectives were accomplished.	4.05	2	1	3	20	13
The instructor(s) made effective presentations.	4.19	2	0	3	16	16
The content was covered in sufficient depth.	4.03	2	1	5	17	14
State Sharing of Action Plans:						
The session was well structured.	4.05	3	1	3	19	16
I understood the objectives.	4	3	1	5	17	16
The objectives were accomplished.	3.95	3	0	7	18	14
The instructor(s) made effective presentations.	4.02	2	2	5	16	16
The content was covered in sufficient depth.	4	2	2	4	19	14
State Team Activity Eight:						
The session was well structured.	4.11	3	0	2	18	15
I understood the objectives.	4.13	3	0	2	17	16
The objectives were accomplished.	4.13	3	0	2	17	16
The instructor(s) made effective presentations.	4.28	2	0	1	16	17
The content was covered in sufficient depth.	4.11	3	0	3	16	16

Friday, August 1, 2003						
		Poor				Excellent
Question	Average	1	2	3	4	5
State Sharing on Making the Case:						
The session was well structured.	3.97	3	0	3	17	11
I understood the objectives.	4	2	1	3	17	11
The objectives were accomplished.	3.97	3	0	3	17	11
The instructor(s) made effective presentations.	4	2	1	3	17	11
The content was covered in sufficient depth.	3.94	3	0	4	16	11
State Team Follow-up:						
The session was well structured.	4.13	1	0	4	16	11
I understood the objectives.	4.25	1	0	2	16	13
The objectives were accomplished.	4.22	1	0	2	17	12
The instructor(s) made effective presentations.	4.19	1	0	3	16	12
The content was covered in sufficient depth.	4.22	1	0	2	17	12

Comments

Friday, August 1, 2003

1. **State Team Activity Three: Please provide an assessment of the session indicating your agreement with each of the following statements:**

   What specific suggestions do you have for improving this session?

   - Good work in the A.M.
   - Good opportunity for consensus.
   - Better and clearer objectives.
   - N/A.
   - Most effective day.
   - Insufficient time.

2. **State Sharing of Action Plans:**

   What specific suggestions do you have for improving this session?

   - N/A.
   - Decide how sharing will alter previously destined action items–never integrated shared plans to action plans of listeners.
   - (Question 14). Variable by state.

3. **State Team Activity Three:**

   What specific suggestions do you have for improving this session?

   - N/A.
   - Define the objective better–seemed like an exercise unrelated to actions.
   - N/A.

4. **State Sharing of Action Plans:**

What specific suggestions do you have for improving this session?

- N/A.
- Drop this or better define how this will be applied.

5. **State Team Activity Eight:**

What specific suggestions do you have for improving this session?

- N/A.

6. **State Sharing on Making the Case:**

What specific suggestions do you have for improving this session?

- N/A.

7. **State Team Follow-up:**

What specific suggestions do you have for improving this session?

- **General Observation** of entire session:
  - Too much information, too little time.
  - No one should travel to a city and all they can say about the city is that they saw the hotel/airport, etc. To all work, there should be some fun.
  - Very good facilitator.
  - Some information redundant, facilitator could have given us information we needed for the activity instead of a presenter.
- Excellent pilot training.
- Thanks for letting us leave early!
- Excellent training!

Very well thought and conducive to action.

Nice and helpful staff/CDC/ACS/NCI.

Thanks for all the work you put into this.

- Better understanding upfront to all parties attending would have made a clearer understanding of what to expect.
- More concise evaluation.
- Hotel was good, food was good, was good meeting.
- N/A.
- Thank you so much!
- Heather Freeborn was an excellent facilitator.
- Completed earlier.
- Overall–A "disconnect" between the role of concept mapping and the activities, i.e., how did concept mapping guide planning and action work of small state groups. Time frames for discussion and state planning were far too short.
- Do not see how concept mapping fit this practical action plan.

Appendix D

State Action Agendas

State	Meetings	Analysis	Program development	Partnership	Planning	Funding
A	➢ Convene meeting of organizations represented at July meeting to initiate data entry for E-tool	➢ Use Cancer Registry data to overlay BC & CC mortality and incidence rates by legislative districts	➢ Create & disseminate state-wide co-events for CC activities ➢ Engage youth groups to serve as messengers	➢ Expand the partnership (Medical, CHA, worksite, other	➢ Work with organizations to develop plan for establishing relationship with 1st lady for cancer initiatives	
B	➢ Train extension agents (and other partners like wellness coordinators w/Area Agencies on Aging) using community health advocate training	➢ Decide which high mortality counties to focus on		➢ Involve partners/consumers from high mortality counties in planning activities/interventions		
C		➢ Pull data for high mortality counties to determine priority counties	➢ Identify evidence-based tools on PLANET		➢ Plan, develop and implement in-service training for team to held in September 2004	
D	➢ Establish list-serve ➢ Hold planning meeting with partners in first 3 months	➢ Compile data	➢ kick-off with minority cancer awareness month ➢ ACS mother's day breast cancer campaign ➢ ON-GOING campaign continues	➢ each lead person will provide agency capabilities and contact information ➢ identify agency personnel who will participate on a local level	➢ Plan trainings ➢ Develop evaluation tools	

State	Meetings	Analysis	Program development	Partnership	Planning	Funding
E	➢ Learn about each other			➢ Expand core planning group (identify potential partners)	➢ Develop a work plan	➢ Apply for funding ($2,000)
F	➢ Convene meetings through conference call	➢ Decide criteria for choosing target counties ➢ Gather and analyze data on target counties ➢ Assess existing community activities, partnerships and screenings for selected counties ➢ Research and interviews identify pockets of un and underserved women	➢ Identify educational material that is most effective with women in the community	➢ Recruit public health and specific leads at local health department ➢ Establish partnerships in the community	➢ Meet with county groups to develop implementation plan	
G		➢ Data Analysis ➢ Define existing activities for B& C and related services		➢ Identify partners		
H			➢ Create unified message- Identify what is available ➢ Apply for "Wise Woman" program	➢ Expand Partnership to include Extension, Cancer Registry, SPN, CIS, ACS etc.	➢ Explore the Rural Medical School Scholars program to increase the number of techs available	➢ Apply for Komen $10,000

Appendix E

Three- and Six-Month Reports

Partnership to Increase Cervical and Breast Cancer Screening in High Mortality Counties: Three-Month Evaluation of the Pilot Training

June 3, 2004

Introduction

A national partnership between the Centers for Disease Control and Prevention (CDC), United States Department of Agriculture (USDA) Cooperative State Research, Education, and Extension Service (Cooperative Extension Service), the National Cancer Institute (NCI), and the American Cancer Society (ACS) resulted in the development of a Pilot training, *"The Partnership To Increase Cervical and Breast Cancer Screening in High Mortality Counties: Pilot Training,"* which was held in Atlanta, Georgia, from July 30 to August 1, 2003. States with the most with consistently increased cervical cancer rates above the U.S. national average over the past 10 years were selected to attend. Eight state teams participated in the Pilot training: Alabama, Georgia, Illinois, Kentucky, Mississippi, Missouri, South Carolina, and Tennessee.

The goal of the Pilot training program was to develop partnerships between the collaborating organizations at the state level, with a focus on increasing screening in high mortality counties among women who have *rarely or never been screened* for cervical or breast cancer. The training provided access to resources available for screening promotion via the web base Cancer Control Plan, Link, Act, Network with Evidence-based Tools (PLANET) and allowed for the creation of state action agendas that would build local partnerships, identify local resources for implementation and evaluation, and create a plan to increase screening in high mortality counties.

A followup evaluation of state teams was conducted for 3 months, and another evaluation was planned for 6 months following the Pilot training. The 3-month followup assessed the usefulness of the Pilot training, communication and planning by the state teams, use of available resources, and utilization of state action agendas. This report focuses on the 3-month followup evaluation.

Methods

Design

An interview employing a survey design was chosen. Pilot training state participants (n=72) were contacted via email to request their participation in a telephone interview. The interviews were designed so that both qualitative and quantitative information could be collected. Depending on a participant's initial response to a question, some responses were probed or additional questions asked to obtain clarification.

Procedure

An email was sent to all Pilot training participants on October 28, 2003. Participants were asked to select two possible times from blocks of potential times when they would be available for a telephone interview. They were then sent a response confirming a specific time for an interview. Telephone interviews occurred between October 31 and November 18, 2003. Participants were informed that the interviews would be taped to ensure that the information communicated was captured appropriately. Telephone interviews lasted 15 to 35 minutes. The same CDC employee conducted all interviews. Additional information was gathered from state meeting minutes sent to the evaluator by two state teams.

Instruments

The questionnaire developed for the phone survey was modified from a Comprehensive Cancer Control Institute for State Leaders' followup survey. The instrument was modified with input from the CDC evaluator, the core Pilot training planning team, and state-team facilitators. The instrument included both open- and closed-ended questions. The telephone interview focused on feedback from the Pilot training. Specifically, questions addressed whether the Pilot training was useful and whether it led to subsequent communication within the state teams, state-team planning, and the development of action steps associated with the individual action agendas.

Participants

Seventy-two individuals attended the Pilot training. Many of them were regional, state, or local representatives of the four *Public-Private Partnership* participating organizations (CDC, USDA, NCI, and ACS). Additionally, some CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP) providers and other cancer professionals from within identified states participated. A total of 32 interviews were completed (see Table 1 for participation information), resulting in a response rate of 48 percent (32/67). Lack of participation was due either to no response to the email requesting participation or to no response when called for a scheduled interview. Interviews per state ranged from two to five, with an average of four interviews per state.

Table 1. Three-month followup interview participation

Request for participation		
n=72	67/72	5/72
Individuals listed as participants in the Pilot training	Number of participants who received the email requesting their participation in an interview	Number of emails returned to sender; one because of medical leave and four due to inaccurate email address provided
Scheduled interview		
n=34	32/34	2/34
Number of interviews scheduled	Number of interviews completed	Number of interviews not completed due to no response when called for scheduled interview

Results

Training Assessment—Across States

Respondents were asked if the objectives of the Pilot training were clear prior to their arrival at the training. Fifty-nine percent of the respondents reported that "yes" the objectives were clear, and responses were distributed fairly evenly across states. Of the respondents who felt the objectives were not clear, 54 percent were from the Cooperative Extension Service. Among those who thought the Pilot training goals and objectives were not clear, the majority of responses related to issues such as lack of clarity regarding the purpose and goals of the training as well as post-training expectations. Those who reported that goals were unclear included a small number of individuals who were invited to the training at the last minute and who did not understand that the training was only one step in an ongoing commitment.

Overall, most participants were satisfied with the training. When asked, "what worked" at the training, most respondents reported that the formal presentations were informative, working on action plans and goals with their state teams was extremely valuable, and that spending time together with other members from an individual's state, were worthwhile activities. Other themes that emerged as being useful included ongoing and cooperative teamwork within state teams and having a neutral facilitator to encourage the teams to work together and be productive. Additional themes that developed from the "what worked well" question included recommendations for more time for states to work together as a group, more time for Cooperative Extension Service agents to explain to other state members how they operate and function locally within a state, and for Cooperative Extension Service personnel to clarify their roles and expectations in the project. One participant

from another Federal agency stated, "Had the people from Extension understood more clearly our role and expectations, we could have interacted more effectively and been better prepared" prior to the Pilot training.

State Progress—Across States

After the Pilot training, most state teams communicated predominately through email. At 3 months after the Pilot training, two of the state teams had communicated only by email and telephone, two had at least one group conference call, three teams had held a face-to-face meeting, and one team had conducted both a conference call and a face-to-face meeting. Three of the eight state teams narrowed their action agenda focus to a specific list of counties (usually ranging from six to nine counties), and those state teams that had not yet identified local team participants indicated that this would be a priority in the near future.

Five of the state teams reported a change in their infrastructure; three of the teams changed leadership either to a new leader or developed co-chairs to lessen the responsibility of leaders selected at the Pilot training. Six of the eight teams reported additions or changes to their working group membership. For example, at least one addition for five of the six state teams was Cooperative Extension Service-related, whereby a university or regional Cooperative Extension Service director or supervisor not invited to the Pilot training was invited to join a team. State-specific partnership growth and reconfiguration was considered an essential ingredient to the future success and health of certain teams, especially those that needed additional expertise to guide them in planning and implementing their programs.

No group had secured additional funding for its project. At the national level, the Cooperative Extension Service planned to provide $2,000 for each team as seed money. The mechanism for securing these funds, however, was not established at 3-months post-Pilot training. At 3 months, representatives from States A, C, E, and F reported that they actively were investigating the Cooperative Extension Service seed money or another funding mechanism. One state team was exploring the use of incentives (i.e., gift cards) to encourage women to be screened. All eight teams reported the use of a number of data sources in their planning efforts, including using Cooperative Extension Service data to help identify high priority counties.

Seven of the teams reported that they had yet to mobilize support within their communities. Most teams reported that they intended to do so in the future, but they had not progressed to that point yet. One team indicated its intention to actively mobilize community support in January 2004.

All eight teams reported having used the action agendas created during the Pilot training. Three teams reported having made no changes to their agenda. One team (State C) reported having expanded the scope of its agenda from cervical cancer screening only to including both breast and cervical cancer screening. Four teams reported a change in timeline for the agenda action items. Three teams pushed their timelines back (States A, E, and H); and one team (D) moved its timeline forward.

Barriers and Assistance

Participants were asked to report what they perceived as the greatest "barriers" to moving forward with their state action agendas. There was no limit to the number of barriers a participant could report. Responses ranged from one to three barriers, and no ranking occurred. Two areas were consistent across state teams. Fifty-six percent of all participants reported that funding was a barrier (all states except B & F; State F representatives reported that interpersonal dynamics among team members were an impediment to progress and that logistical issues regarding implementing the planned action agendas also were a barrier). Representatives from State B reported that a lack of clarity of the objectives set at the Pilot training was a primary barrier because there had been little team activity since the Pilot training. A common theme among other teams was, "How are we going to pay these people (field agents) who come in?" or "when we go out for training?" Thirty-eight respondents reported time and/or their job as a barrier and stated that, "This project is adding additional work onto what we already do." Other issues raised included common issues surrounding a "lack of communication, "uninspiring leadership," and "no transportation to meetings or trainings."

Only 14 participants reported a need for technical assistance. Those from States A and F reported no technical assistance needs. Representatives from three states (B, G, and H) commented that there was a need for educational materials, two (D & E) cited a need for funding to produce their own materials, and two (B & E) cited a need for facilitation of meetings and conference calls. Team members from one state (D) made multiple comments regarding assistance with evaluating the implementation of their action plan, but this issue was not raised among other states.

All but two participants responded positively when asked about interest in developing some type of Web forum to facilitate contact between state teams. One comment was that, "It would be great to share information on successes and failures, stealing and not reinventing the wheel when it comes to interventions that have worked with particular groups."

State-Specific Data

State A: The State A team met face to face in late September 2003 and completed an e-tool training. No specific date had been established for a future meeting. At 3 months after training, the team had not narrowed its geographic focus to specific counties. The group was in the process of collecting data on cervical and breast cancer, compiling a calendar of events, and contacting the governor's wife so as to have a high-profile individual endorse the program. There was no agreement among respondents on the most- and least-active organizations in the project. The team had yet to identify a specific leader. The team wanted to broaden its activities to include activities associated with the Comprehensive Cancer Control Institute for State Leaders and to involve members of the Breast and Cervical program.

State B: The State B team met in October 2003. Most of the time was spent on presentations from the various organizations. The team was in the process of analyzing additional data to determine the "need" for interventions and available human resources. In addition, the team was eager to narrow its geographic focus to a small number of specific counties rather than to have a broad-based program. Also underway were preparations for winter school (Cooperative Extension Service field agent training), where individuals planned to present cancer information, discuss potential data collection techniques, gather best practices of interventions that are evidence-based, and address human resources. The team had scheduled another face-to-face meeting for February 2004. There was no agreement among respondents on most- and least-active organizations in the project. A common theme that emerged across the team, however, was the lack of clarity between the Cooperative Extension Service members and the rest of the team. One participant reported that, "The USDA Extension did not have a clear understanding of the intention of the Pilot program, and they were asked to come to the meeting but did not know it was the beginning of a long-term project." The team was being co-lead by an ACS representative and a Cooperative Extension Service staff person. The university extension agent was a new partner. This arrangement appeared to be working well.

State C: The State C team was the only team in which all interview participants reported that the objectives of the training were clear. The team met face to face in late September 2003. At that time, team members reviewed recent data and selected nine counties as key targets for the project. The team planned to meet again at the end of November 2003. Before progressing with specific interventions, the team planned to determine what other researchers in the nine counties were doing. A goal was to identify possible evidence-based cervical and breast cancer interventions that may have been successful with specific population groups and to apply ACS's e-tool where applicable. This state felt that there had been increased state-, local-, and county-level coordination and that all members were in concordance with one another. There was no agreement among respondents concerning the most- or least-active organizations in this project. The team had two co-leaders, one from the Cooperative Extension Service and the other from NCI/CIS.

State D: The State D team met three times via conference call. The team planned to continue to meet monthly via conference call. The team had completed a Memorandum of Understanding (MOU) statement, a plan of how it intended to work together. In addition, the team had developed and updated a PowerPoint presentation to inform Cooperative Extension Service personnel of the project, had compiled cervical and breast cancer incidence and mortality data for selected counties, and was preparing an Institutional Review Board (IRB) application for an evaluation of training for local Cooperative Extension Service staff. Seven counties and one city had been identified. Team members felt they had received good participation by team members, and they were satisfied with their progress to date. Future plans included exploring how to increase community participation in the project. Three of the five State D interview respondents reported that the evaluation they intended to conduct might require a request for technical assistance. The team had identified a CDC Breast and Cervical Cancer program participant as the team leader.

State E: The State E team had conducted both a conference call and a face-to-face meeting. The team planned to narrow its geographic focus at its January 2004 meeting. Team members had established a communications protocol and were in the process of reviewing data and inviting more appropriate Cooperative Extension Service personnel to join the partnership. Members of the team who were direct providers who had been invited by the Cooperative Extension Service had taken a step back. It was assumed that they might or might not become involved again as the planning and implementation of action items progressed. Respondents reported that the Cooperative Extension Service did not have a clear understanding of the purpose of the Pilot training and of the events that followed. Subsequent to the initial meetings, Cooperative Extension Service agents reported that their participation had improved as more appropriate people had joined the team. Future plans included broadening the involvement of the Cooperative Extension Service agents once they were

educated concerning the purpose of the Partnership. An outcome of these transitions was that the team had changed leadership from co-chairs to a single chair. The team was now being lead by a Cooperative Extension Service participant.

State F: The State F team had communicated via telephone and email and had held no in-person meetings. The team had not identified a specific date for a future meeting, nor had it identified a specific geographic focus for the project. The team was examining state cervical and breast cancer statistics and had conducted a literature search on recommended cervical and breast cancer outreach strategies. The State F team was small and one member had been on maternity leave, which had slowed progress somewhat. The team had identified a leader from the state Department of Health and was satisfied with this choice because it allowed potential collaborations with other Department of Health entities and with local hospitals. There was no agreement among participants regarding most- or least-active organizations. Based on participant feedback, this team appeared to be struggling with team dynamics that could take time to resolve and perhaps could impede progress.

State G: The State G team had a conference call in September 2003. During the call, team members reviewed the Pilot training, discussed goals, and decided what they would do when they met face to face in January 2004. The team had narrowed its focus to six counties. The team made significant progress. A physician started to educate other health care providers, the Cooperative Extension Service started to educate local offices, and the team had begun compiling statistics on cervical and breast cancer incidence and mortality. The team identified a leader from the CDC's Breast and Cervical Cancer program. There was no agreement among respondents regarding the least or most active organization in this state's project. An important outcome was reaching out to build alliances with Cooperative Extension Service offices in various counties that would benefit from knowing about this program.

State H: The State H team had communicated only via telephone and email. The team reported having planned a meeting that did not occur because team members needed to review the cervical and breast cancer incidence and mortality data before proceeding. The team planned to meet in January 2004. No counties or specific geographic framework had yet been selected. The team was small to begin with and one member had been on medical leave, a loss which hampered progress. Rural medical scholar information was dispersed to the team; one participant was examining this data to determine whether it could be applied to the state action agenda. There were no other items in progress at the time. Three Cooperative Extension Service members had a new supervisor who was to become involved with the planning and development process. State H had identified a participant team leader from the NCI/CIS.

Discussion

A common impression among states was that the Cooperative Extension Service Agents were poorly informed prior to the Pilot training and, as a result, were more likely to report a lack of understanding of the Pilot training goals and objectives, particularly as they pertained to the USDA mission at the community level. Clarification by USDA officials would enhance the understanding of the Cooperative Extension Service Agents' roles with regard to other partners, during the training, after training, and as joint partners with state teams in general. This lack of communication may have explained the Cooperative Extension Service Agents' lack of understanding of the mission of the Partnership and the use of evidence-based interventions to be adapted to or adopted by *rarely or never screened women*. This impression was not isolated and appeared to apply to several states after the Pilot training. It was apparent that the work states tried to accomplish during the first 3 months after training was slow in most cases and that many problems and expectations remained to be addressed by state-team members before they could progress toward accomplishing state agendas.

Despite the reported lack of clarity regarding the objectives both prior to and after the Pilot training in Atlanta, most feedback about the training was positive, and communication between teams continued afterward. Those who were involved and reported progress had a clear understanding of their state team's goals. Even if they had not yet made substantial progress, they were amenable to obtaining technical assistance from Partnership leaders to encourage continued progress.

Partnership leaders did not expect that every team would be at the same place 3 months after training. It was surprising, however, that two teams had not met via conference call or face to face and were having difficulty planning and making progress on their action plans. It was encouraging that all teams reported using their action agendas and that some were ready to advance the agenda initiated at the Pilot training to a more sophisticated level. Other teams needed to take a step back, learn more about and from each other, find out about activities in their local communities, and then refocus their agendas. Overall, the impression is that those teams that had made the most progress had strong leaders who were able to communicate well with their teams.

Strengths and Limitations

This evaluation had several strengths. Nearly one-half of all Pilot training participants completed a followup interview. Because of the interview design, the interviewer was able to probe or ask additional questions as necessary, according to participants' responses. Additionally, participants

were encouraged to ask questions or obtain further clarification on specific issues relating to the Pilot training. Interview participants represented many different organizations. This had both advantages and disadvantages, because each organization had a unique mission, and collaborating in a partnership on a common problem was a new concept for many.

This evaluation also had limitations. As a result of the interview design, many questions were qualitative in nature. Consequently, it was difficult to compare responses across participants because issues were unique to specific states. There were unequal numbers of respondents across the state teams; at least three organizations were represented for all state teams, except for one team that had only two organizations represented. Lastly, the sample was not random, and those who were scheduled for and completed the interview may have been more passionate about the training because of their involvement, compared to those who were not interviewed or who resisted an invitation to participate.

Recommendations

- Send a clear and consistent message about the purpose and objectives of the program to *all* organizations represented in the Pilot training partnership.
- Work to establish a clear understanding of the expectations for post-training work, such as how long it may take to identify and implement evidence-based interventions, what is involved, and who will provide financial and technical support.
- Help teams to establish a first meeting or conference call date, with a backup date, prior to leaving the Pilot training.
- Partnership leaders need to endorse the state leaders' progress, provide feedback, and establish a centralized point of contact for state leaders to ask questions and discuss concerns as issues arise.

Partnership to Increase Cervical and Breast Cancer Screening in High Mortality Counties: Six-Month Evaluation of the Pilot Training

May 26, 2004

Introduction

With mounting concern that some women *never* or *rarely are* screened for cervical and breast cancer, unique Federal and non-Federal partnerships have formed to promote evidence-based methods to reach these women. Links between these entities can play an integral role in disseminating rigorous scientific research that promotes the adoption of screening into practice. Optimizing the transfer of effective evidence-based interventions into practice requires overcoming the gap between the best available research and applying this knowledge into practice. Strategies that encourage women to adopt cervical and breast cancer screening modalities are well known, but the division between knowing what is effective and the day-to-day provision of health services is extensive. Disseminating sound research evidence involves a triangle that includes dedicated partnerships that embrace population-based health principles, the best available scientific interventions, and practitioners willing to adopt or adapt new approaches.

The paradigm for an ideal partnership continues to evolve, and the approach outlined here is being tested through a pilot program, "*The Partnership To Increase Cervical and Breast Cancer Screening.*" This pilot program is a joint effort between Federal and non-Federal organizations formed in 2001 and includes the Centers for Disease Control and Prevention (CDC); United States Department of Agriculture (USDA) the National Cancer Institute (NCI); and the American Cancer Society (ACS). To encourage widespread adoption of research-tested interventions, practitioners representing the parent organizations were invited to learn about and to embrace evidence-based principles in their everyday work. In July and August 2003, a training entitled, "*The Partnership To Increase Cervical and Breast Cancer Screening in High Mortality Counties: Pilot Training,*" was held in Atlanta, Georgia. The purpose of the training was to develop and support state-level partnerships to identify, synthesize, and implement evidence-based approaches that encourage women who *rarely or never have been screened* for cervical or breast cancer to be screened. The 1½-day training was attended by eight states with cervical cancer rates above the U.S. national average and included representatives from Alabama, Georgia, Illinois, Kentucky, Mississippi, Missouri, South Carolina, and Tennessee.

Recognizing that widespread awareness and adoption of these evidence-based principles will have a profound impact on public health education and practice and, ultimately, on the public's health, the training utilized a variety of methods. These included formal presentations by cancer control experts, demonstration of and instruction on accessing evidence-based screening interventions via Cancer Control PLANET, breakout sessions that promoted the creation of state action agendas and

encouraged building of local partnerships, and discussions on identifying resources to support strategies to increase screening in high-mortality counties.

To determine whether evidence-based principles were being integrated into competing priorities and day-to-day workloads and whether local partnerships were successful and functional, a followup evaluation of state teams was conducted at both 3 months and 6 months after the pilot training. The 3-month evaluation, conducted in November 2003, assessed the usefulness of the pilot training, state-team planning and subsequent communication, use of available resources, and utilization of state action agendas. These results are reported elsewhere. This report describes state-team progress at 6 months, assesses process in four key areas, and presents possible strategies for change to assist in the dissemination of research into practice:

- Progress on action agendas and activities since the 3-month followup interview
- Upcoming plans and goals
- Anticipated needs for support
- Partnership, collaboration, communication, organization, and leadership.

Methods

Overview

Sixty-eight of 72 pilot training state participants were asked to participate in a telephone survey that consisted of 20 questions with both closed- and open-ended responses. A total of 32 interviews were completed (Table 1).

Participants

Participants were regional, state, or local representatives of the three Federal and one non-Federal planning organizations (CDC, NCI, USDA, and ACS). Community groups included CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP) providers and cancer professionals from the NCI's Cancer Information Service (CIS), identified by states, as well as individuals from USDA cooperative extension services. Though most individuals belonged to one

state team, some participants contributed to two teams because they worked in a region that covered more than one state.

Sixty-eight state pilot training participants were contacted via email to request their participation in a telephone interview at a day and time convenient to the participant. Three participants could not be contacted because of inaccurate email addresses. Another participant was not contacted by CDC but received the email request from a coworker and completed the interview. In all, 29 phone interviews were completed, and three surveys were completed via email. Two participants who served on two state teams completed one interview for each state they represented. In all, 21 of the interviews were with participants who also completed the 3-month interview. On average, four team members per state participated in the survey, with a range of from two participants (State H) to five participants (States A, D, and E).

Table 1. Participation in 6-month followup interview

Request for participation in the interview			
68/72	94.4%	65/68	95.6%
Participants sent an email requesting interview		Participants successfully contacted	
Completed interview			
29/32	90.6%	3/32	9.4%
Interviews completed by phone		Interviews completed by email	

Procedure

On January 26, 2004, a CDC employee contacted pilot training participants by email requesting participation in the telephone interview. A second email was sent (January 30, 2004) to four of the state teams who did not respond to the first email request, and these individuals received a followup telephone request. Telephone interviews were conducted between February 2 and 10, 2004. Participants were informed that the telephone interviews would be recorded to ensure the accuracy of response interpretation during analysis. Telephone interviews lasted 10–35 minutes. Respondents were probed for further detail depending on their response to a question (i.e., if they responded "yes" or "no" and the question required additional input).

Three participants who were unable to schedule a phone interview completed the identical survey with via email during the same timeframe.

Instrument

The phone survey drew from questions that were modified from the Comprehensive Cancer Control Institute for State Leaders' followup survey and were supplemented with questions specific to the Partnership Pilot Training. The instrument contained 20 open-ended questions. Broadly categorized, questions inquired about state progress since the 3-month interview, future meetings, the development and execution of action steps associated with individual state action agendas, state-team leadership, collaboration and partnership, responsiveness to community needs, and anticipated needs.

Results

State Progress—Meetings, Communication, and Team Membership:

The state summaries were based on the period between the 3-month followup and the current interview. Four questions asked were:

- "I know your state team (met in _____ month). What group meetings or conference calls have taken place since then?"
- "Have any additional meetings or calls been scheduled?"
- "Have there been any additions or changes in the membership of your state team?"
- "When I last checked in with your team in November 2003, your team was in the process of (e.g., selecting counties to work with); has your team (e.g., selected a specific geographic framework)?" State-team member's responses are reported below.

State A: The team held a conference call in January 2004. A followup meeting was scheduled for March 2004. The team was exploring how best to identify potential counties to collaborate with and had not altered the original team membership.

State B: Two members reported meeting on the day of the interview (February 2004); two other members reported not having met since November 2003. Two team members stated that they planned to meet in May 2004, and two other state-team members were unaware of this meeting. The team was working to reduce the list from 20 counties to a more workable number. Not all team members were aware of changes to the state-team membership; a university employee began participating in fall 2004, two individuals left the team due to a lack of funding, and one had retired.

State C: The team met in person twice (most recently in November 2003) and spoke by phone on several occasions. Meetings were productive, and there was good participation by team members. A meeting was scheduled for February 2004 to discuss the possibility of conducting focus groups with women rarely or never screened for cervical or breast cancer. The team brought in new members from the USDA Cooperative Extension Service, and from the Appalachian Cancer Network; these new members had training in scientific research and implementation of interventions and were expected to substantively enrich the team's work since. The team identified nine additional counties willing to work with the core team members. There were no additional changes to report.

State D: The team had conducted two teleconference calls (December 2003 and January 2004) and had been in contact via email. A training session for USDA Cooperative Extension Service health educators was scheduled for February 2004. The team had identified eight counties that had expressed interest in participating. One additional county was added since the 3-month followup interview. No additional changes in team membership were reported.

State E: The team met in person in January 2004. The team identified new group members from a university extension who met in January 2004. A team meeting was scheduled for March 2004 to introduce new community agents, define their roles, and to explain the Pilot Project. The general consensus of group members was that they had identified five counties willing to participate with the core state team that would propel the team forward.

State F: No meetings had taken place and none were scheduled. State-team members had communicated by email. The team had not identified counties to participate, and no changes had taken place in team membership.

State G: The team met in November 2003 and had communicated via email since then. Planning for a February 2004 meeting had been discussed but was not confirmed at the time of this interview. In the interim, individual team members planned to proceed with their state action plan. Team membership had not changed except for the loss of an ACS employee. The team identified six additional counties willing to work with the state team. There were no further changes to report.

State H: No meetings had taken place and none were scheduled in the near future. The team had not identified additional counties that might be interested in participating with the team. One team member reported that three new team members recently had been added, but, as of the interview, it was unclear what roles they would assume on the team.

State-Specific Data—Action Items: What Is Each Team Doing?

The state summaries described below were based on the following seven questions:

- "Is your state utilizing the action agenda that was created during the training?"
- "If so, have there been adjustments and/or revisions to the action agenda?"
- "If not, have you created a new plan, or what is being used as guidance?"
- "When I last checked in with your state.…What additional items have been completed?"
- "What is currently in progress for your state?"
- "What are the next steps your state team should consider or has already planned for your state team?"
- "Have the strategies that have been implemented or that your state team is proposing to implement been responsive to the needs in the identified counties?"

State-team responses are reported below.

State A: Team members reported that the state action agenda created during the Pilot training *was* being utilized with minor adjustments (e.g., the timeline had been modified to reflect accomplishments that were more realistic). Since the 3-month followup, participants reported developing a statewide calendar based on their state's Office of Minority Health Current projects included partnering with other groups, preparing an overlay of past data with legislative districts, using data to identify target communities, and engaging in more outreach through worksites. Team members reported that the next steps would include working with the First Lady, expanding community partnerships, lobbying, and conducting more outreach to communities-in-need. Participants found it difficult to judge the team's responsiveness to overall state needs with regard to identifying women *rarely* or *never* screened for cervical and breast cancer.

State B: Team members reported that the state action agenda created during the Pilot training *had not* been utilized and that the agenda would need adjustments to account for the lack of resources before it could be utilized. Since the 3-month followup, participants reported that the following items had been completed:

- presentation at USDA winter school

- presentation at the FVSU conference
- achievement of a greater sense of clarity about the project overall and about how to accomplish stated action items.

Current projects included presenting exhibits at health fairs, presenting information on a Web site for the USDA Cooperative Extension Service, including Cooperative Extension agents in future-state team meetings, and identifying how to make partnerships work effectively. Team members reported that the next steps would include involving county agents and the CIS regional representative and promoting the program to FNEP Participants remarked that they had not yet evaluated the team's responsiveness to their state's needs.

State C: Team members reported that the state action agenda created during the Pilot training *was being* utilized, with some adjustments (e.g., specific interventions). Participants reported that no additional items had been achieved since the 3-month followup, with the exception of identifying potential interventions and other interested collaborators in the field.

Current projects included:

- identifying people at the community level suitable for a focus group
- networking
- researching existing activities being implemented at the county level.

Team members reported that next steps would include conducting focus groups, identifying barriers, and identifying evidence-based interventions. Some participants believed that the team's responsiveness to state needs was "good" but noted that they had not evaluated this sentiment.

State D: Team members reported that the state action agenda created during the Pilot training was being utilized and that it had been refined (e.g., the timeline was revised to be more realistic). Since the 3-month followup, participants reported receiving Institutional Review Board (IRB) approval for conducting a training and developing a training agenda that was accompanied by a budget.

Current projects included:

- conducting multiple tasks in preparation for training
- developing evaluation tools to assess the training

Team members reported that the next steps would include training in implementation and management of a training plan and as guidance in evaluation. Most participants anticipated that the team would be responsive to state needs and noted that they would be able to assess their success at the conclusion of the Pilot training program.

State E: Team members reported that the state action agenda created during the Pilot training *was being* utilized, with minor adjustments (e.g., a more realistic timeline was being implemented). Since the 3-month followup, participants reported that the following items had been completed:

- selecting counties
- including more individuals as state team members
- reviewing data on cervical and breast cancer incidence and mortality.

Current projects included planning for future funding of new projects and actively identifying and recruiting prospective team members. Team members reported that the next steps would include implementing state agendas, understanding how to assist organizations in providing services, improving collaboration, and integrating the state team's evidence-based intervention message into all projects. Participants found it difficult to judge the team's responsiveness to their state's needs.

State F: Team members reported that the state action agenda created during the Pilot training *had not* yet been utilized. Participants reported that no additional items had been achieved since the 3-month followup, although one team member started a cervical cancer coalition that was not related to the partnership. This coalition, however, may be interested in joining the state-team's partnership. No projects currently were in progress. Responsiveness to current state needs had not been assessed.

State G: Team members reported that the state action agenda created during the Pilot training was being utilized without revisions or modifications. Participants reported that no additional items had been achieved since the 3-month followup.
Current projects included:

- planning a conference
- conducting CHP training
- accomplishing individual action plans

- talking to community providers about translating and applying research-based national findings on a local level.

Team members reported that next steps would include understanding how to coordinate efforts, strengthen coalitions, and improve awareness; and implementing county-by-county training on disseminating evidence-based interventions. Participants had mixed thoughts about whether the state's needs were being met.

State H: Team members reported that the state action agenda created during the Pilot training *had not* been utilized, and one team member reported that the state was using a different plan altogether. Since the 3-month followup, one participant reported that the team had selected counties to conduct pilot testing of one or more evidence-based interventions. No other activities had been completed, but one participant reported developing a cervical cancer curriculum that would be pilot tested at the county level. If successful, the curriculum could be extended in the future to include breast cancer. Participants reported that next steps would include collaborating with state cancer control planning efforts to identify the breadth and depth of the cervical and breast cancer problem in specific counties throughout the state.

State Specific Data—Process: How Are Groups Working Together?

The analysis of state collaboration was based on the following five questions:

- "How effective is the coordination of communication and organization of activities and meetings or calls for your state team?"
- "How effective has your team leadership been in motivating and empowering people to be involved in the partnership?"
- "Since November, what has your role been as part of your state team?"
- "How satisfied are you with your role in the partnership and the way in which your team's plans are being implemented?"
- "Have any new partnerships been formed as a result of your state team participating in this project?" Responses of state team members are reported below.

State A: Team members recognized the need for strong leadership, focus, and team cohesiveness to help motivate members to accomplish their action plans. There were diverse opinions with regard to what the team leadership would look like. Some individuals suggested that the current team leader

was keeping the group on task, and a majority of members were satisfied with the current leadership, communication, and organization. This notion was reinforced by the fact that team action plans were being implemented. On the other hand, a minority of members reported a need for team focus and expressed dissatisfaction with the current leadership. In fact, these members had discussed forming a new partnership. At the time of this interview, this topic had not been discussed with the group as a whole.

State B: Half of the team members reported that communication was effective; the other half reported that they were unable to comment accurately on the status of their state's communication with team leaders. Most agreed that the current leadership had helped the state to move its project forward. Regardless of an individual participants' role on the team, participants reported satisfaction with their role in the partnership as a whole and especially with the way in which state-team plans had been implemented. Some participants reported that new partnerships had subsequently formed since the Pilot training.

State C: Team members reported that they were satisfied with communication, organization, and efficiency. Participants also reported being pleased with team leadership. Regardless of team role, participants mentioned that they were enthusiastic and satisfied with their roles in the partnership. Most team members stated that they were content with the speed with which team plans were being implemented. Some participants reported that new community partnerships hade been formed and that others were being explored.

State D: All team members reported that communication was effective among members and their leadership, and this resulted in all members feeling well-informed and satisfied with where the team was headed. Regardless of a participants' team role, all participants reported satisfaction with their roles in the partnership. They also stated that what they were accomplishing was worthwhile; this was reflected in the way in which team plans had enthusiastically been implemented. Some participants reported that new partnerships had been formed (University Extension).

State E: Team members reported that communication generally had improved since the meeting held in October 2003. Part of this improvement resulted from team member involvement. It would be more effective if the USDA Cooperative Extension Service team members were more active team players. Participants reported that team leadership was less than optimal. One participant suggested that a neutral facilitator be included at meetings to help soften the tone, improve productivity, and advance the agenda. Regardless of individual participants' team roles, they reported

satisfaction with their position and function in the partnership and the way in which the team plans had been implemented. Some participants reported that new partnerships had been formed.

State F: There had been no recent communication among team members, which s led to a general dissatisfaction with the current team leadership. Team members who had participated in the past 3-month's evaluation reported feeling that the team as a whole had under performed and could do better in the future with stronger leadership. No new partnerships had been formed as a result of state team participation at this point.

State G: Three of four members reported being satisfied with communication and organization, which primarily had been managed via email. One member, however, reported a lack of clear vision in executing state action agendas and plans. In general, participants were satisfied with the current leadership, largely due to regular communication among team members. One participant suggested that greater delegation of tasks to other team members would improve morale. In terms of individual team members' roles within the partnership, two of four participants reported satisfaction with their roles as state-team members and were content with the way in which the state-team plans were being implemented. On the other hand, two members expressed frustration with their roles as team members because of issues related to the way in which state plans were implemented. One of the individuals felt that the state program as a whole was a failure. Another member reported being frustrated by having been assigned specific tasks that were not related to the state plan. No new partnerships had been formed or were planned by this team in the future.

State H: Members reported an absence of communication, and to resolve this there was mention of bringing in new team members to help improve communication and organization at the state level. Participants reported general dissatisfaction with the existing team leadership, yet did not offer any solution to their dissatisfaction. One participant reported feeling frustrated with regard to his/her role within the team, a complaint that was due generally to a lack of responsiveness from other team members. No new community partnerships had been formed at this juncture.

Partnership-Level Analyses

Identification of Additional Needs, Potential Barriers, and Relationships With Other Organizations

Responses to questions about identifying additional needs, potential barriers for moving forward, and relationships with other organizations are summarized below. Several questions were not asked of participants who previously had reported that they were inactive participants during the time period covered by the evaluation. Responses across state teams were combined due to similarities in responses from state-team members. State-specific information is included when it was available and unique.

Exploration of additional resources: Individual state members reported varying levels of awareness about the availability of additional funding and where and how to obtain it. Members across teams reported that they were aware of available funds from USDA, and a few state members (States C, D, and E) reported having investigated or applied for additional funds from alternate sources on their own. In particular, teams wanted additional financial support to hold face-to-face meetings or to develop their own evidence-based initiatives. Additionally, many team members reported being unaware of additional funding availability and where or how to obtain it. The only technical assistance need mentioned was how to identify and acquire funds so that state programs could continue (State B).

Greatest barriers to moving forward: To move projects forward, state-team members were vocal and in consensus about the most important state-level barriers. The most frequently mentioned barriers were time and money. Other barriers included convincing partners and colleagues of the significance of this project, comprehending mixed levels of clarity and expectations from different partners, dealing with the physical distance between team members, being concerned about the sustainability of the program, receiving mixed communication and messages from leaders and among team members, and remaining focused on team goals so as to accomplish the defined action items.

Identification of how community programs fit with state goals: Team members actively involved in their programs were asked about their ability to identify how different community services and programs related to the individual state goals that had been identified at the Pilot training. Overall, most respondents were able to identify problems only in the specific region with which they were familiar and that they knew was in need of assistance. In many instances, team

members mentioned that USDA Cooperative Extension Service staff were open and particularly helpful in identifying target areas in need of assistance, and offered valuable information on potential avenues for resources. A minority of respondents felt that significant progress needed to be made to identify how community programs would fit with identified state goals.

Satisfaction with the participation of other organizations: Team members from three states (States A, C, and D) reported high levels of satisfaction with the participation of other organizations in this project. Team members from States B, E, F, and G generally were satisfied with the participation of other organizations, whereas State H representatives reported low levels of satisfaction in this area.

Supervisor Support for efforts on this project: Participants all reported having discussed this project with their supervisors, and it was their impression that their supervisors were supportive of individual efforts as well as of the project as a whole. There was little elaboration or insight beyond these statements.

Strengths and Limitations

This process evaluation led to the identification of several strengths and weaknesses of the partnership. *Strengths* of the current evaluation included:

- Identification of factors that currently were working well in many state teams, such as cohesive leadership and open communication among teams and leaders
- Identification of factors that needed improvement, including greater utilization of resources, increased efforts to communicate with *all* team members—especially new members—and greater collaboration beyond the immediate team
- Updates of team progress from each state needed to be conducted on a regular basis
- Encouragement of team members to think critically about team progress and functioning
- Identification of team goals among team members.

Limitations of the current evaluation included the following:

- Limited questions about how collaborations were formed and functioned, whether there was team synergy, and how other team processes influenced the implementation of state

action items. These questions did not provide sufficient insight on specific problems or promising strategies to remedy them.

- Lack of a theoretical and empirical basis for developing questions that related to the partnership process. For example, information on what the partnership meant to state participants and how they viewed the partnership in light of their own workload and competing priorities was missing. Further, questions did not delve into whether the partnership process was a realistic vehicle to implement change and to assist states in disseminating evidence-based research into their practice environments.

- Less than optimal rates of participation in the 6-month evaluation made it difficult to draw definitive conclusions about whether responses were representative of all teams and team members or whether they were limited to a subset who functioned either very well or very badly.

Discussion

In general, states have been meeting every 2 to 3 months, and both the frequency and type of meetings (e.g., face-to-face, phone) vary across states. Two states reported having very little or no activity and minimal communication since the 3-month evaluation. Five of the eight states were using the state action agendas (or modifications of the agenda) created during the Pilot training. Examples of current or upcoming state activities included making presentations, identifying evidence-based interventions, and planning training activities. In general, participants suggested that improvements could be made in the areas of increased involvement at the state and local level and assistance in identifying potential partnerships.

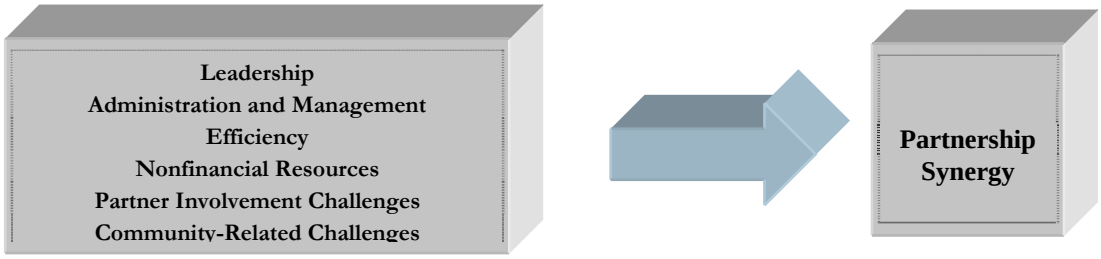
Results from the 6-month pilot training evaluation revealed several successes as well as areas of improvement among states involved in the Pilot training for the *Partnership To Increase Cervical and Breast Cancer Screening*. Overall, most interview respondents reported that they were satisfied with their state's progress in the partnership and that these teams were dedicated not only to the partnership, but to their state team as well. Specifically, those state teams and team members who reported high levels of satisfaction with state progress were more likely to report that communication was effective between team members and with leadership and that regular team meetings were being held. In addition to influential patterns of communication, a common key ingredient of successful teams observed is the way leaders are able to successfully influence others. For instance, effective leaders can influence what is implemented in the community, such as demonstrating how to form active, successful, and sustained collaborations with others.

Areas for improvement varied by state team, but can be generalized into several categories. First, greater communication was considered the most important element lacking in state teams. Research suggests clear evidence that the failure of simple communication, such as holding regular meetings and presenting regular updates, can inhibit the social influence of common agenda-setting, achievement of group consensus, and building of collaborations beyond the immediate group. Second, the desire to form collaborations between partners within local communities and to tap into existing organizations and structures might have enhanced state team progress if alternate approaches had been adopted. Third, the lack of resources inhibited face-to-face meetings and potentially hampered these new teams in exploring potential avenues to disseminate evidence-based interventions in an efficient and creative manner.

The findings from this evaluation can be understood best within the context of *partnership synergy*, an empirical perspective on the social influence of partnerships. Weiss, Anderson, & Lasker (2002) hypothesize that specific dimensions of the functioning of partnerships relate directly to partnership's synergy, including leadership, individual empowerment, and bridging social ties (see Figure 1). Weiss, Anderson, & Lasker (2002) believe that special kinds of leaderships form, are able to collaborate with each other, and are able to be successful. As was seen with some state teams, these collaborations form early, can be sustained throughout a project, and can overcome obstacles in successful and creative ways. Failing to consider partnership synergy can result in collaborations that are less effective, less successful, and that never realize their full potential. A partnership's synergy can be assessed via process evaluations specifically designed to assess synergy.

In addition to the impediments mentioned above, Weiss, Anderson, & Lasker (2002) identify several key obstacles for people involved in partnerships. First, the full body of knowledge about collaboration expectations or about solving a particular problem is not always readily available, especially if target populations are not trained to solve particular types of problems or if problems are presented in ways that are difficult to comprehend. Second, partners and stakeholders frequently come from different disciplines and have different interests than does the funding organization. Consequently, they may not have a common goal to effectively communicate with each other to solve a particular problem. A third obstacle is the difficulty in building synergistic partnerships.

Figure 1. Dimensions of partnership functioning connected to partnership synergy



Recommendations

Based on this evaluation, the following are recommended:

From the 6-month evaluation, members of the Partnership could:

- *Communicate* regularly with *all* team members and collaborators to reinforce not only the importance of the project from the partners' perspective, but also from the stakeholders' perspective. Based on responses from Pilot training participants (stakeholders), it is apparent that regular communication is highly essential for effective team functioning. Ongoing in-person, phone, and email communication all are effective forms that can be used between all collaborators. In particular, many participants expressed the desire for additional face-to-face meetings to clarify issues, strengthen relationships, provide assistance, and share similar issues encountered by other states.

- Encourage the use of the *USDA Partnership Pilot* (Partnership) *Forum*, an Internet-based message board and chat room developed by CDC staff member Chastity Walker. This communication modality was developed as an open and ongoing forum for state members to share progress, discuss problems, and potentially provide technical assistance to each other. As CDC states, the purpose of this Web-based forum is "to share information among state pilot program participants and national partners." Participants may post documents, such as individual state action plans, articles of interest, intervention materials, position descriptions, or other documents found useful in planning, implementing, and evaluating cancer control activities. The potential of this forum as a communication tool is large, but until now it has been underutilized both by state participants and national partners. It is strongly recommended that participants regularly check for Web updates and postings (e.g., training announcements, posting of the summaries of the evaluations) and actively participate in this Forum. Participation by leaders is an appropriate social influence that could influence behavior, transmit new knowledge and information, and clarify issues. This Forum also could be used as a training venue for new collaborators. In addition, a facilitator could use this medium to convene regular online "live chats" among state groups.

- Distribute feedback from previous evaluations (i.e., the 3- and 6-month evaluations) to team members, both directly and as a posting on the Forum noted above.

- Use facilitators to help state teams maintain focus on accomplishing team goals.

From the 6-month evaluation, the following are recommended for **future process evaluations**:

- Assess how the feedback from the 3- and 6-month evaluations has been implemented by state teams and whether findings from these evaluations were integrated into future partnership relationships.

- Communicate future evaluation results to team members, both directly and as a posting on the Forum.

- Develop an online focus group to collect data on group processes using the Weiss, Anderson, & Lasker (2002) paradigm to guide question formation.

- Incorporate questions related to *partnership synergy* in future process evaluations. Below are examples of such questions developed from the sample *Web-Based Partnership Self-Assessment Tool* developed by the Center for the Advancement of Collaborative Strategies in Health (the instrument can be found at: *http://www.partnershiptool.net*):

  – **Leadership**

    1. Empower people involved in the partnership.

    2. Foster respect, trust, inclusiveness, and openness in the partnership.

    3. Combine the perspectives, resources, and skills of partners.

    4. Help the partnership be creative and view things differently.

  – **Administration and Management**

    1. Coordinate communication among partners.

    2. Coordinate communication with people and organizations *outside* the partnership.

  – **Efficiency**

    1. Use the partners' financial resources.

    2. Use the partners' in-kind resources.

  – **Nonfinancial Resources**

    1. Explore partners' skills, expertise, data, and information.

  – **Partner Involvement Challenges**

    1. How satisfied are you with your influence in the partnership?

  – **Community-Related Challenges**

    1. Address the challenges of uncommon partners now working together, and consider how well these partners are able to communicate clearly to those in the community how the partnership's actions will address problems that are important to them.

- Future evaluations should include the following additional questions not covered in the Weiss, Anderson, & Lasker (2002) paradigm:
  - Has the Pilot training increased *understanding* of evidence-based approaches to reaching target populations? If not, why not? If so, how was it accomplished?
  - Has the Pilot training increased *the application of* the evidence-based approaches to reaching target populations?
  - How has the collaboration accomplished its *state-specific action plans and visions*?
  - Were programmatic goals *achieved*? If so, what was the timeline? If not, why not?

Conclusion

The 6-month process evaluation provided a brief snapshot of how states were functioning 6 months after they had received the Pilot training. It was intended to track and describe the implementation and growth of the new Federal and non-Federal partnership program within states, identify factors that may inhibit or thrust certain states into the limelight because of their ability to form or not to form partnerships beyond their immediate state teams, and identify and follow activities related to implementing state action agendas. Furthermore, the process evaluation served to identify specific program resources needed to continue to guide this program toward success on all levels. Continued tracking remains an important key to the success of this program, because dissemination of sound evidence involves a triangle that uses dedicated partnerships that embrace population-based health principles, the best available scientific interventions, and practitioners willing to adopt or adapt new approaches. Understanding how these elements intertwine will set the stage for other Federal and non-Federal partnerships. Partnership leaders are integral in supporting state-team efforts and in ensuring that states understand the importance of disseminating research-tested interventions that encourage the adoption of cervical and breast cancer screening modalities in the local communities they serve.

References

Weiss, E.S., Anderson, R.M., and Lasker, R.D. (2002). Making the most of collaboration: exploring the relationship between partnership synergy and partnership functioning. Health Education & Behavior 29(6):683-698.

Appendix F

PATH Visit Reports

Team Up PATH Visit Report and Technical Assistance Plan

State A

Prepared by: Elizabeth Randall-David

October 2005

Team Up PATH Visit Report and Technical Assistance Plan

State A – October 2005

Introduction

Technical assistance is an important cornerstone of the Team Up project. Technical assistance in the Team Up project consists of tailored and general assistance to the state teams in order to monitor and document progress and to problem solve on issues related to team building, the development and refinement of state action plans, and the identification, adaptation, implementation and evaluation of evidence based interventions. Technical assistance can take many forms such as (1) coaching, (2) sharing information with other Team Up partnerships via quarterly teleconferences, the web forum, quarterly Team Up newsletter, webinars, and (3) assisting in partnership development and capacity building via individual interactions with national partners, PATH visits, regional meetings, and retreats.

There were several methods for assessing the technical assistance needs of the Team Up state partnerships: telephone interviews with each of the primary partners in fall 2004, brainstorming during the PATH visits in spring 2005 and at the regional meetings in summer 2005, and telephone interviews with either the chairs/co-chairs or full partnership in fall 2005. Some technical assistance needs such as assistance with identifying and securing financial support for the project have remained constant over time while others such as team building have changed as the state partners have moved along in the developmental process.

The technical assistance plan for State A is best understood in the context of reviewing the background of State A's Team Up partnership.

Background

The State A Team Up partnership has developed a strong partnership between ACS, BCCEDP, ACS, CIS, County Extension, the Deep South Network (DSN) and a university in State A. Many of these partners have had a long history of working together and they have a non-profit or 501C3 status. More recently they have collaborated on the development of the comprehensive cancer

control plan. The team meets on a monthly basis by telephone under the shared leadership of CIS and DSN.

The State A Team Up partnership selected one county of focus based on several criteria: high mortality for cervical cancer, not already saturated with research projects and a staff presence from ACS, DSN, CES and BCCEDP.

In the first couple of years of the Team Up project, the State A partnership implemented and evaluated the Youth as Messengers project. Most of the partners described this project as evidence influenced rather than evidence based. They are still determining whether or not they will adapt an EBI from RTIPs of whether they will use the lay health advisor model of the Deep South Network as their evidence based approach. This model has been evaluated and published in peer reviewed journals. There is some resistance to starting a whole new effort when they feel that the Deep South Network's efforts have been so successful in recruiting women for breast and cervical cancer screening services.

PATH Visit:

The State A PATH visit took place on May12, 2005. Thirteen individuals attended the meeting (8 state partners, 3 national partners and 2 coaches). (See Attachment 1.) During the PATH meeting, State A's Team Up members reviewed their key partnership accomplishments over the past year and a half. They felt they work well together, are optimistic, and have established a good reputation among community members and service providers. They have increased the number of local partners. They have also completed many cancer related projects (although it was not clear how many of those involved all four of the Team Up partners in addition to DSN and UAB) as well as effected policy and legislative changes.

The State A Team Up partnership also acknowledged challenges within their partnership. They were still not clear about the objectives of Team Up and how Team Up can interface with and be distinct from many of their other projects. They have been challenged by staff shortages both at the state and local levels. They also feel challenged by the current status of the BCCEDP where there are 5,000 women on call for rescreening. They wondered if it was feasible to recruit new women into a program that was essentially closed. Different resource levels among Team Up partners and

difficulties in communication have strained the relationship among the partners at times. There has also been a void in leadership.

Since some of the group did not seem to be certain that Team Up offered anything special, the coaches asked them to think about the benefits and costs of participating in Team Up. They answered as follows:

Benefits	Costs
■ National recognition	■ Time
■ National support	■ Taking from state to local
■ Educational materials	■ Communicate with national Team Up partners
■ National data	■ Listening to front line
■ Human capital	■ Translating commitment to others
■ Best practices	■ Participate in national evaluation
■ Turn work into evidence based practice vs. community empower model	■ Human capitol
■ Expertise shared	

They decided that the benefits outweighed the costs and worked with the coaches and national partners to create a list of action steps for partnership development and program implementation. The action steps are as follows:

1. Establish a structure, leadership, goals, time line;
2. Select Co Chairs (Gail and Claudia);
3. Plan to prioritize intervention sites;
4. Plan meetings for the first Friday of each month after DNS calls; and
5. Planned to have a discussion on EBIs after the regional meeting.

Regional Meeting

The regional meeting was attended by nine members of the State A partnership. Unfortunately the new BCCEDP coordinator was being oriented to her new job in and could not be present at the regional meeting. Those present developed an action plan during the state breakout session. Among their action steps were the following:

- Explore evidence based interventions;

- Pick counties for Team Up intervention;
- Develop and implement a cervical cancer education campaign for January; and
- Determine culturally appropriate cervical cancer messages for older women.

Technical Assistance Needs

Based on data collected during the fall 2004 interviews from all the States, technical assistance needs were sorted into four main categories and fifteen sub-categories. These are described in the table below:

Technical Assistance Categories of Need Identified from Telephone Interviews (10/04)

Categories of Need
Communication
Forum to communicate with other state teams regarding "best practices" and lessons learned
Program Planning
Use of cancer data
Strategic planning
General program planning (including design, implementation, and evaluation)
Adapting or adopting evidence based strategies
Partnership
National Partnership: purpose, expectations, and institutional support available to teams
Team building (e.g., partnership and collaboration, learning about each other's organizations)
Negotiation (includes partnership conflict resolution, turf issues, etc)
Funding (includes grant writing, searching for funding)
Leadership development
Content
Cancer control expertise for the community
Educational resources (includes displays, materials, etc,)
Tailoring educational methods for various audiences
Cancer PLANET Training
Cultural competency (includes barriers, low income, literacy)

The coach discussed these and other possible technical assistance areas with the co-chairs by telephone in October 2005. Following that call, the State A Chairs discussed their current technical assistance needs with the rest of the partners. They developed the following list:

Current Technical Assistance Needs (10/05)

Need	Recommended actions
Training in leadership development for community members	Regional meeting; PATH visit; Coach provide training at DSN Institute
Train partners in negotiation skills including conflict resolution and effective strategies for dealing with turf issues	Regional meeting; PATH visit; Webinar; webforum
Assistance in grant writing (including boiler plate)	National partners
Assistance in searching for funding	Coach/national partners

Discussion

The State A Team has significant partnership and program planning skills. Similar to other Team Up states, the State A Partners requested financial assistance for implementing Team Up interventions. In addition they would like to secure funds to hire a Team Up coordinator. They also would like assistance with identifying potential funding sources and help with grant writing including a boiler plate from the national partners. They would like training for the partners in negotiation skills including how to resolve conflicts and deal effectively with turf issues. Lastly, they want training for community members in leadership development. The co-chairs suggested that the annual DSN Institute might be good venue for this training. The State A Team Up partnership seems eager and open to technical assistance from the coach, the national partners and other state Team Up partnerships.

Attachment 1: State A PATH Meeting Evaluation
May 12, 2005
6 Evaluations Completed (participation estimated at 13)

Q1-Q2. What were participants' expectations? Were they met?

- 4/6 reported "Yes" expectations met;
- 0/6 reported "No" expectations met; and
- 2/6 either did not answer or were undecided.

Expectation	Met?	If no, why not?/Comments
Next steps for our team	Yes/No	We talked so much we did not have enough time to spend on next steps.
Catch-up and build partnership	Yes	
To be able to identify with the objectives of Team Up	Yes	
A better understanding of Team Up	Yes	
Background Information	Yes	

Q3. To what extent were PATH Visit Objectives (as outlined at the beginning of the training) met?

Objective	Met	Unmet	Why unmet
Enhance the relationship among State A state partners and national partners.	6	0	
Achieve a common understanding of the Team Up goals, objectives, methods and timeline.	6	0	■ Not sure it is "digested" yet
Identify action steps necessary for the state partners to establish productive communication and collaboration among the state partners. *Undecided/nonresponse: 1*	5		■ Preliminary
Identify action steps to continue to assess, adapt and implement evidence based cancer control programs in a sample of high risk counties of State A.	5	1	
Discuss technical support needs and potential methods for State A state partners. *Undecided/nonresponse: 4*	2		■ Briefly

Q4. What was useful about the meeting?

- Discussions; meeting people; clarifying what we're supposed to do; and
- Sharing creates sense of Team Up nationally.

Q5. What additional information would have been helpful?

- Needed more time; not sure all reps/organizations <u>really</u> have "buy-in."

Team Up PATH Visit Report and Technical Assistance Plan

State B

Prepared by: Elizabeth Randall-David

October 2005

Team Up PATH Visit Report and Technical Assistance Plan

State B – October 2005

Introduction

Technical assistance is an important cornerstone of the Team Up project. Technical assistance in the Team Up project consists of tailored and general assistance to the state teams in order to monitor and document progress and to problem solve on issues related to team building, the development and refinement of state action plans, and the identification, adaptation, implementation and evaluation of evidence based interventions. Technical assistance can take many forms such as (1) coaching, (2) sharing information with other Team Up partnerships via quarterly teleconferences, the web forum, quarterly Team Up newsletter, webinars, and (3) assisting in partnership development and capacity building via individual interactions with national partners, PATH visits, regional meetings, and retreats.

There were several methods for assessing the technical assistance needs of the Team Up state partnerships: telephone interviews with each of the primary partners in fall 2004, brainstorming during the PATH visits in spring 2005 and at the regional meetings in summer 2005, and telephone interviews with either the chairs/co-chairs or full partnership in fall 2005. Some technical assistance needs such as assistance with identifying and securing financial support for the project have remained constant over time while others such as team building have changed as the state partners have moved along in the developmental process.

The technical assistance plan for State B is best understood in the context of reviewing the background of State B's Team Up partnership.

Background

The State B Team Up partnership has developed a strong partnership between ACS, BCCEDP, County Extension, the regional CIS, a university, and a hospital. They meet quarterly either in person or by telephone.

The State B Team Up partnership selected their counties of intervention based, both on data and the availability of county extension agents who were committed to this issue. Fifteen counties were selected based on breast cancer morbidity and mortality. Additional counties were selected based on cervical cancer morbidity and mortality data. Initially there was some resistance to adopting or adapting evidence based interventions because they felt they were reaching their screening numbers through their own interventions which consisted of weaving breast and cervical cancer messages into the presentations and interactions county extension agents had with women in their communities. After the regional meeting, there was real movement in this area.

PATH Visit:

The State B PATH visit took place on June 20, 2005. Nineteen individuals attended the meeting (12 state partners, 5 national partners and 2 coaches). (See Attachment 1.) During the PATH meeting, State B's Team Up members reviewed their key partnership accomplishments over the past year and a half. In terms of the partnership itself, they had taken time to understand and appreciate each others organizations, been inclusive, developed a model of shared leadership (CES and ACS), and achieved synergy. They had developed and utilized a 2 year work plan to guide their efforts, shared resources, engaged local partners in their priority counties, done provider trainings and explored evidence based interventions on Cancer Control PLANET. They also had implemented a mechanism for monitoring county extension agents' activities related to breast and cervical cancer. They developed a tracking mechanism for determining if BCCEDP clients found out about the program from an interaction with a county extension agent. They interviewed some of the rarely and never served Latinas in their communities to learn more about ways to effectively reach them for breast and cervical cancer screening.

When asked by the meeting facilitators how they would define evidence based interventions, they gave thoughtful answers that indicated that they really understood evidence based programming (see Attachment 2).

The State B Team Up partnership also acknowledged challenges within their partnership. They felt they could improve the communication between the state TU leaders and the local county extension agents. They also felt they need to develop better tracking and monitoring mechanisms to evaluate the effectiveness of their efforts at the local level. They acknowledged that since many of the rarely and never screened women are Spanish speaking, they need to find local staff who are bilingual.

During the PATH meeting the State B Team worked with the coaches and National partners to create a list of action steps for partnership development and program implementation.

Partnership Action Steps**:**

1. Provide an orientation program for new members to the partnership;
2. Implement an ASC collaboration training;
3. Plan a retreat;
4. Hold quarterly meetings;
5. Provide mentoring for new members of the partnership; and
6. Identify appropriate evidence-based program that fit the State B partnership and engage local partners in this decision
    a. Contact PI at Morehouse working;
    b. Look at community guide; and
    c. Go on PLANET to look for investigators.

Regional Meeting

The regional meeting was attended by 10 members of the State B partnership. In addition to representatives from the state team, three of the attendees were local county extension agents. The partners developed an extensive action plan during the state breakout session. Among their action steps were the following:

1. Develop partners at local level (BCCEDP, ACS, CES);
2. Train CES (county extension agents) on cervical cancer issues (winter school or retreat) to increase comfort level with this topic and emphasize that CES agents don't need to do the trainings by themselves but could partner with ACS and BCCEDP staff at local level;
3. Develop a feasibility assessment form to evaluate the EBIs on RTIPs;
4. Evaluate each of the programs listed on cancer Control PLANET;

5. Work with Kathi Wilson to get recommendations of researchers at Emory who might be helpful; and

6. Convene full team meeting on 11/15 (including county extension agents from 15 counties) to choose EBI, report what happened at regional meeting and discuss retreat.

Technical Assistance Needs

Based on data collected during the fall 2004 interviews from all the States, technical assistance needs were sorted into four main categories and fifteen sub-categories. These are described in the table below:

Technical Assistance Categories of Need Identified from Telephone Interviews (10/04)

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National Partnership: purpose, expectations, and institutional support available to teams
Team building (e.g., partnership and collaboration, learning about each other's organizations)
Negotiation (includes partnership conflict resolution, turf issues, etc)
Funding (includes grant writing, searching for funding)
Leadership development
Content
Cancer control expertise for the community
Educational resources (includes displays, materials, etc,)
Tailoring educational methods for various audiences
Cancer PLANET Training
Cultural competency (includes barriers, low income, literacy)

The coach discussed these and other possible technical assistance areas with the co-chairs by telephone in October 2005. During that call, the State B Chairs discussed their current technical assistance needs. They are listed in the table below.

Current Technical Assistance Needs (10/05)

Need	Recommended actions
Assistance with development of an evaluation plan.	Coach work with national TU evaluation team to identify a mechanism for meeting this need
Assistance with conducting a feasibility assessment of the EBIs on RTIPS in order to select one for adaptation in State B	Coach provide assistance
Assistance with adapting or adopting evidence based strategies	Coach; Webinar; Webforum; TU newsletter
Assistance in grant writing (including boiler plate)	National partners
Assistance in searching for funding	Coach/national partners
Assistance in getting local CIS incorporated into the TU partnership	Coach work with regional CIS and discuss strategies for accomplishing this yet to be hired person into the State B TU partnership; retreat

Discussion

The State B Team has significant partnership and program planning skills. Similar to other Team Up states, the State B Partners request assistance with identifying potential funding sources and help with grant writing including a boiler plate from the national partners. They also would like assistance in developing an evaluation plan. Some attempts at contacting researchers at Emory to assist in this area have not proven successful. Lastly, there is a need to incorporate local CIS staff into the partnership once a new staff person has been hired. The State B Team Up partnership seems eager and open to technical assistance from the coach, the national partners and other state Team Up partnerships.

Attachment 1:
PATH Visit Evaluation
(unavailable at time of this report)

Attachment 2:
When Asked What Evidence Based Meant to Them They Replied:
"Evidence Based Programs Are..."

- Cost effective and result oriented because those are based on scientifically tested theories;
- Programs developed with scientific "proof" or research "proof" as to the validity effectiveness;
- Proven based upon resources/facts;
- Have outcomes data that support the effectiveness of the program;
- Interventions that have been implemented and evaluated and proven to work;
- Programs with specific guidelines developed from scientific theory and actual data;
- Science based, proven programs that provide change that improves one's health;
- Only as good as the implementing group's understanding of what makes the program effective, how to implement, tailor and track it, and the context in which it was tested;
- Proven to work in specific trials settings with specific target audiences; and
- Tried and tested and proved to be effective through practice and research.

Team Up PATH Visit Report and Technical Assistance Plan

State E

Prepared by: Elizabeth Randall-David

October 2005

Team Up PATH Visit Report and Technical Assistance Plan

State E – October 2005

Introduction

Technical assistance is an important cornerstone of the Team Up project. Technical assistance in the Team Up project consists of tailored and general assistance to the state teams in order to monitor and document progress and to problem solve on issues related to team building, the development and refinement of state action plans, and the identification, adaptation, implementation and evaluation of evidence based interventions. Technical assistance can take many forms such as (1) coaching, (2) sharing information with other Team Up partnerships via quarterly teleconferences, the web forum, quarterly Team Up newsletter, webinars, and (3) assisting in partnership development and capacity building via individual interactions with national partners, PATH visits, regional meetings, and retreats.

There were several methods for assessing the technical assistance needs of the Team Up state partnerships: telephone interviews with each of the primary partners in fall 2004, brainstorming during the PATH visits in spring 2005 and at the regional meetings in summer 2005, and telephone interviews with either the chairs/co-chairs or full partnership in fall 2005. Some technical assistance needs such as assistance with identifying and securing financial support for the project have remained constant over time while others such as team building have changed as the state partners have moved along in the developmental process.

The technical assistance plan for State E is best understood in the context of reviewing the background of State E's Team Up partnership.

Background

The four partnering organizations have a history of working together on the local level but the Team Up initiative afforded a new opportunity to work together on a state level. Prior to the PATH visit, there had been a number of miscommunications and misunderstandings among the partners at both

the state and local levels and some expressed dissatisfaction with leadership. The partnership reconvened regular meetings and communication as the PATH visit became imminent.

In the early months of the partnership, a data committee reviewed data sources and identified counties with high mortality and morbidity associated with cervical cancer. Since then, the partnership has decided to narrow its focus from five counties to one. One county was chosen based on human resources (e.g., providers, CES staff, universities etc) as well as high mortality and morbidity associated with cervical cancer.

Since the regional meeting in August 2005, there has been a lot of activity focused on determining the feasibility of the EBIs listed on RTIPs. Based on the feasibility assessment conducted by one of the sub-committees, the FoCaS project was selected for adaptation in State E.

PATH Visit:

The State E PATH visit took place on April 21, 2005. Nineteen individuals attended the meeting (11 state partners, 7 national partners and 1 coach). (See Attachment 1.) During the PATH meeting, State E's Team Up members discussed the unique perspectives, resources and skills of each partner and how each benefits the Team Up partnership. They developed a structure to operate and renewed everyone's commitment to the partnership. In addition, they defined leadership roles within the partnership and gained commitments from the new chair, vice chair, secretary and meeting coordinator. They also established a structured meeting time. Perhaps most importantly they identified problems in group dynamics and began addressing them. During the PATH visit, individuals who hadn't spoken in person in many months shared personal stories and engaged in group problem solving. This sharing was enabled in part by the Lasker and Weiss results which highlighted areas in need of improvement. After the PATH visit, the new chair arranged leadership training for the four main partners. The partnership is considering extending this training to all the partners.

Partnership challenges that remained at the end of the PATH visit were: confusion over what is meant by evidence based programming; frustrations related to lack of funding within extension; and lack of clarity over how extension fits into intervention implementation.

Regional Meeting

The regional meeting was attended by eight members of the State E partnership. Those present developed a very detailed action plan during the state breakout session. Among their action steps were the following:

1. Identify an EBI that is feasible and appropriate for adaptation by State E;
2. Conduct an asset mapping to help determine the counties to focus on;
3. Develop criteria to determine which women to recruit;
4. Develop an evaluation plan; and
5. Identify resources for following up with those diagnosed with abnormal results.

The partners formed sub-committees and a timeline for the accomplishment of each task listed above.

Technical Assistance Needs

Based on data collected during the fall 2004 interviews from all the States, technical assistance needs were sorted into four main categories and fifteen sub-categories. These are described in the table below:

Technical Assistance Categories of Need Identified from Telephone Interviews (10/04)

Categories of Need
Communication
Forum to communicate with other state teams regarding "best practices" and lessons learned
Program Planning
Use of cancer data
Strategic planning
General program planning (including design, implementation, and evaluation)
Adapting or adopting evidence based strategies
Partnership
National Partnership: purpose, expectations, and institutional support available to teams
Team building (e.g., partnership and collaboration, learning about each other's organizations)
Negotiation (includes partnership conflict resolution, turf issues, etc)
Funding (includes grant writing, searching for funding)
Leadership development
Content
Cancer control expertise for the community
Educational resources (includes displays, materials, etc,)
Tailoring educational methods for various audiences
Cancer PLANET Training
Cultural competency (includes barriers, low income, literacy)

The coach discussed these and other possible technical assistance areas with the chairs by telephone in October 2005. The chair indicated that the following technical assistance areas were important for the State E Team Up partnership:

Current Technical Assistance Needs (10/05)

Need	Recommended actions
Assistance in developing an evaluation plan	Coach consult with the national evaluation team to develop a mechanism for addressing this need
Assistance with specific questions related to implementing FoCaS	Webinar; webforum; Coach facilitate interaction with FoCaS PI and program manager
Assistance in searching for funding	Coach/national partners

Discussion

The State E Team has significant partnership and program planning skills. The State E partnership could benefit from getting more information about the FoCaS program as it moves towards implementation. In addition, the State E partners would like assistance with developing an evaluation plan. Similar to other Team Up states, the State E partners would like assistance with identifying potential funding sources. The State E Team Up partnership seems eager and open to technical assistance from the coach, the national partners and other state Team Up partnerships.

Attachment 1:
State E PATH Meeting Evaluation
April 21, 2005
11 Evaluations Completed

Q1-Q2: What were participants' expectations? Were they met?

- 11/11 reported "Yes" expectations met; and
- 0/11 reported "No" expectations met.

Expectation	Met?	If no, why not?/Comments
My specific role and goal for the partnership.	Yes	
Identify roles within partnership.	Yes	
Begin planning and identifying areas we have in common	Yes	
To understand the partnership and roles of each partner.	Yes	
To understand the communication piece of each organization.	Yes	
Revisit partnership structure, understanding of roles within partnership	Yes	
Clear the air about group interaction issues.	Yes	
Clarify purpose and roles.	Yes	
Understand the State E partnership.	Yes	
Effective ways to work as a group to implement the goals and objectives that would attend to the needs of the rare/never screened.	Yes	As best as could be expected (to me)
A clearer idea of the roles and direction of the process.	Yes	
Reorganization of State E Team Up Group.	Yes	
Re-vitalization of the partnership	Yes	

Q3: To what extent were PATH Visit Objectives (as outlined at the beginning of the training) met?

Objective	Met	Unmet	Why unmet
Enhance a relationship among State E state partners and national partners.	10	1	■ Not sure, too much passing the buck
Achieve a common understanding of the Team Up goals, objectives, methods and timeline.	11	0	
Identify action steps necessary to establish (1) productive communication and collaboration among the partners and (2) to assess, adapt and implement evidence based cancer control programs in a sample of high risk counties in State E.	4	7	■ Hands down ■ Partially met ■ Objective met #1 and not met #2 ■ We identified action steps to produce communication and collaboration. ■ We need to do too much to assess, adapt, etc. ■ Not enough time ■ Met 1st part ■ Not enough time for 2nd part still, good progress ■ What programs are happening in each organization/and how we are working together to accomplish the mission of the partnership. ■ There was not enough time spent on the work and on structure as needed. ■ Time was spent on developing roles and responsibilities.
Discuss technical support needs and potential methods for State E partners. *Undecided/nonresponse: 2/11*	5	4	■ There was not enough time spent on the work and on structure as needed. ■ Not enough time ■ "Methods"? – What methods are you referring to here? ■ Time constraints

Q4. What was useful about the meeting?

- Meeting the coaches face to face and allowing them to guide us on what is needed to move forward.
- Developing a structure to operate.
- Renewing everyone's commitment to the partnership.
- Defining roles.
- Afternoon—development of structure.
- The communication and roles of the partnership and how we benefit each organization.
- Identifying problems in group dynamics and addressing them.

- Establishing leadership roles and commitments from new chair, vice chair, secretary and meeting coordinator.
- Reorganization
- Overview of unique perspectives, resources and skills.
- Facilitation by national partners a coach assigned is very useful.
- Information shared from each partner.
- Hearing the voices of State E partners.

Q5. What additional information would have been helpful?

- None at the moment.
- Thank you for arranging a coach and having the national partners here to help move on forward.
- Contact information from other states.
- Just not enough time, but made good progress.
- More info about technical support. Would have liked to have been able to spend more time on identifying specific counties that we share resources.
- We needed more time.
- I think this could have been better if more time spent on what we as the State E partnership need to do. I am glad we did the structure and officers but I think we need more time on this area.
- Needed a little more time. Training was very helpful!

Team Up PATH Visit Report and Technical Assistance Plan

State C – October 2005

Background

The State C PATH visit took place on May 19, 2005. Fifteen individuals attended the meeting (11 state partners, 2 national partners, and 2 coaches). (See Attachment 1.)

During the PATH meeting, State C's Team Up members reviewed their key partnership accomplishments over the past year and a half. They reported having met monthly or every six weeks to accomplish the goals of their plan. These regular meetings and the time spent learning about each others' partnership helped to strengthen their partnership. As a result, they chose a program from Cancer PLANET, adapted it, and implemented it successfully in the eastern part of the state. Many of these accomplishments (reported in greater detail below) were attributed to the strong leadership of the State C Team Up partner organizations, particularly the CIS and Cooperative Extension, who chair the partnership.

Partnership Challenges

At the same time, they acknowledged challenges within their partnership. Early on they experienced turf struggles within target counties among other research projects and state cancer partners. Since then, they have worked out these issues with the researchers and continue to work on collaboration with the State C Cancer Program partners. They also acknowledge significant competition for human resources at the local level and at times at the state level. They need evaluation expertise on their partnership and committed to finding an evaluator during this PATH visit.

They also voiced a lack of understanding and, as a result, some frustration regarding the national partners' vision of Team Up, the overall project evaluation plan and their expectation of the states. They are concerned with "not measuring up" to national expectations in terms of evidence-based procedures. More recently, they were also frustrated with the plans for limited attendance at the

regional trainings and expressed concern that partnership synergy among the state and national partners may be challenged.

State C TEAM UP Program Accomplishments

The State C Team Up Partnership has been particularly productive and successful in the past year and a half in terms of program development. Specifically they:

- Reviewed county data to clarify the geographic focus of their intervention;
- Created and disseminated county-specific cancer data notebooks;
- Reviewed Cancer PLANET with Extension staff to choose an appropriate evidence based program;
- Informally assessed feasibility of the Forsyth program, from RTIPS, with Extension staff;
- Selected and adapted Forsyth intervention with input from CES staff;
- Worked with CIS media specialist to adapt Forsyth materials to eastern State C communities;
- Acquired Komen funding for developing and disseminating further educational materials to be used with community volunteers to talk with rarely or never screened women;
- Piloted adapted materials in nine counties;
- Created/branded materials for counties and put on CD for dissemination; and
- County staff are implementing program and gathering process information.

At the time of the PATH visit their greatest challenges in program implementation concerned their need for process and outcome evaluation resources and data sources. They were also uncertain how the National partners would assess their adaptation and implementation efforts.

During the PATH meeting the State C Team worked with National partners to create a list of Action Steps for program implementation and evaluation. They have made considerable progress on these items at recent meetings.

- Identify an evaluation partner/resource and contact the Forsyth PI (ACS has recently secured funding for assistance with evaluation);
- Email evaluation questions to breslaue@mail.nih.gov;
- Contact other researchers for coalition database model for data collection. (looking into possible options);
- Refine process evaluation questions and methods;
- State C Cancer Program agreed to share evaluation report from KCP coalitions (this was accomplished at the Nashville meeting);
- Explore possibility of dissemination proposal;
- Explore QIO at state and national levels capturing cervical cancer screening data (recently found other data source possibilities);
- Consider content analysis of meeting minute notes to document local effort; and
- Explore possibility of tobacco tax and other funding sources (determined that tobacco taxes are not at option, instead they are using ACS, Komen, and USDA funds, as well as in-kind contributions in labor).

Methods for Assessment of Technical Assistance

The eight states of project Team Up have been assessed for their technical support needs at three points in time during the past year. Each primary partner participated in the telephone interviews from November through December 2004. Technical assistance needs were also assessed during the PATH visits April through June, 2005 and the recent Team Up regional trainings in August, 2005. Each of these venues allowed members of state teams to express needs for technical expertise and, more recently at the regional trainings, provided a setting for National Partners to assess needs while participating in panels and discussion sessions with the Teams. More recently and following the Team Up regional trainings in July and August, the coaches met with each state team, via phone, to revisit current technical assistance needs and to create this plan.

Results

At the time of the Interviews and PATH visits, identified technical assistance needs of all the States fell into four main categories and fifteen sub-categories.

Technical Assistance Needs – Results From Interviews

Categories of Need
Communication
Forum to communicate with other state teams regarding "best practices" and lessons learned
Program Planning
Use of cancer data Strategic planning General program planning (including design, implementation, and evaluation) Adapting or adopting evidence based strategies
Partnership
National Partnership: purpose, expectations, and institutional support available to teams Team building (e.g., partnership and collaboration, learning about each other's organizations) Negotiation (includes partnership conflict resolution, turf issues, etc) Funding (includes grant writing, searching for funding) Leadership development
Content
Cancer control expertise for the community Educational resources (includes displays, materials, etc,) Tailoring educational methods for various audiences Cancer PLANET Training Cultural competency (includes barriers, low income, literacy)

At that time, State C Team members had requested help identifying money for program implementation, team-building assistance, and clarity of national expectations. During recent phone calls with the Team Chairs in August and September 2005, they reviewed their own history of technical assistance needs and determined that they had been met for the most part.

During that call, the State C Chairs also discussed technical assistance that they felt they would need in the coming months.

Future Efforts and Technical Assistance Needs

Need	Status/Notes
Needs time to meet with team to regroup.	Believe they have the expertise that they need within State C
Need clean data from BCCEDP	Recommended that they talk to Chastity
Want to know more about the National partner's evaluation expectations	
Provider intervention is next step	Believe they the expertise that they need within State C to move forward on this
They would like a support letter from National describing Team Up and how they are involved	They will use this to help find evaluation support staff, to acknowledge student input, and to engage additional partners in their efforts
Need boiler plate information from National for grant writing and other efforts	

Discussion

The State C Team has significant partnership, program planning, research, and grant writing skills. Similar to other Team Up states, the State C Partners have limited technical assistance needs from the National Partners in any of these areas because of their extensive expertise. Those areas where they could benefit from support continue to be in process and outcome evaluation – where recent advice and the PATH meeting and skill development at the regional training appeared to be beneficial. Additionally, they continue to request help getting national data for outcomes evaluation and getting updated clean data from the BCCEDP program in State C.

They will be embarking on a professional education effort in the next months on breast and cervical cancer early detection for eastern State C providers. It is likely that they will benefit from knowing how other states who are implementing the Forsythe County model have implemented and evaluated the professional education component of the program.

They are re-running media advertisement on breast and cervical cancer screening at this time and, while they did not mention it on recent calls, they may benefit from technical support regarding evaluation of the effect of these ads.

Lastly, State C Team Up technical assistance needs continue to involve increased communication from the National partners regarding evaluation expectations, other states' program and evaluation efforts, and possibly future funding sources.

Attachment 1: PATH Evaluation Summary:
State C PATH Meeting
May 19, 2005
9 Evaluations Completed (participation estimated at 11 state partners)

Q1-Q2: What were participants' expectations? Were they met?

- 7/9 reported "Yes" expectations met;
- 1/9 reported "No" expectations met; and
- 1/9 either did not answer or were undecided.

Expectation	Met?	If no, why not?/Comments
Evaluation tools and methods	No	National committees unsure of what and where to go.
National direction and overview	No	We are so far ahead, not having answers today!
Understanding of the national vision	Yes	
Insight on evaluation	Yes	
Clearer picture of national partnership and how it impacts state and local partnerships	Yes	
Research potential	Yes	
National expectations of state projects	Yes	
Evaluation components	Yes	
A better understanding of where State C falls in with national vision with Team Up.	Yes	
To provide necessary answers to questions of state team.	Yes	
Update members of state team of initial training because I did not attend that training.	Yes	
Next steps.	Yes	
Better perspective of the national team and what they're expectations are of each state team.	Yes	

Q3: To what extent were PATH Visit Objectives (as outlined at the beginning of the training) met?

Objective	Met	Unmet	Why unmet
Enhance a relationship among State C state partners and national partners.	9	1	
Achieve a common understanding of the Team Up goals, objectives, methods and timeline.	9	0	
Identify action steps necessary to establish (1) productive communication and collaboration among the partners, and (2) to assess, adapt, implement and evaluate evidence based cancer control programs in a sample of high risk counties in State C.	8	2	■ No evaluation to develop ■ Moderate. Would like to hear more
Discuss technical support needs and potential methods for addressing these needs for the State C partners.	8	1	■ Clear picture of standard evaluation across the board

Q4. What was useful about the meeting?

- National timeline;
- Meeting national team members;
- National goals and objectives;
- Sharing where we are (key) in our pilot;
- Meeting folks;
- Dialogue with national team members and coaches;
- Reinforcement that we are on track;
- Everything;
- Open dialogue, facilitators guiding the session; national partners' perspectives;
- Sharing creates sense of Team Up nationally; and
- The facilitators did great with keeping discussions on track.

Q5. What additional information would have been helpful?

- Would still like discussion about integrating existing programs.
- How does Team Up fit with existing B&C Coalition work? And comp cancer?
- A person identified to help with statistical or data questions.
- More funding opportunities for Team Up related activities (evaluation, research, etc.)
- Future goals for Team Up.
- Team Up PATH Visit Report and Technical Assistance Plan.

State D

Background

The State D PATH visit took place on May 16, 2005. Fifteen individuals attended (9 state partners, 4 national partners and 2 coaches). (See Attachment 1.)

State D's Team Up partnership is highly collaborative and, as a result, very productive as illustrated by numerous partnership strengths highlighted by the partners during the PATH visit. Specifically, they believe that members are focused and task oriented, share common goals, have regular communication and meetings, strong leaders as well as shared leadership and a sense of egalitarianism among members. They show respect for each other and each other's organizational strengths and limitations and they have local buy-in from the communities involved in Team Up as well as from Extension educators.

At the same time, they acknowledged challenges within their partnership. Some members believe they are too focused on building awareness and process-related results and have not spent enough time working to increase screenings. All acknowledge that they are very committed to this project but feel over-extended. Extension, in particular, has lost numerous staff state-wide, and Team Up is not a significant priority among the Extension educators. Additionally those educators, who are involved, are not yet fully comfortable as cancer educators. More recently, new members to the State D Team have struggled to determine the direction of the partnership in ways that they can best enhance their own roles in the partnership. Partnership meetings, sharing of historical documents and increased communication in the past month (August, 2005) have begun to bring the group together and member commitment is very strong.

State D Team Up Accomplishments

Beginning with the 2003 meeting, where they created a detailed Action Plan, the State D partnership was strongly engaged in Team Up. Via that plan, the major accomplishments of the partnership have included development of:

- Partnership Capacity
  - Memorandums of understanding among all the partners;
  - Consumer Health Profiles training by the Cancer Information Service;
  - IRB process for demographics + for data collection tools 25% R +NS;
  - Project Website; and
  - Database with program information.
- Capacity Building for Cooperative Extension Educators
  - Focus group discussions with Extension staff to discuss strengths and weaknesses of program implementation;
  - Training curriculum and training for Cooperative Extension Educators;
  - Newsletters to Cooperative Extension Educators;
  - Presentation in PowerPoint for Extension faculty;
  - Educational displays on breast and cervical cancers;
  - Communication with Extension Regional Directors.
- Program Planning Efforts
  - Brochure on screening awareness with beads;
  - Referral, business cards for public;
  - Advertisement of program in rural areas to farm families;

- Focus group discussion with Extension staff; and
- Support for seven counties and a major city (*recently determined to pilot Team up a rural and urban region at this time.)

Perceptions of Evidence-based Program Planning

Discussion with partnership members during the interviews and PATH visit showed a wide variety of interpretation of the concept "evidence-based" (see Attachment 1). Some team members showed resistance toward the concept, as seen in flip chart statements such as "We need to do it because national wants us to." and "If only evidence-based activities are allowed, how can new types of activities have the ability to become evidence based?" In addition, barriers to following proscribed program planning include extension agents discomfort talking about breast and cervical cancer and the time and resources required to fully implement a research tested program with CES agents who are already very overextended.

At the same time, the State D partnership values the use of data to plan and track program efforts and describes their efforts as "evidence informed." Such data-focused efforts include: a web tracking system to capture local activities, a review of RTIPS programs to gather effective approaches to increased cancer screenings and use of Department of Health screening data and cancer incidence to choose priority counties.

Methods for Assessment of Technical Assistance

The eight states of project Team Up have been assessed for their technical support needs at three points in time during the past year. Each primary partner participated in the telephone interviews from November through December 2004. Technical assistance needs were also assessed during the PATH visits April through June, 2005 and the recent Team Up regional trainings in August, 2005. Each of these venues allowed members of state teams to express needs for technical expertise and provided a setting for National Partners to assess needs while participating in panels and discussion sessions with the Teams. More recently, coaches met via phone with each state team to revisit current technical assistance needs and to create this plan. Lastly, coaches reviewed the on-line resources (meeting minutes, action plans etc.) on the Team Up Web Forum to assess current State Team efforts.

Results

At the time of the Interviews and PATH visits, identified technical assistance needs of all the States fell into four main categories and fifteen sub-categories.

Technical Assistance Needs Identified Via Interviews and PATH Visits

Categories of Need
Communication
Forum to communicate with other state teams regarding "best practices" and lessons learned
Program Planning
Use of cancer data
Strategic planning
General program planning (including design, implementation, and evaluation)
Adapting or adopting evidence based strategies
Partnership
National Partnership: purpose, expectations, and institutional support available to teams
Team building (e.g., partnership and collaboration, learning about each other's organizations)
Negotiation (includes partnership conflict resolution, turf issues, etc)
Funding (includes grant writing, searching for funding)
Leadership development
Content
Cancer control expertise for the community
Educational resources (includes displays, materials, etc,)
Tailoring educational methods for various audiences
Cancer Planet Training
Cultural competency (includes barriers, low income, literacy)

Of these, State D Team members specifically requested support to use evidence-based approaches effectively and to develop and implement an evaluation plan for the program that they chose. (see table below). They also wanted ideas for educational resources such as displays and handouts, etc. A specific need was educational materials for male cooperative extension agents to use in cancer education with the community. Partners still need to learn more about each other organizations and how they function. Recently, 3 people have left the team and 4 new members joined. Because of these changes, they also appeared to need team building and orientation for new members. That orientation occurred in August 2005 and the Team has recently regained cohesion and momentum.

During phone calls with each team in August and September 2005, state partners reviewed their own history of technical assistance needs from the sources listed above and assessed whether those technical needs had been met or not, either by themselves or the National Partners.

State D Technical Assistance Needs From Interviews and Path Visits

State D Technical Assistance Needs	Met?
Evidence and Evidence based strategies	Yes
Develop/implement an evaluation plan	No but have resources for this
Educational resources such as displays etc	Yes
Understanding each others organizations and work	Yes
Educational methods for male cancer educators	Not Yet
Team building to address conflicts regarding expectations/vision	Yes

In all cases but one, State D Team members stated that they felt that these needs had been met or that they had the resources within their group to meet them.

During that call, the State D Team also discussed technical assistance that they felt they would need in the coming months. These needs are based on a new Action Plan that they created at the time of the Team Up regional trainings (Attachment 2).

Future Technical Assistance Needs

Need	Status/Notes
Educational methods for male cancer educators	Continued need to be addressed within State D Team
Communication - Increase use of web forum	Coach showed how to load materials onto web forum and began the process for them. The Team will continue to address this themselves
Evaluation	(1) Team wants to better understand the expectations of National partners in the evaluation process at this time (2) They also want to learn about evaluation efforts from the other states particularly when states are implementing the same programs from RTIPS
County Foci	With coach, the team discussed reducing number of focus counties from 8 to 2 (one rural/one urban) to pilot programs and that has recently been done
Funding	Team will first determine program goals and objectives and then consider if there are funding needs. If so, they may need assistance from national.
Cultural competency	Would like to learn success stories from other states on forum, via listserv or coaches.
Help with organizational recruitment (see below)	This is a specific area of need from National at this time that has been stated by State D and other states.

Discussion

The State D Team is composed of organizational members who have very strong skills in partnership development, leadership, program assessment, planning, evaluation, and implementation. They also have excellent skills in data collection and management as well as research design. They stated that they believe that State D Team Up has the resources needed to move forward with their new action plan. (Attachment 2).

This team has limited immediate technical assistance needs from the National partners in any of these areas. Instead, their needs listed in the table above are more related to increased communication from the National partners regarding evaluation expectations, other states' program and evaluation efforts, and future funding sources. They would also still like the National Partners to assist in reaching out to other national partners whose state affiliates could work with Team Up in State D (e.g., National Chamber of Commerce, League of Women Voters, Welfare to Work Programs, Association of State Governors, the Komen Foundation.)

Similar to other states, the State D partners would benefit from working with their own organizational counterparts among each of the states. Such collaboration among Extension faculty, CIS program staff etc. would be best facilitated via listserves, BLOGs, the Web Forum and conference calls.

Attachment 1: PATH Evaluation Summary:
State D PATH Meeting
May 16, 2005

Q1-Q2: What were participants' expectations? Were they met?

Expectations (n=7)	Met?	If no, why not?/Comments
Idea's on how we can be pro-active in making referrals of eligible women to receive their breast and cervical screenings.	Yes	
Learn more about how PATH and state – level programs will work together.	Somewhat	
What resources does PATH have to offer state-level programs?	Somewhat	
How can we work with PATH national coaches?	Somewhat	
Evaluation, how and what are we looking at.	Somewhat	
I hope to learn terminology and relationships.	Yes	
Access, whether technical assistance is needed.	Yes	
What is available?	Yes	
What are other states doing that may apply to State D, help us improve.	Yes	
ID State D problems/limitations.	Yes	
Application of evidence based practices	Yes	
Action steps measured	Yes	
Overview	Yes	
Progress	Yes	
Current issues	Yes	
Program expectations	Yes	
Problems → solutions	Yes	
Partner roles	Yes	
National partner expectations of this pilot	Yes	
Resources available	Yes	
Develop action plan to move into the community	Yes	Need more time around the action plan
Surpassed	Yes	

(5/7 reported "Yes" expectations met, 0/7 reported "No" expectations met, 2/7 either did not answer or were undecided).

Expectations (from flip charts):

- Learn about other states;
- What is EB, what tool?
- Identify State D Resources and conditions;
- TEAM Up plus expectations and measure;
- Progress and Partner accomplishments;
- Partner problem?
- State D Team measure success;
- Develop action steps;
- How to work with TU and coaches (national);
- Technical assistance—what?
- Learn more about TEAM since July '03; and
- Understand current initiatives.

Q3: To what extent were PATH Visit Objectives met? (as outlined at the beginning of the training)

Objective (n=7)	Met	Unmet	Why unmet
Enhance a relationship among State D state partners and national partners. *Undecided: 1*	6	0	
Achieve a common understanding of the Team Up goals, objectives, methods and timeline. *1 undecided*	6	0	■ Not the timeline
Identify action steps necessary to establish (1) productive communication and collaboration among the partners and (2) to assess, adapt and implement evidence based cancer control programs in a sample of high risk counties in State D. *Undecided: 1*	5	1	■ Need to spend more time at regional meeting
Discuss technical support needs and potential methods for State D partners. *Undecided: 2*	4	1	

Q4. What was useful about the meeting?

- Yes, was a useful meeting;
- I gained understanding of partner's roles;
- We followed the agenda and were very focused;
- Coaches did a great job of facilitation;
- Meeting partners and gaining understanding of program;
- Learned more about the objectives of the National collaboration;
- Meeting partners and discussing needs and possibilities;
- Addressing partnership issues; and
- Great interactive meeting format, exchange of ideas recommended ideas and plans to improve.

Q5. What additional information would have been helpful?

- Thanks for everyone's help. I appreciate our national partners commitment to improve and I wish …….a safe trip home;
- Timeline of project;
- More in-depth definition of evidence based resources;
- List of successful activities barriers and success of other state collaborations;
- Learning the history of this partnership, plus the vision, is very helpful; and
- Now I want to know what is going on in other states.

Perceptions of "Evidence-Based" from PATH visit

Know	Feel	Don't know
■ Change of behavior ■ Adaptation of regular Pap smear ■ Research based ■ Web pages to find evidence activities ■ Behavior changed ■ Based in research ■ Funding is becoming more and more based on EB approaches ■ There exist approaches that have been proven to be EB but you have to search them out ■ I know evidence based outreach is best done on a one on one basis ■ Evidence based programs are based on studies demonstrating efficacy ■ May also use community guides for looking at effectiveness of interventions ■ Research that shows measurable outcomes should drive social interventions/programs	■ That it is very difficult to measure ■ Easy to misunderstand ■ Only makes sense when doing programs ■ We need to do it because national wants us to ■ Improve/increase efficiency and effectiveness of resource allocation ■ That if only evidence based activities are allowed, how can new types of activities have the ability to become evidence based? ■ May help with additional funding	■ Cancer related evidence based ■ How application is applied to populace? ■ I don't know everything we are doing in State D and how it fits together ■ How to adapt evidence based activities to meet program needs ■ Where to find EB interventions ■ How to determine what EB interventions are ■ How many women will be affected by Medicare budget cuts? How much more money will it cost taxpayers? ■ How does this group think about evidence based when comparing research tested interventions and meta-analysis of intervention studies? ■ Level of acceptance? ■ How well embedded in program design?

Attachment 2: State D Team Up Action Plan, July 2005

Next Steps

- Review MOU;
- Review Plan of Work (POW);
- Revise Plan of Work (POW);
- Upload POW and other materials to web forum;
- Upload POW to program website;
- Regroup and move forward
  - Define and refine roles (MOU);
  - Identify new partners; and
  - Orientation of collaborating partners (challenges/contributions).

Agenda – August Meeting (in no particular order)

- Agency Overviews
  - Agency Orientation;
  - Agency Resources;
  - Potential Challenges;
  - New Potential Partners; and
  - Identification of new to do list.
- Team Up State D orientation;
- Review MOU;
- Upgrade Action Report; and
- Refine and define roles (assignments).

Task List: "*Doing creates evidence*"

- Data by County
  - Joan – incident, mortality, rarely or never seen;
  - CHP – Hope; and
  - Phyllis – GIS – Census.
- Review MOU
  - Bruce, Dianne, Hope, and Bruce.
- Review Action Plan
  - Victoria; and
  - All.
- Review evidence-based programs
  - Toyin.
- Identify county level partners
  - All.

Team Up PATH Visit Report and Technical Assistance Plan

State F – October, 2005

Background

The State F PATH visit took place on June 1, 2005. Twelve individuals attended the meeting (9 state partners, two coaches and one national partner). (See Attachment 1.)

Shared leadership of the partnership is provided by the State F Breast and Cervical Cancer Early Detection Program and faculty from Cooperative Extension. Having gotten off to a delayed start, this partnership quickly made up for lost time. They began in August 2004 by hosting three video teleconferences to introduce the project to regional CES and BCCEDP staff. The efforts were very successful in gaining needed buy-in from state and regional partners. They conducted a basic breast and cervical cancer training in December 2004 for county extension agents. Extension resources have been used to purchase exhibit boards and breast models for educators and to redo the State F breast and cervical cancer brochure. Other funds are being used to create low literacy cancer education and outreach materials. The Team also hosted three trainings for Extension agents, ACS, BCCEDP and CIS staff in February and March 2005.

The State F partnership has used cancer registry and BCCEDP data to target their intervention efforts. There are 10 counties involved in State F Team Up. In addition, a faculty member at a state university conducted an independent data analysis using 25 years of cervical and breast cancer data. They have recently visited the Cancer Planet website to review the RTIP programs. They mentioned that the Forsythe County model was one they are considering. They are concerned with costs associated with such extensive programs.

State F Partnership Challenges

During the Path visit the State F Team identified a number of challenges within their own partnership as well as frustrations with the National Team Up partners. At that time, the State F Team had not had a full meeting in a number of months and they were concerned that the county

partners were frustrated because of a lack materials and momentum. They had also had some internal frustrations over the choice of target counties using the ETSU data.

The State F partners were also frustrated with the National partners because of abundant Team Up emails, the difficult process of the Lasker and Weiss survey, and some of the information gathering of the coaches and Team Up personnel. They seemed to also be somewhat frustrated with differences in perspectives on the definition of *adaptation* of evidence-based programs. And, lastly, they were quite frustrated with a lack of additional seed funding from the National Partners such as the funds that the USDA had provided in the first months of the program. More recently they were tentatively approved to receive funding from ACS National for Team Up efforts which may have reduced some of these tensions.

Team Up State F Action Steps from PATH Visit and Recent Regional Training

Despite these challenges and frustrations, the State F Team determined a number of ambitious action steps at the PATH meeting, and more recently at the Regional Meeting, and have continued to move forward at an exciting pace. Specifically, Action Steps identified at the PATH meeting that were identified and completed include:

- Identify local ACS staff to link with Extension, CIS and BCCEDP regional coordinator;
- Provide list of Extension folk to ACS staff;
- Form county partnerships among these individuals;
- Hire a Team Up coordinator by July 1 funded by BCCEDP funding and located in Extension;
- Schedule an in-person meeting after July 1 of all project partners (state and local);
- Meet in July at Regional Training;
- Get Team Up newsletter electronically to disseminate;
- Do homework on Community Guide and Cancer PLANET RTIPS. Identify approaches and programs;

- Write a budget for program and provide to Debbie Saslow ACS; and
- Talk about the Retreat opportunity and get back to ACS.

More recently the State F state partners began to host three regional meetings to bring county partners together to disperse resource information and provide structure for county level action planning. These regional meetings are attended by representatives from the Health Department, UT Extension, CIS, ACS, Health Councils, etc. The Team is also evaluating the meetings and action steps using an evaluative response form and logic model. As counties develop activities and action plans, the State F Team Up Coordinator provides resources including RTIPs information, CIS Consumer Health Profile information, support in planning, and cancer materials.

Just this past week, for example, four counties left the regional meeting with varying levels of activities in place. Some counties need assistance in obtaining funds for incentive plans; other counties already are coordinating screening events with the health department. In the long term they will collect information about the county level activities in the region via a logic model used by UT Extension agents and the State F Breast and Cervical Cancer Early Detection Program Staff.

Methods for Assessment of Technical Assistance

The eight states of project Team Up were assessed for their technical support needs at three points in time during the past year. Each primary partner participated in the telephone interviews from November through December 2004. Technical assistance needs were also assessed during the PATH visits April through June, 2005 and the recent Team Up regional trainings in August, 2005. Each of these venues allowed members of state teams to express needs for technical expertise and, more recently at the regional trainings, provided a setting for National Partners to assess needs while participating in panels and discussion sessions with the Teams. More recently and following the Team Up regional trainings in July and August, the coaches met with state team members, via phone and email, to review the Action Plans from the regional training and to revisit current technical assistance needs to create this plan.

Results

At the time of the Interviews and PATH visits, technical assistance needs of all the states fell into four main categories and fifteen sub-categories.

Technical Assistance Needs – Results From Interviews

Communication
Forum to communicate with other state teams regarding "best practices" and lessons learned
Program Planning
Use of cancer data
Strategic planning
General program planning (including design, implementation, and evaluation)
Adapting or adopting evidence based strategies
Partnership
National Partnership: purpose, expectations, and institutional support available to teams
Team building (e.g., partnership and collaboration, learning about each other's organizations)
Negotiation (includes partnership conflict resolution, turf issues, etc)
Funding (includes grant writing, searching for funding)
Leadership development
Content
Cancer control expertise for the community
Educational resources (includes displays, materials, etc,)
Tailoring educational methods for various audiences
Cancer PLANET Training
Cultural competency (includes barriers, low income, literacy)

Previous and Current Perceptions of Technical Support

During the Team Up interviews this past fall, State F Team members requested help to create a strategic plan to increase group cohesiveness and to help the less active partners become more involved in decision making. They also asked for help to learn how to adapt evidence-based methods to diverse community settings for little cost. In addition, they wanted help with formal grant searching and wanted to be able to link with other states to share program ideas.

More recently though, when queried about their technical assistance needs, one of the state chairs said that their needs were minimal but that they might like support with evaluation, particularly when national evaluation was involved. She did not believe that their state needed a "coach" and reported during the regional training that funds for such support could be better used directly by the state. Specifically, she would like funds for travel, lunches, and making copies of resources for the counties. She also stated that the term "coach" implied that their state needed hand holding, which it did not. Instead she believed that a person who was a "facilitator" might be a more valuable resource to link states together to know what others are doing for program planning. A facilitator could also link states to the National partners.

When the State F Team Up coordinator was asked about technical assistance needs for the coming months she too replied "unless you have funds we can access, our needs are pretty much met by the partners in each of the counties…Luckily, our partners work so well together that these resources have been brought to the table already. CIS is our best data resource, and most of the partners, including myself as coordinator, are familiar with grant writing and funding searches…most of the partners--county and state level--come from backgrounds and positions of broad experience with partnership building and program implementation. I don't know how we would have done our jobs otherwise!" While this coordinator was appreciate of the Team Up offer of assistance and, wants the counties to have as many resources as possible, her closing words were "Really at this point, though, I would just like to be able to offer them money to fund all their great ideas."

Discussion

Neither the ACS, CIS, nor BCCEDP partners responded to questions about the kind of technical support they felt that State F needed from the National Partners. Instead, feedback came from Cooperative Extension and the project coordinator located in Extension and they stated that they are confident they have what they need to implement programs in their state. The State F Team's assets are reflected through their well-established infrastructure, training efforts, local and state partners, partnership resources and expertise, program planning/evaluation skills and cost sharing across organizations.

Both of the Team Up Chairs and the CIS partner are on the Executive Committee of the Comprehensive Cancer Plan so they are also well positioned in the state to engage diverse partners to make their efforts sustainable.

State F Team Up has been tentatively offered funding from ACS National for the Team Up programs described in their PATH visit, although it is not known if those funds have been received.

It is not known to what extent this team is implementing and evaluating evidence based efforts locally, but given their record to date, it is likely they are moving toward that end. If this team could be linked more closely to the larger Team Up efforts via the web forum, they could be a good model for other states to learn from. They have used the forum a few times to share their efforts and may be willing to do more in the future.

Attachment 1: State F PATH Meeting
June 1, 2005
7 Evaluations Completed (participation estimated at 11)

Q1-Q2: What were participants' expectations? Were they met?

- 5/7 reported "Yes" expectations met;
- 1/7 reported "No" expectations met; and
- 1/7 either did not answer or where undecided.

Expectation	Met?	If no, why not?/Comments
General review of where we are as a state.	Yes	
Some directions for how/what Extension and Public Health is to do to implement program. What is expected	No	It seems we are still heading down a long road and we are only part of the way.
Improved direction and I'd involvement at local level	Yes	
How to develop partnerships at local level	Yes	
An understanding of my role!	Yes	
Not sure – action plan	Yes	

Q3: To what extent were PATH Visit Objectives (as outlined at the beginning of the training) met?

Objective	Met	Unmet	Why unmet
Enhance a relationship among State F state partners and national partners.	7	0	■ Began to build relationships and understand better than expectations of national partners
Achieve a common understanding of the Team Up goals, objectives, methods and timeline. *Undecided: 2*	5	0	■ Goals, do and methods have been changed from beginning
Identify action steps necessary to establish (1) productive communication and collaboration among the partners and (2) to assess, adapt and implement evidence based cancer control programs in a sample of high risk counties in State F.	7	0	■ Again made progress
Discuss technical support needs and potential methods for State F partners. *Undecided: 3*	4	0	

Q4. What was useful about the meeting?

- Meeting by partners in this program;
- Ideas;
- Organizing steps, etc;
- Meeting of the minds;
- Developing relationships;
- Making future plans; and
- Est. an action step.

Q5. What additional information would have been helpful?

Appendix G

Regional Meeting Evaluation Report

Team Up Nashville and Atlanta Regional Meetings 2005
Summary and Discussion

Prepared by: Karen Melnyk-Vutrano

Introduction

This report summarizes evaluation findings from the Team Up Nashville and Atlanta Regional meetings, July 20-22 and August 2-4, 2005, respectively. It is based on data collection from surveys, observations, and informal interviews. Data was analyzed through frequencies, percentages, and medians. Medians were used to modify the effect of outlier values, and ensure greater accuracy as compared to simple averaging. Twenty-six out of 36 (72%) state team members in attendance at Nashville participated in the anonymous surveys, and 29 out of 30 (97%) participated from the Atlanta meeting.

Report Contents:

- A summary and discussion for both Nashville and Atlanta
- A comparison of the Nashville and Atlanta meetings
- A set of recommendations for future Team Up meetings
- Data summaries of each meeting
- All open-ended question responses, arranged categorically
- Full data sets for each meeting

Each summary and discussion includes an "overall" impression, a break down of the most and least successful sessions, and observer comments. Actual quotes from the surveys are included to illustrate strengths and weaknesses and are representative of the category or session to which they are attributed.

The following results demonstrate both meetings as successful, with some evident improvements from the Nashville to the Atlanta meeting. This quote from an Atlanta attendee sums up the positive sentiments expressed at both meetings:

- "Thank you for a great conference. I am so glad that I had the opportunity to participate in this conference - thank you. We all need to remember: What we do can save lives."

Summary and Discussion

Nashville

Overall

The meeting as a whole scored a median value of 4 on a scale of 1 to 5, where 1 equals "Poor" and 5 equals "Excellent."

The strong point of every session was that the objectives were understood. The weak point varied by session.

Two sessions were compromised such that there was a significant affect on evaluation results and were therefore removed from analysis: *Funding Your Evidence Based Intervention (PM)* was minimally attended and was evaluated by only 3 respondents; the change of *Discussion Round Tables* to *Team Networking* appeared to confuse attendees and was confusing for their evaluation process. Additionally, there was little communication and awareness of the *Gallery Walk*. However, it was included in analysis because as this was a planning error, the impact of this error should be considered, and a significant number of attendees did in fact evaluate and rate the *Gallery Walk and Messages from the Day* on their surveys.

Meeting Expectations:

- *Seventy percent* of the respondents felt that the meeting met their expectations.
- "Yes (somewhat). Wanted to spend more time with state team to develop plan of work based on "new" information learned at this regional meeting."
- Question 4: What was most useful about the Regional Meeting? "Talking to Fed team, evaluation session and hearing what others have done."

- Question 5: What was least useful about the Regional Meeting? "The national partner's presentation, the Dating Game at the reception. The poster session the way it was presented."

Sessions

Highest scoring session:

- *Evaluating Your Evidence Based Intervention:* This session had no scores below "3". Ninety-one percent of the respondents understood the objectives. Sixty-five percent of the respondents felt the instructor was "Excellent" (high score of the meeting).

Representative comment about this session:

- "Excellent presenter. Wish we had more time. Yes, content covered will be useful in meeting our team up goals."

Other high scoring session:

- *Facilitated Team Meeting*: Eighty-five percent of the respondents found this session to be useful.
- "Best part! Having time to meet and think how national partners might help."

Lowest scoring session:

- *Gallery Walk and Messages from the Day*: There was low attendance, and a low response rate. The response ratings spanned the 1-5 scale, but the session was represented by the middle value, "3" neither poor nor excellent. This was the lowest overall rating of a session at the meeting.
- "Objectives: never discussed. Way too much time was spent on trying to figure out what to do with the breakfast roundtable time period."

Other low-scoring session:

- *Work Shop: Funding Your Evidence Based Intervention (AM)*: Nineteen percent of respondents rated three out of the four measures below a "3" (excepting "Understood the objectives").

Only comment on the session:

- "Really disappointed. Do not presume to know more or understand our states or our knowledge of our institutions better than we do."

Other low-scoring session:

- *Opening Session:* Thirty percent of respondents rated this session below "3" in terms of "Usefulness" (the highest negative response rate for the meeting). However, it's important to note that 52% rated this measure above "3". The comments also demonstrated a balance of positive and negative responses.

- "Dating game w/national partners wasn't very effective. Successes weren't shared appropriately - games/poster didn't illustrate the magnitude of the state partners successes."

- "All of it was informative - helped group become active immediately and was also very fun."

Observer Comments

This group was very high energy in both negative and positive ways. There was a great deal of audible enthusiasm, as well as a "buzz" of critical comments, as supported by their comments on the surveys.

It appeared that the poster sessions did not get enough attention and state team members seemed frustrated to not be able to showcase their work in a formal venue. Though there was a great deal of verbal enthusiasm for *Opening Session*, it was clear that the *Dating Game* did not resonate as well as *Jeopardy*. Throughout the meeting there were repeated requests for more teamwork time for individual groups. The program lost momentum during the post-lunch work shop *Adapting Evidence Based Interventions*. They seemed burned-out after the second day with no interest for more information, as demonstrated by their vote for team building instead of round tables on the final morning of the meeting. The second (PM) funding session appeared unnecessary as hardly anyone attended. Laura Linnan received extremely enthusiastic reactions to her *Evaluating Your Evidence Based Intervention* session. The attendees were very responsive, participatory and disappointed to not have more time on this session.

The group raised a lot of questions and criticisms on their access to funding. National Partners, particularly observers, sensed a tension between how they were relating to the state team members

and how the state team members were perceiving them. States seemed on the one hand very dependent on guidance (web forum, funding sources, evidence-based research, etc.), and on the other very proprietary (don't be presumptuous, show us the money, let us work on our own, etc.). They were also very sensitive to being condescended, and complained that they were "over facilitated". This may reflect that prior to this meeting they felt under-supported and now they feel micromanaged. However, some expressed appreciation of the National Partners making efforts to be supportive and provide resources rather than dictate specifically how they conduct their interventions. It would appear that much of this tension has been carried over and the National Partners are succeeding in changing their perceived image and gaining state's trust.

Summary and Discussion

Atlanta

Overall

The meeting as a whole scored a median value of "5" on a scale of 1 to 5, where 1 equals "Poor" and 5 equals "Excellent." All but one session (*Wrap Up*) received an overall rating of Excellent.

With only one exception 40% of respondents and higher rated every measure at this meeting as "Excellent" (thirty-eight percent of respondents rated "The objectives were accomplished" at Wrap Up as "Excellent").

Only one measure at one session (*Wrap Up*) in the entire meeting was rated "Poor" by one respondent: *The content covered will be useful to me in meeting our TEAM UP goals*. Interestingly, it was also the highest rated measure at this session (above "3") by 84% of respondents.

"Networking and finding new resources and contact people. This will be a training I will actually apply in my programming. Grant info will really help us in finding funding for our outreach. Great wrap up and power point - entertaining and good review."

"No more info. We received plenty. Suggestion for future meetings like this: fewer plenary sessions, a few more breakouts, more state team planning time."

Meeting Expectations:

- *Ninety-five percent* of the respondents felt that the meeting met their expectations.
- "Understand more about evidence-based interventions and how we can move to the next step our team."
- "Extremely well organized conference! Kept us on schedule! Fun, creative activities. Great meals and breaks - very good hotel staff."

Sessions

Highest rated session:

- *Facilitated Team Meeting*: This session received no scores below 3.
- "Facilitators great. Kept us on track. We have a great partnership and we are all committed."

Other high-scoring session:

- *Work Shop: Adapting Evidence Based Interventions*: 100% of the respondents rated "Understanding the objectives" a 4 or higher.
- "Very important info to assist us with our implementation."

Lowest rated session:

- *Wrap Up*: Though "Content Usefulness" rated the highest at this session, it was also the only question to receive a "Poor/1" response.
- "Most people were overload by now!"

Observer Comments

This group appeared almost low energy, but displayed predominantly positive responses to the meeting.

The meeting was generally well-paced but there were some complaints that there could have been more break-out sessions. Though the energy level seemed intrinsic to this particular group, spending too much time in one room as a large group may have had a subduing affect.

The most outstanding criticism from the group was confusion about Team Up's emphasis on cervical cancer. This carried on throughout the meeting and though it seemed settled during *Wrap Up*, one comment from a survey indicated a lingering feeling of uncertainty.

During *Wrap Up* the National Partners were very antsy and appeared burned-out. The state team members remained engaged and made very positive comments about how well the entire meeting was coordinated and conducted. However, surveys indicated they too felt burned-out at this point.

Comparing Nashville and Atlanta

Every session that was conducted at both meetings improved at Atlanta. The following demonstrate the most significant improvement (note: 1 = **Poor**, 5 = **Excellent**):

Nashville	Atlanta
#3 Were your expectations met?	
Yes = 70%	Yes = 95%

Work Shop: Adapting evidence based interventions	Score 5		Measure median		Session median	
I understood the objectives	40%	71%	4	5	4	5
The objectives were accomplished	22%	59%	4	5		
The instructor(s) made effective presentations	17%	53%	3.5	5		
The content covered will be useful to me in meeting our TEAM UP goals	17%	59%	4	5		

Opening Session	Overall medium		Highest scoring measure		Lowest scoring measure	
	4	5	Understood the objectives	The content covered will be useful to me in meeting our TEAM UP goals	The content covered will be useful to me in meeting our TEAM UP goals	The instructor(s) made effective presentations

Other comparisons of interest:

- The funding session improved, but was not the "big winner" we thought it would be at either meeting.
- Similarly, *Wrap Up* improved significantly, demonstrated by the jump in survey responses (16 to 26), but both were weak sessions at both meetings.
- In *Facilitated Team Meetings*, the measure "The instructor(s) made effective presentations" inverted. In Nashville this was the weakest feature of the session, in Atlanta, the strongest.

Discussion

Although as noted, the Atlanta group was lower key than the Nashville group, they were also more positive in general. This positive attitude and the absence of the *Dating Game* are likely to be factors in the higher score for Opening Session. The states also seemed to appreciate the opportunity to present their posters formally. Jeopardy seemed to be a hit at both meetings.

While rearranging sessions proved beneficial particularly for the *Adapting Evidence Based Interventions* work shop, the resulting loss of additional break out sessions created a negative effect. In Atlanta there was a complaint of too much time sitting together in one room, while in Nashville it seemed the extra break-outs created repetitive information.

Throughout both meetings there were repeated requests for more teamwork time for state groups. This was true for Atlanta even though they did receive comparatively a great deal more time with their teams.

Both groups experienced burn-out at the end of second day. Removing the round tables automatically from the third day o f the Atlanta meeting may have alleviated some burn-out, and having this decided formally before the beginning of the meeting reduced confusion.

Only the Nashville meeting had a stand-out instructor, Laura Linnan.

Both groups raised questions on their access to funding, however it was the Nashville group that was more openly negative about this.

While both meetings gave the impression of some strain between National and State partners, it was more evident and Nashville. The tension appears to be related more to the particular stage achieved by individual state teams; the states demonstrated themselves to be in different stages in comparison to each other.

Recommendations

Help avoid burn out by spreading out the meeting over the three days instead of concentrating everything on the second day. This will also help avoid early morning sessions.

If possible, having presenters do a demo of their presentation would help meeting planners arrange presenting styles appropriately to maintain pace.

Having more break-outs without repeating information would keep the pace up.

Presenters should pay careful attention not to condescend state team members. Increasing their participation and contributions to session will help this.

More time should be given to allow for team building (this worked in Atlanta), but *not* at the cost of the primary goals of the Regional Meetings. National Partners should make clear the purpose or Regional Meetings—remind them that they can and should do more team building on their own time.

All hand outs should be ready before the start of the meeting and be available in a central location throughout the meeting.

A greater effort should be made to engage state teams in formal program planning to ensure events and meetings reflect their input. Feedback from Technical Assistance mechanisms can be applied to this purpose as well.

Make reminders or "promos" for various Team Up tools visible in every way possible. For example, since many participants claimed not to know about the forum, put an "ad" for the forum as part of a Team Up signature in e-mails, in all newsletters, at the bottom of other correspondence and Team Up material as appropriate.

Appendix H

Webinar Evaluations

Team Up Webinar

FoCaS—October 25, 2-3:00pm

Evaluation Summary

Hello, all

Below are evaluation results from the first Team Up Webinar on FoCaS. In response to feedback below, next time we will (1) record the webinar (2) send out slides the morning of the presentation, (3) extend webinar to 1 hour 15 (or 30) minutes to allow more time for questions (this time we had about 30 minutes), and (4) encourage participants to join on time so that they don't miss important information about the technology and process for the Webinar. As a follow-up to the call, we are posting transcripts of the Q and A session to the forum on Monday. The Q and A was quite relevant to Team Up in general; so you may want to read them. If you need your forum password, email Chastity. Thanks to Betsy for being the "hostess with the mostest; " James for managing the attendance and tallying evaluations; Allison Turner, Judy Patt, and Madeline for providing access to the software; and Karen for assistance with the evaluation.

1. Participation

38 Participants, including:

- 28 state team member representing all 8 states
- 7 national partners and Betsy
- 2 Co-presenters

2. Evaluation Results

We received 18 evaluations, for a response rate of 18/28 (64.3%).

- All rated the Webinar as very (11/18, 61.1%) or somewhat (7/18, 38.9%) useful Reaction to the speaker was generally good.
  - All rated her presentation style as excellent or good.

- 17/18 (94.4%) rated her excellent or good at addressing key points and responding to questions, 1 rated her fair.

- All thought the topic was interesting.
- Participants were split on how frequently we should host webinars; 7 chose quarterly, 7 chose bimonthly, and 2 said as needed.

What they liked best was the timeliness of the topic and the opportunity to ask questions. Tallies for comments made by more than one respondent are in parentheses.

- It made such a difference to be able to ask questions directly of a FoCaS implementer. This was very useful in articulating strategies for adjusting the program for a different community. (3)
- I think it was great to actually see the name of participants. I also enjoyed the question and answer section.
- Usefulness, easy to use and the ability to ask questions with the opportunity to read and hear the answers.
- Able to get multiple persons involved in the discussion while viewing pertinent information. A step up from your basic conference call. The time was excellent as well.
- It was very timely.
- Hearing from those who have implemented an EBI (2)
- FoCaS is one of the interventions we are looking at adapting. The Webinar provided valuable information on what can be changed, or not changed as we consider whether or not this intervention is suitable within our time frame.
- Overall summary of project
- The format and PowerPoint Presentation
- Interesting technology
- It's an efficient way to get the information out and presented to a large group of participants.
- Seeing the slides while hearing the presenter was helpful.
- Short and sweet and to the point. The possibility of doing it from our own office.
- It was informative and convenient to obtain this valuable information.

What they liked least was not having access to the slides, not having the call recorded, and not being able to ask questions direction (questions were typed and emailed to Felicia using the online technology; Felicia asked the questions and typed responses live onto to the screen as the presenter answered; persons asking the questions were asked to clarify there questions on the phone or online). Tallies for comments made by more than one respondent are in parentheses.

- Not being able to ask questions directly by phone during the Webinar. Having to submit questions in writing impeded the exchange of ideas. (2)
- The call was not recorded and we were unable to print the slides (2)
- If it costs money to have it on line – then just send out the PowerPoint ahead of time – I think it is very distracting to have to be on the phone and on-line – put the audio on-line.
- Would have liked a little more time to hear some more details. This was a big project.
- At first only typing questions and not being able to talk was awkward. But it makes sense, and worked well in the end. Some of the details about FoCaS (that are available on RTIPs) could have been eliminated to have more time for questions. It was frustrating to have Electra reference another study she has completed in a rural community but not give details.
- Learning the software and trying to focus on the webinar was a bit stressful. Many of us were first time users and it took a while to get the knack of how to answer questions and play with the screen features etc. Might have been nice to have a brief tutorial of some kind first. I wish we could have seen some of the actual tools used in the FoCas project. Would've liked to have talked more on evaluation techniques used.
- It was very difficult to hear the presentation—not sure if the problem was on your end or our end.
- Not being about to see the presenters.
- It was a new system for me – it would have been helpful to have instructions on how to use the site ahead of time…I couldn't figure out the audio part so I have the visual part through the webinar and the audio through the telephone…I spent a good time trying to get the audio to work until I called to the 1-800 #. The same on how to post the questions for the presenters
- Getting into the Webinar was difficult but this will improve as I gain the skills.

To improve, most suggest providing slides ahead and expanding time for questions. Tallies for comments made by more than one respondent are in parentheses.

- This topic could have used more time. More time for questions (2).

- Have access to PPT presentation handouts prior to the session so we can use for note taking. (2)
- Make better use of the technology – good directions on the site – clear and only have one medium at a time – since you e-mailed out the ppt after the meeting – don't see why the webinar is essential – I hope that we use it to value different learning styles – People need to understand that PowerPoint is not for listing things – rather for emotive response – seems with technology pictures are worth millions of words.
- Send a bio out and brief project description before the webinar so questions could be thought of ahead of time.
- In the future, I would like it if the presentations were recorded for members who were unable to participate in the call.
- If you could also implement Webcam along with Webinar.

Appendix I

Retreat Evaluation Report

Team Up Partnership Planning Retreats

PROJECT: Team Up is a national partnership to increase breast and cervical cancer screening among rarely/never screened individuals using evidence based approaches.

Currently Team Up is focusing on increasing breast and cervical screening rates in the following high mortality states: Alabama, Georgia, Kentucky, Missouri, South Carolina and Tennessee.

APPROACH: In 2006 the National Cancer Institute (NCI) extended an invitation to all Team Up partnerships to hold facilitated planning retreats.

RETREAT FOCUS: To develop collaborative action steps to further the goals of the Team Up partnerships by:

- Increasing awareness of each partner's organization,
- Identifying and addressing concerns that limit the effectiveness of the collaborative relationship,
- Establishing and refining procedures for working together,
- Identifying and committing to collaborative activities.

PARTICIPATING PARTNERS: Core partners included the following:

- National Cancer Institute's Cancer and Information Service,
- American Cancer Society,
- Center for Disease Control's National Breast and Cervical Cancer Education Program and,
- USDA's Cooperative State Research, Education and Extension Service with USDA.

Background

Why use a collaborative approach to increase breast and cervical cancer screening rates among rarely/never screened women?

Solutions to complex social issues are typically beyond the knowledge, skills and funding of any one person or organization. Additionally, when organizations act independently to address these social issues they often produce unanticipated obstacles for others and then in turn for themselves (Trist, 1983). To overcome these barriers, many organizations are using collaborative partnerships as a fundamental strategy for creating more sustainable solutions to shared social problems.

Some key benefits to collaborative partnerships include the following (Gray 1989):

1. A broad overview of the opportunities and benefits by diverse participants improves the quality and creativity of solutions;
2. Diverse interests included in solutions broadens acceptance and willingness to implement them;
3. Those most familiar with the problem influence the solutions;
4. Shared power and resources improve relationships between participants.

To address disparities with reaching rarely and never screened women for breast and cervical cancer, collaborative partnerships make strategic sense and have great potential as an effective problem solving approach. However, some common obstacles to collaboration such as lack of knowledge about project partners and lack of clarity about common goals, roles and responsibilities can divert partners from their desired outcomes. Project sponsors can greatly enhance the likelihood of successful outcomes by creating opportunities for partners to address these barriers.

How might project sponsors enhance partnership development?

In 2001, NCI convened leaders from 36 states to address the issue of high mortality from cervical cancer in certain regions of the United States. Following this meeting, NCI and the USDA Extension Service agreed to enhance their partnership and collaborate on increased screening for breast and cervical cancer. From 2003 to 2004, the collaboration was expanded to include the CDC and ACS with a goal of creating local partnerships to increase cancer screening and decrease cancer

mortality among rarely and never screened women in key high mortality states. The national-level sponsors then invited representatives from eight states to participate in this pilot project. During the first year of the pilot, which became known as Team Up, state partners focused on relationship building and choosing an evidence-based intervention based on information provided on Cancer Control PLANET. To enhance state partnership development, the national sponsors hired several coaches to work with the state Team Up Partnerships on team-building, planning and evaluation.

While team members were working at the state and local levels, the national partners continued to clarify overall program goals, strategies and evaluation components for the project. They identified the following key project components: (1.) Rarely or never screened women would be the audience; (2.) Evidence-based projects would be the focus; and (3.) Partnerships would be the underlying strategy. They also convened two regional meetings to train state teams regarding evidence-based approaches and offer opportunities to continue to build the partnerships.

To further enhance partnership development, NCI extended an invitation to all Team Up projects to hold facilitated planning retreats using an ACS retreat model. The ACS retreat model was created to the outcomes of an extensive needs assessment of their regional collaborations with the Breast and Cervical Cancer Early Detection Program (BCCEDP), including a survey of 15 ACS Divisions and more than 41 state and 14 Tribal BCCEDP programs. Assessment results showed that in most cases partners enjoyed very good working relationships; however, lack of clarity about collaborative goals, roles and responsibilities and channels of communication.

Georgia, Tennessee and Missouri held retreats using the ACS retreat model. Alabama and Kentucky chose not to have retreats. South Carolina began the retreat planning process and then realized that the timing of their retreat would distract the team from carrying out their intervention so they eventually decided not to hold a retreat. This report is a summary of observations and key results of three collaborative planning retreats that were conducted for Team Up partnerships in Georgia, Missouri and Tennessee using the ACS retreat model.

Phases of Collaboration

At what stage in the development of the partnerships were the retreats held?

Two overarching phases of development for a collaborative partnership are Planning the Partnership, and Managing the Partnership. Typically, project sponsors have a more significant role during the up-front planning phase and participants are more involved during the management phase.

While each phase of development includes distinct activities, the phases often overlap and some may be revisited throughout the partnership. For example, it is very important to focus on developing partner commitment at the beginning of the project, but it is also important to renew commitment as the project moves forward.

Steps for each phase of development are as follows:

Planning the Partnership

1. Initially defining the problem or focus of the potential collaborative,
2. Evaluating potential approaches or strategies,
3. Designing the partnership,
4. Organizing the participants.

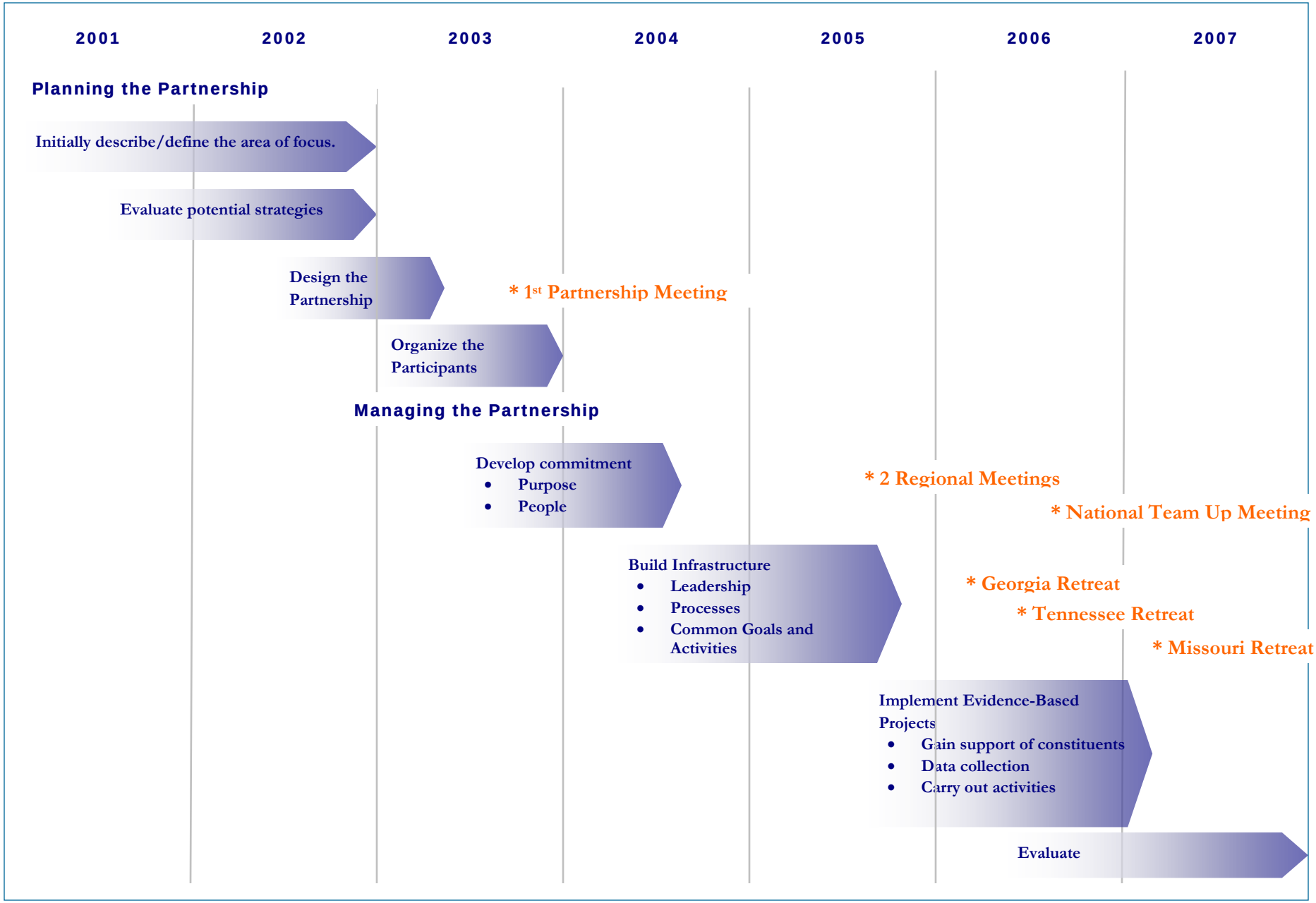
Managing the Partnership

1. Developing partner commitment,
2. Building infrastructure,
3. Implementing project activities.

(Cummings, 1984; Gray, 1989, Motamedi, 1984 and McCann, 1983)

Following is a graph of the development of the Team Up partnerships. This timeline was created using the key Milestones in the Team Up Pilot article from the July 2006 Team Up newsletter and the collaborative phases of development listed above.

Development of the Team Up Collaboration



Retreats

What is involved in planning a retreat?

To preserve the integrity of the retreat planning model it was important that the retreat address the barriers to collaboration identified in the national ACS-BCCEDP assessment including enhancing relationships, clarifying roles and responsibilities, defining collaborative goals and activities, and uncovering any issues that might limit collaboration.

The desired outcomes for the retreat were specifically defined as follows:

- Increasing awareness of each partner's organization
- Identifying and addressing areas of concern and issues from each partner organization that limit the effectiveness of the collaborative relationship,
- Establishing and refining procedures for working together,
- Identifying and committing to actions to strengthen local collaborations.

Steps in planning and conducting the retreats included the following:

1. **Initiating a Retreat:** Assessing organizational readiness for a retreat and applying for funding.
2. **Pre-Retreat Planning:**
    a. **Getting Started:** Hiring a facilitator, setting up a planning committee and coordinating logistics.
    b. **Data Collection:** Conducting a pre-retreat survey, discussing partnership issues and concerns.
    c. **Retreat Activities:** Structuring the agenda and designing retreat activities.
3. **Retreat:** Conducting a retreat and making onsite adjustments to maximize achievement of meeting goals.
4. **Follow-up:** Strategies for ensuring the utilization of retreat outcomes and follow-up actions to sustain and further strengthen collaborations.

While the retreat model includes specific guidelines, it was also designed to be adapted to the needs of each partnership. This flexibility is built into the pre-retreat survey process. The information collected using the survey tool provides a snapshot of the dynamics and needs of the partnership. The planning committee and the facilitator used the survey results to design an agenda tailored to the needs of each Team Up partnership. See the tables below for summaries of the qualitative survey results from each partnership.

Pre-Retreat Survey Findings

Survey questions	Georgia team up	Tennessee team up
If you need any assistance, what kind of assistance do you need?	■ Training about Team Up goals and how to implement them. ■ Better understanding of how to work with cooperative extension and a better understanding of how they are working with the community.	■ Opportunities to discuss possible activities with coalition partners. ■ County level money for implementation.
What areas of training would make your county partnership stronger?	■ Training about Team Up goals and how to implement them. ■ Better understanding of partner roles and responsibilities.	■ Training is not the issue, it is time. County level staff has other professional roles and responsibilities and this project is just one aspect of their work
What are the most important issues for the leadership of the participating organizations to address at the retreat?	■ Better understanding of partner goals, roles and who is responsible for what. ■ Better understanding of CIS's role. ■ Get to know each other better and work more closely together. ■ Clear collaborative work plan.	■ Clarity about partner roles. ■ Sustaining the partnerships and expanding projects into new counties.
If this retreat were a smashing success what would you leave with that you don't have in your current relationship?	■ Better understand the partnership, partner goals, roles and responsibilities. ■ Stronger relationships at all levels. ■ Clear collaborative work plan. ■ More frequent and open communication.	■ More time to collaborate with partners. ■ A roadmap of where we are going and when it will be completed. ■ Strengthen understanding of each other. ■ Mini lessons that can be used in other counties.
What would you like to see developed that would make collaborating together even more effective?	■ Stronger connections and relationships. ■ Clearer plan for regular communication. ■ Build relationships with and team with other groups.	■ A clearer explanation and understanding of Team Up. ■ Communication at all levels of the partnership.

Since the Missouri team included 6 people and their intervention did not currently include other partners, the online survey tool was not the most effective way to assess their situation. The facilitator interviewed the team members and summarized the information that was collected.

Interview questions	Missouri team up
In your opinion what is the purpose of the retreat?	■ The purpose of the retreat is to build synergy among organizations and possibly to replicate the projects in other counties if we are ready. ■ It is a very good idea to have a working meeting for the team.
How would you describe the Missouri team?	■ We genuinely enjoy each other and respect each other's work. ■ We have well-intentioned people on the team. ■ We are facing some of the challenges teams often face: we are geographically dispersed, we do this project in addition to other full time jobs, we rarely find times when everyone can meet and there has been turn over of team members. ■ We are not clear about next steps as a team.
What do you think about inviting other potential state-level partners to the retreat?	■ Do not invite the community people unless we are clear what the next steps are and how they might be involved. ■ The retreat is a time to bring partners together to discuss barriers to implementation. ■ We want to bring community screening facilities up to date so everyone is informed about their capacity.
What are the most important issues for the partners to address at the retreat?	■ How has this project made an impact/generated results? ■ What are our plans/next steps as a team? ■ Are we going to replicate this project in other counties? ■ What are the benefits to continuing or not continuing as a team? ■ If we decide to move forward as a team, how are we going to roll this project out at the community level?

How did the survey results impact the retreats?

Based on the survey responses, the Georgia and Tennessee teams were much more focused on building relationships and meeting infrastructure needs such as clarification about goals, roles and responsibilities. The Missouri team was more focused on meeting as a team to discuss the implementation of their intervention and their next steps as a team. Retreat activities were designed to address each team's focus areas.

Each team had different training needs depending upon their progress with planning and implementing their intervention. Training was also tailored to the needs of each team. Additionally, the type of intervention influenced who was invited to the retreat and the topics that were discussed.

Retreat Highlights

What were the top successes of the retreats?

	Georgia	Tennessee	Missouri
Project Successes	1. Leadership of the state partners in planning and participating in the retreat. 2. Integration of the new CIS representative into the team. 3. Good opportunity to get the county cooking schools underway.	1. Opportunity for them to work together face to face. 2. Celebration of project successes.	1. Persistence with the planning process. 2. Open discussion with the team and with potential new partners. 3. List of creative and realistic collaborative activities.
Factors That Supported Success	1. Enthusiasm of the leaders. 2. Working together on the planning process, Dr. Randall-David's long-term relationship with the team. Working together at the retreat to strategize for day 2. 3. Excellent tools offered by cooperative extension. Partners working with each of the tables on their plans.	1. A unique funded opportunity through national partners. 2. Many projects underway so there was data available.	1. Motivation of the planning team. Support of NCI to let them have their retreat in January. 2. Leadership and creativity of the planning team. 3. Creativity of retreat participants.

What was unique about the Team Up retreat process as compared to the ACS-BCCEDP retreats?

Coaching

A unique aspect of pre-retreat planning process was collaborating with coach Betsy Randall-David. Dr. Randall-David began working with the six partnerships in October 2004 to provide technical assistance. As an experienced coach and trainer she had developed an excellent working relationship with each of the partners. Her long-term perspective of the partnerships and ability to confirm survey findings was very helpful to the planning process. Her expertise was also invaluable when conferring about partnership dynamics on-site.

Interventions

Another unique aspect of planning retreats for the Team Up partnerships was taking into consideration implementation of their evidence-based interventions. As noted in the background section of this document, the South Carolina team decided not to hold a retreat because they believed it would distract the team from their primary focus on the intervention.

In the case of the Georgia partnership, they had a larger team to handle the pre-retreat planning work, planning for their intervention was underway, and their intervention included many county extension agents so the retreat served as a useful vehicle to bring together the larger group to further their collaborative planning efforts. The Tennessee team had a staff person who was hired to coordinate the partnership and she was able to handle much of the pre-retreat planning work. Again the retreat was well timed to further the team's planning efforts.

Implementation

An important step for all the planning retreats was implementing the collaborative action plans and in particular, following up with staff regarding their commitments. In some cases state leaders from each of the participating organizations took primary responsibility for follow up, in other cases local staff took on these responsibilities. In one case, a staff person from one of the partner organizations was dedicated to specifically overseeing implementation of the action plan.

Once again the Team Up partnerships greatly benefited from the support of dedicated coaching after the retreats. The Team Up coach Dr. Betsy Randall-David was able to contact the teams and bolster implementation of the retreat action plans.

Sustainability

The Team Up partnerships were initially designed as a pilot with a scheduled end date of September 2007. A critical step that is often missing in the development of such collaborative projects is a plan for what happens after partners complete their current activities. In most cases participants are so busy with their day-to-day work they do not have the time to plan for how they might sustain themselves in the future.

Some partnerships have natural momentum and find ways to continue while some have reached a natural ending point as they complete their projects. However, some may need guidance to transition to the next phase and continue their efforts.

The timing of the Missouri intervention, the fact that the intervention did not require the whole team once it was underway, and the timing of their retreat provided Missouri with a unique opportunity to consider what would happen after they completed their project. They began an important discussion about the future of their team.

Perhaps it is important for all partnerships to ask questions like those raised by the Missouri team members:

- Are we going to replicate this project in other counties?
- What are the benefits to continuing or not continuing as a team?
- If we decide to move forward as a team, are we going to replicate this project in other counties?

Closing Observations

Using a collaborative partnership model to address high-mortality rates from breast and cervical cancer in key regions makes strategic sense for a variety of reasons that were previously discussed. When using a collaborative approach, it is useful for project sponsors to be aware of the obstacles that participants will face through the development of their partnerships. Sponsors can then provide resources and tools to address these issues at key stages and greatly enhance the likelihood of successful project outcomes.

The retreat model was one approach the national partners/sponsors utilized to support the development of the Team Up partnerships. Additional approaches employed by the national partners included training participants early in the process, hiring a coach to support planning and team building efforts, convening project participants for national and regional meetings and providing evaluation support. All of these efforts and most notably the coaching support, served to further enhance retreat planning, implementation and follow up.

Based on the phases of Team Up partnership development outlined in this document, retreats were conducted while the partnerships were focused on building infrastructure and initiating

implementation of their interventions. While the timing of the retreats was very useful for some states such as Georgia and Tennessee, it was less beneficial for other states such as South Carolina and perhaps others. It may be that the development of each partnership needs to be examined for the appropriate timing of a retreat and it may also be worthwhile to consider whether retreats planned at several key stages throughout the partnership might be useful.

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Appendix J

Description of Lasker and Weiss Synergy Framework

Lasker and Weiss Synergy Framework

Synergy is defined as "the power to combine the perspectives, resources, and skills of a group of people and organizations" (Lasker and Weiss, 2001). By combining the individual perspectives, resources, and skills of the partners, the group creates something new and valuable together- a whole that is greater than the sum of its individual parts. As defined by this framework, a partnership's level of synergy is "the extent to which the perspectives, resources, and skills of its participating individuals and organizations contribute to and strengthen the work of the group." Synergy is a product of group interaction.

The Lasker and Weiss Partnership Framework identified five factors of partnership functioning that are related to synergy: resources, partner characteristics, relationships among partners, partnership characteristics, and external environment. The framework discusses specific attributes of each determinant that influence a partnership's level of synergy and resulting effectiveness (Lasker, Weiss & Miller, 20001).

Partner Resources

Both financial and in-kind, are the basic building blocks of synergy. By combining resources, partners are able to create something new that they could not accomplish alone. Resources include money, space, equipment, goods, skills and expertise, information, connections to people, organizations, and groups, endorsements, and convening power.

Partner Characteristics

Partners are the source of most partnership resources. They provide the partnership with many resources directly, as well as, obtain external funding and in-kind support. To achieve high levels of synergy, partnerships must be able to recruit and retain partners that can provide needed resources, despite the voluntary nature of partnerships. The mix of partners and the way they participate needs to be optimal for defining and achieving partnership goals. The level of involvement of partners is dependent on the perceived benefits and drawbacks of their participation and the authority organizations grant their representatives.

Relationships Among Partners

Building relationships is probably the most difficult and time-consuming challenge partnerships face. Trust, respect, conflict, and power differentials are all aspects of partner relationships that influence a partnership's level of synergy.

Partnership Characteristics

In addition to the attributes of individual partners, there are characteristics of the partnership as a whole that influence a partnership's level of synergy. These characteristics include leadership, administration and management, governance, and efficiency.

Partnerships require *leaders* who understand and appreciate partners' different perspectives, can bridge their diverse cultures, and are comfortable sharing ideas, resources, and power.

Administration and management is the unifying factor that makes it possible for multiple, independent people and organizations to work together. Partnerships with high levels of synergy require approaches that are flexible and supportive. Administration and management functions that are likely to be important determinant of partnership synergy are: extensive outreach, orientation, and logistical supports to enable a broad range of community residents and organizations to participate meaningfully in the partnership's work; effective communication strategies and mechanisms to coordinate partner's activities; analysis and documentation capacities to provide partners with materials that synthesize their ideas and help them make timely decisions, as well as to evaluate the functioning and progress of the partnership. Since partners are volunteers, the presence of full-time administrative staff may also increase synergy levels.

Through procedures that determine who is involved in partnership decision making and how partnerships make decisions and do their work, *governance* influences the extent to which partners' perspectives, resources, and skills can be combined. The extent to which governance influences partnership synergy is related to partners comfort level with the decision making process, the degree to which partners support partnership decisions, and the timeliness of partnership decisions.

Efficiency refers to how well a partnership optimizes the involvement of its partners. To maximize synergy and keep its partners engaged, a partnership needs to be efficient. In addition to ensuring

that the thinking and actions of the group benefit from the contribution of different partners, the collaboration process must also make the best use of what each partner has to offer. Aspects of efficiency that influence synergy are the extent to which the roles and responsibilities of partners match their particular interests and skills, and the extent to which the partnership makes good use of its partners' financial resources, in-kind resources, and time.

External Environment

There are also factors that are beyond the control of any individual partner or partnership. One example is the conduciveness of the community to the work of the partnership. Recruiting and retaining members may be more difficult in communities where there is little history of cooperation and trust, significant competition for resources or clients, resistance of key people and organizations to the goals and activities of the partnership, problems bringing partners together due to crime or lack of transportation, or numerous partnerships involving many of the same partners. Many partnerships also experience public and organizational policy barriers, such as the short-term nature of external funding, categorical program requirements, and inadequate funding for administration and management support.

Appendix K

Description of Lasker and Weiss Partnership Self-Assessment Tool (PSAT)

Lasker and Weiss Partnership Self-Assessment Tool

In 2001, The Center for the Advancement of Collaborative Strategies in Health conducted an exploratory study, the National Study of Partnership Function, which tested the hypothesis that partnership synergy is directly related to the following dimensions of partnership functioning: leadership, administration and management, partnership efficiency, non-financial resources, challenges with partnership involvement, and challenges related to the community (Weiss, Anderson, & Lasker, 2002). The study found that higher levels of synergy were related to more effective leadership and to greater partnership efficiency. The results also suggested that synergy may be related to more effective administration and management and greater sufficiency of non-financial resources. Neither partnership involvement challenges nor community-related challenges bore any relationship to synergy. Seventy-three percent of the variance in partnership synergy was explained in this analysis.

The Center used the instruments from and the findings of the National Study of Partnership Functioning to develop the Partnership Self-Assessment tool (PSAT). The tool allows working partnerships to assess how well their collaborative process is working and to identify specific areas on which they can focus to improve the process. The tool measures a partnership's level of synergy and identifies the partnership's strengths and weaknesses in areas that are known to be related to synergy- leadership, efficiency, administration and management, and sufficiency of resources. It also measures partners' perspectives about the partnership's decision making process, the benefits and drawbacks they experience as a result of participating in the partnership, and their overall satisfaction with the partnership.

Starting in 2002, the tool was available on-line and was free to be used by any partnership that registered. If at least 65 percent of partners completed the questionnaire in a 30 day period, a tailored, action-oriented report was generated and available to the partnership in .PDF format. In June 2006, the Center had to bring the tool offline because the software platform upon which the tool was constructed became obsolete. However, since the tool has been so useful to partnerships, the questionnaire and action-oriented report, along with detailed instructions for using the Tool offline are available at http://www.cacsh.org/psat.html.

Appendix L

Lasker and Weiss PSAT Reports

Appendix L included is included as a separate document to maintain confidentiality.

Thank you.

Appendix M

Process Evaluation Telephone Interview Guide

Process Evaluation Interview Guide

May 2006

Note: This is the interviewer copy. It includes interviewer probes and "don't know" response options. Any content that only appears in this version is in red.

NATIONAL CANCER INSTITUTE (NCI)

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Introduction

Thank you for participating in the Process Evaluation of the Team Up partnership to increase cervical and breast cancer screening. In this interview, the phrase "your partnership" refers to //INSERT PARTNERSHIP HERE//, which includes all of the agencies that support Team Up both Core partners (ACS, CDC, NCI, USDA) and non-Core partners. In addition, the phrase "your organization" refers to //INSERT ORGANIZATION HERE//.

This survey will address aspects of synergy and collaboration between your organization and your partnership. The survey begins with a review of your breast and cervical cancer screening activities prior to joining Team Up. It then turns to characteristics of your partnership and of your partners, resources for your partnership, the external environment around your partnership, and the role of the National Partners and their activities in your partnership. We expect that this interview should take forty minutes.

Please note that your responses are confidential and any data collected will be credited to the state partnership. All information that may identify individuals or their organizations will be removed. Only Westat project staff will have access to your responses.

I'd like your permission to tape record our conversation so that we do not miss any of your comments—only the research staff at Westat will have access to these tapes. Do we have your permission to tape this interview? Y N

Probes:
Definition of Partnership- Partnership refers to all types of collaboration (e.g., formal and informal agreements, coalitions, and alliances) among community groups and agencies that bring people and organizations together to support the Team Up program.
Definition of Synergy- Synergy of collaboration results when individual perspectives, resources, and skills of partners create something new and valuable together – a whole that is greater than the sum of its individual parts.
Definition of Collaboration: Partnerships that collaborate work jointly with others on a project, where those collaborating with others take on specified tasks within the project and share responsibility for the project's ultimate success.

0. [NAME OF RESPONDENT]

NAME:_____

ORGANIZATION:_____

PARTNERSHIP:_____

1. When did **//INSERT ORGANIZATION HERE//** join the Team Up partnership?

|__|__| |__|__|__|__|
MONTH YEAR

Don't Know ..... ☐

1a. How long have you been involved with this Team Up partnership?

2. Prior to joining Team Up, what were **//INSERT ORGANIZATION HERE//'s** activities in education, outreach, contacting and screening women for breast and cervical cancer? If you were not involved in any such activities, please state that.

Breast Cancer Activities	Cervical Cancer Activities

3. Prior to joining Team Up, had **//INSERT ORGANIZATION HERE//** worked with any of the other Team Up partners?

YES ..... ☐
NO ..... ☐

3a. [IF YES] Please describe your partners, how often you collaborated and types of activities with that partner

Partner	Frequency of collaboration	Types of Activities
	☐Frequently ☐Occasionally ☐Rarely	
	☐Frequently ☐Occasionally ☐Rarely	
	☐Frequently ☐Occasionally ☐Rarely	
	☐Frequently ☐Occasionally ☐Rarely	
	☐Frequently ☐Occasionally ☐Rarely	

4. In your view, what is the purpose of the Team Up state partnership?

5. Did you or someone from **//INSERT ORGANIZATION HERE//** attend the July 2003 training?

YES ..... ☐ [Go to 5a]
NO ..... ☐ [Go to 6]
DON'T KNOW..... ☐ [Go to 6]

5a. [IF YES] As discussed during the July 2003 training, the purpose of Team Up was to develop State partnerships that addressed the need for cervical and breast cancer screening among rarely or never screened women. These partnerships were to identify, adapt, and implement evidence-based approaches to encourage women from high risk counties to be screened. Has your organization's understanding of the purpose of Team Up changed since the July 2003 training?

YES ..... ☐ [Go to 5b]
NO ..... ☐ [Go to 6]
DON'T KNOW..... ☐ [Go to 6]

5b. [IF YES TO 5a] In what ways has your organization's understanding of the purpose of Team Up changed since the July 2003 training?

6. We would like to know about the active involvement of //**INSERT ORGANIZATION HERE//** in your state's Comprehensive Cancer Control planning and implementation process. Would you say **//INSERT ORGANIZATION HERE//** was …..
Prompt: **Definition of Comprehensive Cancer Control-** Comprehensive cancer control is an integrated approach to reducing incidence, morbidity and mortality through prevention, early detection, treatment and rehabilitation.

Very active ..... ☐
Somewhat active..... ☐
Not very active ..... ☐
Not at all active..... ☐
Don't Know..... ☐

Team Up Partnership Characteristics

The following section on Team Up partnership characteristics will ask you questions about attributes of your partnership. Please note that questions referring to your state "partners" refer to both Core partners (ACS, CDC, NCI, USDA) and non-Core partners unless otherwise specified.

7. Does **//INSERT ORGANIZATION HERE//** contribute any of the following to //**INSERT PARTNERSHIP HERE//**?

	YES	NO	DON'T KNOW
a. Staff time of paid employees	☐	☐	☐
b. Staff time of volunteers	☐	☐	☐
c. Funding	☐	☐	☐
d. Other In-kind resources (for example, publicity, printing, equipment, facilities)	☐	☐	☐
e. Access to special populations of women to be screened	☐	☐	☐

8. Is **//INSERT PARTNERSHIP HERE//** comprised of the right mix of partners needed to accomplish your goals? Please consider partners other than **Core** team (ACS, CDC, NCI, USDA) at the state level.

YES ☐
NO ☐

9. Besides the core partners, has **//INSERT PARTNERSHIP HERE//** recruited other partners into Team Up?

YES ☐
NO ☐ [Go to 11]
DON'T KNOW ☐ [Go to 11]

9a. [IF YES to 9]: Why did your partnership recruit new partners into Team Up?

9b. [IF YES TO 9]: What contributions do the new partners make towards your partnership?

9c. [IF YES TO 9]: How did your partnership recruit other partners into Team Up?

10. Has **//INSERT PARTNERSHIP HERE//** experienced challenges in recruiting partners to Team Up?

YES ..... ☐
NO ..... ☐ [Go to 11]

10a. [IF YES TO 10]: What challenges has your partnership experienced in recruiting new partners?

10b. [IF YES T0 10]: Were you successful in overcoming these challenges. How?

10c. [IF YES TO 10]: What are the gaps that need to be filled in your partnership?

10d. [IF YES TO 10]: What other organizations should be involved in your partnership, in your opinion?

11. Has **//INSERT PARTNERSHIP HERE//** experienced challenges in retaining partners in Team Up?

YES ..... ☐
NO ..... ☐ [Go to 12]

11a. [IF YES]: What challenges has your partnership experienced in retaining partners?

11b. [IF YES]: Were you successful in overcoming these challenges? How?

12. Does **//INSERT PARTNERSHIP HERE//** have:

	YES	NO	DON'T KNOW
a. A written mission statement?	☐	☐	☐
b. Written operating procedures or by-laws?	☐	☐	☐
c. Clear procedures to select a leader?	☐	☐	☐
d. A shared vision of what the partnership wants to accomplish?	☐	☐	☐
e. An orientation for new members?	☐	☐	☐
f. A state action plan?	☐	☐	☐

Probe: **Definition of state action plan:** A state action plan is the agenda of agreed-upon steps to increase cervical and breast cancer screening rates that was developed at the July 2003 training
The state action plan was updated during the 2005 PATH visits.

13. I am going to read you a list of statements about partnership characteristics. Please tell me whether you strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, or strongly disagree with each of the following statements about **//INSERT PARTNERSHIP HERE//.** If you have no opinion, please just tell me that:

	STRONGLY AGREE	SOMEWHAT AGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT DISAGREE	STRONGLY DISAGREE	NO OPINION
a. My organization contributes to the strength of our partnership	☐	☐	☐	☐	☐	☐
b. My organization's contribution to the partnership is clear	☐	☐	☐	☐	☐	☐
c. Our partnership has worked at building trust and respect among partners	☐	☐	☐	☐	☐	☐
d. Our partnership values differences or disagreements	☐	☐	☐	☐	☐	☐
e. Our partnership handles conflict effectively	☐	☐	☐	☐	☐	☐

14. In your opinion, how effective is **//INSERT PARTNERSHIP HERE//** in ….?

	EXTREMELY EFFECTIVE	SOMEWHAT EFFECTIVE	SOMEWHAT INEFFECTIVE	EXTREMELY INEFFECTIVE
a. Communicating between and among partners...	☐	☐	☐	☐
b. Planning Team Up activities	☐	☐	☐	☐
c. Making decisions related to Team Up.....	☐	☐	☐	☐

Team Up Partner Characteristics

This section asks about the role of your organization in your partnership.

15. I am going to read you a list of partnership functions. Please indicate if **//INSERT ORGANIZATION HERE//** has been involved in the following partnership activities. If so, please indicate the average number of hours per month your organization devotes to each activity.

	YES	NO	DON'T KNOW	[IF YES] HOURS IN A TYPICAL MONTH	DON'T KNOW
a. Preparing for partnership meetings and activities.....	☐	☐	☐	____	☐
b. Attending regular partnership meetings	☐	☐	☐	____	☐
c. Participating in committee work.....	☐	☐	☐	____	☐
d. Carrying out partnership sponsored activities	☐	☐	☐	____	☐
e. Delivering educational sessions on screening.....	☐	☐	☐	____	☐
f. Identifying women never or rarely screened	☐	☐	☐	____	☐

16. I am going to read you a list of partnership activities. For each of the following activities, in the past 12 months has **//INSERT ORGANIZATION HERE//** …?

	YES	NO	DON'T KNOW
a. Represented the partnership to other groups (e.g., attended meetings, participated in conferences, etc.)	☐	☐	☐
b. Shared information between partners on evidence-based interventions	☐	☐	☐
c. Collaborated with other partners (for example, share resources, responsibilities, risks, and/or rewards).....	☐	☐	☐

17. I am going to read you a list of statements about partnership leaders. Please tell me whether you strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, or strongly disagree with each of the following statements about partnership leadership. If you have no opinion, please just tell me that:
Note to interviewers: If there are no identified partnership leaders, skip to Q18.

	STRONGLY AGREE	SOMEWHAT AGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT DISAGREE	STRONGLY DISAGREE	NO OPINION
a. Our partnership has one identified leader who manages and administers the partnership.....	☐	☐	☐	☐	☐	☐
b. Our partnership leaders understand and appreciate the differences between partner members.....	☐	☐	☐	☐	☐	☐
c. Our partnership leaders have been effective in coordinating the communication and activities of the partnership	☐	☐	☐	☐	☐	☐
d. Our partnership leaders are able to clearly communicate the partnership's vision.....	☐	☐	☐	☐	☐	☐
e. I am satisfied with our partnership leaders	☐	☐	☐	☐	☐	☐

Resources

The following section will ask you questions about the resources available to your partnership. Resources can be both financial and in-kind, such as space; equipment; goods; skills and expertise; and information. Resources can also be connections (to people, organizations and groups); endorsements; and convening power.

18. Does **//INSERT PARTNERSHIP HERE//** have sufficient resources to successfully implement its activities?

YES ..... ☐
NO ..... ☐
DON'T KNOW..... ☐

19. Which of the following additional resources has **//INSERT PARTNERSHIP HERE//** tried to obtain?

	Attempted to Secure Resources?			[IF YES] , How successful has your partnership been?		
	YES	**NO**	**DON'T KNOW**	**COMPLETELY SUCCESSFUL**	**PARTLY SUCCESSFUL**	**NOT AT ALL SUCCESSFUL**
a. External funding?	☐	☐	☐	☐	☐	☐
b. Space?	☐	☐	☐	☐	☐	☐
c. Equipment? (e.g., computers, copiers)	☐	☐	☐	☐	☐	☐
d. Materials? (e.g., printed materials)	☐	☐	☐	☐	☐	☐
e. Staff with appropriate skills and expertise?.....	☐	☐	☐	☐	☐	☐
f. Information (e.g., about cancer screening)?	☐	☐	☐	☐	☐	☐

20. Does **//INSERT PARTNERSHIP HERE//** have a plan for obtaining additional resources?

YES ..... ☐
NO ..... ☐
DON'T KNOW..... ☐

External Environment

The following section will ask you questions about how the external environment has influenced your partnership. The external environment includes factors such as community characteristics, and public and organizational policies that are beyond the ability of the partnership to control.

21. Has //**INSERT PARTNERSHIP HERE//'s** relationship with other state partner organizations enhanced partnership activities? Please consider partners other than **Core** team (ACS, CDC, NCI, USDA) at the state level.

YES ..... ☐
NO ..... ☐

21a. Please explain how your relationships with non-core state partner organizations have enhanced or hampered your partnership activities.

22. What aspects of the community around **//INSERT PARTNERSHIP HERE//** have served to facilitate the partnership?
CHECK ALL THAT APPLY
Probe: If respondent is unclear as to what "community" means, ask them how they define the community around their partnership.

a. Community trust..... ☐

b. Recognition and respect from other organizations/individuals in the community..... ☐

c. Sharing of community resources..... ☐

d. Availability of community resources ..... ☐

e. Acceptance from key community organizations/individuals..... ☐

f. Other, please specify ..... ☐

23. What aspects of the community around **//INSERT PARTNERSHIP HERE//** are barriers to building the partnership? CHECK ALL THAT APPLY

a. Lack of community trust ..... ☐

b. Lack of recognition and respect from other organizations/individuals in the community ..... ☐

c. Competition for community resources ..... ☐

d. Lack of community resources ..... ☐

e. Resistance from key community organizations/individuals ..... ☐

f. Other, please specify ..... ☐

24. Has //**INSERT PARTNERSHIP HERE//** addressed any of these barriers? How?

National Partners

The following section will ask you questions about how the National Partners' activities have influenced the development and sustainability of your partnership.

25. I am going to read you a list of statements about the activities that were sponsored by the **Core** (ACS, CDC, NCI, USDA) National Partners. Please tell me whether you strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, or strongly disagree with each of the following statements about the National Partners' activities. If you have no opinion, please just tell me that:

	STRONGLY AGREE	SOMEWHAT AGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT DISAGREE	STRONGLY DISAGREE	NO OPINION
a. Overall the activities provided by the National Partners have been helpful in initiating, building, or sustaining our partnership.....	☐	☐	☐	☐	☐	☐
b. The July 2003 training was helpful in initiating or building our partnership	☐	☐	☐	☐	☐	☐
c. The Coaches (Winter 2004 – Spring 2005) have been helpful in building or sustaining our partnership.....	☐	☐	☐	☐	☐	☐
d. The PATH visits (Spring 2005) were helpful in building or sustaining our partnership.....	☐	☐	☐	☐	☐	☐
e. The Regional Meetings (Summer 2005) were helpful in building or sustaining our partnership.....	☐	☐	☐	☐	☐	☐

26. I am going to read you a list of partnership functions. For each of these functions, please indicate which **Core**-sponsored activities were helpful for **//INSERT PARTNERSHIP HERE//**: [CHECK ALL THAT APPLY]

	July 2003 Training	Coaches	PATH Visits	Regional Meetings	Newsletters	Webinars	None	N/A
a. Getting ideas for recruiting new people or partners.....	☐	☐	☐	☐	☐	☐	☐	☐
b. Retaining partners.....	☐	☐	☐	☐	☐	☐	☐	☐
c. Building strong working relationships among partners	☐	☐	☐	☐	☐	☐	☐	☐
d. Managing and staffing the partnership	☐	☐	☐	☐	☐	☐	☐	☐
e. Securing resources for the partnership.....	☐	☐	☐	☐	☐	☐	☐	☐
f. Determining what interventions to implement.....	☐	☐	☐	☐	☐	☐	☐	☐
g. Determining evidence-based methods for reaching rarely or never screened women.....	☐	☐	☐	☐	☐	☐	☐	☐

27. At the July 2003 training, **//INSERT PARTNERSHIP HERE//** developed a state action plan. Has this plan changed since then?

YES..... ☐
NO..... ☐ [Go to 28]
DON'T KNOW..... ☐

27a. [IF YES] How has the plan changed?

27b. [IF YES] Why did the plan change?

28. [FOR PARTNERSHIPS THAT COMPLETED THE LASKER & WEISS PARTNERSHIP SELF-ASSESSMENT TOOL ONLINE]: I understand **//INSERT PARTNERSHIP HERE//** completed the Lasker & Weiss Partnership Self-Assessment Tool online. Has your partnership used the results?
Note to interviewer: If partnership did not complete Lasker and Weiss skip to Q31.

YES..... ☐ [Go to 28a]
NO..... ☐ [Go to 28b]
DON'T KNOW..... ☐ [Go to 31]

28a. [IF YES] For what has your partnership used the results? CHECK ALL THAT APPLY

a. Understanding how the partnership's collaborative process is working..... ☐

b. Identifying specific areas to focus on to make the collaborative process work better ..... ☐

c. Identifying hidden strengths of the collaborative process ..... ☐

d. Making the partnership more responsive to the partners ..... ☐

e. Getting partners more involved in the leadership and management of the partnership..... ☐

f. Other, please specify ..... ☐

28b. [IF NO] What were the reasons your partnership did not use the results?

29. Would you consider using the Lasker & Weiss results in the future?

YES..... ☐
NO..... ☐

30. If someone from the National Partners was available to **//INSERT PARTNERSHIP HERE//** to assist in interpreting and applying the Lasker & Weiss results to your partnership, would you be interested?

YES..... ☐
NO..... ☐

Wrap-up

We are almost finished. The last set of questions address your overall experience with your partnership.

31. I am going to read you a list of activities for sustaining partnerships. For each of the activities that I read, please indicate whether **//INSERT PARTNERSHIP HERE//** is involved in the activity. CHECK ALL THAT APPLY

    a. Budgeting for future partnership activities..... ☐

    b. Creating new positions within the partnership ..... ☐

    c. Seeking additional funding ..... ☐

    d. Seeking additional resources other than funding ..... ☐

    e. Other, please describe... ..... ☐

32. Overall, as a member of **//INSERT PARTNERSHIP HERE//** your organization has experienced: CHECK ONLY ONE

    a. Many more benefits than drawbacks..... ☐

    b. More benefits than drawbacks ..... ☐

    c. Equal benefits and drawbacks..... ☐

    d. More drawbacks than benefits ..... ☐

    e. Many more drawbacks than benefits..... ☐

33. What, if anything, would you change about **//INSERT PARTNERSHIP HERE//**?

34. Is there anything else you would like to share with us about **//INSERT PARTNERSHIP HERE//** or Team Up as a whole?

Thank you very much for your participation.

Appendix N

Process Evaluation Interview Guide Expert Review and Pilot Test Findings

Team Up:
Process Evaluation Interview Guide
Cognitive Testing/Expert Review Findings and Summary Recommendations

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Cognitive Testing/Expert Review Findings

Team Up Process Evaluation Questionnaire

Summary of interview with Respondent A

1/3/06

Overall impressions:

Respondent A felt the questionnaire was too long. The respondent suggested that the actual survey respondents are likely to perceive the instrument as overwhelming.

Respondent A felt some of the questions are very similar to items on the Lasker & Weiss partnership assessment tool. S/he said there's a lot of sensitivity concerning this because some feel state partners are being asked to complete the Lasker & Weiss instrument too frequently. This questionnaire should not repeat these measures. S/he pointed specifically to Q16 and Q17 on this issue.

Q1

Respondent A didn't seem too concerned about this question (I probed specifically on the word "join"). But s/he did say that some of the respondents will likely be too new to know when exactly their organization joined the partnership. S/he suggested that the beginning of the instrument capture how long the person has been with organization "to assess whether this person is a good historian." [Note: if the questionnaire is mailed out in advance, these respondents presumably could get this information before the telephone interview.]

Q2

Respondent A had no real concern about ability of respondents to answer this (unless it's a "very green person.") I probed specifically on "your state's Comprehensive….process" but s/he didn't think it would be an issue.

Q3

Respondent A stated that only CDC is concerned with screening activities. The other partners are mostly focused on education. As worded, this question does not apply to most of the partners. Reframing the question to ask about activities related to education and increasing awareness would be more applicable.

Q4-Q5

Respondent A noted two concerns with these questions. First, s/he noted that the question instructs the respondents to select only one response yet the population groups listed are not mutually exclusive – so the options are rather confusing. Second, since most respondents' organizations are not involved in recruitment activities, the questions won't apply to them. While the questions could be reframed to incorporate awareness and education, the population categories remain an issue. The partners, other than CDC, have not done much to target specific populations of women – most of the activities are geared to increasing general awareness.

Q6a

Respondent A said s/he wasn't sure what "working relationship" means in this question. S/he suggested "types of activities" might work better.

Q12-Q13

Respondent A though that these questions should precede Q11a-b. This modification would present a more logical flow if the questionnaire asked first about recruiting and retaining of partners followed by a question about gaps that exist in the partnership.

Q15f

Respondent A suggested that the wording add: "and updated July/August 2005." S/he said the partners all updated their state action plans. I asked if there is room for a respondent to answer "no" to this item, and s/he said no. While the partners all have a state action plan, perhaps not all of the partners know about it, or follow it. Respondent A suggested the partnership leaders will definitely be aware of the state action plan, but others in the partnership might not be aware of it.

Q16-Q17

I asked Respondent A if Q17 should have neutral and "no opinion" categories as does Q16. S/he pointed out that when you give respondents the option of selecting a neutral category, some will take advantage of it even when they would give a more substantive opinion otherwise (this is correct, by the way).

Respondent A also pointed out that Q16 and Q17 each contain questions that appear to be reiterations of Lasker and Weiss questions.

Q18

Respondent A thinks respondents will be able to answer "number of hours per month" easily enough.

I probed Respondent A on response items c and d since I thought they were a bit redundant. Respondent A suggested deleting response item d and substituting "Participation in committee work" for response item c would suffice. S/he wonders is referring to "committee positions" is appropriate since some of the committee work by partners isn't very formalized (i.e., there may not be a committee chair).

Q19

Respondent A had two comments about this question. First, s/he wondered if respondents will actually be able to count the number of times they performed or accomplished activities in the response item list. S/he suggested asking the question in a Yes/No format. S/he wondered why a count is necessary (especially for item a). At item e, s/he said sharing information on interventions wouldn't apply to many partners, since the partners are the recipients of this sharing. S/he suggested that "participated in a discussion about evidence-based interventions" might be better. S/he also mentioned a website that partners are encouraged to go to that contains this information. Respondent A thinks that the 12 month time frame is appropriate.

Q20

At item a, Respondent A said most of the partnerships have co-chairs – so there are two identified leaders, rather than just one. S/he noted some of the other items here use the plural form (leaders). I probed on the possibility of asking about leadership, rather than leaders. S/he didn't seem to have a strong opinion, but thought it would be fine – although it would be useful to keep item a to determine whether there are clearly identified leaders. Finally, s/he noted that this series seem similar to Lasker & Weiss questions.

Q21-22

Respondent A commented here that these questions about whether the partnerships have sufficient resources should focus on: a) implementation, and b) evaluation. Something like:

- Does //INSERT PARTNERSHIP HERE// have sufficient resources to successfully implement its activities?
- Does //INSERT PARTNERSHIP HERE// have sufficient resources to conduct an evaluation?

Respondent A noted that partners have not been given funds for implementation.

Q25

Respondent A suggested that the definition of "resources" (shown on the previous page) be restated here.

Q29a & 30a

I probed Respondent A about understanding of "community trust." To Respondent A, "community trust" meant "whether the partnership has credibility." Q29a and Q30a could be rephrased as:

- Q29a. Credibility within the community
- Q30a. Lack of credibility within the community

Q33

Respondent A noted that these questions are difficult to answer because the list of elements of partnership functions is not mutually exclusive. Respondent A made several suggestions here:

a. Add an item f: "Determining which interventions to implement."

b. Change "Regional Meetings" to say "July/August 2005 Regional Meetings"

c. Eliminate the requirement to check on activity per partnership.

Q35c

I probed Respondent A on what "hidden strengths of the collaborative process" meant, and whether respondents would have difficulty understanding it. S/he didn't think it would confuse respondents.

Q35b

Respondent A said the wording "Why didn't your partnership use the results?" was confrontational. S/he suggested rewording as something like:

What were the reasons your partnership did not use the results?

Q41

Respondent A thought that this question repeated Lasker and Weiss elements. Respondent A also thought that the "impediments" are partnership, rather than organizational impediments. The current question asks for organizational impediments.

Q43-Q44

Respondent A said that it is too early for most of the partners to know whether their goals have been met. If this question is asked, there should be an additional response category, such as: "Too early to determine."

Team Up Process Evaluation Questionnaire

Summary of interview with Respondent B

1/12/06

General Comments:

Respondent B suggested that when mailing the questionnaire in advance, respondents should be specifically encouraged to seek answers from others in the organization if they do not know the answer to a question.

Respondent B also suggested some language be provided (or at least prepared in case it's needed by the respondent) about how to determine when their partnership began.

Q3

Respondent B said s/he understood why we would want to ask about screening activities prior to Team Up, but s/he did not think it would yield good data. S/he said the partners "either do something or they don't," and so the question "is not going to discriminate a lot." S/he elaborated, saying that some organizations will have done many activities over a long period of time, whereas other organizations did nothing at all. It seemed s/he interprets "activities in contacting and screening women for cancer" broadly and suggested that helping design brochures or helping obtain funding could be relevant here.

Q4 & Q5

Respondent B pointed out there needs to be a way for the respondent to indicate that their organization has not been involved in recruitment activities. Also, s/he suggested that the question needs a "don't know" response choice. S/he also indicated that only a very small subset of respondents will be able to discriminate finely enough among these target population groups – "these are not the way they cut the universe." I tried to get Respondent B to indicate how respondents would be more likely to "cut the universe," but s/he did not offer anything more specific. S/he suggested some response options could be dropped, or combined (such as "women of color" and those from low income communities). Finally, s/he said it's not clear whether these questions are about recruitment for breast/cervical cancer screening "in general" or "our program's screening." S/he suggested that these questions could be dropped.

Q6a

Respondent B suggested that respondents will not be able to determine the number of months of the working relationship. Organizations may have worked together in an ad-hoc fashion and not on

a continuous basis. Estimating the number of months might misrepresent the working relationship. S/he suggested framing the question to the last year, and using response choices such as "monthly…weekly" or "frequently…occasionally." Respondent B also noted that "working relationship" is vague. S/he thought that the question asks "how did you get along?" However, s/he expects that we are really asking "What did you do?"

Q7

Respondent B's response to this question was "At what point in time? Perhaps the role has changed." S/he said that the question needs a point of reference such as "current role" or "within the last year." S/he also noted that "role" is not a concept with which respondents will be familiar; suggesting some might not be able to say much more than "I was part of the workgroup…that's my role."

Q8

Phyllis thinks that respondents will reply with their partnership's *stated* purpose, which might vary from their *actual* purpose.

Q9b

Phyllis thinks the question wording "How has your understanding the purpose of Team Up changed…" is focused on the process of changed understanding, rather than the results of the change. She assumes we are interested in the latter. She suggested rephrasing the question to "In what way has you understanding of the purpose of Team Up changed?"

Q10a-b

Respondent B thought the response options should be clarified so that they are more clearly refer to the organization's staff time. S/he suggested:

a. Staff time of paid employees

b. Staff time of volunteers

Q11

Respondent B suggested clarifying the question to specify "Core team *at the state level*…" (as opposed to local level).

Q12

Respondent B suggested clarifying the question by specifying "state-level."

Q13-13a

Phyllis suggested including "*What have you done to address these challenges?"* and/or "*Were you successful in overcoming those challenges*?" after Q13a

Q14-14a

Phyllis suggested including "*What have you done to address these challenges?"* and/or "*Were you successful in overcoming those challenges*?" after Q14a

Q16a-b

Respondent B thought that items a-b are too "theoretical." S/he suggested that people who don't like their organizations might use these items too vent their feelings. Also said item (b) isn't clear – s/he interprets it as saying "it is always clear to me how my organization contributes to the partnership." [I misunderstood Respondent B's point during the call, but now I realize this would probably be an incorrect interpretation. S/he suggested rewording this as: *My organization makes a clear contribution to the partnership*. Or perhaps: *My organization makes a unique contribution to the partnership*.] Items c-e are easier to answer.

Q17b-c

Respondent B said these items need to be tied directly to Team-up, since the partners may work together outside of Team-up. For example, item (b) could read: "*Planning Team-up activities*."

Q18

Respondent B doesn't understand what item (d) means and thinks it's probably the same as item (c). She also thought that item (e) was redundant. S/he thinks respondents will be able to estimate the number of hours per month the organization conducts these activities. S/he suggested that the question specify "*a typical month*" [I wonder if s/he overlooked the word "average" in the question, since this would mean the same thing. But I agree asking about a "typical month" might be better than asking for the "average" number of hours per month].

Q19

Respondent B had several comments about the response items in this question. S/he said item (e) probably needs a definition for "evidence-based interventions" since some partners are doing things they strongly feel are valid yet they are not truly evidence-based. Also, s/he wondered if this includes

both formal and informal sharing of information. S/he also stated s/he wasn't sure what "contributed" means in items (c) and (d) – especially, how one would count the number of times they "contributed" to educational activities, etc. Finally, s/he discussed item (f), noting that it combines too many things – "It's a question that could be answered four different ways." S/he didn't see how organizations could collaborate in the sharing of risks.

Q20

Respondent B noted s/he didn't know the difference between "managing" and "administering" in item (a) [so perhaps both are not needed]. S/he also expressed concern about the word "identified," in item (a). This wording implies that the leadership is an assigned role. S/he thinks some of the leaders "assumed" their role. A "softer term" might convey more accurate information, e.g.: "*There is one assumed leader who*…." S/he also stated that at the state level each organization has a single leader and "they all work together." These leaders will most likely be the respondents to the survey, so the Q20 series will essentially be asking the respondents to rate themselves.

Q21 & Q22

Respondent B suggested that these two questions about whether the partnerships have sufficient resources to work effectively and achieve their goals could be collapsed. They essentially ask the same question.

Q23

Respondent B thinks Q23 about securing additional resources should be dropped. Question 24 asks if respondents have tried to obtain various specific resources. Some version of Q23a-b, which asks about effective methods of securing resources, could follow Q24. On a broader note about resources, s/he pointed out that the instrument doesn't try to capture "how much" additional resources have been sought, and thinks this information is important. An additional question about securing resources should have a stated time frame (e.g., a year).

Q25

Respondent B thinks the topic of sharing resources with other partners has been covered earlier in the instrument (in questions asking how the organization has contributed to the partnership). In addition, s/he was confused about the meaning of "sharing" in this question.

Q27

Respondent B said this question is too academic for the respondents. S/he pointed to the phrasing "clearly defined roles and responsibilities" as being too formal. Phyllis also said that this question should not be about roles and responsibilities. S/he suggested the question be reworded as something like: "*Does…have a clear plan for obtaining additional resources*?"

Q28

Respondent B said s/he wasn't sure what this question about relationships with non-partner organizations was asking. S/he said that what made it difficult to answer is that the organizations work with many other organizations but the work isn't *relevant* to the partnership. S/he seemed to view the question as a meaningful one only if it's asking about non-partner organizations who potentially could be partners because they do relevant work. Phyllis also said that "non-partner organizations" needed to be defined. S/he also thought this issue has been addresses in prior questions.

Q29 & Q30

Respondent B noted that the response option list for these two question differ somewhat. S/he also wondered why Q29 is about *facilitating* the partnership, whereas Q30 is about (barriers to) *building* the partnership. S/he thinks the two questions should mirror one another. She suggested Q29 ask about *facilitating the partnership*, and Q30 ask about *barriers to the partnership*. For item (a), s/he's not sure "community trust" means at the state level. Finally, s/he's not clear on the difference between items (a) and (b). To Respondent B, "community trust" means that the organization has a good reputation.

Q33

Respondent B suggested that the questionnaire reiterate here that the focus is now on *national* partners. S/he had trouble grasping initially that the question is asking her to pick only one activity for each function. Once s/he understood this, s/he objected to the idea. S/he think all four activities were likely to be viewed as useful, and doesn't think respondents will want (or even be able) to single one out as being most useful. Also, s/he doesn't understand to which "new people" in item (a) refers. Finally, s/he doesn't think all of the relevant activities are listed, including newsletters and web conferences (Webinars).

Q35

Respondent B noted that item (b) should say "identifying" (rather than "identify") so that the series has "parallel construction." I probed Respondent B about item (c) (identifying hidden strengths…) S/he said it's "very theoretical" and that to Respondent B it's referring to identifying value or "positive aspects" of the collaborative process.

Q38

Respondent B said s/he didn't understand the purpose of item (b) in this context of "sustaining partnerships." S/he thought that this question might be connected to "functional gaps" in the partnerships. S/he also suggested that items (a) and (c) could be combined. Note: Items (a) and (c) refer to different things.

Q41-41a

Respondent B noted that the definition of "synergy" here sounds like it came out of a dictionary. The formality of the definition might have the unintended effect of hurting the rapport between the interviewer and respondent. Also, s/he suggested that the question say "*Have you experienced organizational impediments to partnership synergy?"* For the follow-up (Q41a), s/he suggested "*What have they been*?" Finally, s/he pointed out the questionnaire does not ask if the partnership has synergy, and s/he felt this was an important missing element. This question should be asked before asking if there are organizational impediments to synergy.

Q42

Respondent B suggested that this question on trust would likely not yield anything beyond that produced by synergy question. S/he said that this question is "too emotional" and suggested it be dropped.

Q43 & Q44

Respondent B initially thought these questions belonged with Q15. But s/he finally said that if they are left here at the end, some introductory language regarding the intent of these questions would be helpful. S/he said "it just doesn't flow" as it is. S/he suggested something like: "*Finally, thinking about how successful your partnership has been in the Team-up*…"

Recommendations for Modification of the Process Evaluation Interview Guide Based on Cognitive Testing/Expert Review Findings

Recommendations for the Process Evaluation

Interview Guide based on Expert Review

1/17/06

Q1	Clarify what is meant by "joining" Team Up. Add Q about how long the respondent has been affiliated with Team Up.
Q3	Rephrase question to include activities such as education and outreach, in addition to screening.
Q4, 5	Delete these questions. Most respondents' organizations are not involved in recruitment activities so these questions don't apply.
Q6a	Change question to "[IF YES] please describe your partners, how often you collaborate and types of activities with that partner." Change "Working relationship" to "Types of Activities." Change "# of months" to a scale: Frequently, Occasionally, Rarely.
Q7	Include a time frame (a year) in the question. Substitute "the activities of" for "the role of" in the question.
Q9b	Rephrase question to "In what way has your understanding of the purpose of Team Up changed….."
Q10	Change response (a) to Staff time of paid employees. Change response (b) to Staff time of volunteers.
Q11	Rephrase question to" In addition to the Core team (ACS, CDC, NCI, USDA) at the state level" …
Q11a, 11b	Move these questions to after Q13.
Q13a, 14a	Add "Were you successful in overcoming these challenges?" after 13a and 14a.
Q15f	Add "and updated July/August, 2005."
Q16a, b	Delete these questions. They would be difficult to answer. In addition they are reiterations of Lasker and Weiss questions.
Q17b	Reword to "Planning Team Up activities."
Q17c	Reword to "Making decisions related to Team Up."

Q18	Reword Hours per month" to "Hours in a typical month."
Q18c	Reword to "Participation in committee work."
Q18d	Delete this question. It is too similar to Q18c.
Q19	Convert the question and responses to a yes/no format
Q19c, 19d	Clarify the term "contribution"
Q19f	Delete this question. It combines too many elements and can be answered multiple ways.
Q20a-e	Delete these questions, since respondents might be answering about themselves.
Q21	Rephrase to "Does //insert partnership here// have sufficient resources to successfully implement its activities?"
Q22	Delete this question. It is too similar to Q21.
Q23	Delete this question. Q24 already asks if respondents have tried to obtain various specific resources.
Q24	Insert a question to capture the amount and kind of additional resources.
Q25	Delete this question. It has been covered earlier in the instrument.
Q27	Rephrase question to "Does //insert partnership here// have a clear plan for obtaining additional resources?"
Q28	Define "non-partner organizations"
Q29, 30	The response options for Q29 and Q30 should include the same concepts. Rephrase 29a to Credibility within the community. Rephrase 30a to Lack of credibility within the community. Delete option 29b, 30b, redundant in relation to item a.
Q33	Rephrase question to "I am going to read you a list of partnership functions. For each of these functions, please indicate which Core-sponsored activities were helpful for //insert partnership here//: [Check all that apply.]" Eliminate requirement to check only one activity for each partnership function. Add newsletters and Webinars to Core-sponsored activity list. Change "Recruiting new people" to "Recruiting new partners" in item a. Add an item f: "Determining what interventions to implement".
Q35a	Change "identify" in item b to "identifying" to create parallel construction
Q35b	Rephrase to "What were the reasons your partnership did not use the results?"
Q41, 41a	Delete these questions because they repeat elements from Lasker and Weiss.

Q42	Delete this question because it is too emotionally laden.
Q43, 44	Add introductory language regarding the intent of these questions, such as "Finally, thinking about how successful your partnership has been in meeting Team Up goals…" Add a response category "Too early to determine"

Team Up: Process Evaluation Interview Guide

Cognitive Testing/Expert Review Findings and

Summary Recommendations

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Cognitive Testing/Expert Review Findings

Team Up Process Evaluation Questionnaire

Summary of interview with Respondent A

1/3/06

Overall impressions:

Respondent A felt the questionnaire was too long. The respondent suggested that the actual survey respondents are likely to perceive the instrument as overwhelming.

Respondent A felt some of the questions are very similar to items on the Lasker & Weiss partnership assessment tool. S/he said there's a lot of sensitivity concerning this because some feel state partners are being asked to complete the Lasker & Weiss instrument too frequently. This questionnaire should not repeat these measures. S/he pointed specifically to Q16 and Q17 on this issue.

Q1

Respondent A didn't seem too concerned about this question (I probed specifically on the word "join"). But s/he did say that some of the respondents will likely be too new to know when exactly their organization joined the partnership. S/he suggested that the beginning of the instrument capture how long the person has been with organization "to assess whether this person is a good historian." [Note: if the questionnaire is mailed out in advance, these respondents presumably could get this information before the telephone interview.]

Q2

Respondent A had no real concern about ability of respondents to answer this (unless it's a "very green person.") I probed specifically on "your state's Comprehensive….process" but s/he didn't think it would be an issue.

Q3

Respondent A stated that only CDC is concerned with screening activities. The other partners are mostly focused on education. As worded, this question does not apply to most of the partners. Reframing the question to ask about activities related to education and increasing awareness would be more applicable.

Q4-Q5

Respondent A noted two concerns with these questions. First, s/he noted that the question instructs the respondents to select only one response yet the population groups listed are not mutually exclusive – so the options are rather confusing. Second, since most respondents' organizations are not involved in recruitment activities, the questions won't apply to them. While the questions could be reframed to incorporate awareness and education, the population categories remain an issue. The partners, other than CDC, have not done much to target specific populations of women – most of the activities are geared to increasing general awareness.

Q6a

Respondent A said s/he wasn't sure what "working relationship" means in this question. S/he suggested "types of activities" might work better.

Q12-Q13

Respondent A though that these questions should precede Q11a-b. This modification would present a more logical flow if the questionnaire asked first about recruiting and retaining of partners followed by a question about gaps that exist in the partnership.

Q15f

Respondent A suggested that the wording add: "and updated July/August 2005." S/he said the partners all updated their state action plans. I asked if there is room for a respondent to answer "no" to this item, and s/he said no. While the partners all have a state action plan, perhaps not all of the partners know about it, or follow it. Respondent A suggested the partnership leaders will definitely be aware of the state action plan, but others in the partnership might not be aware of it.

Q16-Q17

I asked Respondent A if Q17 should have neutral and "no opinion" categories as does Q16. S/he pointed out that when you give respondents the option of selecting a neutral category, some will take advantage of it even when they would give a more substantive opinion otherwise (this is correct, by the way).

Respondent A also pointed out that Q16 and Q17 each contain questions that appear to be reiterations of Lasker and Weiss questions.

Q18

Respondent A thinks respondents will be able to answer "number of hours per month" easily enough.

I probed Respondent A on response items c and d since I thought they were a bit redundant. Respondent A suggested deleting response item d and substituting "Participation in committee work" for response item c would suffice. S/he wonders is referring to "committee positions" is appropriate since some of the committee work by partners isn't very formalized (i.e., there may not be a committee chair).

Q19

Respondent A had two comments about this question. First, s/he wondered if respondents will actually be able to count the number of times they performed or accomplished activities in the response item list. S/he suggested asking the question in a Yes/No format. S/he wondered why a count is necessary (especially for item a). At item e, s/he said sharing information on interventions wouldn't apply to many partners, since the partners are the recipients of this sharing. S/he suggested that "participated in a discussion about evidence-based interventions" might be better. S/he also mentioned a website that partners are encouraged to go to that contains this information. Respondent A thinks that the 12 month time frame is appropriate.

Q20

At item a, Respondent A said most of the partnerships have co-chairs – so there are two identified leaders, rather than just one. S/he noted some of the other items here use the plural form (leaders). I probed on the possibility of asking about leadership, rather than leaders. S/he didn't seem to have a strong opinion, but thought it would be fine – although it would be useful to keep item a to determine whether there are clearly identified leaders. Finally, s/he noted that this series seem similar to Lasker & Weiss questions.

Q21-22

Respondent A commented here that these questions about whether the partnerships have sufficient resources should focus on: a) implementation, and b) evaluation. Something like:

- Does //INSERT PARTNERSHIP HERE// have sufficient resources to successfully implement its activities?
- Does //INSERT PARTNERSHIP HERE// have sufficient resources to conduct an evaluation?

Respondent A noted that partners have not been given funds for implementation.

Q25

Respondent A suggested that the definition of "resources" (shown on the previous page) be restated here.

Q29a & 30a

I probed Respondent A about understanding of "community trust." To Respondent A, "community trust" meant "whether the partnership has credibility." Q29a and Q30a could be rephrased as:

- Q29a. Credibility within the community
- Q30a. Lack of credibility within the community

Q33

Respondent A noted that these questions are difficult to answer because the list of elements of partnership functions is not mutually exclusive. Respondent A made several suggestions here:

a. Add an item f: "Determining which interventions to implement."

b. Change "Regional Meetings" to say "July/August 2005 Regional Meetings"

c. Eliminate the requirement to check on activity per partnership.

Q35c

I probed Respondent A on what "hidden strengths of the collaborative process" meant, and whether respondents would have difficulty understanding it. S/he didn't think it would confuse respondents.

Q35b

Respondent A said the wording "Why didn't your partnership use the results?" was confrontational. S/he suggested rewording as something like:

> What were the reasons your partnership did not use the results?

Q41

Respondent A thought that this question repeated Lasker and Weiss elements. Respondent A also thought that the "impediments" are partnership, rather than organizational impediments. The current question asks for organizational impediments.

Q43-Q44

Respondent A said that it is too early for most of the partners to know whether their goals have been met. If this question is asked, there should be an additional response category, such as: "Too early to determine."

Team Up Process Evaluation Questionnaire

Summary of interview with Respondent B

1/12/06

General Comments:

Respondent B suggested that when mailing the questionnaire in advance, respondents should be specifically encouraged to seek answers from others in the organization if they do not know the answer to a question.

Respondent B also suggested some language be provided (or at least prepared in case it's needed by the respondent) about how to determine when their partnership began.

Q3

Respondent B said s/he understood why we would want to ask about screening activities prior to Team Up, but s/he did not think it would yield good data. S/he said the partners "either do something or they don't," and so the question "is not going to discriminate a lot." S/he elaborated, saying that some organizations will have done many activities over a long period of time, whereas other organizations did nothing at all. It seemed s/he interprets "activities in contacting and screening women for cancer" broadly and suggested that helping design brochures or helping obtain funding could be relevant here.

Q4 & Q5

Respondent B pointed out there needs to be a way for the respondent to indicate that their organization has not been involved in recruitment activities. Also, s/he suggested that the question needs a "don't know" response choice. S/he also indicated that only a very small subset of respondents will be able to discriminate finely enough among these target population groups – "these are not the way they cut the universe." I tried to get Respondent B to indicate how respondents would be more likely to "cut the universe," but s/he did not offer anything more specific. S/he suggested some response options could be dropped, or combined (such as "women of color" and those from low income communities). Finally, s/he said it's not clear whether these questions are about recruitment for breast/cervical cancer screening "in general" or "our program's screening." S/he suggested that these questions could be dropped.

Q6a

Respondent B suggested that respondents will not be able to determine the number of months of the working relationship. Organizations may have worked together in an ad-hoc fashion and not on

a continuous basis. Estimating the number of months might misrepresent the working relationship. S/he suggested framing the question to the last year, and using response choices such as "monthly…weekly" or "frequently…occasionally." Respondent B also noted that "working relationship" is vague. S/he thought that the question asks "how did you get along?" However, s/he expects that we are really asking "What did you do?"

Q7

Respondent B's response to this question was "At what point in time? Perhaps the role has changed." S/he said that the question needs a point of reference such as "current role" or "within the last year." S/he also noted that "role" is not a concept with which respondents will be familiar; suggesting some might not be able to say much more than "I was part of the workgroup…that's my role."

Q8

Phyllis thinks that respondents will reply with their partnership's *stated* purpose, which might vary from their *actual* purpose.

Q9b

Phyllis thinks the question wording "How has your understanding the purpose of Team Up changed…" is focused on the process of changed understanding, rather than the results of the change. She assumes we are interested in the latter. She suggested rephrasing the question to "In what way has you understanding of the purpose of Team Up changed?"

Q10a-b

Respondent B thought the response options should be clarified so that they are more clearly refer to the organization's staff time. S/he suggested:

a. Staff time of paid employees

b. Staff time of volunteers

Q11

Respondent B suggested clarifying the question to specify "Core team *at the state level*…" (as opposed to local level).

Q12

Respondent B suggested clarifying the question by specifying "state-level."

Q13-13a

Phyllis suggested including "*What have you done to address these challenges?"* and/or "*Were you successful in overcoming those challenges*?" after Q13a

Q14-14a

Phyllis suggested including "*What have you done to address these challenges?"* and/or "*Were you successful in overcoming those challenges*?" after Q14a

Q16a-b

Respondent B thought that items a-b are too "theoretical." S/he suggested that people who don't like their organizations might use these items too vent their feelings. Also said item (b) isn't clear – s/he interprets it as saying "it is always clear to me how my organization contributes to the partnership." [I misunderstood Respondent B's point during the call, but now I realize this would probably be an incorrect interpretation. S/he suggested rewording this as: *My organization makes a clear contribution to the partnership*. Or perhaps: *My organization makes a unique contribution to the partnership*.] Items c-e are easier to answer.

Q17b-c

Respondent B said these items need to be tied directly to Team-up, since the partners may work together outside of Team-up. For example, item (b) could read: "*Planning Team-up activities*."

Q18

Respondent B doesn't understand what item (d) means and thinks it's probably the same as item (c). She also thought that item (e) was redundant. S/he thinks respondents will be able to estimate the number of hours per month the organization conducts these activities. S/he suggested that the question specify "*a typical month*" [I wonder if s/he overlooked the word "average" in the question, since this would mean the same thing. But I agree asking about a "typical month" might be better than asking for the "average" number of hours per month].

Q19

Respondent B had several comments about the response items in this question. S/he said item (e) probably needs a definition for "evidence-based interventions" since some partners are doing things

they strongly feel are valid yet they are not truly evidence-based. Also, s/he wondered if this includes both formal and informal sharing of information. S/he also stated s/he wasn't sure what "contributed" means in items (c) and (d) – especially, how one would count the number of times they "contributed" to educational activities, etc. Finally, s/he discussed item (f), noting that it combines too many things – "It's a question that could be answered four different ways." S/he didn't see how organizations could collaborate in the sharing of risks.

Q20

Respondent B noted s/he didn't know the difference between "managing" and "administering" in item (a) [so perhaps both are not needed]. S/he also expressed concern about the word "identified," in item (a). This wording implies that the leadership is an assigned role. S/he thinks some of the leaders "assumed" their role. A "softer term" might convey more accurate information, e.g.: "*There is one assumed leader who*…." S/he also stated that at the state level each organization has a single leader and "they all work together." These leaders will most likely be the respondents to the survey, so the Q20 series will essentially be asking the respondents to rate themselves.

Q21 & Q22

Respondent B suggested that these two questions about whether the partnerships have sufficient resources to work effectively and achieve their goals could be collapsed. They essentially ask the same question.

Q23

Respondent B thinks Q23 about securing additional resources should be dropped. Question 24 asks if respondents have tried to obtain various specific resources. Some version of Q23a-b, which asks about effective methods of securing resources, could follow Q24. On a broader note about resources, s/he pointed out that the instrument doesn't try to capture "how much" additional resources have been sought, and thinks this information is important. An additional question about securing resources should have a stated time frame (e.g., a year).

Q25

Respondent B thinks the topic of sharing resources with other partners has been covered earlier in the instrument (in questions asking how the organization has contributed to the partnership). In addition, s/he was confused about the meaning of "sharing" in this question.

Q27

Respondent B said this question is too academic for the respondents. S/he pointed to the phrasing "clearly defined roles and responsibilities" as being too formal. Phyllis also said that this question

should not be about roles and responsibilities. S/he suggested the question be reworded as something like: "*Does…have a clear plan for obtaining additional resources*?"

Q28

Respondent B said s/he wasn't sure what this question about relationships with non-partner organizations was asking. S/he said that what made it difficult to answer is that the organizations work with many other organizations but the work isn't *relevant* to the partnership. S/he seemed to view the question as a meaningful one only if it's asking about non-partner organizations who potentially could be partners because they do relevant work. Phyllis also said that "non-partner organizations" needed to be defined. S/he also thought this issue has been addresses in prior questions.

Q29 & Q30

Respondent B noted that the response option list for these two question differ somewhat. S/he also wondered why Q29 is about *facilitating* the partnership, whereas Q30 is about (barriers to) *building* the partnership. S/he thinks the two questions should mirror one another. She suggested Q29 ask about *facilitating the partnership*, and Q30 ask about *barriers to the partnership*. For item (a), s/he's not sure "community trust" means at the state level. Finally, s/he's not clear on the difference between items (a) and (b). To Respondent B, "community trust" means that the organization has a good reputation.

Q33

Respondent B suggested that the questionnaire reiterate here that the focus is now on *national* partners. S/he had trouble grasping initially that the question is asking her to pick only one activity for each function. Once s/he understood this, s/he objected to the idea. S/he think all four activities were likely to be viewed as useful, and doesn't think respondents will want (or even be able) to single one out as being most useful. Also, s/he doesn't understand to which "new people" in item (a) refers. Finally, s/he doesn't think all of the relevant activities are listed, including newsletters and web conferences (Webinars).

Q35

Respondent B noted that item (b) should say "identifying" (rather than "identify") so that the series has "parallel construction." I probed Respondent B about item (c) (identifying hidden strengths…) S/he said it's "very theoretical" and that to Respondent B it's referring to identifying value or "positive aspects" of the collaborative process.

Q38

Respondent B said s/he didn't understand the purpose of item (b) in this context of "sustaining partnerships." S/he thought that this question might be connected to "functional gaps" in the partnerships. S/he also suggested that items (a) and (c) could be combined. Note: Items (a) and (c) refer to different things.

Q41-41a

Respondent B noted that the definition of "synergy" here sounds like it came out of a dictionary. The formality of the definition might have the unintended effect of hurting the rapport between the interviewer and respondent. Also, s/he suggested that the question say "*Have you experienced organizational impediments to partnership synergy?"* For the follow-up (Q41a), s/he suggested "*What have they been*?" Finally, s/he pointed out the questionnaire does not ask if the partnership has synergy, and s/he felt this was an important missing element. This question should be asked before asking if there are organizational impediments to synergy.

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Respondent B suggested that this question on trust would likely not yield anything beyond that produced by synergy question. S/he said that this question is "too emotional" and suggested it be dropped.

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Respondent B initially thought these questions belonged with Q15. But s/he finally said that if they are left here at the end, some introductory language regarding the intent of these questions would be helpful. S/he said "it just doesn't flow" as it is. S/he suggested something like: "*Finally, thinking about how successful your partnership has been in the Team-up*…"

Recommendations for Modification of the Process Evaluation Interview Guide Based on Cognitive Testing/Expert Review Findings

Recommendations for the Process Evaluation Interview Guide

based on Expert Review

1/17/06

Q1	Clarify what is meant by "joining" Team Up. Add Q about how long the respondent has been affiliated with Team Up.
Q3	Rephrase question to include activities such as education and outreach, in addition to screening.
Q4, 5	Delete these questions. Most respondents' organizations are not involved in recruitment activities so these questions don't apply.
Q6a	Change question to "[IF YES] please describe your partners, how often you collaborate and types of activities with that partner." Change "Working relationship" to "Types of Activities." Change "# of months" to a scale: Frequently, Occasionally, Rarely.
Q7	Include a time frame (a year) in the question. Substitute "the activities of" for "the role of" in the question.
Q9b	Rephrase question to "In what way has your understanding of the purpose of Team Up changed….."
Q10	Change response (a) to Staff time of paid employees. Change response (b) to Staff time of volunteers.
Q11	Rephrase question to" In addition to the Core team (ACS, CDC, NCI, USDA) at the state level" …
Q11a, 11b	Move these questions to after Q13.
Q13a, 14a	Add "Were you successful in overcoming these challenges?" after 13a and 14a.
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Q17b	Reword to "Planning Team Up activities."
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Q18d	Delete this question. It is too similar to Q18c.
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Q24	Insert a question to capture the amount and kind of additional resources.
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Q28	Define "non-partner organizations"
Q29, 30	The response options for Q29 and Q30 should include the same concepts. Rephrase 29a to Credibility within the community. Rephrase 30a to Lack of credibility within the community. Delete option 29b, 30b, redundant in relation to item a.
Q33	Rephrase question to "I am going to read you a list of partnership functions. For each of these functions, please indicate which Core-sponsored activities were helpful for //insert partnership here//: [Check all that apply.]" Eliminate requirement to check only one activity for each partnership function. Add newsletters and Webinars to Core-sponsored activity list. Change "Recruiting new people" to "Recruiting new partners" in item a. Add an item f: "Determining what interventions to implement".
Q35a	Change "identify" in item b to "identifying" to create parallel construction
Q35b	Rephrase to "What were the reasons your partnership did not use the results?"

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Q42	Delete this question because it is too emotionally laden.
Q43, 44	Add introductory language regarding the intent of these questions, such as "Finally, thinking about how successful your partnership has been in meeting Team Up goals…" Add a response category "Too early to determine"

Appendix O

Impact Evaluation Historical Assessment and Six Month Assessment Pilot Test Findings

Impact Evaluation Pilot Test Findings and Recommendations

Historical Assessment (approximately 10-15 minutes to complete):

Overall Comments:

- The questionnaire was clear.
- One respondent suggested building in places for respondents to ask questions, since people often don't feel comfortable asking questions unless prompted. One place could be before the breast cancer section of the survey.
- It is possible that organizations were doing one intervention for both breast and cervical cancer. If this is the case, respondents should be able to opt out of the completing the second portion of the questionnaire.

Recommendation:

- Add a question to the introduction asking respondents if their interventions for breast and cervical cancer are the same.

Question Specific Findings and Recommendations:

Introduction:

Finding:

- Respondents may not be familiar with what an informal partnership is.

Recommendation:

- Add a probe in case respondents need clarification.

Q3c:

Findings:

- Respondents may not be familiar with the terms "systematic reviews" or "peer reviewed publications." Also, respondents may not be familiar with the examples of systematic reviews that are listed (i.e., the community guide, Cochran Review)
- Verify when PLANET was created. If it was prior to July 2003, it should not be included in the source list.
- What is meant by "professional organizations"? If a respondent's organization consults with an ad agency, is the ad agency considered a professional organization?
- What is meant by "untested intervention?" If marketing data is used to support an intervention would this be consider "tested" or "untested"

Recommendations:

- Add a probe that includes definitions or examples of "systematic reviews" and "peer reviewed publications."
- Leave PLANET as a source. PLANET was created in April 2003 so it is possible that organizations used it as a source.
- Clarify the meaning of "professional organization."
- Clarify the difference between "tested" and "untested" interventions.

Q4c:

Finding:

- Respondents may feel embarrassed to say they used untested interventions since the source listed above it is "other tested interventions."

Recommendation:

- Keep as is. It is understood that organizations have limited resources, so using "untested interventions" isn't a bad thing.

Six Month Assessment (completion time varied from 15 minutes to 40 minutes)

Overall Comments:

- The questionnaire is really long. One respondent suggested finding ways to shorten the questionnaire to increase the response rate. That respondent stated that even she didn't want to complete the second section (breast cancer specific) section of the six month assessment as part of testing.
- Since this is going to be an email based survey consider calling respondents after a week to see if they have any questions. This may increase the response rate since respondents will have a "face" to associate with the questionnaire.
- All respondents noted that teams may be using the same intervention for breast and cervical cancer. One respondent stated that state partners were trained in how to adapt FoCaS, but no other evidence-based interventions. Therefore, it is likely that the majority of teams are adapting FoCaS, and using this intervention for both breast and cervical cancer.
- Include an approximation of time in the introduction. If respondents are using the same intervention for both breast and cervical cancer the time to complete the questionnaire will be cut approximately in half, so the time burden is less. Include time estimates for (1) respondents using different interventions for breast and cervical cancer and (2) respondents using the same intervention for breast and cervical cancer.
- Both respondents had concerns of when "adoption" and "adaptation" were being used. On respondent thought "adaptation" more accurately described what teams are doing.
- Consider open-ending some of the questions.

Recommendation:

- Add a question in the introduction asking respondents if they are using the same interventions for breast and cervical cancer.

Question Specific Findings and Recommendations:

Introduction:

Finding:

- Several terms, such as "adoption," are very tactical and respondents may not be familiar with them.

Recommendation:

- Add probes for terms that respondents may not be familiar with.

Q1:

Finding:

- One respondent was confused by this question. She did not realize that the question refers to the individual and not their organizations.

Recommendation:

- Reword the question to "Your organization has been involved with Team Up since Month Day, Year. How long have you, specifically, been working on the Team Up partnership?"

Q2:

Finding:

- It is possible that partnerships are doing more than one intervention and that the different interventions are at different stages.

Recommendation:

- Leave as is.

Q3:

Finding:

- Both respondents thought that "adaptation" should be included as a phase; one respondent thought that "adaptation" should replace "adoption."

Recommendation:

- Review the definition of "adaptation" and "adoption" and ensure that these terms are being used appropriately.

Q4:

Findings:

- Not all of the sources a mutually exclusive. For example, PLANET as program evaluations and systematic reviews on it.
- Not sure what "professional organizations" refer to. If information was received from ACS, would this be considered a profession organization, even though ACS is part of Team Up.

Recommendation:

- Add probes for terms that may need clarification.

Q6:

Findings:

- One respondent thought that we should add a category to see how National Partner trainings (specific the one on adapting FoCaS) influenced partnership decisions.
- It is possible that volunteers are implementing some part of the intervention.

Recommendation:

- Leave the question as is.

Q7a:

Finding:

- One respondent thought of the final product when she read this question, and therefore none of the items included on this list were relevant.

Recommendation:

- Add "used in the intervention" to the end of the question.

Q8:

Findings:

- Respondents may need a definition of "adapt."
- It is likely that respondents adapted materials and brochures. Rephrase the question to "Did your partnership adapt materials or products?"
- Use of the word "existing" may be confusing, if respondents think this refers to interventions they were conducting at the organizational level prior to Team Up.

Recommendations:

- Add the definition of adapt.
- Leave the question as is. It is possible that teams adapted parts of the intervention other than just materials.

Q9:

Findings:

- Change wording of the question to include adaptation as well as implementation since some items on the list refer to adaptation.
- The items in the list aren't listed in a logical order.
- "Team Up staff did not recognize the needs of the intended population" does not flow with the rest of the items.

Recommendations:

- Reword question to "What challenges, if any, were encountered when adapting and implementing the intervention(s)?"
- Consider reordering the choices to the following order: Interventions were more complicated than expected; The intervention cost more than expected; It took longer to adapt than we anticipated; Team Up Staff did not recognize the specific needs of the intended population; Instructions for implementing the intervention were incomplete; Staff training was longer and more complicated than expected; evaluation was more complicated than expected; Other; N/A
- Consider rewording "Team Up staff did not recognize the needs of the intended population" to "Intervention did not meet the needs of the intended population."

Q9 and Q10:

Finding:

- Both these questions refer to implementation. Some teams may not yet be at this stage.

Recommendation:

- Leave question as is. There is a N/A category for respondents who are not at this stage.

Q10:

Findings:

- Teams were complaining of not having adequate resources, such as staff. It may be easier for respondents to pick out what they were missing.
- Some of the categories in the list should be clarified.

Recommendations:

- Leave question as is.
- Change "paid staff" to "staff time;" the word "staff" implies that they're paid

- Change "volunteer staff" to "volunteer," since volunteers are not staff
- Consider eliminating staff support as it is duplicative of "staff time"

Q11:

Finding:

- There is no need for both Q11 and Q11a.

Recommendation:

- Collapse 11 and 11a into one question "Would you say that it is very likely, somewhat likely, somewhat unlikely, very unlikely or not likely at all that the intervention(s) can be sustained after the Team Up partnership ends?

Q12:

Finding:

- The way the question is worded it seems like choosing an intervention was a top down approach where one person made the decision. This might not be the case.

Recommendation:

- Leave as is. The question gives respondents the opportunity to list more than one person.

Q12 and Q13

Finding:

- Should "adoption" be "adaptation?"

Recommendation:

- Clarify definitions of "adoption" and "adaptation" and make sure the appropriate term is being used.

Q14

Finding:

- This question may be premature. It is possible that teams do not yet know if their chosen intervention would be appropriate with a different population.

Recommendation:

- Add a don't know response category.

Endpoint Interview (approximately 10 minutes to complete)

Overall Comments:

- Verify the correct use of the terms "adoption" and "adaptation." Adoption does not capture what teams did.
- Since the questionnaire is open-ended make sure to have interviewer probes for respondents why may not be forthcoming.

Question Specific Findings and Recommendations:

Q1:

Finding:

- Respondents may answer Q1a as part of their response to Q1.

Recommendation:

- Leave question as is.

Q2:

Finding:

- It is not clear if we want challenges specific to adapting the intervention or challenges in general.

Recommendation:

- Leave question as is.

Q4:

Finding:

- This question can be simplified.

Recommendation:

- Simplify the question to a Why question (i.e., "Why is it likely (or unlikely) that the intervention will be sustained after Team Up ends") and use the current questions as probes.

Q5:

Finding:

- This question can be simplified.

Recommendation:

- Reword to "If Team Up is to go beyond a pilot project, what additional assistance, if any, can the National Partners provide to help States with their Team Up efforts?"

Q6:

Finding:

- This question can be simplified.

Recommendation:

- Reword to "Is there anything else you would like to tell us about your experience with the Team Up partnership that we have not already asked?"

Appendix P

Impact Evaluation Historical Assessment Interview Guide

IMPACT EVALUATION- HISTORICAL INTERVIEW GUIDE

May 2006

Annotated Version

NATIONAL CANCER INSTITUTE (NCI)

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0. [NAME OF RESPONDENT]

NAME:.....

PARTNERSHIP:.....

ORGANIZATION …….

Thank you for participating in this interview. This interview is the first stage in helping us understand your organization's adoption of interventions designed to increase cervical and breast cancer screening. For the purposes of this interview "your organization" refers to //**INSERT ORGANIZATION HERE//**. We are particularly interested in increasing screenings among women who have rarely and/or never screened for cervical cancer and women who have not received screenings in accordance with the recommended guidelines (that is, not in the past 5 years) for breast cancer. In this interview, we will discuss the interventions that you used before the initiation of Team Up activities, that is, prior to the July 2003 training. We will ask you first about interventions regarding cervical cancer screening. Afterwards, we will discuss breast cancer screening interventions.

Please note that your responses are confidential and any data collected will be credited to the state partnership. All information that may identify individuals or their organizations will be removed. Only Westat project staff will have access to your responses.

I'd like your permission to tape record our conversation so that we do not miss any of your comments-only the research staff at Westat will have access to these tapes. Do we have your permission to tape this interview? Y N

INTRODUCTION

1. In what year did **//INSERT ORGANIZATION HERE//** join Team Up?

2. How long have you been working with your Team Up partnership?

   ___Years ___Months

3. Did your organization use the same interventions for cervical and breast cancer prior to July 2003, the initiation of Team Up activities?

   YES ..... ☐
   NO ..... ☐

CERVICAL CANCER

We will first discuss your organization's intervention(s) to increase cervical cancer screening prior to July 2003, the initiation of Team Up activities.

4. (NCI 1,2) Prior to July 2003, did your organization undertake any interventions to reach women who had never been screened or had rarely been screened for cervical cancer?

YES ..... ☐
NO ..... ☐

4a. Please describe these interventions:

Intervention #1:

Intervention #2:

Intervention #3:

4b. Please tell us the reasons for selecting each intervention mentioned above.

	Why selected
Intervention #1	
Intervention #2	
Intervention #3	

4c. (NCI 3) For each intervention, please indicate the sources consulted to select it:
CHECK ALL THAT APPLY

SOURCE	Intervention #1	Intervention #2	Intervention #3
PLANET/RTIPS	☐	☐	☐
Other tested interventions	☐	☐	☐
Systematic Reviews (such as the Community Guide or the Cochran Review)	☐	☐	☐
Peer reviewed publication	☐	☐	☐
Professional organizations	☐	☐	☐
Untested interventions	☐	☐	☐
Program evaluations	☐	☐	☐
Personal experience	☐	☐	☐
Other, specify _____ _____ _____	☐	☐	☐

4d. How effective do you think these intervention(s) you described were in increasing screening among women who had never been screened or had rarely been screened for cervical cancer? Please tell me whether you think each intervention was extremely effective, somewhat effective, somewhat ineffective, or extremely ineffective.

	EXTREMELY EFFECTIVE	SOMEWHAT EFFECTIVE	SOMEWHAT INEFFECTIVE	EXTREMELY INEFFECTIVE
Intervention #1	☐	☐	☐	☐
Intervention #2	☐	☐	☐	☐
Intervention #3	☐	☐	☐	☐

4e. What were the reasons why the interventions were (or were not) effective?

	Reasons why it was (or was not) effective
Intervention #1	
Intervention #2	
Intervention #3	

Probe: If yes to Q3, ask: Are your survey responses for breast cancer the same as cervical cancer? Y N
If yes to probe: go to Q6; If no to probe: go to Q5

BREAST CANCER

Next we will discuss your organization's intervention(s) to increase breast cancer screening prior to July 2003, the initiation of Team Up activities.

5. (NCI 1,2) Prior to July 2003, did your organization undertake any interventions to reach women who had not received screenings for breast cancer in accordance with the recommended guidelines (that is, not in the past 5 years)?

YES ..... ☐
NO ..... ☐

5a. Please describe these interventions:

Intervention #1:

Intervention #2:

Intervention #3:

5b. Please tell us the reasons for selecting each intervention mentioned above.

	Why selected
Intervention #1	
Intervention #2	
Intervention #3	

5c. (NCI 3) For each intervention listed above, please indicate the sources consulted to select it: CHECK ALL THAT APPLY

SOURCE	**Intervention #1**	**Intervention #2**	**Intervention #3**
PLANET/RTIPS	☐	☐	☐
Systematic Reviews (such as the Community Guide or the Cochran Review)	☐	☐	☐
Peer reviewed publication	☐	☐	☐
Professional organizations	☐	☐	☐
Other tested interventions	☐	☐	☐
Untested interventions	☐	☐	☐
Program evaluations	☐	☐	☐
Personal experience	☐	☐	☐
Other, specify	☐	☐	☐

5d. How effective do you think the intervention(s) you described were in increasing screening among women who have not received screenings for breast cancer in accordance with the recommended guidelines? Please tell me whether you think each intervention was extremely effective, somewhat effective, somewhat ineffective, or extremely ineffective.

	EXTREMELY EFFECTIVE	SOMEWHAT EFFECTIVE	SOMEWHAT INEFFECTIVE	EXTREMELY INEFFECTIVE
Intervention #1	☐	☐	☐	☐
Intervention #2	☐	☐	☐	☐
Intervention #3	☐	☐	☐	☐

5e. What were the reasons why the interventions were (or were not) effective?

	Reasons why it was (or was not) effective
Intervention #1	
Intervention #2	
Intervention #3	

WRAP UP

6. Is there anything else you would like to say regarding the interventions your organization used prior to July 2003?

Thank you very much for your participation.

Appendix Q

Impact Evaluation Six Month Assessment Round 1

IMPACT EVALUATION SIX MONTH ASSESSMENT

DRAFT

MAY 2006

NATIONAL CANCER INSTITUTE (NCI)

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PART 1. INTRODUCTION AND BACKGROUND

0. [NAME OF RESPONDENT]

NAME:.....

PARTNERSHIP:.....

ORGANIZATION ……

Thank you for participating in this survey. This survey is the first of a semi-annual assessment to learn more about the interventions your partnership has adopted, adapted, and/or implemented to increase cervical and breast cancer screening. We are particularly interested in increasing screenings among women who have rarely and never screened for cervical cancer and women who have not received screenings in accordance with the recommended guidelines (that is, not in the past 5 years) for breast cancer. In particular, we are interested about the interventions your partnership has adopted, adapted, and/or implemented since the July 2003 Team Up training. We will ask you first about interventions regarding cervical cancer screening. Afterwards, we will discuss breast cancer screening interventions.

In this evaluation, partnership refers to all types of collaborations (e.g., formal and informal agreements, coalitions, and alliances) among community groups and agencies that bring people and organizations together to support the Team Up program. Please note, "your partnership" refers to //**INSERT PARTNERSHIP HERE//**. In addition, "your organization" refers to //**INSERT ORGANIZATION HERE//**.

INTRODUCTION

1. Your organization has been involved with Team Up since **//Month, Year//**. How long have you, specifically, been working with your Team Up partnership?

__Years __Months

2. Is your partnership using the same interventions for cervical and breast cancer?

YES..... ☐
NO..... ☐

CERVICAL CANCER

We will first discuss your partnership's intervention(s) to increase cervical cancer screening.

3. At what point is your partnership at in the intervention adoption and implementation process?

.....Intervention(s) have not been selected..... ☐ [Go to 16]
.....Intervention(s) have been selected… ..... ☐
.....Implementation materials have been developed..... ☐
.....Intervention(s) have been implemented..... ☐
Other, Specify _____☐

4. List the intervention(s) your partnership is currently undertaking to locate women who had never been screened or had rarely been screened for cervical cancer. **NOTE:** *If you are implementing an intervention with multiple components, such as FoCaS, please describe the different components of the intervention in the "Description" box.*

Intervention Name	**Description**	**Current Status** (Check one)
1.		☐ Adopted ☐ Adapted ☐ Implemented
2.		☐ Adopted ☐ Adapted ☐ Implemented
3.		☐ Adopted ☐ Adapted ☐ Implemented

5. (NCI 3) Please rank the three most important sources consulted for each intervention listed in Q4, with 1 being the most important source consulted.

SOURCE	Intervention #1	Intervention #2	Intervention #3
PLANET/RTIPS	___	___	___
Other tested interventions	___	___	___
Systematic reviews (such as the Community Guide or the Cochran Review)	___	___	___
Peer reviewed publication	___	___	___
Professional organizations	___	___	___
Untested interventions	___	___	___
Program evaluations	___	___	___
Personal experience	___	___	___
Other, specify _____ _____	___	___	___

6. (NCI 4) In general, do you feel that these sources provided the information needed to select intervention(s)?

YES..... ☐ [Go to 7]
NO..... ☐

6a. If NO, what additional sources were needed to select intervention(s)?

Intervention #1:

Intervention #2

Intervention #3

Adoption:

7. (NCI 5) Which of the following influenced the adoption of the intervention(s) listed above? CHECK ALL THAT APPLY.

	Intervention #1	Intervention #2	Intervention #3
Current intervention has clear advantages over earlier interventions	☐	☐	☐
Current intervention has demonstrated effectiveness	☐	☐	☐
Intervention can be easily adapted to meet our state's needs	☐	☐	☐
Intervention is easy to pilot test	☐	☐	☐
Intervention is easy for staff to understand	☐	☐	☐
Intervention is easy to implement	☐	☐	☐
Intervention can be phased in	☐	☐	☐
Intervention matches the goals of my program	☐	☐	☐
Intervention activities mesh will with overall program goals	☐	☐	☐
Intervention is affordable	☐	☐	☐
Intervention matched local policies	☐	☐	☐
Intervention addressed the needs of local population	☐	☐	☐
Other, specify _____	☐	☐	☐

Change agent: This section asks about the individual(s) who influence other Team Up members' decision to adopt interventions.

8. (NCI 11, 11a) By whom was the decision to adopt the interventions listed above made? Check all that apply

	By Group	By Individual	Role of the individual and/ or group in Team Up
Intervention #1	☐	☐	
Intervention #2	☐	☐	
Intervention #3	☐	☐	

9. (NCI 12) Did the National Partners play a role in the adoption of the intervention(s)?

YES..... ☐
NO..... ☐ [Go to 10]

9a. (NCI 11b) If yes, what role did they play?

Adaptation:

10. Did your partnership develop additional materials to assist in adapting the intervention(s)?

YES, for all ..... ☐
YES, for some…… ..... ☐
NO ..... ☐ [Go to 11]

10a. (NCI 6) IF YES for all or some, which of the following were included in the materials used in the intervention? CHECK ALL THAT APPLY

	Intervention #1	Intervention #2	Intervention #3
A description of the core components of the intervention	☐	☐	☐
A history of the development of the intervention	☐	☐	☐
Theoretical basis (framework, logic model) for the intervention	☐	☐	☐
Overall intervention delivery plan	☐	☐	☐
Intervention objectives	☐	☐	☐
Description of the intended population	☐	☐	☐
Costs associated with the program	☐	☐	☐
Characteristics of the delivery person(s)	☐	☐	☐
Methods of delivery (e.g., internet, class, one-on-one)	☐	☐	☐
Location of delivery (e.g., church, classroom)	☐	☐	☐
Languages offered	☐	☐	☐
Evaluation tools (e.g., plan, questionnaire)	☐	☐	☐
Other, specify _____	☐	☐	☐
None of the above	☐	☐	☐
N/A	☐	☐	☐

11. Did your partnership adapt existing intervention(s)?

	YES	NO
Intervention #1	☐	☐
Intervention #2	☐	☐
Intervention #3	☐	☐

11a. [If YES to 11], how were the interventions adapted?

Intervention #1:

Intervention #2:

Intervention #3:

11b. [If YES to 11], why did the interventions need adaptation?

Intervention #1:

Intervention #2:

Intervention #3:

12. What challenges, if any, were encountered when adapting the intervention(s)? CHECK ALL THAT APPLY

	Intervention #1	Intervention #2	Intervention #3
Intervention was more complicated than expected	☐	☐	☐
The intervention cost more than expected	☐	☐	☐
It took longer to adapt than we anticipated	☐	☐	☐
Instructions for implementing the intervention were incomplete	☐	☐	☐
Other, specify _____	☐	☐	☐
N/A	☐	☐	☐

Implementation:

13. (NCI 8) What challenges, if any, were encountered when implementing the intervention(s)? CHECK ALL THAT APPLY

	Intervention #1	Intervention #2	Intervention #3
Intervention was more complicated than expected	☐	☐	☐
The intervention cost more than expected	☐	☐	☐
Intervention did not meet the needs of the intended population	☐	☐	☐
Instructions for implementing the intervention were incomplete	☐	☐	☐
Staff training was longer and more complicated than expected	☐	☐	☐
Evaluation was more complicated than expected	☐	☐	☐
Other, specify _____	☐	☐	☐
N/A	☐	☐	☐

14. (NCI 9) When implementing the intervention(s), did your organization have adequate resources for the following areas? CHECK ALL THAT APPLY

	Intervention #1	Intervention #2	Intervention #3
Direct costs	☐	☐	☐
Staff time	☐	☐	☐
Volunteers	☐	☐	☐
Office space	☐	☐	☐
Team Up partner support	☐	☐	☐
Other, specify _____	☐	☐	☐
None of the above	☐	☐	☐

15. Do you think that the sustainability of the intervention(s) after the Team Up Partnership ends is:

	Intervention #1	Intervention #2	Intervention #3
Very likely	☐	☐	☐
Somewhat likely	☐	☐	☐
Somewhat unlikely	☐	☐	☐
Very unlikely	☐	☐	☐
Not likely at all	☐	☐	☐
N/A	☐	☐	☐

Wrap up:

16. (NCI 12) Will your Team Up partnership continue to use the selected intervention(s) to increase cervical cancer screening with other populations?

YES..... ☐
NO..... ☐
DON'T KNOW..... ☐

NOTE: *If your survey responses for cervical cancer and breast cancer are the same, please stop here. Save this form and email it to TeamUp@westat.com. If any of your responses are different for cervical and breast cancer, please complete Q17-30.*

BREAST CANCER

Next, we will discuss your partnership's interventions to increase breast cancer screening.

Current activities:

17. At what point is your partnership at in the intervention adoption and implementation process?

Intervention(s) have not been selected……..☐
Intervention(s) have been selected……☐
Implementation materials have been developed……☐
Intervention(s) have been implemented……☐
Other, Specify_____☐

18. List the intervention(s) your partnership in currently undertaking to locate women who had not been screened in accordance with the recommended guidelines (that is, not in the past 5 years) for breast cancer. **NOTE:** *If you are implementing an intervention with multiple components, such as FoCaS, please describe the different components of the intervention in the "Description" box.*

Intervention Name	**Description**	**Current Status** (Check one)
1.		☐ Adopted ☐ Adapted ☐ Implemented
2.		☐ Adopted ☐ Adapted ☐ Implemented
3.		☐ Adopted ☐ Adapted ☐ Implemented

19. (NCI 3) Please rank the three most important sources consulted for each intervention listed in Q18, with 1 being the most important source consulted.

SOURCE	Intervention #1	Intervention #2	Intervention #3
PLANET/RTIPS	___	___	___
Other tested interventions	___	___	___
Other systematic reviews (such as the Community Guide or the Cochran review)	___	___	___
Peer reviewed publications	___	___	___
Professional organizations	___	___	___
Untested interventions	___	___	___
Program evaluations	___	___	___
Personal experience	___	___	___
Other, specify _____ _____	___	___	___

20. NCI 4) In general, do you feel that these sources provided the information needed to select intervention(s)?

YES..... ☐ [Go to 21]
NO..... ☐

20a. If NO, what additional sources were needed to select intervention(s)?

Intervention #1:

Intervention #2

Intervention #3

Adoption:

21. (NCI 5) Which of the following influenced the adoption of the intervention(s) listed above? CHECK ALL THAT APPLY.

	Intervention #1	Intervention #2	Intervention #3
Current intervention has clear advantages over earlier interventions	☐	☐	☐
Current intervention has demonstrated effectiveness	☐	☐	☐
Intervention can be easily adapted to meet our state's needs	☐	☐	☐
Intervention is easy to pilot test	☐	☐	☐
Intervention is easy for staff to understand	☐	☐	☐
Intervention is easy to implement	☐	☐	☐
Intervention can be phased in	☐	☐	☐
Intervention matches the goals of my program	☐	☐	☐
Intervention activities mesh will with overall program goals	☐	☐	☐
Intervention is affordable	☐	☐	☐
Intervention matched local policies	☐	☐	☐
Intervention addressed the needs of local population	☐	☐	☐
Other, specify _____	☐	☐	☐

Change agent: This section asks about the individual(s) who influences other Team Up members' decision to adopt interventions.

22. (NCI 11, 11a) By whom was the decision to adopt the interventions listed above made? Check all that apply

	By Group	By Individual	Role of the individual and/ or group in Team Up
Intervention #1	☐	☐	
Intervention #2	☐	☐	
Intervention #3	☐	☐	

23. (NCI 12) Did the National Partners play a role in the adoption of this intervention?

YES..... ☐
NO..... ☐ [Go to 24]

23a. (NCI 11b) If yes, what role did they play?

Adaptation:

24. Did your partnership develop additional materials to assist in adapting the intervention?
YES, for all..... ☐
YES, for some..... ☐
NO..... ☐ [Go to 25]

24a. (NCI 6) If YES for all or some, which of the following were included in the materials used in the intervention? CHECK ALL THAT APPLY

	Intervention #1	Intervention #2	Intervention #3
A description of the core components of the intervention	☐	☐	☐
A history of the development of the intervention	☐	☐	☐
Theoretical basis (framework, logic model) for the intervention	☐	☐	☐
Overall intervention delivery plan	☐	☐	☐
Intervention objectives	☐	☐	☐
Description of the intended population	☐	☐	☐
Costs associated with the program	☐	☐	☐
Characteristics of the delivery person(s)	☐	☐	☐
Methods of delivery (e.g., internet, class, one-on-one)	☐	☐	☐
Location of delivery (e.g., church, classroom)	☐	☐	☐
Languages offered	☐	☐	☐
Evaluation tools (e.g., plan, questionnaire)	☐	☐	☐
Other, specify _____	☐	☐	☐
None of the above	☐	☐	☐
N/A	☐	☐	☐

25. Did your partnership adapt existing intervention(s)?

	YES	NO
Intervention #1	☐	☐
Intervention #2	☐	☐
Intervention #3	☐	☐

25a. [If YES to 25], how were the intervention(s) adapted?

Intervention #1:

Intervention #2:

Intervention #3:

25b. [If YES to 25], why did the interventions need adaptation?

Intervention #1:

Intervention #2:

Intervention #3:

26. What challenges, if any, were encountered when adapting the intervention(s)? CHECK ALL THAT APPLY

	Intervention #1	Intervention #2	Intervention #3
Intervention was more complicated than expected	☐	☐	☐
The intervention cost more than expected	☐	☐	☐
It took longer to adapt than we anticipated	☐	☐	☐
Instructions for implementing the intervention were incomplete	☐	☐	☐
Other, specify _____	☐	☐	☐
N/A	☐	☐	☐

Implementation:

27. (NCI 8) What challenges, if any, were encountered when implementing the intervention(s)? CHECK ALL THAT APPLY

	Intervention #1	Intervention #2	Intervention #3
Intervention was more complicated than expected	☐	☐	☐
The intervention cost more than expected	☐	☐	☐
Intervention did not meet the needs of the intended population	☐	☐	☐
Instructions for implementing the intervention were incomplete	☐	☐	☐
Staff training was longer and more complicated than expected	☐	☐	☐
Evaluation was more complicated than expected	☐	☐	☐
Other, specify _____	☐	☐	☐
N/A	☐	☐	☐

28. (NCI 9) When implementing the intervention(s), did your organization have adequate resources for the following areas? CHECK ALL THAT APPLY

	Intervention #1	Intervention #2	Intervention #3
Direct costs	☐	☐	☐
Staff time	☐	☐	☐
Volunteers	☐	☐	☐
Office space	☐	☐	☐
Team Up partner support	☐	☐	☐
Other, specify _____	☐	☐	☐
None of the above	☐	☐	☐

29. Do you think that the sustainability of the intervention(s) after the Team Up Partnership ends is:

	Intervention #1	Intervention #2	Intervention #3
Very likely	☐	☐	☐
Somewhat likely	☐	☐	☐
Somewhat unlikely	☐	☐	☐
Very unlikely	☐	☐	☐
Not likely at all	☐	☐	☐

Wrap up:

30. (NCI 12) Will your Team Up partnership continue to use the selected intervention(s) to increase breast cancer screening with other populations?

YES..... ☐
NO..... ☐
DON'T KNOW..... ☐

Please save this form and email it to TeamUp@westat.com. Thank you for participating in the first of the Impact Evaluation Six Month Assessment.

Appendix R

Impact Evaluation Six Month Assessment Round 2

Team Up Impact Evaluation

Part 1. Introduction and Background

This survey is intended to provide us with more information about the intervention(s) your partnership has selected to implement since the July 2003 Team Up training.

We will first ask you to list the intervention(s) that your partnership is currently undertaking. For each intervention, we will ask a short series of questions to document the process your partnership is using. We estimate that this survey will take approximately 10-15 minutes to complete.

As you go through this survey, remember that "your partnership" refers to . In addition, "your organization" refers to .

Next Page

This online survey is powered by WebSurveyor.

Team Up Impact Evaluation

Introduction

1) Your organization has been involved with Team Up since /. Since when (month/year) have you, personally, been working with your Team Up partnership.

[ ] Month/Year
Format: 99/9999

2) At what point is your partnership in the intervention adoption and implementation process?

- ○ Intervention(s) have been selected
- ○ Implementation materials have been developed
- ○ Intervention(s) have been implemented
- ○ Other (please specify)

If you selected other, please specify:

[ ]

Previous Page | Next Page

Team Up Impact Evaluation

3) Please list up to 5 interventions that your partnership is currently undertaking.
(**Note**: List up to 5. If you have fewer than 5 interventions leave the remaining fields empty.)

Intervention #1

Intervention #2

Intervention #3

Intervention #4

Intervention #5

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Test Intervention

4) Is intervention #1 (Test Intervention) a breast cancer intervention, a cervical cancer intervention, or a combined breast and cervical cancer intervention?

- ○ Breast Cancer Intervention
- ○ Cervical Cancer Intervention
- ○ Combined Breast and Cervical Cancer Intervention

5) Please describe intervention #1 (Test Intervention).

6) What is the status of intervention #1 (Test Intervention).

- ○ Adopting (Selection of an evidence based intervention)
- ○ Adapting (Modification or changes made to an evidence-based intervention to accommodate the content for a particular setting or population)
- ○ Implementing (Specific set of planned activities designed to put an evidence-based intervention into practice)

7) (From the options given in the dropdown box) Rank up to three most important sources consulted for Intervention #1 (Test Intervention), with 1 being the most important source consulted.

1)

2)

3)

8) In general, do you feel that these sources provided the information needed to select intervention (Test Intervention)?

- Yes
- No
- Don't Know

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9) What additional sources were needed to select this intervention (Test Intervention)?

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ADOPTION OF INTERVENTIONS
This section asks about what and who influenced your selection of the evidence-based intervention.

10) Which of the following influenced the **adoption** of the intervention (Test Intervention)?
Check up to three most influential factors.

- ☐ Current intervention has clear advantages over earlier interventions
- ☐ Current intervention has demonstrated effectiveness
- ☐ Intervention can be easily adapted to meet our state's needs
- ☐ Intervention is easy to pilot test
- ☐ Intervention is easy for staff to understand
- ☐ Intervention is easy to implement
- ☐ Intervention can be phased in
- ☐ Intervention matches the goals of my program
- ☐ Intervention activities mesh will with overall program goals
- ☐ Intervention is affordable
- ☐ Intervention matched local policies
- ☐ Intervention addressed the needs of local population
- ☐ None of the above
- ☐ Other (please specify)

If you selected other, please specify:

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11) By whom was the decision to **adopt** this intervention (Test Intervention) made? *Check all that apply*

- ☐ By group
- ☐ By individual

12) Role of the individual and/or group in Team Up.

13) Did the National Partners play a role in the **adoption** of the intervention (Test Intervention)?

- ○ Yes
- ○ No
- ○ Don't Know

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14) What role did they play? *[Please describe]*

ADAPTATION OF INTERVENTIONS
This section asks about what modifications or changes were made to the evidence-based intervention to accommodate the content for a particular setting or population.

15) Did your partnership **adapt** existing intervention(s)?

- ○ Yes
- ○ No
- ○ Don't Know

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16) How was the intervention (Test Intervention) **adapted**?

17) Why did the intervention (Test Intervention) need **adaptation**? *Please describe*

18) Did your partnership develop additional materials to assist in **adapting** the intervention (Test Intervention)?

- ○ Yes
- ○ No
- ○ Don't Know

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19) Which of the following were included in the materials used in the intervention (Test Intervention)? *Check all that apply*

- ☐ A description of the core components of the intervention
- ☐ A history of the development of the intervention
- ☐ Theoretical basis (framework, logic model) for the intervention
- ☐ Overall intervention delivery plan
- ☐ Intervention objectives
- ☐ Description of the intended population
- ☐ Costs associated with the program
- ☐ Characteristics of the delivery person(s)
- ☐ Methods of delivery (e.g., internet, class, one-on-one)
- ☐ Location of delivery (e.g., church, classroom)
- ☐ Languages offered
- ☐ Evaluation tools (e.g., plan, questionnaire)
- ☐ None of the above
- ☐ N/A
- ☐ Other (please specify)

If you selected other, please specify:

20) What challenges, if any, were encountered when **adapting** the intervention (Test Intervention)? *Check all that apply*

- ☐ Intervention was more complicated than expected
- ☐ The intervention cost more than expected
- ☐ It took longer to adapt than we anticipated
- ☐ Instructions for implementing the intervention were incomplete
- ☐ N/A
- ☐ Other (please specify)

If you selected other, please specify:

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IMPLEMENTATION OF INTERVENTIONS
This section asks about a specified set of planned activities designed to put the evidence-based intervention into practice.

21) What challenges, if any, were encountered when **implementing** the intervention (Test Intervention)? *Check all that apply*

- ☐ Intervention was more complicated than expected
- ☐ The intervention cost more than expected
- ☐ Intervention did not meet the needs of the intended population
- ☐ Instructions for implementing the intervention were incomplete
- ☐ Staff training was longer and more complicated than expected
- ☐ Evaluation was more complicated than expected
- ☐ N/A
- ☐ Other (please specify)

If you selected other, please specify:

22) For which of the following did your organization have adequate resources when **implementing** the intervention (Test Intervention)? *Check all that apply*

- ☐ Direct costs
- ☐ Staff time
- ☐ Volunteers
- ☐ Office space
- ☐ Team Up partner support
- ☐ None of the above
- ☐ Other (please specify)

If you selected other, please specify:

23) Do you think that the sustainability of the intervention (Test Intervention) after the Team Up Partnership ends is...

- ○ Very likely
- ○ Somewhat likely
- ○ Somewhat unlikely
- ○ Very unlikely
- ○ Not likely at all
- ○ N/A

24) Will your Team Up partnership continue to use the selected intervention (Test Intervention) to increase breast and/or cervical cancer screening with other populations?

- ○ Yes
- ○ No
- ○ Don't Know

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Team Up Impact Evaluation

Thank you for participating in the second Impact Evaluation Six Month Assessment.

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Appendix S

Impact Evaluation Six Month Assessment Round 3

Team Up
Six Month Assessment of Evidence-Based Interventions
Round 3

This is the last in our series of surveys asking about your evidence-based intervention for Team Up. We have learned a great deal from you in past surveys and we appreciate your responsiveness. In this final survey, we need a little more detail about the process your team followed in selecting, adopting, adapting and implementing your evidence-based intervention. Please take a few moments to answer the following questions.

Please return the survey to us no later than **Tuesday, May 29, 2007.**

As before, when we receive *all* responses from your team we will provide your team with a $150.00 American Express Gift Card.

ADOPTING THE EVIDENCE BASED INTERVENTION

These questions ask about the people and factors that influenced your decision to select the evidence-based intervention for your team.

Q1. Briefly tell us the about the process your team went through to select this evidence-based intervention by answering the following questions.

Q1a. How did the selection process begin?

Q1b. What were the general steps your team followed?

Q1c. What were the two biggest factors that influenced your team's decision to select this evidence-based intervention?

Q1d. Did your team seriously consider any other evidence-based interventions? If so, please list those interventions.

Q1e. To what extent were your team members involved in the decision making process? Please rate each team member's involvement on a scale from 1 to 5, with 1 being not involved and 5 being extremely involved.

ACS ☐ ☐ ☐ ☐ ☐
Not involved 1 2 3 4 5 Extremely Involved

CDC ☐ ☐ ☐ ☐ ☐
Not involved 1 2 3 4 5 Extremely Involved

NCI ☐ ☐ ☐ ☐ ☐
Not involved 1 2 3 4 5 Extremely Involved

USDA ☐ ☐ ☐ ☐ ☐
Not involved 1 2 3 4 5 Extremely Involved

Q1f. On a scale from 1 to 5, with 1 being strongly disagree and 5 being strongly agree, to what extent did you agree with the evidence-based intervention your team selected?

☐ ☐ ☐ ☐ ☐
Strongly Disagree 1 2 3 4 5 Strongly Agree

Q2. Briefly tell us about the evidence-based intervention your team selected by answering the following questions.

Q2a. Which of the following components of *FoCaS* did your team select? (*Check all that apply*)

- ☐ Media campaigns
- ☐ Educational classes
- ☐ One-on-One sessions
- ☐ Direct Mail
- ☐ Inclusion of Church/Religion
- ☐ Informational Centers
- ☐ Community Events
- ☐ In-service and primary care conference training for providers
- ☐ Educational games to teach exam skills
- ☐ Distribution of literature in the waiting rooms
- ☐ One-on-one counseling sessions and personalized follow-up letters for women with abnormal test results

Q2b. If your team didn't select all the components of *FoCaS*, why were those components not selected?

ADAPTING THE EVIDENCE-BASED INTERVENTION

The following questions ask about the changes or modifications your team made to the evidence-based intervention to make it fit with the needs of your state or your situation.

Q3. Briefly describe how your evidence-based intervention was adapted or modified by answering the following questions.

Q3a. Which of the following components of *FoCaS* did your team choose to adapt or modify? (*Check all that apply*)

- ☐ Media campaigns
- ☐ Educational classes
- ☐ One-on-One sessions
- ☐ Direct Mail
- ☐ Inclusion of Church/Religion
- ☐ Informational Centers
- ☐ Community Events
- ☐ In-service and primary care conference training for providers
- ☐ Educational games to teach exam skills
- ☐ Distribution of literature in the waiting rooms
- ☐ One-on-one counseling sessions and personalized follow-up letters for women with abnormal test results

Q3b. What changes or modifications did your team make to the intervention components that were selected? Why were the changes or modifications needed?

Q4. What challenges, if any, were encountered when adapting or modifying the evidence-based intervention?

IMPLEMENTING THE EVIDENCE-BASED INTERVENTION

The following questions ask about implementing the evidence-based intervention in the field.

Q5. When did your team take the evidence-based intervention to the field?

Month Year

Q6. Did your team develop additional materials to assist in adapting the evidence-based intervention?

☐ YES

☐ NO

Q6a. If YES to Q6, describe what materials needed to be developed.

Q7. What challenges, if any, were encountered when you took the evidence-based intervention to the field?

Q8. Why did your team decided to implement your evidence-based intervention in [name] county?

SUSTAINABILITY OF THE EVIDENCE-BASED INTERVENTION

The following questions ask about using the evidence-based intervention after the Team Up pilot ends.

Q9. Do you think that your team will continue to use this evidence-based intervention in the same counties after the Team Up pilot ends?

☐ YES

☐ NO

Q9a. If YES to Q9, please describe what changes, if any, will be made to the evidence-based intervention.

Q10. Do you think that your team will continue to use this evidence-based intervention in different counties after the Team Up pilot ends?

☐ YES

☐ NO

Q10a. If YES to Q10, please describe what changes, if any, will be made to the evidence-based intervention to accommodate populations in the new counties?

WRAP UP

Q11. What else would you like to tell us about your evidence-based intervention and/or the process you went through?

Thank you.

Please save and send your completed survey to KishaCoa@westat.com by **May 29, 2007.**

If you have any questions, call or email Kisha Coa at
301-279-4550 or KishaCoa@westat.com

Appendix T

Endpoint Interview Report

Team Up: Cancer Screening Saves Lives

Qualitative Interviewing Component of the Evaluation

Memorial Sloan-Kettering Cancer Center
June 18, 2008

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EXECUTIVE SUMMARY

Team Up was a national partnership established in 2003 as a pilot. It was designed to increase cervical and breast cancer screening among rarely and never screened women. Four national partners – the American Cancer Society (ACS), Centers for Disease Control and Prevention (CDC), National Cancer Institute (NCI), and United States Department of Agriculture (USDA) – worked with their counterparts in six states that have counties with high breast and cervical cancer mortality: *Alabama, Georgia, Kentucky, Missouri, South Carolina, and Tennessee.*

This qualitative evaluation was developed to explore how the members of the Team Up state partnerships experienced the processes of adopting, adapting, and implementing an evidence-based intervention, and to capture aspects of collaboration that influenced these processes. There was an interest in interviewing individuals from Team Up states to understand more about the context of what happens when the best scientific evidence is moved into practice. Context frames the range of plausible choices of 'what is done' to transfer evidence, and how research evidence is and is not used in practice.

Between February and April 2008, an independent researcher conducted interviews with four key informants from each of the six state partnerships; in total, 14 individual or group telephone interviews were conducted. For all states, interview respondents included two of the partnership's formal leaders as well as two other individuals who were active in the partnership; all key partnering organizations – the NCI (Cancer Information Service [CIS]), ACS, CDC, and USDA (Cooperative Extension Service) – were represented.

Guided by the conceptual framework underpinning the Team Up pilot, the questions in the semi-structured interview were based on Diffusion of Innovations processes (Rogers, 1995) as well as models of partnership functioning and synergy (Lasker and Weiss, 2003; Weiss et al., 2002). Specifically, questions covered the following areas related to the partnerships' use of evidence-based interventions to increase breast and cervical cancer screening rates: 1) knowledge about evidence-based interventions; 2) the intervention identification, selection, adoption process; 3) the planning and adaptation process; 4) the implementation process; and 5) partnership reflections and intervention impact. Within each of these question areas, the following partnership-related dimensions were explored: coordination, communication and decision-making, roles; responsibilities and leadership; and community involvement.

Two salient themes related to partners' knowledge about evidence-based interventions emerged. The first theme pertained to the partnerships' lack of awareness of the requirement to use an evidence-based intervention until many months or even a year into the pilot. The second related to the difficulties the partnership had building consensus about what "evidence-based intervention" means, due to varying experiences with such interventions and to different organizational perspectives and agendas.

Interview questions about the process of adopting an evidence-based intervention revealed three themes. First, the selection of the evidence-based intervention and the specific intervention

components adopted were based on feasibility within the implementation context. Selection and adoption processes involved extensive deliberations about human resources, funds, and time available, and sought to achieve optimal fit of the new intervention within existing programs and target populations. Second, because the process necessitated that partners understood what each could contribute and commit to their state team, it took a considerable amount of time for partnerships to select an evidence-based intervention. Third, while partnerships' selection of their target county or counties was based in part on mortality and morbidity data for breast and cervical cancer, it was also strongly guided by other complex determinants. These determinants included time to identify local resources and contacts within the different targeted counties, ease of access, and existing programs on which the partnerships could build or leveraged. As a result, it was clear that each of these determinants was subject to individual and collective choices, the result of discrete decisions made over weeks and months.

For many of the partnerships, the adaptation process was marked by a fair amount of uncertainty, and two related theme emerged. Most partnerships were concerned about whether and when adaptation altered the evidence-based intervention to such an extent that it could no longer be considered evidence-based. In addition, partnership members generally expressed that they did not receive sufficiently specific guidance or support from the national partners with respect to how much adaptation is appropriate, and how to gauge if an evidence-based intervention has been altered too much.

Three themes emerged from discussions with the partnership members about implementation. First, partnerships described a very organic process of adaptation – they created a broad strategy of implementation in the planning phase, and then allowed for further local adaptation and tailoring at the county level when the intervention was actually implemented. The second theme was that a number of partnerships experienced negative repercussions as a result of not involving of local community residents and/or county-based USDA Cooperative Extension Agents in earlier pilot phases; those states that did involve them in planning described the benefits of doing so. This involvement or lack thereof was sometimes a point of controversy in the partnerships. The third theme pertained to the contextual challenges the partnerships faced. For example, for a number of the partnerships, transportation was an obstacle for potential program participants and rural distances were a challenge for USDA Cooperative Extension Agents.

In addition to themes that came to light in the context of the Team Up pilot phases, a number of other issues emerged as influencing the partnerships' progress and success. These included challenges that affected all phases of the partnerships' work and are common to partnerships more generally. A particular concern cited was frustration created by competing demands of a partnership member's 'regular' job and partnership work; partner turnover at all levels; power differentials that sometimes created tension; and personality conflicts. Key, however, was that almost all partnerships developed approaches to work through and overcome many of these obstacles. Other salient issues described during the interviews related to technical assistance and money. Some partnerships found

the national meetings and coaches helpful, while others felt that they were a distraction and even at times harmful to their work. More importantly, all partnerships reported that lack of adequate funding, especially for coordination of activities and local travel, posed additional hurdles that impeded forward movement.

Finally, a prominent theme that surfaced was that the partnerships viewed the pilot very positively. Significant encouraging outcomes commonly shared among interviewees included the development of new and valuable organizational and personal relationships, the impact the partnerships made on heightening local awareness and increasing breast and cervical cancer screening rates among rarely or never screened women, and the institutionalization of partnership efforts within a partnering organization or as part of other established cancer control mechanisms or initiatives in their state.

In sum, Team Up was unique pilot that worked to bring together two challenging public health strategies – the translation of evidence-based interventions to other places and populations and collaboration among diverse people and organizations. Taken together, the qualitative findings suggest that while this innovative pilot faced many difficulties it also overcame significant hurdles and produced a number of key accomplishments. In addition, these data suggest that promoting the transfer of evidence to local contexts necessitates a mix of approaches, creative forms of assistance, responsiveness to local needs, support for collaborative structures, processes that facilitate the adoption of new public health practices, and ongoing discourse among all partners about moving the evidence from one environment to another so that it becomes familiar. Thus, while the Team Up experience was highly variable, successes were realized, and the Team Up pilot generated many important lessons, which include:

1) Provide Team Up participants with clear expectations from the inception, and confirm that those expectations are understood. Ongoing communication and technical assistance should be consistent with and supportive of these expectations.

2) In situations of scarce resources and time, feasibility of an intervention becomes paramount.

3) Due to geographic and demographic diversity, adaptation of an intervention occurs at multiple levels and continuously evolves. Key is tracking the context of all of the adaptation processes during implementation.

4) Inter-organizational public health partnerships should involve and listen to local residents and professionals in the planning phases.

5) Partnership work is difficult and time consuming; consequently Team Up timelines need to consider the effort it takes to build an effective collaborative process at all levels.

6) Partnership work is particularly challenging because much of the work done in addition to a "regular job," even if it is consistent with that job's purpose; providing funds for a partnership coordinator, or even for administrative support, can improve the partnership's efficiency and effectiveness.

7) Organizational support, at the highest level, is critical to effective involvement of partnership representatives.

8) Partnerships that are cross-sectorial have tremendous potential to achieve difficult goals.

I. INTRODUCTION

The primary goals of this qualitative component of the Team Up evaluation were to: 1) understand how practitioners view the process of locally adapting and implementing evidence-based interventions, in order to guide the development of future initiatives that systematically bridge the science and practice gap; and 2) capture how the characteristics of the Team Up state partnerships and community context influenced the process of bringing evidence-based interventions into practice. The purpose of this report is to describe key themes that emerged from the qualitative interviews with Team Up partnership representatives and present initial key findings and lessons learned.

In this report, we first provide background information about the Team Up pilot and the rationale for this qualitative component. We next present an Executive Summary. Then, we describe the methods used in gathering the interview data and present the qualitative findings in two parts – the first part describes findings that specifically relate to pre-established topics of inquiry, and the second part describes overarching findings that cross-cut these topics. Finally, we review the most salient findings and discuss lessons learned.

II. BACKGROUND

A. Description of Team Up

Team Up was a national partnership established in 2003 as a pilot. It was designed to increase cervical and breast cancer screening among rarely and never screened women. Four national partners – the American Cancer Society (ACS), Centers for Disease Control and Prevention (CDC), National Cancer Institute (NCI), and United States Department of Agriculture (USDA) – worked with their counterparts in six states that have counties with high breast and cervical cancer mortality: *Alabama, Georgia, Kentucky, Missouri, South Carolina, and Tennessee.* In the Results sections, these partnerships are referred to as Partnerships A, B, C, D, E, and F. Letters were assigned randomly to preserve the anonymity of interview participants.

Team Up focused on three core elements:

- *Rarely/never screened women as the audience:* Women who have not had a Pap test or a mammogram, or who have had an initial screening test but have not been screened recently, are at higher risk for delayed diagnosis of cancer, when there is less chance of successful treatment.

- *Evidence-based interventions as the approach*: Based on a credible body of scientific work, adopting or adapting efficacious interventions has been shown to hold great promise for improving overall health, saving time and money, and increasing the chance of successful outreach efforts. Currently, however, there is no one recommended process for adapting evidence-based interventions to conditions different from those present in the original research, and there is sparse empirical research on how to adapt an evidence-based intervention. Moreover, there is

little known about what happens in the process of adoption, adaptation, and implementation of an evidence-based intervention.

- *Partnerships as an overarching strategy*: The goal of the Team Up partnership was to create synergy, Synergy provides the opportunity for each partner to volunteer strengths, experience, skills, and knowledge in order to achieve what the individual could not do alone. Key was to explore how different characteristics of the state and national partnerships contribute to the creation of synergy, and the success or failure of partnerships to achieve pilot goals in the context of an evidence-based intervention.

B. Rationale for the qualitative evaluation component

This qualitative evaluation was designed to complement the comprehensive evaluation of the pilot. The larger evaluation, guided by both Diffusion of Innovations theory (Rogers, 1995) and models of partnership (Lasker and Weiss, 2003; Weiss et al., 2002), systematically inquired about steps states undertook during the adaptation and implementation of the evidence-based interventions. Three telephone surveys were conducted – one survey examined what interventions were being given to women prior to the Team Up program, a second survey inquired about the adaptation process, and a third survey that inquired about the implementation process. These surveys yielded valuable quantitative information but were not designed to provide many opportunities for in-depth responses to questions. To guide future formative implementation activities that systematically bridge the science and practice gap, this qualitative research was designed to shed more light on how practitioners – specifically partnership members – viewed these implementation processes and the aspects of partnership that affected these processes. Qualitative research is ideally suited for conducting exploratory and evaluative research in an understudied area, such as the process of adaptation and implementation of evidence-based interventions.

III. METHODS

Qualitative telephone interviews with key informants from each of the six Team Up partnerships were conducted by an independent researcher. Four representatives from each of the partnerships were interviewed; based on individual preference, representatives were interviewed either alone, in pairs, or as a group of 3 or 4. In total, 14 individual or group interviews were conducted. Representatives included each partnership's chair and co-chair, as well as two individuals who were active in the partnership, as identified by the chair and/or co-chair. All key partnering organizations – the NCI (CIS), ACS, CDC, and USDA (Extension Service) – were represented in the interviews. The chair and co-chair were first contacted via email by the NCI evaluation scientist, who introduced this phase of the evaluation, and then by the independent researcher, who obtained the names of two additional partnership representatives and scheduled the interviews. Interviews took place during February, March, and April of 2008. The interviews followed an interview guide (Appendix A) that is comprised of structured and semi-structured questions.

The interview guide was based on a qualitative interviewing matrix that was grounded in Diffusion of Innovations processes (Rogers, 1995), as well as models of partnership functioning and synergy (Lasker and Weiss, 2003; Weiss et al., 2002). Questions derived from the matrix covered the following areas related to the partnerships' use of evidence-based interventions to increase breast and cervical cancer screening rates: 1) Knowledge about evidence-based interventions; 2) the intervention identification, selection, and adoption process; 3) The planning and adaptation process; 4) The implementation process; and 5) Partnership reflections and intervention impact. Within each of these question areas, the following partnership-related dimensions were explored: coordination, communication and decision-making, roles; responsibilities and leadership; and community involvement.

The individual and group interviews lasted approximately 45 minutes to 75 minutes each; the group interviews tended to last longer than those conducted with individuals. Respondents were assured confidentiality and informed that their comments would not be identifiable in any reports. They were also informed that they did not have to answer every question presented and could end the interview at any time. No respondent chose to end the interview early or refused to answer any questions. Interviews were not tape recorded, in order to maximize respondents' comfort in speaking about the range of issues of interest. All respondents were thanked for their time and participation via email after their interviews.

During the interviews, the content of the discussions was captured using extensive handwritten notes as well as live computer transcription, and findings are based on extracted themes resulting from the interviews. The independent researcher and staff came to a consensus about the coding classification scheme, and independently coded the interview text. Discordances were then re-coded as necessary based on discussion. The independent researcher and staff then agreed on overarching themes, and placed classified text within these themes.

IV. RESULTS PART 1: TOPIC AREAS FROM THE INTERVIEW GUIDE

A. <u>Knowledge and buy-in of evidence-based interventions</u>

Two salient themes related to partners' knowledge about evidence-based interventions emerged. The first theme pertains to lack of awareness that the partnerships had to use an evidence-based intervention, and the second relates to the difficulties the partnership had in building consensus about what "evidence-based intervention" means. Note that, during the interviews, respondents typically referred to an evidence-based intervention as an "EBI," and to Cooperative Extension Agents as simply "Extension Agents."

i. Lack of awareness of the need to use an evidence-based intervention

Many Team Up members reported that they had not been aware of the national partners' intention for them to use an evidence-based intervention until well into the pilot. A representative from Partnership A noted that "*at first, it was challenging to figure out what the national partners wanted from us*." As one respondent from Partnership F stated, "*I think that different partners realized at different times that we were supposed to be doing an EBI. I don't think anyone really felt clearly instructed to do an EBI until much later*." This respondent also noted that Cancer P.L.A.N.E.T. was discussed at the Atlanta meeting, but their group did not think that the evidence-based intervention approach was required – "*It felt like we were being given a bucket of resources, but not a directive to use an EBI*." Some said that they discovered they were supposed to use an evidence-based intervention as late as a year or so into the pilot; for many, the Nashville meeting was a turning point since it was here that they realized that they had to implement an evidence-based intervention. As one respondent from Partnership E reported, "*Before the call for [implementation] proposals, our group thought that its charge was to see how we could work together to find and reach rarely or never screened women. We didn't really know that an EBI was supposed to be part of this*." This delayed realization resulted in a protracted period during which time and resources were spent on interventions (not evidence-based) that were later abandoned. A few teams reported that as a result of not realizing that they were supposed to be using evidence-based approaches, they tried to fit in an evidence-based intervention "retroactively." In other words, they reviewed what had already begun to do and identified which aspects of evidence-based approaches they had used: *"We were given the assignment of Team Up, then weren't sure that we had to do an EBI and then realized we did have to do an EBI, and as a result kind of did a retroactive fit,*" said one Partnership F representative. Similarly, a representative from Partnership E offered: "*Now that people in the partnership were starting to realize that we were supposed to do an EBI, we were wondering if this meant that we should 'retrofit' what we were doing to the EBI model*."

ii. Working to build consensus about the meaning of an evidence-based intervention

After partners recognized that they were supposed to be using an evidence-based intervention, many partnerships struggled with defining what, exactly, an evidence-based intervention was. Often different partner organizations within the same partnership had different interpretations, and these varying perspectives took time to reconcile. One respondent from Partnership E stated that her partnership developed agreement about what an "evidence-based intervention" means over the course of a year. Another respondent from the same partnership explained, "*How performance and success [were] measured differed among the four partners. Different states and different organizations had different perceptions of what an 'evidence-based intervention' was*." Similarly, a respondent from Partnership D reported, "*The way the [various] national partners explained and illustrated evidence-based approaches was not the same from organization to organization. . . . The NCI, Extension, etc., each had a different perception of what evidence-based meant."* Similarly, there was consensus during one group interview that it had been really hard for the partnership, as a group, to fully understand what an evidence-based intervention was, and this made progress slow; another one of the respondents from Partnership D stated: "*We had to constantly remind ourselves of what exactly we were supposed to be doing. We had to keep going back to what*

had already been decided in order to move forward." Partnership A implemented an intervention that they believed to be an evidence-based intervention, only to have the national partners inform them that they need to "*go back to Cancer P.L.A.N.E.T and use something more rigorous and evidence-based.*"

B. Selection and adoption of an evidence-based intervention

In all of the partnerships, the evidence-based intervention was selected through a collective and iterative review of existing evidence-based interventions by the full partnership, or a designated sub-committee and then full group determination of the evidence-based intervention that is most appropriate for the partnership and locale. The interviews clearly revealed the following three themes association with this process: First, for all of the partnerships, the selection of the evidence-based intervention and the specific components of the evidence-based intervention were based primarily on feasibility of implementation given the human resources, funds, and time available, as well as the fit with existing program and target populations. Second, selecting the evidence-based intervention necessitated that the partners understood what each partner brought to the team, a process that took time. Third, while selection of the target county or counties was based in part on mortality and morbidity data for breast and cervical cancer, it was also strongly determined by available local resources and contacts that were available in different areas, ease of access, and existing programs.

i. Feasibility as the rationale for evidence-based intervention selection

Evidence-based intervention selection was determined by feasibility, given the time frame of the Team Up pilot, funds, and resources partners could contribute (e.g., time, connections, and in-kind resources such as clerical capacity, paper, mailing services, etc.). One respondent from Partnership D stated that "*the team knew some of the limited resources that they were going to have with staffing, and the EBI that [we] chose seemed like a good and feasible fit, both in terms of the resources that the group had and the existing programs that [we] had up and running.*" Another respondent from the same partnership indicated that they selected their evidence-based intervention based on "*thorough discussion of what was feasible in [our state] and with the partnership we had, knowing what we knew about our state and the resources that we had.*" A respondent from Partnership F noted, "*FoCaS seemed good for us because it had a menu of options that we could most closely make fit the work that we had already done, our capacities, etc.*" A respondent from Partnership B commented, "*We evaluated the interventions based on practicality, resources and what would work in the communities.*" One Partnership C representative specifically stated that "*the ACS in [our state] had relationships with our medical association; this was a resource that we felt like we could leverage, and they had a provider base and a volunteer base that we could go to. This made it so we weren't starting from scratch.*"

A couple of the partnerships determined local fit and their selection of evidence-based intervention components based on feedback from the community and Cooperative Extension Agents. A representative from Partnership A, which involved "community liaisons," noted: "*We selected FoCaS because it seemed the most relevant to the communities we serve.*" Several partnerships reported that they encountered challenges finding evidence-based interventions that were appropriate for specific

populations, including rural white women. One Partnership F representative emphasized that they were not satisfied with their choice of evidence-based intervention, but could not find a better one: "*We picked FoCaS by process of elimination, simply because it was the only one that fit even remotely. And even with FoCaS, we didn't really like the way it fit.*"

ii. Time needed to learn about the other partners

Because the assessment of resources, as well as partnership and local fit, figured so greatly into the selection process, the six partnerships spent a lot of time learning about each other's different organizational cultures and priorities, including expertise and what each could contribute to the collective effort. As one partnership D representative emphasized, a key part of the "*start up period was getting to know what each organization could bring to the table.*" Another representative from Partnership D commented that it was important in this process that "*everyone was open and honest about what they could/couldn't do.*" Several respondents from different partnerships noted that this was a long, difficult process but ultimately strengthened their partnership. One Partnership E respondent reported, "*We spent a lot of time going over and over and over what we do. A lot of people were not familiar with the Extension Agents and what they did.*" As another respondent from Partnership C observed: "*I think that this tension of working through the roles and relationships – even what we could all come together to agree on in a unified voice (what we should be saying to the people at the local level, even) – I think this really hampered us. However, once we figured this out, I think that the pilot worked really beautifully. But it takes a long time to get out all of the 'kinks' worked out.*"

Although one respondent from Partnership E stated that "*many of us felt that there was too much time wasted in introductions,*" most agreed that the frequent introductions and intensive communication around roles and expertise early on resulted in the creation of a unique partnership among partners who may not typically collaborate. "*One positive outcome of this pilot was that it helped the local entities who weren't always at the table together to come together - it did create that relationship, and I feel like the relationships improved over this process,*" reflected one partner from Partnership C. Another from the same partnership discussed the novelty of bringing together unlikely elements: "*There were a lot of people around the table who were not the 'usual players,' which I think was good. Because of the non-traditional players, not a lot of us were familiar with their program or what resources they brought to the table."*

iii. Determining the county or counties chosen to receive the intervention

To select their target county or counties, the partnerships consulted cancer morbidity and mortality data and factored these into their deliberations; however, in most cases, they did not drive the selection of locations. Most partners reported selecting counties based on the presence or proximity of Cooperative Extension Agents and other existing partners in the area, as well as the presence of existing programs to make the interventions more efficient in terms of human and financial resources: "*We had to find people in counties who wanted to do this work; we couldn't pick counties that had staff vacancies, very new people, no infrastructure, etc. We didn't necessarily end up with the ten 'worst' counties in terms of cancer burden, because we used an iterative process (including feasibility) to pick the locations,"* said one Partnership F representative. Another Partnership F representative echoed the balance of need and

realism that they needed to strike: "*We looked at where the highest mortality rates for breast and cervical cancer were. In the course of this, we thought that we needed counties who had partnerships pretty well established (counties where there were Extension and ACS people who could carry out the work and were interested), so we were looking not only at the statistics but at the conduciveness of people there who were willing to do these partnerships.*" Similarly, a respondent from a Partnership B commented that "*priority counties were determined by looking at state and national data, and also at the ability of the Extension Agents, since these would be the lead people for the [intervention] in each county.*"

Additionally, partnerships not only looked for counties in which there were resources to carry out the work, but also areas in which the need was not already being addressed. For example, another respondent from Partnership A noted that "*there were a lot of other projects going on in [one high morbidity/mortality county] and they were doing good work; the area was kind of saturated. We chose [the area that we worked in] because we had the most staff members in that area, and the people there were really strong."*

C. Adaptation of an evidence-based intervention

Questions pertaining to adaptation of the selected evidence-based intervention yielded responses that can be grouped into two prominent and related themes. The first is that most partnerships were concerned about whether and when adaptation altered the evidence-based intervention to the point that it could no longer be considered evidence-based. The second and related theme is that partnerships thought that they did not receive sufficiently specific guidance or support from the national partners with respect to how much adaptation is appropriate, and how to gauge if an evidence-based intervention had been altered "too much."

i. Concerns about the degree of adaptation

Several partnerships reported feeling confused and unsure of the authenticity of their adapted evidence-based interventions. A representative from Partnership B noted that with respect to the extent that what they ultimately ended up doing resembled one of the EBIs, she was *"not sure."* She said that they *"just pulled out aspects that we could adapt with [our current capacities and activities].*" Another group of respondents from Partnership F echoed this uncertainty: "*We had to adapt, but I think that with the adapting, the 'evidence' part goes out the window.*" Sometimes, time and resources also limited the extent to which an evidence-based intervention could be implemented with fidelity: "*There was absolutely no way that we could possibly have done all the parts of the EBI, and the evidence shows that these evidence-based interventions only work if you implement all the parts,*" commented one Partnership A respondent. Similarly, another Partnership F respondent stated, "*We never could get a clear sense of at what point of changing the EBI it was no longer in line with the science.*" One Partnership C representative commented that *"this work is evidence-based meets reality."* Challenges to adaptation and retaining fidelity had to do not only with limitations of resources and time, but also differences in demographics between the original evidence-based intervention target groups and the Team Up target communities with respect to ethnicity and environment (urban vs. rural), as noted above. A number of partnerships commented that because of the difference in audience, all materials had to be "re-designed."

Moreover, a few partnerships adapted components of their selected evidence-based intervention and attached them to other existing programs and curricula related to, for example, healthy families programs and cooking classes.

ii. Need for more direction and feedback during the adaptation process

Many expressed that it would have been helpful to have more guidance about the adaptation process from the national partners. As one respondent from Partnership B commented, "*I think that the national partners tried not impose on the partnership, but yet at the same time had a very clear idea of what they wanted the partnership to do. It would have been better if we had been given a clearer outline.*" Similarly, another representative from Partnership F reflected, "*If you were a purist, then one could argue that it was difficult to adapt the intervention. There wasn't really much oversight from the national partners over our process in order to guide us. We didn't know if what we were doing was right.*" A couple of respondents commented that they asked the national partners how to determine how much change was too much, and they did not receive an answer. Finally, one partner from Partnership E expressed that "*it would have been helpful to know how the different components of FoCaS compared in terms of their effectiveness. There wasn't a way to gauge which part of the intervention would have been most effective given our resources.*"

D. <u>Implementation of evidence-based interventions</u>

Questions about the process of implementing the selected evidence-based intervention led to three key thematic findings. First, partnerships described the necessity of general adaptation at the state level during their planning phase and then further local adaptation during implementation, which in some cases was anticipated and in others unanticipated. The second theme is how the involvement (or lack thereof) of local community residents and Cooperative Extension Agents in earlier pilot phases can affect implementation. The third theme pertains to the contextual challenges the partnerships faced.

i. Adaptation at both the state partnership and county levels

All of the partnerships developed some kind of written plan for implementation, but this plan was simply a guide, and how the intervention got carried out in the designated counties tended to evolve over time and vary from county to county within each state. A number of state partnerships reported that giving counties flexibility was intentional; due to the diversity within their state, they felt that a "one size fits all" model would be inappropriate. Often, the need to accommodate different intra-state demographics and landscapes resulted in a loose framework for adaptation and implementation. For example, one respondent from Partnership C stated: *"The partnership did develop a written plan – we had some curricula that were developed, and a system. We didn't develop a plan for the communities though, because the communities were developing how they would implement the materials – it was different in each of the communities. . . . We gave local people a menu of options, and they made the decision. . . . Really, our role was more of a nurturing, supporting role rather than an implementation role.*" A respondent from a Partnership F emphasized, "*We came up with some core activities within the EBI that had to be done, but we gave the counties some flexibility to implement according to the resources that they had.*" Another representative

from Partnership F described the same organic phenomenon: "*Once it reached the county level, I think that some of the Extension Agents altered [the program] even more. I don't know if the rest of the group was really aware of this until after the fact, when they reported back to the group.*" One Partnership B representative doubted that their partnership would have succeeded at all if uniform implementation had been enforced: *"If they had tried to impose one version of implementation in all areas, it wouldn't have worked.*" And finally, one Partnership C representative commented that they *"didn't envision implementation, but rather went along with it."*

In some cases, county-level adaptation resulted in successful innovations. One representative from Partnership C stated that "*the core process was planned, but once each county started going out and doing the work, different areas started doing their own thing (for example, one area. . . put together an educational DVD that they had raised money for).*" A couple of partnerships reported that materials that had been developed on the local level had proven popular beyond the duration of the pilot study. One partner from Partnership C reported, "*We have found that there were some faith-based pieces that were (and still are) very popular…We had a template that had the messages that we wanted people to get re: screening, and then people from churches could add their own church-related information, verses, etc., in it and then run it off on their church copier. The bookmarks were really popular.*"

ii. Involvement of local residents and Cooperative Extension Agents

In a number of the partnerships, local residents and Cooperative Extension Agents were not involved in the planning process. Many partners reported feeling that, in hindsight, this was a substantial mistake, and that local people had a lot to offer from the beginning. *"If I were to do this again, I would say that it is absolutely necessary to involve the community from the beginning,"* commented one Partnership E representative. One partner from Partnership C agreed that community partners should have been welcomed more in the beginning: "*I feel that the local level people felt dictated to at first; they didn't feel ownership over the pilot. If we could have spent a little more time at the very beginning getting people to the table who should be involved in this, and having these people go to the initial meetings, that would have solved a lot of this issue.*" Partnership C had involved the community in the selection process, but did not involve them in planning the implementation, and as a result was not sure that the community had *"really bought in."*

Partnerships that did include local people in the planning stages and during implementation believed that this benefited them considerably. One Partnership B representative attributed the partnership's success to the inclusion of local members: *"The involvement of local people was a great part of the group's success. We have included local people in everything – planning, making decisions, implementing, etc.*" Likewise, another respondent from Partnership C reported that "*the local people who went to the national meetings really liked it, and got a lot out of it, but they should have been invited to be there from the very beginning.*" Yet another Partnership A representative who felt that the community was very receptive and "*seemed to embrace the opportunity to come out and learn"* reported that they worked closely with "*two grassroots*" ladies who helped them "*do restructuring and refocusing in terms of how to 'strategize' in the communities (for example., 'these people won't go here; they'll only go here; you need to divide the community into 4 areas, not 3, etc.').*"

With respect to Cooperative Extension Agents, it was sometimes not until the implementation phase that they were brought on board for Team Up. In some cases, this was an oversight, and in others, it was deliberate. Many partnership members interviewed felt that it burned bridges within the community. One partner from Partnership E stated: "*Two historically black colleges that have Extension programs were not invited to the kickoff in 2003, and I think that was very unfortunate. We were really leaving out key community partners. This also, I think, caused some issues with getting things off the ground later on.*"

Partnership B reported keeping in close touch with Cooperative Extension Agents and had consistent back and forth dialogue between the partnership and Extension Agents as well as across Extension Agents themselves that enabled the partnership to make similar "modifications" to the intervention in different counties. Representatives from this partnership commented that "*having everyone's input in the planning process, continuously, to modify the implementation, was very helpful."* They also noted that "sharing sessions," which enabled everyone involved, including Cooperative Extension Agents, to keep "so up to date with the process" were extremely helpful.

iii. Local contextual challenges

The qualitative interviews also highlighted the local challenges to implementation that the six Team Up partnerships faced. Perhaps some of the challenges could have been better anticipated or avoided had there been more local input earlier on in some if not all partnerships. Transportation difficulties emerged as an obstacle for potential program beneficiaries. In some rural regions, very few rarely/never screened women have cars, and had other life circumstances that made it difficult for them to attend screening events. "*Many of the women didn't have cars…and for many women, they were busy working (and yet still had no insurance), or were busy with family responsibilities,"* reported one Partnership B respondent. Sometimes these transportation difficulties combined with resource and cultural barriers, which hindered even more women from participating in screening events, especially in rural regions. For example, one respondent from Partnership C reported that "*for some of the counties we're targeting, some of them don't have mammography centers, so people would have to drive several hours etc, this was something we had to deal with…even issues like 'I have to get my husband's permission,' for things like Pap smears.*" Another often mentioned challenge to local implementation was attracting younger women, who in many cases believed they were impervious to cancer. Partnership E found: "*The younger women do not know that they should be screened – their attitude is 'this doesn't affect me; I'm too young to get cancer.'… The younger women weren't really coming to the programs…they had care responsibilities for older parents, responsibilities for young children, etc. And these women were commuting probably 1-1.5 hours each way every day. Coming to a program after a long day of work is not something that they are going to make a priority…However, we were able to convince the older women to talk to their daughters, nieces, etc. about the importance of getting screened.*"

Challenges to local implementation also emerged due to geographic issues. Cooperative Extension Agents were relied on heavily for program delivery, and travel for partnership members and Cooperative Extension Agents – to carry out programs and attend meetings - was an issue for a couple of the partnerships due to the cost and time involved. Additionally, several representatives

stated that in their state one Extension Agent has to cover more than one county and a representative from Partnership B offered: *"In some counties, it was more challenging than others due to higher turnover, etc."* Similarly, a representative of Partnership C stated that Cooperative Extension Agent turnover "*affected the Team Up pilot in some counties, and also, the personal problems of some Extension Agents affected the pilot momentum, although the county was reached [in other ways]*." Another representative from Partnership E noted that distance and manpower constraints prohibited them from casting a "wider net," and a different partner from this same partnership noted the difficulties that resulted from the lack of a strong regional or state Cooperative Extension leader. Also, a few partners in Partnership C reported that there had been boundary-related conflicts between Cooperative Extension Agents: *"In some counties, I think that coordination of extension activities with other organizations worked better than in others. Some counties have 'turf war' type relationships."*

A few partnerships mentioned that physicians and clinics demonstrated very little buy-in, resulting in a paucity of support for their clinic-focused activities. One respondent from Partnership C reported, *"The other thing was that the physician understanding of how our screening program works wasn't very good."* Another Partnership C representative commented that they *"struggled with getting the message to the physicians and training them*" due to a lack of connections to the Area Health Education Centers (AHEC). Similarly, a respondent in a Partnership E offered: *"The hospital we were going to work with was having some transitional issues with their employees, and so the provider component of FoCaS never really got off the ground. I see now why FoCaS was a long-term program; it really takes a long time to develop those relationships, especially with providers. We also had issues getting a venue to do the training. We really needed some providers on the committee, but that didn't happen. If we had, it probably would have been easier to work out some of the logistics."*

V. RESULTS PART II: ADDITIONAL PROMINENT THEMES

In addition to themes that came to light in the context of the pilot phases, as described above, a number of other issues emerged as critical to the partnerships' progress and success. These included: 1) Challenges that affected all phases of the partnerships work and are common to partnerships more generally; 2) Issues related to technical assistance and money; and 3) Positive outcomes of the pilot, including new relationships, making an impact, and continuation of pilot efforts.

A. <u>Partnership-related challenges that affected all phases of the pilot</u>

Overarching challenges that related to the development and maintenance of partnerships were prominent in the Team Up partnerships and are common to most new partnerships. These are: 1) Competing demands of job and partnership work; 2) Partner turnover; 3) Power differentials; and 4) Personality issues. Each will be discussed in turn.

i. Competing demands of job and partnership work

Many partners expressed that balancing Team Up work with the responsibilities of their full-time job was difficult. This was mentioned many times across partnerships as a challenge, and often a frustration. *"A constant frustration with Team Up was that we are all doing a whole lot of projects . . . trying to juggle everything was very difficult, especially since this was something that was on top of stuff that we were already doing that was very similar,*" explained one partner from Partnership A. Another Partnership A representative commented, "*For me, trying to be in the 'Team Up pilot manager' position was a disaster; it was too much to try to do this on top of my other responsibilities.*" Similarly, a representative from Partnership D noted, *"It would have been really nice to have a designated person for each agency to handle all the stuff. . . . Everyone in the partnership was doing this outside their normal full-time jobs.*" Sometimes, the competing demands led to positive solutions. For example, one representative from Partnership B commented that "*at first, the chair was just her*," but she couldn't do it all by myself, so she asked someone else to join her, and they have worked together since 2003. Partnership F hired a part-time coordinator with funds provided by one of the partners; members of this partnership all felt that having this coordinator who was working with all of the partners on a day to day basis was a key element of success.

According to a number of those interviewed, the stress of balancing their job and Team Up was often compounded by problems with organizational and supervisory support for partners in each state partnership. One Partnership E representative reported that *"there was frustration among the partners – both frustration with each other, as well as frustration over feelings of lack of support from their organizational heads."* A representative of a different partnership (Partnership D) noted that, for a while, people *"were not satisfied with the EBI concept, and were not respectful of it and its importance – their organization didn't buy into it*." Similarly, one respondent from Partnership F offered that "*the Extension Agents didn't really even have the infrastructure to carry out the work with ease – they didn't even have luggage carts to carry around their A/V equipment*."

ii. Partner turnover

An additional challenge that affected almost most of the partnerships was that of turnover on two levels: 1) turnover among people who were actual partnership members, and 2) turnover within the partnering organizations, even if individuals were not directly involved with Team Up. The turnover among partnership members resulted in the need to bring new members up to speed, which could be time intensive. Sometimes new members were not aware of what had happened previously. One member of Partnership C described the challenge in joining the partnership after an evidence-based intervention had been selected: "*We centered on Cancer P.L.A.N.E.T. and some of the interventions there. So I knew pretty early on what we were going to be doing. However, I didn't fully understand how we had gotten to that point, and I didn't really understand the partnership (who was involved, how this had come to be, who had generated it, etc.).*" Another partnership representative talked about the delays that turnover created for Partnership D: "*We had a strong team established from the very beginning, but then we had turnover, and had these new members who have a different team management style, different way of thinking, and a different way of viewing the world.*" Similarly, turnover within the organizations, even if individuals were not directly involved

with Team Up, had an impact on partnership progress. One partner from Partnership A reported that a change in leadership in a partner organization had a trickle down effect, even though the directors were not involved: "*By this point, the [partner organization] had had so many different directors ... this made it difficult because the leadership really sets the tone. Their style varied from director to director.*"

iii. Power differentials

Another challenge reported by respondents was that power differentials existed between partners and were a source of frequent tensions. In Partnership F, a couple of representatives commented that *"the hardship really fell to the Extension Agents. . . . [who initially] felt like they didn't really fit, that it wasn't really a priority of their organization, that they weren't the right people for the job*." Some expressed the belief that the decision-making process was not inclusive enough: *"I'm a firm believer that everything should be grassroots driven. I didn't think that it should be the people at the state level (rather than at the local level, [including] people who would be doing the intervention) to be deciding what we were going to do. I think that this was a tension throughout the whole process,*" said one respondent from Partnership C. One respondent from Partnership F reported very similar tensions that arose because of decision-making power differentials: *"I think it is important to mention that there was a powerful differential. [Two organizations] had more deciding power. We needed them to carry out the project, and so what they wanted to do always overruled the advice/suggestions that they were given…I felt like it kind of mutated into not really being a true collaboration; the interest of some organizations trumped that of others given what was needed to do what."* According to a few partnership representatives, some power differentials resulted from pre-existing relationships among partners. Explaining the disproportionate "pull" of some partners, one respondent from Partnership F said that these partners had "*been around for decades*," whereas their tenure had been much shorter.

At the same time, it is important to note there were partnerships in which power issues did not appear to come into play. For example, one respondent from Partnership B commented that "*there has been no territoriality,"* and *"all of [our] skills were different but complementary; we become a whole even though we were all parts. It never felt like any one person was dominating, and didn't feel like any one person wasn't contributing enough.*" A representative of Partnership D commented, "*I felt like [I] was fully informed throughout the whole process. We had in-person meetings, but we also communicated by e-mail. The big group met in person every couple of months, and then there was lots of back-and-forth in the interim.*"

iv. Personality issues

Personality conflicts also arose within the partnerships and occasionally hindered progress. In one extreme case, a conflict occurred that led to a partnership member's resignation, which led another member of this partnership (C) to comment: "*This taught me that partnerships are fragile, and one person can devastate a partnership.*" However, in most partnerships, conflicts resolved less dramatically. For example, one Partnership E member reported that some partners, who later changed positions, had been very hard to work with: "*There were some personality conflicts within the partnership. . . . These people eventually left the pilot. . . . I felt like they made the process difficult when they were involved.*" Similarly, another Partnership E representative portrayed personality differences as follows: "*We had a very interesting*

group, to say the least - a lot of different personalities. There were a lot of personality issues; several people didn't really 'gel' too well." And a representative from a Partnership D stated: "*There had been a lot of turnover, and so we then had a number of new members coming on who hadn't been involved since the beginning, and there was also a bit of a personality clash. This made things challenging.*" On the other hand, in a couple of partnerships, existing relationships and a history of positive interaction proved to be beneficial – "*We all knew each other and had worked together before. There weren't a lot of territory issues, and we worked together pretty well,*" commented one Partnership F representative.

B. <u>Issues related to technical assistance and money</u>

There were also several issues related to technical assistance and money that emerged as salient to the partnership members.

i. Technical assistance

The national meetings were a matter of some controversy among members. Some found these meetings very helpful, while others found them tedious. One partner from Partnership E said that the experience in the meetings had improved over time: *"I felt like the national meetings got better and better. The kick off meeting was definitely the hardest one; lots of feelings about 'why are we here, and what are we supposed to do?'*" Others reported that they felt like the national partners were unhelpful, and in some cases insensitive to their particular office cultures and comfort zones: "*I think that the national partners need to understand people's comfort zones. Not all people like to be silly in that type of framework, especially when they have their bosses in the room,*" said one Partnership D representative. Similarly, another respondent from the same partnership commented: *"Doing little goofy activities at the meetings was kind of uncomfortable for me (we had to do a song, etc.); this was frustrating to me – it felt like a bit of a waste of time.*"

Another controversial element of Team Up was the coaches. These individuals were viewed very differently by various partnerships and partnership members. Some saw them simply as 'translators' between national partners and state partners, while others found them instrumental in helping to put together and implementing the evidence-based intervention. Still others saw them as a bit of both. One Partnership C member who found the coaches useful reported: "*We definitely made use of the coaching and the PATH visit. Our big concern from the beginning was 'How are we going to evaluate this?' 'What do we evaluate?' We did get a lot of support on the data end of things. Also from a motivational standpoint, it was nice to have some recognition, confirmation that we were on the right track, etc. - this helped get people energized."* A representative from Partnership E also said that coaches helped their group to clarify the national partners' expectations: "*I felt that the coaches were really helpful in helping the state team start to understand more what the national partners were expecting of us. The coaches helped the teams think more operationally – e.g., 'How are we going to do this?'*" However, some respondents found the coaches' presence irrelevant and distracting: "*As far as the coaches were concerned, in my mind, there was really not a good connection between what we had going on at the state and what was going on at the national level,*" commented one Partnership C member. One member of Partnership F found the coaches somewhat harmful: "*I found the meetings with the (coach) to not be helpful. In fact, I found it to be pretty destructive.*" Another representative from

Partnership F wished the coaches had been more "effective" in addressing problems integrating partners (especially Cooperative Extension Agents) into the partnership. Finally, yet another representative from Partnership F suggested: "*I think that the extent to which the states were willing to accept the idea of a coach depended on how much they needed them.*"

ii. Sufficiency of monetary resource

All partnerships noted, to greater and lesser degrees, that money shortages were a barrier in the Team Up pilot. A number of partnerships raised funds for the pilot, and many contributed their own organizational funding. Nonetheless, writing even small grants was not easy; as a representative from Partnership A stated: "*Seeking additional funds was difficult to do given the time constraints."* In some cases, tensions resulted from the perception that the national partners had money that the states did not, and would ask states to do things they did not feel they had the resources to do. And, a couple of partnerships felt that the money spent on elaborate meetings would have been better spent on implementation efforts. One partnership F representative felt that "*the national partners were making all these mandates, but then not giving us funds to actually back up these mandates."* Others pointed out that the lack of funds simply forced them to be more resourceful and to make the most out of their partner organizations: *"There wasn't any money that came with this, so choosing what to do involved really taking stock of what each partner organization could bring to the table; what our capacities were without having to pay extra,"* said another Partnership F representative However, all seemed to acknowledge that the possibilities of the partnership were significantly limited by funding constraints: *"Having sufficient funds would have given us much more flexibility in terms of what we could have had as options while we were planning our work. This also would have decreased the level of 'disgruntledness' in the partnership.*" (Partnership F)

The lack of funds resulted in an inability to travel for many Cooperative Extension Agents. And, several partners expressed regret that more local and state partners could not attend national meetings because of cost. One Partnership E member reported that "*People were kind of spread out…I have no trouble with travel, but all the Cooperative Extension Agents were not as free to travel as I was [as a result of] cost concerns, etc."* Similarly, another partner said it would have improved the pilot if more meetings had occurred in the beginning, but this was impossible because of travel costs. "*It might have been better to have met more at the beginning of the implementation phase, but the different people in our partnership were kind of spread out geographically, and not everyone was able to travel for meetings because of cost and time concerns,*" commented a representative from Partnership E.

C. <u>Building partnership relationships, making an impact, and the continuation of Team Up partnership efforts</u>

Despite the many challenges the partnerships faced throughout the pilot, they all described positive outcomes of their efforts, including the development of valuable, new organizational relationships; impact that they are beginning to see in their target community; and the institutionalization and/or continuity of their Team Up effort in different forms.

i. Development of new and valuable relationships

A consequence of the Team Up pilot was the creation of important relationships between individuals and organizations who had not worked together before, especially Cooperative Extension Agents and who now felt that they could tackle this and other problems together. One partnership F representative noted that "*at least from [my organization's] perspective, the Tam Up pilot has helped us strengthen our relationship with the national partner organizations involved in the partnership. Prior to this, [we] didn't really have a relationship with the Extension Agents in our state, and now we do.*" Similarly, a respondent from Partnership A stated: "*I didn't feel like this [effort] was forced. For me, this was about figuring out how we can work together as a team. Over the time that we worked together, we learned a lot; we learned that we can work together if the expectations are clear up front."* And another respondent from this same partnership (Partnership A) stated: "*We hadn't worked with Extension much, and I think that working with them was a really valuable result of working on the Team Up pilot.*" A representative from a Partnership D noted that before Team Up, they had not collaborated much with the Extension office, and part of what made this pilot "great" was that the partners learned about the "various services available" in their area and "how to share resources."

A Partnership E representative emphasized that relationship building was as important to them as the increase in screening: "*For me, it's as much about what the partner organizations learned about each other and what it takes to adapt an EBI as it is about getting women screened.*" Similarly, a Partnership C representative shared that "*one positive outcome of the Team Up pilot was that it helped the local entities who weren't always at the table together to come together – it did create that relationship, and I feel like the relationships improved over this process. . . Building a relationship is the time-consuming part; once you have dealt with the barriers and gotten them out of the way, then it's so much easier to work together.*" Finally, one respondent from Partnership D stated that Team Up "*gave variety to my job, and working with a different group of people was a pleasure. In fact, when I moved to the diabetes program, I asked them if there was a way for me to stay involved and link diabetes to the Team Up partnership.*"

ii. Views about the partnership's impact

Although members of Partnership E felt that "*they accomplished some things with Team Up*" but *"could have accomplished so much more*," most of the partnerships expressed that they had made a difference in breast and cervical cancer awareness and screening in their target areas. One partnership representative (Partnership F) reported that, in their counties and "*despite confounding variables,*" the "*Team Up program was having an effect*" on breast and cervical cancer screening rates. A representative of Partnership C stated that "*we're just now able to show some impact in our intervention counties when compared with our control counties.*" Another representative from Partnership C commented that *"in the end, everyone felt proud of the work. . . . . The group achieved a lot with what they had."* And yet another respondent (Partnership B) noted that since November of last year, *"we've had over 600 [program] participants and 42% of the women referred were never or rarely screened women.*" A number of partnership members stated that they were proud of their efforts. Nonetheless, a number of partners from Partnership B expressed: "*The program is working, but we want to reach more people*"; nonetheless, these partners reported that, "*in general, the experience was very positive.*" Finally, one partnership (Partnership D), at the time of

the interview was still implementing the intervention and was waiting "*until the next batch of numbers comes through before we can attribute our work to the cancer screenings.*

iii. Continuation of the partnerships' work

In most of the partnerships, it is clear that the efforts to reach rarely and never screened women are ongoing, and that the need to reach these women is now recognized more broadly in their state; the structure, within which this work continues, however, takes different forms depending on the partnership. One respondent from Partnership F emphasized that their partnership had succeeded in making cancer a priority where it was not before: "*We (Cooperative Extension Agents) have benefited a lot from the Team Up pilot in terms of putting cancer on the map in terms of all diseases that we focus on. This is now being viewed as a viable program in the state. . . . The Team Up model has really become institutionalized. It works and people are impressed with it.*" Another respondent from this partnership noted that "*ownership*" of Team Up "*really now resides with Extension*," and activities are being expanded to include colon cancer and other cancers; they and other partners are still informally involved. Respondents from Partnership A described how their partnership's work has been folded into a larger, pre-existing local initiative; a number of the partners are still involved, and their "community liaisons" are part of this continued effort. In another state, the Team Up partnership (E) merged with the state's cancer alliance and developed a "breast and other female cancers workgroup statewide," as well as a subcommittee that concentrates on education, which received a small grant from the alliance.

VI. DISCUSSION

Team Up was a unique pilot that brought together the great potential of disseminating evidence-based interventions with the collaboration of diverse, inter-organizational public health partnerships. Because much is still unknown about what it means to effectively translate evidence-based interventions to other places and populations, and because creating new partnerships – in any context – is inherently and tremendously challenging, it is not surprising that this innovative pilot faced some significant hurdles from its inception.

Qualitative data presented in this report suggested that, for the partnerships, these hurdles included simultaneously working through the lack of understanding and clarity about what an evidence-based intervention was; building relationships and learning about what each of the partners could contribute and what was feasible give their resources and time; reconciling the need for local adaptation with concern about fidelity to their selected evidence-based intervention; determining how to best involve local residents and the various partners, especially US Department of Agriculture (USDA) Cooperative Extension Agents, in the process; and addressing contextual challenges. In addition, throughout the pilot the partnerships had to address internal dynamics that affected their progress, such as partners' lack of time and competing demands, turnover of partners and organizational leaders, and power and personality conflicts. Finally, the partnerships' general sense of insufficient and/or inappropriate technical assistance and the lack of adequate funding posed additional challenges.

Nonetheless, the qualitative data collected indicated that Team Up, as a novel pilot, succeeded in many respects. Public health partnerships were created that fostered lasting organizational and personal relationships, which have strengthened the cancer prevention and control infrastructure in the participating states. A number of the partnerships reported that they made an impact in breast and cervical cancer screening rates and had provided wide-spread screening education in their target communities, and that cancer outreach and education programs have been institutionalized as part of ongoing programmatic Extension activities in some states, and in others as part of state-wide initiatives. And, true to the purpose of a pilot, this effort yielded many informative lessons learned that can be applied to future initiatives. In this section, the challenges encountered in this pilot and how a number of these challenges were overcome will be reviewed first, and then the Team Up pilot key accomplishments will be summarized.

A. Challenges Faced

The partnerships' lack of awareness that they were required to implement an evidence-based intervention and the work they did prior to coming to this understanding, combined with need to identify appropriate and willing partnership representatives and build a cohesive group, was immensely time consuming and often frustrating. It is important to note that many of the partners who participated in their state's team had not worked together before, and this was particularly true for the USDA Cooperative Extension. The involvement of the USDA Cooperative Extension in the Team Up pilot was one of its more creative and novel characteristics, and the partnerships uniformly felt that the involvement of this organization was critical to their accomplishments; at the same time, involving a new partner, especially one in which most of the other partners were not familiar, created a learning curve about what the USDA Cooperative Extension was, how it was structured (which is different state by state), and what its role in the pilot should be.

Moreover, all of the organizations involved – the ACS, CDC, NCI, and USDA – had very different organizational cultures, agendas, resource capacities, and understandings of what an evidence-based intervention was and what it meant to implement one. As in any partnership initiative, reconciling these different cultures and beliefs, and identifying and integrating complementary resources, took time and considerable effort. Thus, the processes of choosing target counties for their intervention, selecting an evidence-based intervention, and identifying the components of that evidence-based intervention that were most feasible and suitable for the population were often tedious and drawn out. Nonetheless, the qualitative data suggested that almost all of the partnerships accomplished the adoption and adaptation processes in ways that involved all partners and gave them a voice; as a result, their plans were, for the large part, realistic.

With respect to adaptation of the selected evidence-based intervention, the qualitative data also revealed that the partnerships had similarly strong concerns about fidelity and a sense that they were not true to the evidence-based intervention. However, partnership representatives all felt that they did what they could with the resources they had, the time they had (both in terms of the duration of the pilot and their own personal time constraints), and given the necessity to adapt the evidence-based intervention to their locales and populations served. Interestingly, although all of the state

partnerships had a written implementation plan, they also all allowed for tremendous flexibility in implementing their intervention at the local level, much of which was done by county USDA Cooperative Extension Agents. Often, components of the evidence-based intervention were woven into existing local programs. Due to the diversity of target areas, most partnerships believed that a "one size fits all" model was inappropriate, and that any efforts to enforce uniformity would have hampered their effectiveness. Nonetheless, the extent to which the concern about "how much adaptation is too much," and "when is our intervention no longer evidence-based" loomed over a number of these partnerships throughout the pilot. Moreover, the widespread sense across the partnerships that there was little direction from the national partners in this regard created insecurities about the process they were undertaking.

In a few of the partnerships, representatives felt that local residents and/or USDA Cooperative Extension Agents were not sufficiently involved in the planning process, including selection of evidence-based intervention components and adaptation prior to implementation. In some cases, this was a point of controversy in the partnership – partners did not agree on whom to involve when. For others, in hindsight, it was a collective oversight. The partnerships expressed that, as a result, the target communities and even local clinics and physicians did not "buy in" as much as they otherwise might have, and local Extension Agents in particular did not have sufficient ownership over the Team Up pilot. A number of the partnerships, however, did include local residents and/or local USDA Cooperative Extension Agents in the various planning phases of the pilot. Those partnerships that included these residents and/or Extension Agents before implementation felt that this was critical to their team's success, because it facilitated more precise tailoring and key strategies for reaching the target population of rarely and never screened women. The partnerships that included both USDA Cooperative Extension Agents and community members in all, or almost all, phases of the pilot appeared to be most satisfied with the processes they created.

Contextual challenges to implementation were minimized when community members and USDA Cooperative Extension Agents were involved from the beginning, but they were by no means eliminated. Transportation difficulties were an obstacle for program beneficiaries in a couple of places, and cultural barriers to screening were reported to be pervasive. Moreover, these transportation issues (distance and cost of transportation) made the USDA Cooperative Extension Agents' work particularly challenging and influenced the partnerships' ability to reach women and to have in-person meetings with all of those involved in the pilot.

Challenges related to the development and maintenance of partnerships – challenges common in all partnerships – also figured prominently in Team Up. Moreover, these challenges, including competing demands of job and partnership work, partner turnover and turnover in partnering organizations, power differentials, and personality issues, were sometimes exacerbated due to the time constraints and structure imposed by the pilot, as well as the difficulties presented by selecting, adapting, and implementing an evidence-based intervention with relatively little Team Up funding. Nonetheless, the partnerships worked to overcome these challenges; and often, collective commitment to the goals of Team Up and a respect for fellow partners kept the partnerships going.

The vast majority of those involved in Team Up partnerships felt that they were doing the pilot's work "on top of their regular jobs," and indicated that competing time demands and a dearth of funding made giving consistent, adequate attention to Team Up difficult. Yet, most viewed the pilot as highly important, and partners' in-kind contributions, including time, were universally seen as quite substantial. One partnership managed to hire a coordinator with in-kind funds, which they found invaluable and key to their success. Another partnership used in-kind funds to support community liaisons, which they also saw as critical. Although some power differentials did persist in a couple of the partnerships, most worked through these issues to create a broadly inclusive partnership. Nonetheless, in a few partnerships, funding constraints did make it difficult to convene partners in person, and especially Extension Agents, as many as hoped. In addition, almost all of the partnerships experienced personality clashes, and in some cases these led to turnover; however, strong leadership in most of the partnerships navigated the partnerships through the most difficult periods.

Finally, for some of the partners and partnerships, the technical assistance – whether delivered at the national meetings or through the coaches – was a source of annoyance, while others found it helpful. Some partners felt that there was a substantial disconnect between what was happening in their state and the kinds of assistance and communication being provided by the national partners and coaches, such that their efforts were seen as irrelevant and even, in a couple of cases, as having a negative impact on their partnership. Other partners enjoyed the technical assistance offered at meetings and/or by the coaches, and found it helpful and supportive. Partners views about the technical assistance varied widely based on their past and current partnership experiences, knowledge they brought to the Team Up pilot, and even their organizational rank (those in higher level positions tended to view the technical assistance in general and the meetings specifically in a more negative light).

B. Accomplishments

Some of the partnerships' accomplishments are mentioned above in this section, in the context of substantial challenges that were overcome. In addition, and despite the considerable challenges, the partnerships described a number of important, positive outcomes of their collaborative efforts. First, virtually all qualitative interview participants indicated that, as a direct result of Team Up, they and their organization had developed new, valuable relationships and attributed these relationships to what they perceived as true collaboration. At the time of the interviews, many of these relationships were already acting as the basis for grant writing and planning of continued cancer control efforts. These trusted relationships were also viewed, in an ongoing way, as providing support and sharing resources in times that are increasingly fraught with political tensions, competition for scarce public health resources, and general uncertainty.

Second, most of the partnerships reported that they were having an impact on cancer screening rates among rarely or never screened women in their target communities, or at the very least, they reported raising awareness in their communities of the importance of screening. Most of the partnerships also felt that their efforts were mostly or entirely successful, and that their success

would not have been possible without the involvement of all of the partners that participated, particularly the USDA Cooperative Extension, which was the partner that had often never worked with the others in the past. It is important to note that while most viewed the Team Up pilot as difficult and wished some things about the pilot had been done better or differently, they also saw it as positive and worthwhile – both in terms of what they accomplished and what they learned through the process.

And lastly, almost all of the partnerships reported that the importance of cancer screening for rarely or never screened women has received broad recognition in their state, and, as a result, the work of the partnerships is continuing in various forms. For example, in a couple of the partnerships, the partnerships' efforts have been institutionalized as part of the outreach and education curricula of the USDA Cooperative Extension. In other states, screening of rarely or never screened women has become one of the priorities of the state's cancer control efforts. In yet another state, the work of the partnership has been folded into another pre-existing local initiative, with many of the partners still involved.

C. Lessons Learned

Due to the complexities of Team Up, the challenges the partnerships faced and in many instances overcame, as well as its accomplishments, this pilot achieved what pilots should – it has yielded important lessons that can be applied to future cancer prevention and control efforts. Key lessons learned from the qualitative data are enumerated below; unquestionably, the larger evaluation has generated many more.

1) *Provide Team Up participants with clear expectations from the inception, and confirm that those expectations are understood. Ongoing communication and technical assistance should be consistent with and supportive of these expectations.* Additionally, technical assistance and meetings, to the extent possible, should be tailored to the needs, experiences, and feedback of participants. The tone is set in any pilot at the outset, and, clear expectations and recognition of differences across participants (here partnerships) are key to building trust. In Team Up, while the state partnerships were able to build a substantial amount of trust within their group, many retained some wariness of the national partners due to a lack of clear guidelines related to selection and adaptation of evidence-based interventions, inconsistent messages, and inadequate support for difficult directives.

2) *In situations of scarce resources and time, feasibility of an intervention becomes paramount.* Because this pilot had a fixed timeline and limited funding for the state partnerships, particularly for the implementation of evidence-based interventions, and because public health funding at the state and local levels is increasingly scarce, it was not possible for the partnerships to implement all aspects of an evidence-based intervention, which, typically, have been developed and carried out under large grant mechanisms. The partnerships took a very rational-choice approach to selection and implementation – i.e., maximize chances of achieving the pilot's goal in their local area, even if it meant sacrificing some degree of fidelity.

3) *Due to geographic and demographic diversity, adaptation of an intervention occurs at multiple levels and continuously evolves. Key is tracking all of the adaptation during implementation.* The partners repeatedly expressed the idea that "one size does not fit all," and in their states, which are quite diverse, this translated into innovative, community-level adaptation, beyond what was planned by the state partnerships. Adaptation and implementation became an organic process by necessity rather than by design.

4) *Inter-organizational public health partnerships should involve and listen to local residents and professionals in the planning phases.* In some partnerships, contextual challenges that had an impact on their success could have been addressed and/or avoided in some measure with earlier input from local residents and those who work in the target communities. Also, those who have experience working in the target communities typically know what is feasible and realistic. In addition, involving local residents and professionals early on in the pilot improves "buy-in" and participation in later phases of Team Up. Involving individuals who will carry out the intervention in the planning phase increases ownership, communication, commitment, and reduces turnover.

5) *Partnership work is difficult and time consuming, consequently Team Up timelines need to consider the effort it takes to build an effective collaborative process.* Selecting and planning an evidence-based intervention as a group necessitates the development of effective decision-making and conflict resolution processes; identification of partner's various resources, agendas, and priorities; determination of roles; providing opportunities for different kinds of involvement; and many group meetings, including in-person gatherings. This is all more time consuming than when one or even two organizations carry out a particular intervention. To be effective and ongoing, partnerships must have the time to build trusting relationships. This is key to sustainability over time.

6) *Partnership work is particularly challenging because much of it is done in addition to one's "regular job," even if it is consistent with that job's purpose; providing funds for a partnership coordinator, or even for administrative support, can improve the partnership's efficiency and effectiveness.* Team Up partnerships that had garnered in-kind resources or obtained external funding for this kind of support tended to report fewer frustrations and partners seemed more satisfied with the partnership's processes overall.

7) *Organizational support, at the highest level, is critical to effective involvement of partnership representatives.* A number of organization's local offices experienced difficulty participating fully in the partnership, were not involved sufficiently at the beginning, and/or experienced turnover in their partnership representative, in part because there was not sufficient organizational support for involvement in Team Up at the state and or national level. Even strong partnership leadership can have difficulty working around lack of organizational support of key partners.

8) *Partnerships that are cross-sectorial have tremendous potential to achieve difficult goals.* Involving the USDA Cooperative Extension Agents in Team Up which was designed to reach rarely or never screened women in predominantly rural areas proved to be groundbreaking. It enabled the state Team Up partnerships to not only foster new, lasting relationships, but to reach populations and

carry out strategies that would have otherwise been almost impossible. It also laid the groundwork for institutionalization of the partnerships efforts at the most local level.

VII. REFERENCES

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APPENDIX

Team Up: Cancer Screening Saves Lives - Guide for Qualitative Interviewing

Note to Interviewer: Review confidentiality, options to refuse questions and end interview.

Knowledge/Buy-in

1. At what point in this pilot did you feel that you fully understood what an 'EBI' was, and what using one would entail? How did members of your partnership feel about having to use an EBI?

Selection/Identification/Adoption

1. How did the partnership determine where (i.e., in which county/counties) it was going to focus its efforts?

2. How did the partnership determine what EBI to implement – what was the selection process? Why did your team choose the intervention (and intervention components) that it did?

Probes:

- To what extent did the nature of the selected community determine which EBI was chosen, and in what ways?
- Were all Team Up members involved in the EBI selection process?
- To what extent were additional (non-core) partners, including community stakeholders, brought in at the beginning and involved in the EBI selection process? Who were these partners? In hindsight, are there individuals or organizations that should have been involved in the selection process that weren't?
- Do you feel that the role your organization was asked to play in this process was appropriate/a good fit?

3. To what extent did you feel that the EBI options available fit the selected community and the partnership's capacity? Probe: To what extent were the options different from, or consistent with, the interventions that partnering organizations had carried out in the past?

Planning/Adaptation

1. To what extent was the intervention changed from the original EBI, and why? (Refer back to FoCaS and Breast Cancer Screening Among Non-adherent Women [Missouri] as needed.)

Probes:

- How did the partnership decide how it would alter the intervention?
- Did the National Partners play a role in helping you adapt your selected EBI?
- What was your experience of the adaptation process – easy/smooth, hard/challenging, etc. (describe). What was it about the experience that was easy/smooth, hard/challenging?

2. Who took a leadership role in planning and adapting the intervention to your community? What other roles did partners play during the planning and adaptation process?

Probes:

- To what extent do you feel that the different core partners made sufficient time and resource commitments during this phase?
- Do you feel that there were individuals or organizations that were not contributing as expected? If so, what was the impact?

3. Did the partnership develop a written plan for implementing the intervention components?

Probes:

- If no, how did not having a plan impact your work?
- If yes, when was it developed? Was it required as part of the pilot? Did the plan have a timeline? Were there specified roles and responsibilities for who would carry out the intervention? How were roles and responsibilities determined?

4. Do you feel that the partnership had the information and experience needed among its members to adapt/tailor and plan the implementation of the EBI? If no, who (or what expertise) was missing?

Probes:

- To what extent did the planning and adaptation process involve more than just the original partners?

- Were the target population and/or key stakeholders involved in this phase? If yes to either, Did you feel that the inclusion of these additional people was beneficial, and why or why not?

5. Were outside coordinators and facilitators used (for meetings, to help with the adaptation of the intervention etc.), and were they helpful?

6. How was everyone informed about what was happening in the partnership and the planning process? Probe: Did you feel that communication during the planning phase was adequate?

Implementation

1. How do you think the implementation process went (is going)?

Probes:

- To what extent did the implementation process reflect the plan that the partnership agreed upon? If different from the plan, what led to the changes? Did the changes occur in response to unanticipated circumstances?
- To what extent were the planned intervention and the work it entailed realistic, given the capacities of the partnership and timeframe of the pilot?
- What were some challenges to implementing the EBI as planned?
- How did the community context facilitate or hinder the implementation of the selected intervention?
- To what extent did partners feel that the roles assigned/taken on during the implementation were appropriate and optimal?

2. To what extent do you feel that the intervention components you implemented were true to the original EBI? (Probe) If not, what was not 'true' to the original EBI? Do you think it is important/unimportant to maintain as much of the original EBI?

3. What kind of decision-making process was used to address issues that arose during the implementation process? Do you feel that the people involved in physically carrying out the intervention were sufficiently included in these discussions?

4. How were members kept informed of what was happening?

Probes:

- Do you feel that the partnership met frequently enough during the implementation of the intervention?
- To what extent were the partnership's coordination and communication processes during the implementation process sufficient?

5. Did the partnership need technical assistance or other outside support during the implementation phase?

Probes:

- If yes:
  - What kind of assistance/support was needed?
  - Did the partnership get the help it needed? If so, from whom?
  - Were there areas where the group needed assistance, but never received it?

6. How, if at all, were community members/community-based organizations that were not members of the partnership involved in carrying out the intervention?

7. Are there individuals or organizations that should have been involved in the implementation but were not? Probe: Were there specific problems that the group encountered during implementation that the involvement of these additional people would have helped with?

Partnership Reflections/Impact

1. In retrospect, is there anything you would have done differently that we have not already covered? Would you ask the National partners to do anything differently?

2. Do you think that the intervention was successful in changing the behavior of rarely or never screened women?

3. Are you aware of (other) ways that the work of the partnership had an impact on the community, or on relationships in the community, including those of the partners?

Appendix U

Outcome Evaluation:
Control County Matching Scores

Team Up Intervention and Control Counties

State	Intervention/Control	Matching Score
A	Intervention County 1	
	Control	2.4
	Control	3.9
	Control	4.2
B	Intervention County 1	
	Control	1.4
	Control	2.8
	Control	4.2
B	Intervention County 2	
	Control	1.6
	Control	4.1
	Control	1.2
B	Intervention County 3	
	Control	8
	Control	9.8
	Control	10.1
B	Intervention County 4	
	Control	4
	Control	5.3
	Control	7
B	Intervention County 5	
	Control	2.6
	Control	4.5
	Control	5.4
B	Intervention County 6	
	Control	2.8
	Control	1.9
	Control	5.1
B	Intervention County 7	
	Control	2.5
	Control	3.1
	Control	4.1
B	Intervention County 8	
	Control	2.1
	Control	2.7
	Control	3.5
B	Intervention County 9	
	Control	2.4
	Control	2.6
	Control	2.6
B	Intervention County 10	
	Control	1
	Control	1.2
	Control	1.6

Team Up Intervention and Control Counties

State	Intervention/Control	Matching Score
B	Intervention County 11	
	Control	2.9
	Control	3.4
	Control	2.9
B	Intervention County 12	
	Control	2.4
	Control	2.6
	Control	2.6
B	Intervention County 13	
	Control	0.7
	Control	0.8
	Control	1.2
C	Intervention County 1	
	Control	0.7
	Control	1
	Control	1.2
C	Intervention County 2	
	Control	0.5
	Control	0.7
	Control	4.1
C	Intervention County 3	
	Control	0.9
	Control	1.3
	Control	1.4
C	Intervention County 4	
	Control	0.7
	Control	1
	Control	1.7
C	Intervention County 5	
	Control	0.9
	Control	3
	Control	3.4
C	Intervention County 6	
	Control	0.4
	Control	2.5
	Control	3.9
C	Intervention County 7	
	Control	1.4
	Control	2.9
	Control	3.4
C	Intervention County 8	
	Control	1.4
	Control	1.8
	Control	3

Team Up Intervention and Control Counties

State	Intervention/Control	Matching Score
C	Intervention County 9	
	Control	0.8
	Control	2
	Control	4.5
D	Intervention County 1	
	Control	1.4
	Control	1.8
	Control	4.9
D	Intervention County 2	
	Control	1.3
	Control	1.6
	Control	1.9
D	Intervention County 3	
	Control	2.2
	Control	2.3
	Control	2.7
D	Intervention County 4	
	Control	2.5
	Control	2.9
	Control	3.3
E	Intervention County 1	
	Control	2.2
	Control	2.5
	Control	2.8
F	Intervention County 1	
	Control	0.4
	Control	1.7
	Control	1.9
F	Intervention County 2	
	Control	0.6
	Control	0.9
	Control	2
F	Intervention County 3	
	Control	1.1
	Control	1.2
	Control	1.5
F	Intervention County 4	
	Control	0.9
	Control	1
	Control	1.5
F	Intervention County 5	
	Control	1
	Control	1.1
	Control	1.6

Team Up Intervention and Control Counties

State	Intervention/Control	Matching Score
F	Intervention County 6	
	Control	0.6
	Control	0.8
	Control	1.8
F	Intervention County 7	
	Control	1.4
	Control	1.8
	Control	1.9
F	Intervention County 8	
	Control	1.1
	Control	1.2
	Control	1.8
F	Intervention County 9	
	Control	0.5
	Control	2.1
	Control	2.5
F	Intervention County 10	
	Control	0.6
	Control	0.6
	Control	1
F	Intervention County 11	
	Control	1.3
	Control	1.4
	Control	2

Appendix V

Team Up Exit Interviews: Findings From Illinois and Mississippi

Team Up Exit Interviews:

Findings From Illinois and Mississippi

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Introduction

Many women in the United States still do not receive routine cervical and breast cancer screening according to recommended intervals, despite their proven effectiveness to reduce morbidity and mortality. To reduce cancer health disparities among women rarely or never screened for cervical and breast cancer, a public-private partnership developed in 2001 between three Federal agencies: The Centers for Disease Control and Prevention (CDC), the National Cancer Institute (NCI) and the United States Department of Agriculture (USDA); and one non-profit agency, the American Cancer Society (ACS). Together, the public-private partnership (Team Up) initiated a demonstration pilot program in 2003 with regional and local public health practitioners from eight Appalachian states (Alabama, Georgia, Illinois, Kentucky, Mississippi, Missouri, South Carolina, and Tennessee). These sites were chosen because they represented states with the highest cervical and breast cancer morbidity and had the lowest screening rates for these cancers.

In July 2003, a training entitled "The Partnership to Increase Cervical and Breast Cancer Screening in High Mortality Counties: Pilot Training" was held in Atlanta, Georgia. The purpose of this training was to develop and support state-level partnerships to identify, synthesize, and implement evidence-based approaches to identify and encourage women who rarely or never have been screened for cervical or breast cancer to be screened. Specifically, the training provided an opportunity for participating states to: (1) understand how to access and adapt effective research-tested screening interventions for use in high mortality regions; and (2) develop, create or strengthen partnerships at the local level.

The 1 ½ day training was attended by representatives from the eight states. Local stakeholder partners included USDA Cooperative Extension agents, National Breast and Cervical Cancer Early Detection Program outreach staff, Regional Cancer Information Service Partnership Program staff, American Cancer Society Regional planners and other practitioners or educators from the identified states.

Since the inception of the demonstration pilot program in July 2003, two states (Illinois and Mississippi) have discontinued their participation in the pilot program. This report will describe the results of the Exit Interviews conducted with representatives from these state partnerships to more fully understand the reasons why they terminated their involvement in Team Up and if there were any changes that could have been made that would have helped that partnership to continue in the Team Up program. These findings can be used to inform changes that can be made to improve the Team Up project, if it is to go beyond a pilot program.

Methodology

Westat developed a qualitative interview guide based on recommendations for questions from the Team Up Evaluation Committee. The interview guide was tailored for all respondents based on their respective state and organization. (See the Appendix for a generic copy of the interview guide.) Once the interview guide was finalized, NCI provided Westat with a list of potential respondents. The list included members of each state partnership, including representatives from ACS, CDC's Breast and Cervical Cancer Early Detection Program, NCI's Cancer Information Services, and USDA's Cooperative Extension Service. Westat staff contacted each named individual up to 4 times. Initially, respondents were sent an email asking them to participate. This initial contact was followed by a reminder email and two phone calls, as needed, to make contact.

Westat staff then conducted 15-20 minute interviews with each individual who agreed to participate. The interviews were taped, if the respondent granted permission, and following the interview, the interviewer finalized interview notes using the tape for assistance.

Data Analysis

For each state, Westat staff reviewed the interviews, question-by-question, and summarized respondents' answers. Based on the questions-by-question summaries, themes were identified and the following results section will describe the state-specific findings. Both similarities and disparities in responses will be discussed. The discussion section will then compare and contrast the findings from both states.

Results

Illinois:

Response Rate

Thirteen potential respondents from Illinois were identified. Of those thirteen, six were interviewed, five refused to participate, and Westat was unable to contact two individuals.

Characteristics of Respondents

Of the six respondents, four represented state-level organizations and two represented local-level organizations. Three of the four Core partner organizations (ACS, CDC, NCI, USDA) were represented. All but one of the respondents had been involved in the Illinois Team Up partnership since the July 2003 training.

Findings

Purpose of Team Up:

Respondents were asked to state their view of the purpose of Team Up. Most respondents (n=4) viewed Team Up's purpose as a mechanism to reduce cervical cancer mortality rates. However, two respondents emphasized building the partnership between the four Core organizations, while three focused on developing strategies to reach rarely or never screened women.

Decision to Leave Team Up:

Respondents were asked why their partnership decided to leave Team Up. Four of the six respondents noted that the lead agency made the decision. All respondents viewed existing state activities and/or a newly introduced state mandate that caused duplication of efforts as a factor leading to the Team Up partnership's dissolution. The state operates both a Cervical Cancer Elimination Task Force as well as the Comprehensive Cancer Control Program. Many Team Up partners were already partnering around cervical cancer via these initiatives, which have similar goals to Team Up. Lack of funding was another reason given for leaving Team Up. Two respondents stated that Illinois already has a waiting list of 700 women waiting to receive cervical cancer screenings through the Breast and Cervical Cancer Program, but no funding for their screenings. Respondents thought that the focus of Team Up should be on funding screenings for these women rather than identifying new methods to reach rarely or never screened women.

The decision to leave Team Up was not supported by all of the partners. Only two of the partners fully supported the decision. One partner wanted to continue participating in Team Up. Three others recognized that the partnership could not continue without the support of all four Core partners, but did not necessarily want to leave Team Up. These respondents felt that they could not continue to participate in Team Up without the cooperation of all of the partners. Several partners plan to continue partnering at the local level.

Aspects of the Partnership that Worked Well:

Respondents discussed aspects of the partnership that worked well. Many of the partners had a history of working together and thought their ability to work well together facilitated the partnership. Although three of the four Core organizations had worked together in the past, one of the organizations had not previously partnered with any of the other organizations. This new partnership was cited as a positive outcome of Team Up.

Aspects of the Partnership that did not Work Well:

Respondents discussed several barriers to the partnership achieving its goals. Barriers included duplication of efforts, lack of funding to provide screenings, lack of funding to hire additional staff, too much focus on evidence-based interventions/lack of funding to implement evidence-based interventions, continuous changing of priority counties, and lack of an evaluation plan.

- **Duplication of Efforts** (n=6). As noted earlier, there were two state-wide efforts, the Cervical Cancer Elimination Task Force and the Comprehensive Cancer Control Program, which both had goals similar to Team Up. Several of the partners were already partnering together via these initiatives and saw Team Up as duplicative of these efforts. One respondent stated that the state partners "were already doing the things that [Team Up] brought us together to do."

- **Lack of funding to provide screenings** (n=4)**.** The Breast and Cervical Cancer Program has been successful in identifying women who need cervical cancer screening. Currently, there is a waiting list of over 700 women. However, the program does not currently have the funding to provide Pap tests to these women. Several respondents stated that they would like Team Up to fund screenings, rather than Team Up meeting-related expenses.

- **Lack of funding to hire additional staff** (n=2). Two respondents suggested providing the lead agency with funding to hire a staff member dedicated (at least part-time) to conducting Team Up activities.

- **Too much focus on evidence-based interventions/lack of funding for evidence-based interventions** (n=3). Three respondents noted that it was expensive to implement evidence-based interventions and that if they were expected to implement such programs, they would need additional funding. One respondent noted that when s/he joined Team Up the focus was on building the partnership, not on implementing evidence-based interventions. Another respondent stated that although s/he understands the importance of using evidence-based interventions, the focus should be on providing additional funding to provide screenings to women who have already been identified.

- **Lack of time to dedicate to Team Up activities** (n=4). Four respondents noted that the lead agency no longer had the time to dedicate to Team Up activities due to competing priorities.

- **Continuous changing of priority counties** (n=3). Half of the respondents thought the continuous changing of priority counties inhibited the partnership from achieving its goals. Originally, the partnership was given a list of 22 counties with high cervical cancer rates. This list was reduced to 6 counties, when the data was reviewed for accuracy. After initially identifying counties, the group would consult with the state cancer registry on a regular basis to keep abreast of which counties had the highest mortality rates. If the counties with high cervical cancer rates changed, then the partnership changed its focus accordingly. This caused the partnership to have to identify new local partners and familiarize these partners with Team Up, which impeded their progress in implementing programs.

- **Lack of an evaluation plan** (n=2). Two respondents discussed the lack of an evaluation to determine whether or not they were reaching their goals as a barrier.

Summary

The decision to leave Team Up was not supported by all of the partners. The lead agency made the final decision and the main factors that contributed to this decision were duplication of efforts with statewide initiatives and lack of funding. In addition, the lead agency no longer had the time to dedicate to Team Up activities. Respondents thought that their history of working together helped facilitate the development of the partnership. One of the partners had not previously partnered with the other three, and this new partnership was noted as a positive outcome of Team Up. There were several barriers that preventing the partnership from achieving their goals, which included duplication of efforts, lack of funding (to provide screenings and hire staff), too much focus on utilizing evidence-based interventions to the exclusion of screening, lack of time, continuous changing of priority counties and lack of an evaluation plan. Overall, Team Up was a positive experience for the majority of respondents and several of the partners plan to continue working together.

Mississippi:

Response Rate

Ten potential respondents from Mississippi were identified. Of those ten, six were interviewed, one refused to participate and Westat was unable to contact three individuals.

Characteristics of Respondents

Five of the six respondents represented state-level organizations and one represented a regional-level organization. Respondents represented three of the four Core partner organizations and two non-Core partner organizations. One of the respondents had been involved in Team Up from the July 2003 training, while four respondents had been involved since May 2005. One respondent stated that although their organization had agreed to participate in Team Up they were never contacted other than receiving occasional emails from the National Partners.

Findings

Purpose of Team Up:

Respondents' understanding of Team Up's purpose varied. However, most respondents emphasized cervical cancer and rarely or never screened/underscreened women. Two of the six respondents mentioned the use of evidence-based interventions as a focus of Team Up.

Decision to Leave Team Up:

Respondents were asked why their partnership decided to leave Team Up. Five of the six respondents stated that one of the core partners "did not get on board;" that is, never actively participated in Team Up activities. The respondent from the organization in question disagreed, and felt that their organization was mistakenly blamed for the ending of the partnership. Two respondents felt as though the partnership had not "ended," but rather was put on "hold." Other factors that contributed to the decision to leave Team Up included lack of time and changing priorities after Hurricane Katrina.

According to the respondents, the decision to leave Team Up was not supported by all of the partners. Two respondents supported the decision to leave Team Up. Two respondents did not support the decision because they thought Team Up was an avenue to reach rarely or never screened women. Two respondents could not answer this question. One of these respondents did not know about the decision until s/he received a confusing and surprising email from the partnership lead. This email, which was sent to the state partnership Team Up listserv, stated that Mississippi would be leaving Team Up because the respondent's organization did not want to be involved in the partnership. The other respondent could not answer the question because her organization had never officially joined Team Up and therefore was not involved in this decision, or any other Team Up activities. Four of the six respondents stated, without prompting, that they would like to see the Team Up partnership reestablished in Mississippi.

Aspects of the Partnership that Worked Well:

Respondents discussed aspects of the partnership that worked well. The majority (n=4) of respondents noted that the four Core partner organizations had a history of working together successfully. Respondents noted that the working relationship participating organizations already had facilitated the development the partnership.

Aspects of the Partnership that did not Work Well:

Respondents also discussed barriers to establishing the partnership. Barriers included difficulty getting the partnership started, the absence of one of the core organizations, lack of communication, lack of resources, lack of time, the impact of Hurricane Katrina, and too much focus on evidence-based interventions.

- **Difficulty getting the partnership started.** None of the respondents were able to attend the Regional Meeting in 2005. Therefore, the coaches came to Mississippi to conduct a mini-training to discuss the information covered at the regional meeting. This was the first time that the majority of respondents had participated in a Team Up activity, although Team Up started almost two years earlier in July 2003. When asked when their organizations joined Team Up, many respondents (n=3), including two representatives from Core partners, stated that their organizations first became involved in 2005.

- **Absence of one of the core organizations** (n=5). The absence of one of the core organizations prohibited the partnership from getting off the ground. The partnership felt as though they could not begin Team Up activities until all four Core partners were committed to participating.

- **Lack of Communication** (n=1). The respondent from the "absent" organization noted that lack of communication was a barrier. S/he noted that, contrary to what other individuals believed, her organization is interested in participating in Team Up. S/he stated that meetings would be scheduled and then cancelled at the last minute because not all of the partners could attend. S/he thought that lack of leadership contributed to communication problems.

- **Lack of resources** (n=3). Respondents also felt that lack of resources inhibited the partnership from succeeding. Specific reasons cited for needing funding included implementing interventions and hiring staff dedicated to Team Up.

- **Lack of time** (n=2). One respondent's organization received a new grant that was very time consuming and therefore could not dedicate the time to Team Up. S/he had agreed to participate in Team Up prior to receiving this grant.

- **Impact of Hurricane Katrina** (n=2) Respondents noted that their organizations' priorities changed after Hurricane Katrina struck. One respondent stated that after Hurricane Katrina struck, their organization focused on linking cancer patients to medical services.

- **Too much focus on evidence-based interventions** (n=2). Two respondents thought that Team Up focused too much on evidence-based interventions. One respondent felt as though their screening and intervention programs, although not evidence-based, were working for them. She noted that lack of resources prevented them from hiring someone who could document their success. Therefore, she wanted flexibility in using interventions that might not have been evidence-based. Another respondent felt overwhelmed by all of the evidence-based interventions from which they could choose. S/he would have preferred if the National Partners had provided a short, finite list of interventions from which to choose.

Summary

The decision to leave Team Up was not supported by all of the partners. Some respondents do not even believe the partnership has "ended," but rather feel that it has been put "on hold". The majority of respondents have a history of working together and many would like to continue participating in Team Up. The deciding factor in leaving Team Up was the inability to get one of the partners to actively participate in Team Up. That partner stated that s/he was misrepresented, and was never asked whether their organization would like to participate prior to receiving the email that was sent to the Team Up listserv. Other barriers to forming the partnership included lack of communication, lack of time, lack of resources, changing priorities after Hurricane Katrina and too much focus on implementing evidence-based interventions.

Discussion

Both partnerships were at different stages in developing their partnership when they decided to terminate their involvement in Team Up. Illinois had established their partnership, whereas Mississippi was having difficulty getting their partnership off the ground. Illinois' reasons for leaving focused on lack of funding and duplication of efforts, whereas Mississippi's reasons for leaving focused on the inability to establish a working partnership involving all four partners.

The decision to leave Team Up was not supported by all of the partners in either state. Some respondents in both states would have preferred to continue with Team Up, and some are still interested in staying involved with Team Up.

Despite the different experiences of each partnership, there were some similarities in responses in both states. First, neither state partnership had a clearly defined interpretation of the purpose of Team Up. Each respondent gave a different response when asked what the purpose of Team Up was in their view. All respondents focused solely on cervical cancer (not on breast cancer). One individual noted that there was a change in focus from cervical cancer to breast and cervical cancer, but s/he was unsure when that change occurred.

The majority of partners in both states, had a history of working together around reducing cervical cancer mortality rates and plan to continue working together to address this issue. When asked what changes could be made to improve Team Up, respondents in both states thought that providing additional funding would have helped sustain the partnerships.

Lack of time was another issue addressed by respondents in both states. Some respondents had competing priorities (e.g., other job responsibilities) that prohibited them from dedicating the necessary time to Team Up. Other respondents were involved in other initiatives with goals similar to those of Team Up.

Respondents in both states discussed the use of evidence-based interventions. One respondent noted that although the strategies currently used are not evidence-based, they are working. S/he wanted flexibility to use interventions that might not be evidence-based. Other respondents focused on the need for funding if they are expected to implement evidence-based interventions. Another respondent found it overwhelming to pick an evidence-based intervention, and would have preferred if the National Partners selected some interventions from which the state partnerships could choose.

Finally, in both states, there were occurrences beyond the control of the state partnership that contributed to their decision to leave Team Up. In Illinois, a recently enacted state mandate with essentially the same goals as those of Team Up led to a duplication of efforts on the part of the state partnership. In Mississippi, Hurricane Katrina led to changing priorities and the partnership was indefinitely put on the hold. One respondent noted that after Hurricane Katrina struck, her organization was in a "reactive mode" in which their priority shifted to linking cancer patients with medical services. Both of these external factors were seen by the states as impediments to maintaining the state partnership.

APPENDIX

Exit Interview Guide

Exit Interview Guide

Introduction

Thank you for participating in this Exit Interview. We are interested in more fully understanding the reasons why //INSERT PARTNERSHIP HERE// terminated their Team Up activities. In addition, we would like to understand whether there were any changes that could have been made that would have helped the partnership continue in the Team Up program. This interview will last approximately 15 minutes.

Please note that your responses are confidential and any data collected will be reported in aggregate form for the state partnership. All information that may identify individuals or their organizations will be removed. Only Westat project staff will have access to your responses.

I'd like your permission to tape record our conversation so that we do not miss any of your comments—only the research staff at Westat will have access to these tapes. Do we have your permission to tape this interview? Y N

1. When did your organization become a member of the **//insert partnership here//**? (Month, Year)

    a. When did you join your organization?

    b. How long have you worked on the Team Up partnership?

2. In your view, what was the purpose of the Team Up state partnership?

3. We are interested in learning more about your partnership's decision to leave Team Up. Can you please tell me why your partnership decided to leave Team Up?

4. Did your organization support the partnership's decision to leave Team Up? Why or why not?

5. Can you please tell me 2-3 things that worked well for //insert partnership here// in Team Up?

6. Can you please tell me what 2-3 things did not work well for //insert partnership here// in Team Up?

7. What would have made it easier for your partnership to continue to participate in Team Up?

8. We've discussed a number of the challenges your partnership has faced and what might have made it easier to continue participating in the project. Thinking along those lines, what do you think could have been done differently if this program were to go beyond a pilot program?

9. Is there anything else you would like to add?

Appendix W

Summary of Evidence-Based Interventions

Intervention components	The Forsyth County Cancer Screening Project (FoCaS)	Breast cancer screening among non-adherent women	Filipino women's health project
Program	The Forsyth County Cancer Screening Project (FoCaS) was designed to improve beliefs, attitudes, and screening behaviors of women age 40 years and over who resided in low-income housing communities in two North Carolina cities. The program's ultimate goal was to improve the rate of breast and cervical cancer screening among low-income, predominately African-American, women age 40 and older. Public health clinic in-reach strategies included the implementation of chart reminders, exam room prompts, in-service meetings, and patient-directed literature. Community outreach strategies include educational sessions, literature distribution, community events, and church activities. The intervention has its basis in the PRECEDE/PROCEED model for planning, the Health Belief Model, Social Learning Theory, and the PENII model (cultural appropriateness and sensitivity).	The program is designed to address some barriers to mammography screening and to identify strategies for motivating women to have regular mammograms. The program is guided by the Stages of Change Model, which explains the process of change for either acquiring or eliminating a particular behavior. The intervention compared the effectiveness of a Tailored Telephone Counseling (TTC), Tailored Print Communications (TPC), and Usual Care (UC). Researchers expected that women who received either TTC or TPC would have higher mammography screening rates than women who received the usual care messages about mammography from their health maintenance organization.	The program aims to increase breast and cervical cancer screening among Filipino women by combining elements from the Health Belief Model, the Theory of Reasoned Action/Planned Behavior, and the Precede Model. Women are made aware of screening guidelines for breast and cervical cancer, that age and length of stay in the United States are risks factors for developing cancer, and that screening procedures are critical to early detection and successful treatment. Individual barriers, such as cost, fear of radiation and of finding cancer, and embarrassment are discussed and women who have undergone cancer screening provide peer support and peer norms. Drawing on the cultural values of collectivism, inter-dependence, and community – common among many Asian groups – the importance of staying healthy to enjoy life and take care of family members and friends is emphasized.
Program Focus	Awareness building	Motivation	Awareness building
Population Focus	Underserved women	Under-screened women	Underserved women
Intervention Mode	Multicomponent intervention using media, education, and enhanced access	One-to-one education using tailored strategies	Group education
Purpose	Designed to improve the beliefs, attitudes, and behaviors regarding breast and cervical screening among low-income, predominately African-American, women age 40 and older.	Designed to address barriers to mammography screening and to identify strategies for motivating women to have regular mammograms.	Designed to increase breast and cervical cancer screening among Filipino women.

Intervention components	The Forsyth County Cancer Screening Project (FoCaS)	Breast cancer screening among non-adherent women	Filipino women's health project
Time Required	FoCaS is a multifaceted intervention and was implemented in four phases over a four year period. Time requirements will vary when replicated based on the activities selected to be implemented. Community outreach activities include parties held at the housing community centers, church programs, media campaigns, monthly classes held in the housing community centers, the sending of mails, and one-on-one educational sessions delivered in the home. Public health clinic in-reach activities include in-service and primary care conference trainings for providers, educational games to teach exam skills, distribution of literature in the waiting rooms, and one-on-one counseling sessions and personalized follow-up letters for women with abnormal test results.	The average time for a telephone call is 6 minutes. One to three calls were made over a three year period.	The group sessions last between 60 and 90 minutes.
Intended Audience	Participants were women age 40 years and older, predominantly African-American, and residing in low-income housing communities in Winston-Salem and Greensboro, North Carolina.	Study participants were women ages 50 - 80 years who had been identified through medical records as having had two or fewer mammograms in a 36-month period.	Participants were Filipino women over 40 years of age from nine community based organizations and six churches in Los Angeles County.
Suitable Settings	Community outreach activities are implemented in community centers, individual homes, and community churches. Public heath clinic in-reach activities are implemented in the clinics' waiting and exam rooms.	TTC can be implemented over the telephone to the homes of the participants. TPC materials can be sent to participant homes.	This intervention is suitable for implementation in community-based organizations, churches, or private homes.

Intervention components	The Forsyth County Cancer Screening Project (FoCaS)	Breast cancer screening among non-adherent women	Filipino women's health project
Required Resources	Required resources include educational brochures, posters, church flyers, class outlines for monthly sessions and educational classes and birthday cards. Mass media techniques such as public bus ads, newspaper and radio ads can also be utilized. Costs associated with the program's implementation are not provided.	The Mammography Telephone Counseling Protocol is required. It included three sections: Brief description of mammography and a stage-related section which assessed the woman's stage of mammography readiness. 2. Selection devoted to identifying and overcoming a woman's barriers to getting a mammogram, and 3. Section on respondent's perceptions about their risk for breast cancers, appropriate screening intervals, and the importance of the clinical breast exam.	The curriculum for the intervention session is required, as are delivery agents who are fluent in both English and Tagalog. Take-home packets, in English and Tagalog, should include a list of local facilities where free mammograms and Pap smears are available. No cost information is available. For the study, participants were given tote bags with the study's logo, personalized certificates of completion, and traditional Filipino snacks. Two brochures were used in the intervention that can be acquired from the publishers: "A Mammogram Saved My Life" from Education Programs Associates, Inc., 1 West Campbell Avenue, Suite 40, Campbell, CA 95008, (408) 374-3720. "What You Need To Know About Your Pap Exam" from Krames Health and Safety Education, www.staywell.com.

Intervention components	The Forsyth County Cancer Screening Project (FoCaS)	Breast cancer screening among non-adherent women	Filipino women's health project
Intervention Components	The community based interventions included: "Women's fest" (a free party held in the community); Church program; Educational brochures; Mass media techniques; Monthly classes conducted by a health educator; Birthday cards with the FoCaS logo; Targeted mailings and door knob hangers with invitations to events; and One-on-one educational sessions in women's homes. The clinic-focused activities included: In-service and primary care conference training for health care providers; Visual prompts in the exam room; Educational games; An abnormal test protocol; Posters and literature for distribution in the waiting room; and One-on-one counseling sessions and personalized letters for follow-up testing for women with abnormal test results.	Intervention for women included: Breast cancer screening telephone counseling protocol. What you need to know about breast cancer screening (Tailored brochure) Mammogram appointment reminder (Tailored material) Mailing envelope (Tailored material) Mailing envelope for thank you letter at end of study Intervention for physicians/counselors/monitors included: Summary of patient barriers to screening Women's health advisor check list for counselors Women's health advisor telephone counseling checklist for monitors Women's health advisor project fact sheet	Take home packets for women included: Tote bag One brochure for mammography, and One brochure for Pap test.

Team Up intervention	Program	Program focus	Population focus	Intervention mode	Purpose	Time required	Intended audience	Suitable settings	Required resources	Intervention components
The Forsyth County Cancer Screening Project (FoCaS)	The Forsyth County Cancer Screening Project (FoCaS) was designed to improve beliefs, attitudes, and screening behaviors of women age 40 years and over who resided in low-income housing communities in two North Carolina cities.	Awareness building	Underserved women	Multicomponent intervention using media, education, and enhanced access		Designed to improve the beliefs, attitudes, and behaviors regarding breast and cervical screening among low-income, predominately African-American, women age 40 and older. FoCaS is a multifaceted intervention and was implemented in four phases over a four year period.				

Team Up intervention	Program	Program focus	Population focus	Intervention mode	Purpose	Time required	Intended audience	Suitable settings	Required resources	Intervention components
	The program's ultimate goal was to improve the rate of breast and cervical cancer screening among low-income, predominately African-American, women age 40 and older. Public health clinic in-reach strategies included the implementation of chart reminders, exam room prompts, in-service meetings, and patient-directed literature.					Time requirements will vary when replicated based on the activities selected to be implemented. Community outreach activities include parties held at the housing community centers, church programs, media campaigns, monthly classes held in the housing community centers, the sending of mails, and one-on-one educational sessions delivered in the home.				

Team Up intervention	Program	Program focus	Population focus	Intervention mode	Purpose	Time required	Intended audience	Suitable settings	Required resources	Intervention components
	Community outreach strategies include educational sessions, literature distribution, community events, and church activities. The intervention has its basis in the PRECEDE/PROCEED model for planning, the Health Belief Model, Social Learning Theory, and the PENII model (cultural appropriateness and sensitivity).					Public health clinic in-reach activities include in-service and primary care conference trainings for providers, educational games to teach exam skills, distribution of literature in the waiting rooms, and one-on-one counseling sessions and personalized follow-up letters for women with abnormal test results.				