DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Health Promotion and Disease Prevention Section

Evaluation Plan Proposal for Delaware's Comprehensive Cancer Control Program

Delaware Department of Health and Social Services
Division of Public Health
Health Promotion and Disease Prevention Section
Chronic Disease Bureau

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Appendix

Executive Summary

This document is the proposed evaluation plan for the State of Delaware's Comprehensive Cancer Control Plan. Cancer Control in Delaware is composed of initiatives and programs supported through funds from the Centers for Disease Control and Prevention (CDC) and in large part with resources allocated through the Delaware Health Fund. The Delaware Cancer Consortium provides guidance and strategic leadership to cancer prevention, early detection and treatment services. The Division of Public Health (DPH) is responsible for the administration and oversight of all cancer control activities.

The evaluation strategy in this plan is based on Rossi's systematic approach to evaluation (Rossi, Lipsey, & Freeman, 2004) and is consonant with key conceptual frameworks promulgated by CDC (USDHHS) and leading evidence-based or evidence-informed practices. In accordance with grant requirements, a final evaluation plan for the implementation phase of the cancer plan will be submitted to the Centers for Disease Control and Prevention in July 2006.

This evaluation plan proposal consists of these major sections:

- Description of Comprehensive Cancer Control Program Components
- Evaluation Overview
- Process Evaluation Methodology
- Impact Evaluation Methodology
- Evaluation Dissemination Plan
- Recommendations

Delaware's Comprehensive Cancer Control Program

A. Cancer Burden in Delaware (Bureau of Chronic Disease, 2006)

Cancer is the second leading cause of death in Delaware and in the nation. A total of 20,793 cancer cases were diagnosed among Delaware residents during 1999–2003, 10,850 cases (52.2 percent) in males and 9,943 (47.8 percent) in females. The five-year average age-adjusted all cancer incidence rate among males (594.4 per 100,000) is more than one-third higher than that among females (439.7 per 100,000) in 1999–2003.

Eighty-two percent (17,095) of cancer cases in 1999–2003 are White, 14.8 percent (3,072) are African American, 1.1 percent (219) are Other, and 0.9 percent (196) are Unknown Race. In addition, Hispanic cancer cases account for 1.0 percent (211) of the total incidence cases. Overall, African American Delaware residents have a higher all cancer incidence rate (539.8 per 100,000 in 1999–2003) than do White residents (493.4 per 100,000). Incidence rates among African American males and females are 20.3 percent higher and 1.0 percent lower, respectively, than their White counterparts.

The all cancer incidence rate has declined among the population of Delaware. The rate among males declined 11.2 percent since 1990–1994, whereas the rate among females remained relatively stable during the same time period. The rate decline in cancer among Whites (3.7 percent) since 1990–1994 is less than half that of African Americans (13.2 percent) over the same time period. Delaware's 1999–2003 overall cancer incidence rate is 5.3 percent higher than the U.S. estimate.

During 1999–2003, 8,466 Delaware residents died from cancer; 51.8 percent (4,388) were male, and 48.2 percent (4,078) were female. Overall cancer mortality in 1999–2003 was about 46 percent higher among Delaware males (256.1 per 100,000) than among females (174.9 per 100,000). Whites made up 82.8 percent (7,010) of decedents, African Americans made up 15.5 percent (1,312), 63 decedents were of Other, and 1.0 percent (81) were Hispanic. The overall cancer mortality rate was 25 percent higher among African American (250.6 per 100,000) than among White residents (200.3 per 100,000) during 1999–2003. All cancer mortality in Delaware declined by 18 percent from 1990–1994 to 1999–2003,

B. Demographic Characteristics of Delaware

According to the 2004 American Community Survey conducted by the U.S. Census Bureau, the population of Delaware is 805,421. This survey is limited to household population and excludes the population living in institutions, college dormitories and other group quarters. This survey reveals that the median age is 37.5 years with 103,986 individuals being aged 65 or older. With respect to race, Delaware is predominately White with 75.5% of the population, or 612,417 individuals, reporting their race as White only; followed by 19.8% of the population, or 159,870 individuals, reporting their race as Black or African-American. With respect to ethnicity, 5.9% of the population or 47,526 individuals reported being of Hispanic or Latino descent. Delaware has both rural and urban population centers. The 2000 census data show that 19.9%, or 155,842, of the state's population of 783,600, resides in rural areas.

C. Background and Description of the Delaware Cancer Consortium

In response to Delaware's high cancer incidence and mortality rates, Delaware Governor Ruth Ann Minner appointed a 15-person advisory council in 2001. The Delaware Advisory Council on Cancer Incidence and Mortality (Advisory Council) was charged with advising the Governor and the Delaware Legislature on the causes of cancer incidence and mortality and potential methods for reducing both.

The Advisory Council began meeting with a shared understanding that its work would be focused on developing a clear and usable cancer control plan. Another priority was to obtain extensive input from professionals in cancer control, as well as from citizens affected by cancer. With these priorities in mind, the Advisory Council worked on developing a system to create a shared awareness and agreement on the range of cancer control issues to be addressed now and in the future, create a structure and agenda for addressing those needs, and enable Delaware to move forward with meaningful action.

The Advisory Council heard from experts, including Dr. Jon Kerner from the National Cancer Institute, as well as from cancer survivors or family members with loved ones impacted by cancer. The Advisory Council also initiated Concept Mapping to get input on cancer issues from citizens, medical and public health professionals and to help establish priorities for the its upcoming scope of work. Two-hundred Delawareans participated in the brainstorming phase, at which time they offered their ideas on completing the statement, "A specific issue that needs to be addressed in comprehensive cancer control in Delaware is…." More than 500 statements were submitted. To avoid duplication, the statements were then edited to 118 ideas about controlling cancer in Delaware. These ideas were then rated, relative to each other, on importance and feasibility.

The results of the Council's Concept Mapping work, plus the information gleaned from numerous speakers, helped the Council develop a clear set of priorities and establish seven subcommittees to address the issues. These seven (7) committees are: Insurance; Colorectal Cancer; Tobacco; Quality; Public Education; Environment; and, Disparities. Chaired by a Council member, each subcommittee was given the list of priorities in its focus area. The subcommittees then made specific recommendations to accomplish those goals.

Delaware's early establishment of the Health Fund from the Tobacco Settlement greatly expanded the state's capacity to fund cancer treatment and prevention programs. Currently, Delaware is one of four states that are at or above the CDC minimum recommended funding level for tobacco prevention and control programs. In Year One of implementation, the legislature allocated $4.84 million, followed by $9.52 million in Year Two and $12.24 million in Year Three. Approximately $14.6 million has been requested for Year Four (FY2007).

The keys to the success of the Delaware Cancer Consortium (DCC) have been:

- Political support from Governor Ruth Ann Minner and the Delaware General Assembly
- Substantial state funding provided through the Delaware Health Fund
- Legislative mandate to create a permanent DCC
- A broad DCC membership – 60 individuals with DPH staff support
- Clear and concise plan with feasible goals based on input from hundreds of Delawareans
- Evaluation of cancer plan-initiated programs and activities

Table 1. Comprehensive Cancer Control Timeline							
	1997	2001	2002	2003	2004	2005	2006
Screening for Life (SFL) Program Implemented (Breast & Cervical)	◆						
DE Advisory Council on Cancer Incidence and Mortality Formed		◆					
Screening for Life (SFL) Program expanded to include Colorectal Cancer Screenings			◆				
Turning Commitment into Action – the state's Comprehensive Cancer Control Plan is released			◆				
CDC Funding for Planning				◆			
Delaware Cancer Treatment Program (DCTP) Implemented					◆		
Colorectal Cancer Screening Coordination/Advocacy Program Implemented					◆		
Year One Accomplishments Report Released					◆		
Champions of Change Toolkit Implemented					◆		
CDC Funding for Implementation						◆	
Cancer Care Coordination Program Implemented						◆	
Year Two Accomplishments Report Released						◆	
Evaluation Proposal Submitted to the CDC							◆

D. Division of Public Health - Comprehensive Cancer Prevention and Control Branch

Delaware's Department of Health and Social Services, Division of Public Health (DPH), Comprehensive Cancer Control Branch is responsible for planning, implementing, evaluating, budgeting, and reporting for Cancer Advisory Council recommendations. DPH provides administrative support for the DCC.

The DPH Comprehensive Cancer Prevention and Control Branch received implementation funding in FY 2006 as a result of meeting or exceeding expectations for the six (6) building blocks of Comprehensive Cancer Control Planning. These six include: enhancing the infrastructure, building partnerships, utilizing data and research findings, assessing the cancer burden, mobilizing broad-based support, and conducting evaluation. By developing a strong evaluation strategy, Delaware will be able to secure the data needed to increase effectiveness, increase participation, and build more support for its programs. DPH proposes herein a robust array of strategies for assessing the effectiveness of its Comprehensive Cancer Control Plan.

E. Delaware Cancer Plan

The Delaware Cancer Plan was developed in April 2002 in a report titled *Turning Commitment Into Action*. The report contained 26 specific recommendations to lessen the cancer burden in Delaware. Those recommendations were grouped in the following categories:

- Increase screening for and early detection of colorectal cancer
- Provide the highest quality of care for every Delawarean with cancer
- Pay for cancer treatment for the uninsured
- Provide reliable and usable cancer information
- Reduce the threat of cancer from the environment
- Increase our knowledge about cancer including environmental causes
- Reduce tobacco use and exposure
- Eliminate the unequal cancer burden borne by minorities and the poor

The cancer plan and yearly accomplishment reports can be found at http://www.dhss.delaware.gov/dhss/dph/dpc/consortium.html.

I. Evaluation Overview

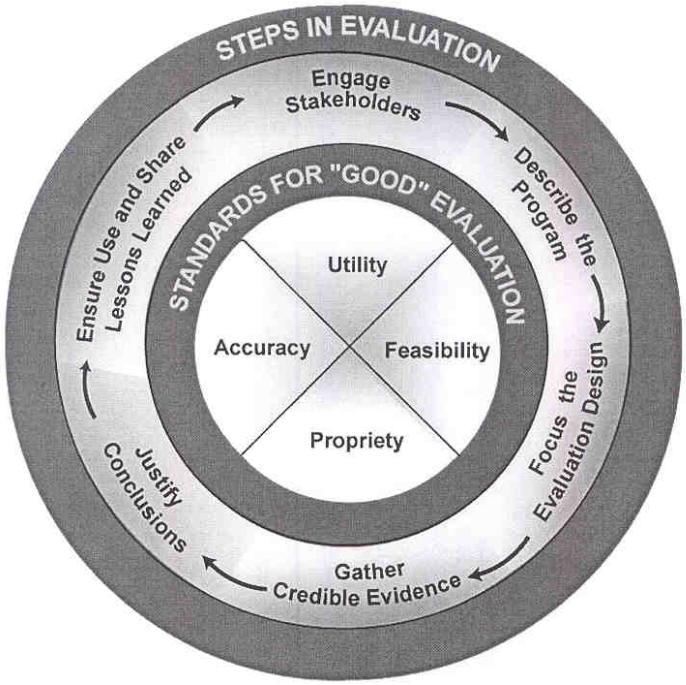
A. Primary Evaluation Paradigm

The evaluation paradigm selected for this proposal is that proposed by Peter H. Rossi et al which is as follows "…a social science activity directed at collecting, analyzing, interpreting, and communicating information about the workings and effectiveness of social programs." Rossi notes these important reasons for conducting evaluative research:

- aid in decisions concerning whether programs should be continued, improved expanded, or curtailed;
- assess the utility of new programs and initiatives;
- increase effectiveness of program management and administration; and,
- satisfy the accountability requirements of program sponsors.

Rossi also posits that evaluation may assess program outcomes, describe the degree to which a program is needed, and examine its design, operation, or efficiency. This proposal incorporates all of these aspects. Delaware intends to carry out a practical, dynamic evaluation process that will "…provide answers to questions about a program that will be useful and actually used."[1] This approach is consonant with the Centers for Disease Control and Prevention's evaluation framework [2] which is depicted below in Figure 1.

Figure 1. CDC Prevention Evaluation Framework



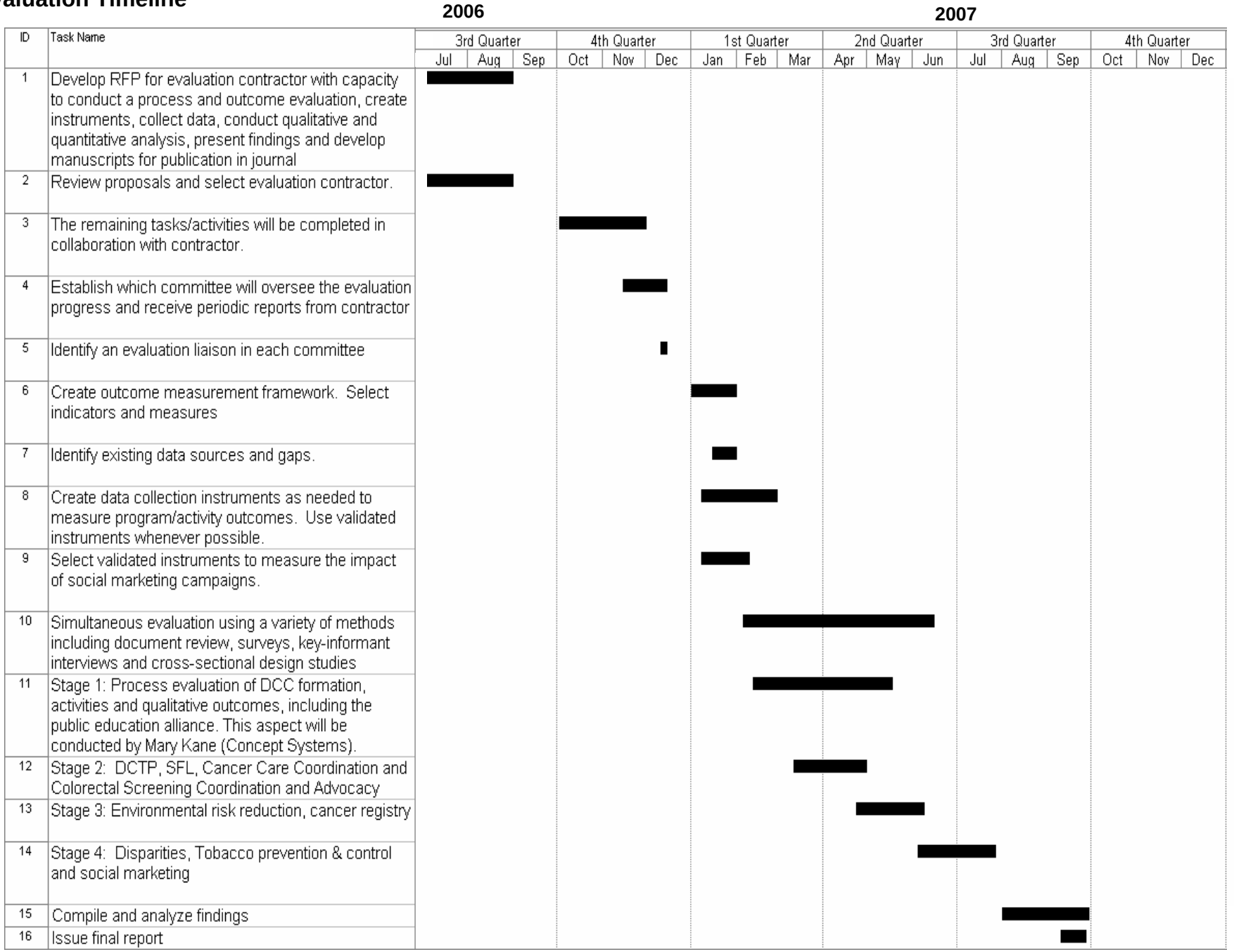
Other influential thinkers in evaluation have also informed this proposed evaluation strategy. Because the Delaware Cancer Consortium's work involves population-based interventions as well as individual clinically-oriented interventions, and targets complex issues, Delaware proposes to draw upon the Community Risk Estimation model (Rossi et al., 2004) espoused by Harriet H. Imrey, PhD as included in Gilmore and Campbell's text on Needs and Capacity Assessment Strategies. Timmreck's practical tools and strategies for planning and evaluating health promotion services are also noted in this proposal. Specifically, the variables to determine program effectiveness and efficiency suggested by Timmreck are directly referenced in the Section III.

B. Other Relevant Frameworks for this Evaluation Plan Proposal

Delaware seeks to utilize evidence-based or evidence-informed practices and approaches as well as models widely acknowledged as "Best Practice" to the greatest degree possible. To this end, both the CDC Building Blocks for Comprehensive Cancer Control Planning (Centers for Disease Control and Prevention, 2002) and Logic Models (*Logic Model Development Guide: Using Logic Models to Bring Together Planning, Evaluation, and Action*, 2004) are incorporated in this plan. The Logic Models will be a central focus for interpretation of evaluative data. The qualitative analysis for the Consortium will be tied back to the CDC Building Blocks. Further, several states which have already evaluated their respective comprehensive cancer control plans were consulted directly and personally by members of the evaluation plan proposal team. Additionally, resources such as Cancer Control PLANET (*cancerplanet.org)* were tapped in order to access pertinent models.

The precise way in which these building block milestones were reached is depicted in the following Evaluation Timeline.

C. Evaluation Timeline



II. Process Evaluation Methodology

A. Process Evaluation Questions

Delaware proposes using these seven (7) primary evaluation domains (Timmreck, 2003), augmented by an eighth domain created by DPH to elicit process outcomes. Note that the actual phrasing of the questions may differ because the cancer control programs subject to this proposed evaluation are systems, not direct clinical services.

1. **Availability**
   a. Can the clients or patients get to the service [note: education or advocacy efforts will be understood to be included as "service"] or program when they need it or desire it?
   b. Geographically, are enough services being offered for those who want to attend or participate?
2. **Accessibility**
   a. Can the client or patient use the program that is offered?
   b. Is the cost reasonable and can the participant get transportation to the service?
   c. Are there barriers to getting to the service?
3. **Quantity**
   a. Are the services or programs being offered often enough and in enough places to accommodate those who wish to participate?
4. **Quality**
   a. Are the services provided at the highest level that can be offered in all aspects of the service or program?
5. **Cost**
   a. Do the costs, charges, or insurance reimbursements allow the client or patient to access the service?
   b. Are the charges reasonable?
6. **Acceptability**
   a. Are the services or programs of the type, nature, and quality to satisfy the participants?
   b. Are the services offered on a regular basis and in a timely fashion?
   c. Is waiting time reasonable or are there long lines?
   d. Are appointments available without waiting a long time?
   e. How satisfied with the service or program are the participants?
7. **Continuity**
   a. Does the program have succession and ongoing services that build one on the other?

DPH plans to augment these domains with the following essential utilization questions:

1. Who is eligible for the programs?
2. Who is utilizing the programs?
3. Are those individuals at greatest risk for cancer accessing the programs?

4. If not, why?
5. Are there any patterns (geographic, income, other) that are associated with under-utilization of programs?

These are the secondary evaluation questions:

1. Should the program be enhanced?
2. Should the program be expanded?
3. Should the program be curtailed?
4. What, if anything, should be developed (or eliminated) in order to maximize program effectiveness?

B. Process Qualitative Analyses

At its core, process evaluation answers these two fundamental questions: 1) was the program implemented as designed?; and, 2) is it serving the target population? A variety of qualitative methods are anticipated in order to elicit meaningful data, especially with respect to cultural competency, client satisfaction and various aspects of the Consortium's operations. Case studies will be employed to examine certain programs depending on their degree of development. The case study is a form of qualitative research that is used to provide a complete and holistic view of a program. Case studies generally involve the use of multiple methods to collect different kinds of information. Triangulation, which refers to using different methods of collecting information, adds to the validity of case studies since findings are based on varied information sources (Hammel, 1993). Delaware proposes to use a "Multiple Case, Replication Design" (Yin, 1994).

The one aspect of the overall Comprehensive Cancer Control Program that merits significant attention in the evaluation is the Delaware Cancer Consortium. The hypothesis which will be examined is that collaborative partnerships create synergies and results that are otherwise unobtainable.

C. Qualitative Analysis of the Consortium

Strategically developed partnerships across multiple organizations, each of which brings important resources and relationships to bear on an issue, are needed to take on complex, persistent challenges such as cancer prevention and control. Delaware Cancer Consortium has chosen to pursue a collaborative approach to cancer control. Delaware has sought out examples of tools used by other states to assess these and related variables.

It is proposed that evaluation planning and conduct, focusing on the functioning of the Consortium and the projects it has developed, will use a mixed methods approach. To ensure an appropriate level of inquiry and triangulation of findings, web-based surveys, structured interviews, observations of meetings, and document review will be conducted. Our goal is to ensure that the evaluation is evidence-based and includes

both process and progress measures that reflect the Consortium's goals as articulated over the past three years.

The evaluation will contain several “units” of inquiry: the committees of the Consortium and the Council as an operating entity. The following steps are proposed for the evaluation of the Consortium:

1. Develop a Process Model framework for the evaluation. The process model will provide an overview of the relationship of Council activities to date to desired outcomes, and will assist the Council in understanding progress thus far toward the outcomes of burden reduction. It will link committees’ efforts to the distal outcomes of improvement in health status related to cancer in the State. The process model will be based on Logic Models (see Section III).
2. Create criteria for assessment. The model will enable efficiency in evaluation planning and conduct by acting as a template upon which agreed-upon criteria for assessment will be developed, and by linking information sources to the criteria to be used. Categories of assessment may include leadership, operational functioning and progress of the Council and its committees, as well as process or approval indicators regarding programs that are linked to the Consortium.
3. Review documents to assess committee processes and initiatives, and consider (identify?) indicators of progress or achievement. Documents may include task force output, charges and expected outcomes. Specific programs of the Committees will be considered, to provide input for interviews and surveys that will follow.
4. Conduct interviews with each Committee Chairperson and other identified leaders, to assess the scope of influence the Council has had to date. It is proposed that key themes from the document review, above, will frame and inform the interview protocol (and instrument?). A 360-degree-like approach will be taken with the interviews, to enable leaders to comment not only on the work of their own group or area of interest, but also regarding their awareness of the work of other committees. Interviews will focus on expectations, achievements, unmet objectives and unplanned achievements or progress.
5. Deploy a web-based survey, customized to collect data from members of cancer committees and/or program audiences; analyze responses to evaluate committee program output such as Champions of Change and other current programs.
6. Conduct data integration and analysis to support reporting on the units that will have been prioritized by the DPH in the evaluation planning discussions.
7. Report to the Council.

D. Media Evaluation

One cross-program evaluative function that should be evaluated is the social marketing effort that was/is associated with all program areas. The theoretical framework for

interpretation of this part of the evaluation is McGuire's "Communication for Persuasion" (McGuire, 1984) for interventions targeting individuals and "Diffusion of Innovations Theory" for community level impact. The CDCynergy Social Marketing educational guide (Centers for Disease Control and Prevention, 2006) was consulted to help inform the approach to this programmatic element. According to the CDSynergy, Social Marketing Guide:

> Basic evaluation questions for the media campaign include:
>
> 1. Was fidelity to the intervention plan maintained?
>
> 2. Were exposure levels adequate to make a measurable difference?
>
> 3. Were behavioral determinants affected by intervention components as predicted?
>
> 4. Did the determinants, in turn, affect behavior as predicted and desired (i.e., was the internal logic of the intervention valid)?
>
> 5. Can the observed effects be attributed to the intervention?
>
> 6. Were there any unintended effects?

III. Outcome Evaluation: Logic Models, Areas of Focus, Goals and Objectives, and Key Evaluative Questions by Program and Committee of the Delaware Cancer Consortium

A. Delaware Cancer Consortium

1. Logic Model

Inputs	Activities		Systemic Outcomes
• Leadership from Governor Minner and her administration by making cancer incidence and mortality reduction a priority in her administration	• Mobilize support, form and maintain a consortium	→	System changes to support priorities of DCC in member organizations
• Support of Delaware State legislature by allocating funding toward cancer, Year 1 $4.84 million; Year 2 $10 M; Year 3 $13.27million; Year 4 $15.103 million	• Develop strategic priorities through the formation of seven committees: colorectal cancer, quality, environment, disparities, public education and data, insurance and tobacco	→	Cross-cutting partnerships between different sectors of government, private and public sectors to achieve the goal of reducing the cancer burden in Delaware
• Delaware Advisory Council on Cancer Incidence and Mortality with appointment of Mr. William Bowser as Chair	• Create the Delaware cancer plan in the form of a Green Book composed of twenty-six recommendations		
• Creation of the Delaware Cancer Consortium with representation from the State Legislature, private	• Assess the burden of cancer on Delawareans	→	Increased public education and awareness through a public education alliance

Inputs	Activities		Systemic Outcomes
sector, hospitals and physicians, advocacy organizations and public health			
• CDC funding and pre-existing programs such as Screening for Life	• Create relationships with medical providers, nurses, health systems, federally qualified health centers, community clinics and hospitals	→	Government leadership and support for cancer prevention, screening, early detection and treatment
• Leverage the support and strategic guidance of the Comprehensive Cancer Prevention and Control program within the Division of Public Health	• Partner with state agencies such as Department of Natural Resources and Environmental Control (DNRC) and Department of Education	→	Institutionalized funding for cancer screening, prevention and treatment into base state budget
• Support of Delaware residents	• Form alliances with community and faith-based organizations	→	Coordination and integration of resources and elimination of duplication
	• Develop innovate and culturally and linguistically competent programs and effectively use pre-existing evidence-based programs for colorectal cancer early detection and screening, cancer care coordination, environmental risk reduction, tobacco cessation and control, payment for cancer treatment and initiatives to reduce and eliminate cancer disparities		Focused attention, resources and activities toward elimination of health disparities

Inputs	Activities	Systemic Outcomes
	• Examine and optimize the use of the state registry • Develop infrastructure and enhance the capacity of community and faith-based organization to educate and enhance public awareness • Make data-driven decisions by analyzing existing sources of population-based local, state and federal data • Compile data findings into comprehensive and credible reports on cancer incidence, mortality, disparities, retrospective examination of cancer cases and self-reported screening practices • Compile lessons learned and best practices for systemic changes and collaborative initiatives • Evaluate activities of DCC and publish findings in state medical journal and national peer-reviewed journals	Achievement of twenty-six recommendations Unanticipated outcomes and synergy from collaborative approach developed and sustained by the DCC Reduction in cancer incidence and mortality

2. Domains, Goals & Objectives and Evaluative Questions

Domain	Goals & Objectives	Key Evaluative Questions
A1. Case Study	Describe the evolution of the Consortium Describe the social capital of the Consortium	How was it formed? How was it maintained? Did it grow, why or why not? How can we estimate the social capital of the consortium?
A2. Synergy	Delineate the added value to participants for participation in the Consortium	Did the number of opportunities to provide new services increase? Did the number of partnerships developed increase? Did revenues of medical providers increase, e.g., implementation of DCTP, expansion of SFL? Did costs decrease because duplications of efforts in an organization were reduced or eliminated?
A3. Effectiveness	Measure the effectiveness of the Consortium across several domains (to be determined)	To what degree were Consortium goals met? To what degree did you feel your input was solicited? How well did you feel your input was incorporated?
A4. Leadership	Ascertain Consortium participant views of the nature and impact of the Consortium's leadership	Were clear goals set for committee meetings? Were timeframes kept for meetings? Were committee members routinely apprised of the Consortium's progress?

B. Insurance Committee

1. Logic Model

Delaware Cancer Treatment Program (DCTP)

Planned Work ***Intended Results***

			Outcomes		
Inputs	**Activities**	**Outputs**	**Initial**	**Intermediate**	**Longer-term**
In order to accomplish our activities we need the following:	*In order to achieve the program goals we will take the following actions:*	*We expect that once achieved these activities will produce the following evidence/service delivery:*	*We expect that if the program meets target goals it will lead to the following changes within 1-2 years:*	*We expect that if the program meets target goals it will lead to the following changes within 3-5 years:*	*We expect that if the program meets target goals it will lead to the following changes within 6-10+years:*
• Financial resources from the Delaware legislature in the amount of $5 million • Tangible support from State leadership (Governor Minner and Lt. Gov. Carney) • Leadership, guidance and	• Develop eligibility criteria to qualify for treatment • Create linkages with the medical community to increase awareness and promote the program among providers	• Provision of treatment coverage for eligible Delawareans • Through collaborative agreements clients will receive high quality cancer treatment care at institutions in Delaware and surrounding areas.	• 170 clients will be enrolled in DCTP in the first year of which 30% will be clients of African-American race and/or Hispanic ethnicity • 10% increase in the number of providers who enroll in DMAP to serve clients	• 200 clients will be enrolled in DCTP in the second and third year of which 35% will be clients of African-American race and/or Hispanic ethnicity • 5% decrease in cancer expenditures per person served and cancer type compared to	• 100% of Delawareans diagnosed with cancer who meet eligibility guidelines will have DCTP coverage for the length of their cancer treatment • 40% of clients served under DCTP will be of minority

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
strategic direction from the Delaware Cancer Consortium (DCC) Chair, Advisory Council, Division of Public Health and Insurance Committee of DCC • Cancer Director • Chronic Disease Epidemiologist • DCTP staff member • Consumers-residents of Delaware living with cancer • Medical providers • External technical assistance from contractor •	• Develop integrated media campaigns that target African-Americans and Hispanics • Create promotion, education and enrollment materials in Spanish • Contract with a vendor to create a data/fiscal electronic management system • Train program staff to understand eligibility criteria and process applications • Train staff to interact with potential patients in a culturally and linguistically	• Clear and comprehensive eligibility guidelines • Payment structure that mirrors the Delaware Medicaid program • Documented interpretive guidance • Data dictionary • Provider policies and procedures for Delaware Medical Assistance Program (DMAP) providers • Regional arrangements with Medicaid for enrollment of DMAP providers beyond Delaware borders • Standard periodic reports to DHSS • Monthly data transfer from EDS to use for analysis	under DCTP • 20% of clients enrolled in the program will report that family members have received age-appropriate cancer screening tests • 75% of clients no longer eligible for DCTP will have Medicaid coverage or other source of insurance secured upon completion of one year eligibility • 75% of clients will report that the quality of services provided through DCTP were excellent • 80% of clients actively enrolled in DCTP will receive cancer	previous two years due to more clients seeking care in earlier stage of disease • 10% decrease in cancer related mortality among African-Americans in Delaware • 50% of clients enrolled in the program will report that family members have received age-appropriate cancer screening tests • 90% of clients will report that the quality of services provided through DCTP was excellent • 95% of clients no longer eligible for DCTP will have Medicaid coverage or other source of insurance	ethnic/racial status • Cancer related mortality among African-Americans in Delaware will be equal to that of Whites • 10% decrease in cancer expenditures per person served per cancer type compared to previous five years due to more clients seeking care in earlier stage of disease • 100% of clients will report that the quality of services provided through DCTP was excellent • 100% of clients no longer eligible for DCTP will have

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
	appropriate manner • Hire and train bilingual/bicultural enrollment staff • Monitor quality assurance • Manage fiscal expenditures by cancer, month and charges • Report program expenditures to Division leadership • Forecast potential declines/increases in enrollment or expenditures • Develop procedure to link clients into medical care who no longer qualify for payment through DCTP after one year	• Average cost of cancer treatment by type and stage • Clear and comprehensive procedure to transfer clients to Medicaid for more complete medical coverage after the end of DCTP coverage • Data findings that add to the body of knowledge surrounding cancer staging, standard of care and cost utilization • Nationally recognized model for cancer treatment • Sustainability plan that considering alternative funding mechanism (e.g. reinsurance option)	treatment consistent with accepted standards of care • 90% of clients enrolled in DCTP will have accurate and up-to-date data in the DE Cancer Registry • 15% of clients enrolled in DCTP will have received services through Screening for Life	secured upon completion of one year • 95% of clients actively enrolled in DCTP will receive cancer treatment consistent with accepted standards of care	Medicaid coverage or other source of insurance secured upon completion of one year eligibility • 100% of clients actively enrolled in DCTP will receive cancer treatment consistent with accepted standards of care

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
	of eligibility • Follow-up with patients enrolled in program to determine level of satisfaction with medical care and administrative process • Manually adjudicate claims when necessary • Write new rules and make modifications to the electronic system so more claims will process for payment electronically • Develop stop gap measures for clients who qualify for Medicaid but whose eligibility has not yet been activated				

2. Domains, Goals & Objectives and Evaluative Questions

Domain	Goals & Objectives	Key Evaluative Questions
B1. Enrollment system	Determine how well the enrollment system works. Enrollment of disparate or higher risk populations Provider participation in DMAP Enrollees receive care according to accepted standards of care Enrollees are reflected in Cancer Registry	Are qualified applicants denied access to the program? Are any eligible populations significantly under-represented as enrollees? Are benefits of the program properly explained to enrollees? How many days does it take to receive introductory materials? What is % utilization? What are characteristics of those who enroll in DCTP but who do not access services?
B2. Billing and payment system	Determine how well the billing system works. Determine how well the payment system works.	What is average number of days between service utilization and billing? What is average number of days between submission of bill and payment? What is percentage of disputed bills? What types of billing errors occur? What is % accuracy of billing data?
B3. Client Satisfaction	Define how well satisfied clients are with major aspects of the DCTP.	CSQ1 How would you rate the quality of service received? CSQ2 Did you get the kind of service you wanted? CSQ3To what extent has DCTP met your needs? CSQ4 If a friend were in need of similar help, would you

		recommend the DCTP to him or her? CSQ5 How satisfied are you with the amount of help you have received? CSQ6 Have the services you received helped you to deal more effectively with your cancer? CSQ7 In an overall, general sense, how satisfied are you with the service you have received? CSQ8 If you were to seek help again, would you come back to DCTP? Does staff adequately perform complaint resolution functions to address client issues?
B4. Provider Satisfaction	Define how well satisfied providers are with major aspects of the DCTP.	How do you rate DCTP provider communications? How satisfied are you with the service you have received related to your DCTP provider inquiries? How would you rate DCTP claims processing? How satisfied are you with the DCTP appeals process? How would you rate the DCTP provider enrollment process? How satisfied are you with DCTP reimbursements? Of providers who elect not to join DCTP, what are their reasons?

C. Colorectal Cancer Committee

1. Logic Model

Colorectal Cancer Nurse Coordination & Advocacy

Planned Work			*Intended Results*		
			Outcomes		
Inputs	**Activities**	**Outputs**	**Initial**	**Intermediate**	**Longer-term**
In order to accomplish our activities we need the following:	*In order to achieve the program goals we will take the following actions:*	*We expect that once achieved these activities will produce the following evidence/service delivery:*	*We expect that if the program meets target goals it will lead to the following changes within 1-2 years:*	*We expect that if the program meets target goals it will lead to the following changes within 3-5 years:*	*We expect that if the program meets target goals it will lead to the following changes within 6-10+years:*
• Delaware Health Fund funding in the amount of $1.2 million in Year 1, $1.7 million in Year 2 , $2.23 million in Year 3, and $2.73 million in Year 4 for colorectal screening, evaluation, marketing, coordination and	• Hire and orient registered nurses experienced in gastroenterology or community health education • Recruit, train and orient advocates from racially underserved and geographically isolated messages • Educate the general public on	• Screening eligibility criteria which includes screening of at-risk individuals under 50 • Organized and linked network of nurses and other healthcare professionals providing colorectal education and promoting	• 500 clients screened for colorectal cancer each year (100 per 5 sites) • 25% of all clients screened will be deemed at-risk • 100 clients will receive case management services for abnormal	• 80% of all eligible Delawareans will report being screened for colorectal cancer • 15% increase in the number of at-risk African-American men (all ages) receiving colorectal cancer screening • 100% of clients will report	• Delaware will be one of five states with the lowest rate of CRC in the nation • 95% of all eligible Delawareans will report being screened for colorectal cancer • Elimination of racial/ethnic disparity in colorectal cancer

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
advocacy • Tangible support from State leadership (Governor Minner and Lt. Gov. Carney) • Leadership, guidance and strategic direction from the Delaware Cancer Consortium (DCC) Chair, Advisory Council and Division of Public Health • Nurses and administrators in all 5 hospital systems • Community health advocates • Division of Public Health Cancer Director • Division of Public Health Chronic Disease	the importance of colorectal cancer screening and the different screening options • Provide education in a culturally sensitive and linguistically appropriate manner • Use tools (e.g. NCI maps, SFL lists and Medicaid information) to inform outreach and education efforts • Provide one-on-one assistance to individuals interested in services • Enroll eligible clients in Screening for Life • Assist clients to find a provider accepted by their insurance • Help clients choose the best screening option,	screening, especially among at-risk populations • Comprehensive list of colonoscopists providing colorectal cancer screening • Trained community health advocates who are representative of target populations • Social marketing messages that target underserved groups, especially African-American men and women • Plan to distribute and fully implement the Champions	results • 25 clients screened each year will be enrolled into the Delaware Cancer Treatment Program • 60% of clinicians surveyed will report having used the CRC services within the last six months • 50% increase in knowledge (pre/post assessment) of colorectal screening types including advantages and disadvantages • 75% of clients served will report increased self-efficacy to obtain screening services • 80% of at-risk	having received culturally and linguistically appropriate services • 100 community and faith based partnerships will be established through the Champions of Change program	mortality

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
Director • Medical Providers • Delaware residents • Vendors and contractors	advocating colonoscopy as the preferred method • Distribute educational materials including those developed by ACS and other national organizations and those developed through the Delaware Cancer Consortium efforts • Provide case management services for all Delawareans diagnosed with an abnormal colorectal screening result - this includes privately insured clients and persons screened through Screening for Life. This will be done in combination with SFL Nurse	of Change program • System to case manage every abnormal screening result that minimizes hand-offs and ensures a continuum of care between screening and treatment • Best practices for teaching and raising awareness of colorectal cancer • Targeted maps based on census tract, BRFS data, NCI information and other surveillance data that identifies communities at highest risk of colorectal cancer	clients who have a family member within the eligible age range will commit to have a family member screened in the next 6 months • 90% of • clients will report having received culturally and linguistically appropriate services • The number of community and faith-based organizational partnerships through the Champions of Change program will increase 10% each year		

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
	Coordinator • Partner with the State-funded cancer care coordinators to ensure all clients diagnoses with colorectal cancer are linked into the care coordination service				

2. Domains, Goals & Objectives and Evaluative Questions

Domain	Goals & Objectives	Key Evaluative Questions
C1. Create a screening coordination and advocacy system	Describe the screening system and how well this system is working	How did this system evolve? Who is involved and how does it work? What do participants think of it? Does it do what it was intended to do?
C2. Create a screening advocacy tool kit ("Champions for Change" and distribution plan	Describe how this tool was developed, how it is being used and how effective it is	How did this tool kit evolve? Who is involved and how does it work? What results can be attributed to it? What do participants think of it? Does it do what it was intended to do?
C3. Create a screening reimbursement system	Describe how this tool was developed, how it is being used and how effective it is	What are the components of this system? How well does it work? What is provider satisfaction with this system? % bills reimbursed within X days % errors
C4. Provide case management services for every Delawarean with an abnormal cancer screening result	Describe how this tool was developed, how it is being used and how effective it is	What are the components of this system? How well does it work? What is participant satisfaction with this system? What is satisfaction of support service partners? What possible enhancements should be considered?

D. Tobacco Committee

1. Logic Model

Planned Work ***Intended Results***

			Outcomes		
Inputs	**Activities**	**Outputs**	**Initial**	**Intermediate**	**Longer Term**
• IMPACT Tobacco Prevention Coalition • Delaware's Division of Public Health, and • Partners	• Community Mobilization • School-based Prevention • Social marketing • Counter marketing • Policy and Regulatory Action • Evaluation and Surveillance Research	Completed activities to: • counteract pro-tobacco messages • develop effective tobacco prevention messages • disseminate tobacco prevention, pro-health messages • increase tobacco-free policies and use of tobacco prevention curricula in schools • increase cigarette excise tax • increase restrictions on tobacco sales to minors and enforce those restrictions • disseminate information about	• Increased knowledge of, improved tobacco prevention attitudes toward, and increased support for policies to reduce youth initiation • Increased tobacco prevention policies and programs in schools • Increased restriction and enforcement of restrictions on tobacco sales to minors • Reduced tobacco industry influences	• Reduced susceptibility to experimentation with tobacco products (Youth) • Decreased access to tobacco products (Youth) • Increased price of tobacco products • Increased number of quit attempts, and quit attempts using proven cessation methods	• Reduced initiation of tobacco use by young people • Reduced tobacco use prevalence among young people • Reduced tobacco consumption • Increased cessation among adults and young people • Reduced tobacco use prevalence among adults

		secondhand smoke and tobacco-free policies • create and enforce tobacco-free policies • disseminate information about cessation • continue cessation quitline and enhance comprehensive cessation support services • work with healthcare systems to institutionalize PHS-recommended cessation interventions • support cessation programs in communities, workplaces and schools • increase insurance coverage for cessation interventions • Report on Social marketing research • Form alliances with non-traditional partners	• Increased use of cessation services • Increased awareness, knowledge, intention to quit and support for policies that support cessation • Increased number of health care providers and health care systems following Public Health Service (PHS) guidelines • Increase insurance coverage for cessation services • Increased knowledge of, improved attitudes toward, and increased support for the creation and active enforcement of tobacco-free policies • Creation of tobacco-free policies • Enforcement of	• Compliance with tobacco-free policies • Decline in the Social Acceptability of smoking and tobacco use/ Increase public opinion that smoking is not acceptable • Maintained leadership position in progress of tobacco prevention	• Reduced exposure to second-hand smoke • Reduced tobacco-related morbidity and mortality: cancer, heart disease, respiratory disease • Decreased disparities in tobacco-related health outcomes

			tobacco-free public policies • Coordinated, multilayer delivery of effective prevention messages • Increased participation of policymakers and other public and private opinion leaders in pro-health advocacy groups		

2. Domains, Goals & Objectives and Evaluative Questions

Domain	Goals & Objectives	Key Evaluative Questions
D1. Prevent tobacco use among young Delawareans through age 24	Determine the degree to which Delawareans up through 24 years of age did not use tobacco	What were the strategies for achieving this goal? What legislative, rule or regulatory changes occurred? How have they been enforced? How well did they work? And with whom did it work (Describe the attributes of those who did not start/started using tobacco) What possible enhancements should be considered?
D2. Increase tobacco cessation among Delawareans	Delineate the effectiveness of tobacco cessation programs	What were the strategies for achieving this goal? How well did they work? And with whom did it work (Describe the attributes of those who remained smoke free for at least six months/those who did not complete cessation programs and /those who completed cessation program, but resumed tobacco use within six months) What possible enhancements should be considered?
D3. Reduce routine exposure to environmental tobacco smoke	Define the degree to which routine exposure to tobacco smoke has been reduced	What were the strategies for achieving this goal? What legislative, rule or regulatory changes occurred? How have they been enforced? How well did they work? What possible enhancements should be considered?
D4. Decrease the social acceptability of tobacco use	See how effective programs were in changing social norms	What were the strategies for achieving this goal? How well did they work?
D5. Maintain leadership position to sustain progress of tobacco	Assess the role of the Consortium in supporting tobacco prevention and control	What strategies were undertaken to: - assure adequate funding for comprehensive statewide tobacco control activities

prevention	efforts in Delaware	- strengthen, expand and enforce DE's Clean Indoor Air Act - endorse, coordinate and implement "A Plan for a Tobacco-free Delaware" - expand and sustain a comprehensive public awareness campaign and resources available to help quit smoking - increase Delaware's excise tax How well did they work? What possible enhancements should be considered?

E. Quality Committee

1. Logic Model

Cancer Care Coordination

Planned Work ***Intended Results***

			Outcomes		
Inputs	**Activities**	**Outputs**	**Initial**	**Intermediate**	**Longer-term**
In order to accomplish our activities we need the following:	*In order to achieve the program goals we will take the following actions:*	*We expect that once achieved these activities will produce the following evidence/service delivery:*	*We expect that if the program meets target goals it will lead to the following changes within 1-2 years:*	*We expect that if the program meets target goals it will lead to the following changes within 3-5 years:*	*We expect that if the program meets target goals it will lead to the following changes within 6-10+years:*
• Delaware Health Fund funding in the amount of $1.5 million in Year 1, $1.5 million in Year 2, and $1.9 million in Year 4 for cancer care coordination • Tangible support from State leadership (Governor Minner and Lt. Gov. Carney)	• Create a data system to track types and numbers of services delivered by site and collectively • Develop client intake form to be completed by Cancer Care Coordinator for each client served • Case manage all cancer clients	• Statewide cancer care coordination services available at all hospitals, health systems and other institutions • Comprehensive internal data tracking system to monitor services rendered • Cancer care coordination policy and	• 1000 clients served with coordination services per year • 25% of clients served will be of racial/ethnic minority groups • 5000 interventions per year • 10% of analytic cancer cases at each participating hospital will be accrued into clinical trials • 10% increase in the number of	• 10% increase in the number of clients receiving services • 20% increase in the number of minority clients	• All Delawareans diagnosed with cancer will receive cancer care coordination services, as will their families

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
• Leadership, guidance and strategic direction from the Delaware Cancer Consortium (DCC) Chair, Advisory Council, Quality Committee and Division of Public Health • Section Chief & Chronic Disease Bureau Chief • Cancer Director • SFL Nurse Consultant • Chronic Disease Epidemiologist • CRC Nurse Coordinators • Medical Providers • Consumers-residents of Delaware and their families living with	who elect services regardless of insurance status • Enroll eligible clients into Medicaid • Enroll eligible clients into DCTP • Educate and encourage clients to enroll in clinical trials • Refer clients to internal hospital-based programs • Refer clients to external clients into CHAP • Obtain durable medical equipment for clients • Make medical referrals for home care, appointment coordination, hospice, counseling and other services as needed	procedure manual • Best practices for cancer care navigation that are holistic, patient and family centered and that address the continuum of cancer including palliative care, rehabilitation and survivorship • Needs assessment of minority and underserved community to asses knowledge, attitudes and beliefs regarding utilization of cancer care coordination services	racial/ethnic minority clients accrued into clinical trials • 40% of clients served will report that the Cancer Care Coordinator services helped to:1) ease the emotional stress of their cancer diagnosis and treatment; 2) navigate the system of appointments; 3) manage/reduce family issues and concerns • 50% of providers will report that cancer care coordination service contributes to positive patient outcomes • 80% of providers will report referring their patients to the Cancer Care Coordinator within the last six months		

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
cancer • Vendors and contractors	• Address clients' social issues; e.g., obtain medications, assist with high insurance co-pays, transportation, support system, assist with family responsibility concerns • Implement continuous quality improvement tools/techniques to systematically evaluate program operations and outcomes. Make changes as needed • Develop a formal program evaluation framework to assess individual and family impact				

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
	• Obtain patient, family and medical provide feedback on the acceptability and accessibility of the program • Use community and stakeholder input to make added-value additions and/or modifications to the program • Create and distribute culturally and linguistically appropriate educational materials promoting cancer care coordination services • Distribute educational materials including those developed by ACS and other national				

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
	organizations and those developed through the Delaware Cancer Consortium efforts • Contact medical providers to promote cancer care coordination services				

2. Domains, Goals & Objectives and Evaluative Questions

Domain	Goals & Objectives	Key Evaluative Questions
E1. Care Coordination	Determine usefulness of care coordination protocols	Do protocols provide guidance for 100% of eventualities? Is protocol adherence linked to participant/client outcome? Are there areas for future improvement?
E2. Develop a care coordinator system	Describe how well the care coordination system functions	How is the care coordination system designed? How did the system evolve? What is utilization of services, by type? How well are participants satisfied with care coordination? Coordinators? Medical providers? Support providers? What are unique aspects of this system? Are there any barriers to its success?
E3. Accrual into clinical trials	Describe the development of an infrastructure within the hospitals to promote and track accrual of analytic cancer cases into clinical trials (to be developed in 2006-2007)	How was the infrastructure created and incentives for partnerships established? What has been the impact of this system on the accrual of patients, especially minority patients, into clinical trials?
E4. Insurance Coverage for Clinical Trials	Determine how well this program working	What are the components of this program? How is it being used? Who is using this coverage? How well satisfied are participants with this coverage? What are possible enhancements that should be considered?
E5. Chart Review	Describe the evolution of the goal from credentialing to chart review and then describe the program and how well it is	What were the factors affecting a change in this strategy?

	working	
E6. Training	Describe these efforts and their related successes	Is there training? Who is being trained? What is the result of the training? What are the unique aspects of this program? What are possible enhancements that should be considered?

F. Environment Committee

1. Logic Model

Reduction in Cancer Risk due to Environmental Exposure

Planned Work			*Intended Results*		
			Outcomes		
Inputs	**Activities**	**Outputs**	**Initial**	**Intermediate**	**Longer-term**
In order to accomplish our activities we need the following:	*In order to achieve the program goals we will take the following actions:*	*We expect that once achieved these activities will produce the following evidence/service delivery:*	*We expect that if the program meets target goals it will lead to the following changes within 1-2 years:*	*We expect that if the program meets target goals it will lead to the following changes within 3-5 years:*	*We expect that if the program meets target goals it will lead to the following changes within 6-10+years:*
• Delaware Health Fund funding in the amount of $245,000 in Year 1, $1.35 million in Year 2, $1.14 million in Year 3, and $1.02 million in Year 4 for environmental studies of cancer risk and related	• Sample fish • Survey data about known water sources • Radon education and outreach • Ad-hoc studies • Develop innovative media messages that enhance public awareness about	• Analyze 40 samples of fish • Risk assessment of chemical hazards in Columbia aquifers • Recommendations issued about fin fish consumption for Delawareans • Delaware Healthy Homes, e.g., Cancer Can, web presence, printed materials • Studies or results of	• 5,000 of the 98,500 Delaware residents who get their drinking water from the Columbia Aquifer will drink water free of carcinogenic substances • 656,683 Delaware residents will have access to	• 75% of Delaware residents who get their drinking water from the Columbia Aquifer will be aware of the chemical compounds that may be detected in their drinking water • 50% of Delaware residents will be aware of DNREC's long-term community-	• 50% of cancer cases associated with exposure to carcinogenic substances found in the environment, home and workplace are averted due to all efforts

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
activities • Tangible support from State leadership (Governor Minner , Lt. Gov. Carney, and General Assembly) • Leadership, guidance and strategic direction from the Delaware Cancer Consortium (DCC) Chair, Advisory Council, DCC Environment Committee and Division of Public Health (DPH) • DNREC • Department of Labor (DOL) • DPH Health Systems Protection • DPH Office of	environmental contributors to cancer • Develop innovative media messages that enhance public awareness about common household contributors to cancer • Develop outreach, educational and promotional campaigns to communicate the Delaware Air Toxics Study findings • Based upon the results of the Delaware Air Toxics Assessment Study, develop community-based stakeholder programs to augment other	research from DE Air Toxics Assessment Study, esp. increased risk in certain geographic areas (e.g. inner-city Wilmington) • Radon testing and remediation support program • Assessment of hazardous substances found in the workplace • 1-3 community-based stakeholder committees formed to identify specific air toxic reduction activities • Assessment of Training Needs as identified from the Hazardous Substances found in the Workplace Study • Recommendation(s) for media campaign about workplace exposures • DOL will enhance	air toxins data for their community. • Specific air toxics reductions programs implemented in 1-3 Delaware communities. • 8,345 recreational fishermen will follow the finfish consumption advisory messages • 25% increase in the number of hits on the DHSS Healthy Homes website • 25% increase in the number of phone calls about radon remediation and radon testing • 50% increase in the number of Delaware residents aware	based air toxics reduction programs • 75% of all recreational fishermen in Delaware recall media messages related to finfish consumption advisory warnings • 25% of all property transactions include a test for radon gas prior to settlement • 25% of Delaware households reduce their exposure to hazardous substances in their homes by utilizing “green” options • 50% of the Delaware workforce is aware of the potential cancer risks associated	

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
Drinking Water • DPH Environmental Health Evaluation Branch • Chief, DPH Health Systems Protection Section • DCC Environment Committee Chair • State Toxicologist • Delaware residents • Vendors and contractors	DNREC air toxic reduction activities • Develop Risk Assessment of Fish in Delaware waters • Conduct statewide Hazardous Substances in the Workplace survey	training programs to fill gaps identified in the analysis of the Hazardous Substances in the Workplace survey	of exposures to hazardous substances in their homes • 50% percent of all Delaware workplaces participate in the hazardous substances survey • 75% increase in the number of phone calls inquiring about workplace hazardous substance exposure and prevention strategies	with hazardous substances in their workplace	

2. Domains, Goals & Objectives and Evaluative Questions

Domain	Goals & Objectives	Key Evaluative Questions
F1. Air Exposures	Determine the degree to which goals were met	Were an adequate number of monitoring sites selected? To what degree were monitoring tools able to collect samples with sufficient power to assess toxins of interest? What are the trends? What are potential future areas of improvement? How does Delaware's experience compare with another State which is implementing similar programs?
F2. Water Exposures	Determine the degree to which goals were met	Were an adequate number of monitoring sites selected? To what degree were monitoring tools able to collect samples with sufficient power to assess toxins of interest? What are the trends? How are findings being shared? What is most successful about this program? Are there any barriers to the success of this effort? What are potential future areas of improvement? How does Delaware's experience compare with another State which is implementing similar programs?
F3. Fish Monitoring	Determine the degree to which goals were met	Were an adequate number of monitoring sites selected? To what degree were monitoring tools able to collect samples with sufficient power to assess toxins of interest? What are the trends? How are findings being shared? What is most successful about this program? Are there any barriers to the success of this effort?

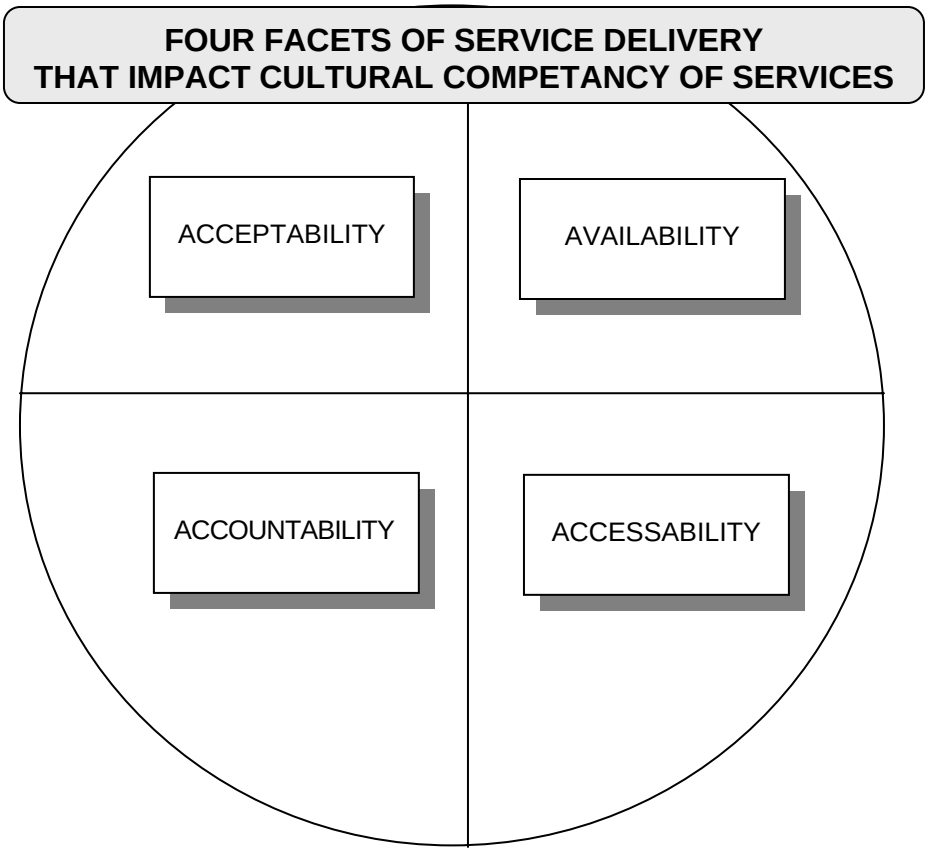
Domain	Goals & Objectives	Key Evaluative Questions
		What are potential future areas of improvement? How does Delaware's experience compare with another State which is implementing similar programs?
F4. Workplace	Determine the degree to which goals were met	Were an adequate number of monitoring sites selected? To what degree were monitoring tools able to collect samples with sufficient power to assess toxins of interest? What are the trends? How are findings being shared? What is most successful about this program? Are there any barriers to the success of this effort? How does Delaware's experience compare with another State which is implementing similar programs?
F5. Indoor (Radon Testing)	Determine the degree to which goals were met	Did a Bill pass with substantive impact? What are unique aspects of the Bill? Are there any barriers to the successful implementation of this Bill? How well do rules and regulations associated with this Bill support its intent? How does Delaware's experience compare with another State which is implementing similar programs?

G. Disparities Committee

1. Model

The following figure illustrates the main domains to be considered in the evaluation of disparities.

Figure 2. Disparities Evaluation Framework (Zuniga et al., 2006)



2. Domains, Goals & Objectives and Evaluative Questions

Domain	Goals & Objectives	Key Evaluative Questions
G1. Case Study of Program	Illustrate the progression of the effort to reduce disparities, with special attention to instances where collaboration among partners (or acts by the Consortium) or evidence-based or evidence-informed practices were central to the effort	To what extent are disparate populations targeted? To what degree are those who are affected involved in programming and evaluation? What are potential future areas of improvement?
G2. Case Study of System Change	Illustrate the progression of the effort to reduce disparities, with special attention to instances where collaboration among partners (or acts by the Consortium) or evidence-based or evidence-informed practices were central to the effort	What changes have been made to policies, procedures, materials, or staff in order to connect with disparate populations more effectively? To what degree are those who are affected involved in programming and evaluation? What are potential future areas of improvement?

H. Public Education

1. The work of the knowledge and information committee will be evaluated within the context of the DCC work. Indicators such as population-based increases in screening, early detection and treatment can be indirectly attributed to enhanced public awareness and education regarding cancer risks.

2. Domains, Goals & Objectives and Evaluative Questions

Domain	Goals & Objectives	Key Evaluative Questions
H1. Form an alliance to enhance public education on cancer	Determine how well this goal was met Assess the availability of public information on cancer	Is there an alliance? Which organizations or individuals comprise this alliance? How does the alliance function? What are unique aspects of this alliance? Are there any barriers to its operation? What are potential future areas of improvement? Do public libraries have sufficient resources on cancer prevention, screening and treatment? To what extent can public information resources (e.g. public libraries and internet websites) be enhanced to serve as one of the primary information resources for the public?
H2. School Health Councils	Conduct school health leadership institutes Assist schools in creating improvement plans to prevention youth tobacco use	How many leadership institutes were offered and to which schools? How many school improvement plans were created? What was the impact on youth smoking as measured by responses to Youth Behavioral Risk Survey (YRBS)?

I. Division of Public Health Administered Programs – Screening for Life

LOGIC MODEL
Screening for Life (SFL)

Planned Work ***Intended Results***

			Outcomes		
Inputs	**Activities**	**Outputs**	**Initial**	**Intermediate**	**Longer-term**
In order to accomplish our activities we need the following:	*In order to achieve the program goals we will take the following actions:*	*We expect that once achieved these activities will produce the following evidence/service delivery:*	*We expect that if the program meets target goals it will lead to the following changes within 1-2 years:*	*We expect that if the program meets target goals it will lead to the following changes within 3-5 years:*	*We expect that if the program meets target goals it will lead to the following changes within 6-10+years:*
• CDC funding in the amount of $1.16 million for breast and cervical cancer screening annually for the past three years • Delaware Health fund funding in the amount of $405,200 in Year 1, $512,500 in Year 2, $544,000 in Year 3, and	**PROGRAM** • Create an integrated data system that tracks of client enrollment, processes payments, and assures appropriate billing (by CPT code) for services rendered • Create and maintain	• Comprehensive internal data tracking system to monitor screenings, provider and client outcome information • Provider reimbursement processing system managed by 3rd party vendor • SFL policy and procedure manual • Published eligibility guidelines	• 10% increase in the number of women 50-64 screened for breast cancer • 10% increase in the number of women between the ages of 18-64 screened for cervical cancer • 5% increase in the number of men and women between the ages of 50-64 receiving	• 80% of all eligible Delawareans will report being screened for colorectal cancer • 90% of all eligible women will report being screened for breast cancer • 90% of all eligible women will report being screened for cervical cancer • 15% increase in the number of at-risk	• A nationally recognized model for the provision of cancer screening and early detection services • 95% of all eligible Delawareans will report being screened for colorectal cancer • 95% of all eligible women will report being

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
$544,000 for SFL infrastructure • Delaware Health Fund funding in the amount of $443,000 In Year , $750,000 in Year 2, $1million in Year 3, and 1.5million in Year 4 for colorectal screening • Tangible support from State leadership (Governor Minner and Lt. Gov. Carney) • Leadership, guidance and strategic direction from the Delaware Cancer Consortium (DCC) Chair, Advisory Council and Division of Public Health • Section Chief &	a current list of CPT codes and reimbursement rates based on CDC approved rates • Develop enrollment forms to be completed by providers enrolling as SFL providers • Develop (tracking) forms completed by providers and submitted with bills for services. These forms will be used to track service utilization • Pay all eligible claims on a bi-weekly basis • Coordinate the mobile mammography services • Case manage	• Integrated media messages through a comprehensive social marketing campaign • Mammograms for women in medically underserved and geographically isolated areas • SFL designated providers in all areas of Delaware • Standard of Care feedback report for providers who serve SFL clients. These reports identify the number of clients who received all age-appropriate screenings and an analysis of those clients who did not	colorectal cancer screening • 10% increase in the number of at-risk African-American men (all ages) receiving colorectal cancer screening • 25% of surveyed population will report recall of SFL social marketing messages • 75% of providers surveyed will report being “highly satisfied” with SFL enrollment and reimbursement processes • 5% increase in the number of women receiving mammograms in geographically isolated areas through the mobile mammography	African-American men (all ages) receiving colorectal cancer screening • 50% of surveyed population will report recall of SFL social marketing messages • 85% of providers surveyed will report being “highly satisfied” with SFL enrollment and reimbursement processes • 10% increase in the number of women receiving mammograms in geographically isolated areas through the mobile mammography van • 100% of SFL clients will report having received culturally and linguistically	screened for breast cancer • 95% as above comment of all eligible women will report being screened for cervical cancer • 35% increase in the number of at-risk African-American men (all ages) receiving colorectal cancer screening • 60% of surveyed population will report recall of SFL social marketing messages • 100% of providers surveyed will report being “highly satisfied” with SFL enrollment and reimbursement processes

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
Chronic Disease Bureau Chief • Cancer Director • SFL Director • Nurse Consultant • Chronic Disease Epidemiologist • CRC Nurse Coordinators • Medical Providers • Consumers-residents of Delaware living with cancer • Technical assistance from CDC • Vendors and contractors	all clients with an abnormal result • Enroll clients diagnosed with breast or cervical cancer into the state Medicaid program • Enroll clients diagnosed with colorectal cancer into the Delaware Cancer Treatment Program • Implement continuous quality improvement tools/techniques to systematically evaluate program operations and outcomes. Make changes as needed • Develop a formal		van • 90% of SFL clients will report having received culturally and linguistically appropriate services	appropriate services	

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
	program evaluation framework to assess individual and population-based impact • Obtain community feedback on the acceptability and accessibility of the program • Use community and stakeholder input to make added-value additional and/or modifications to the program **AWARENESS & EDUCATION** • Develop and implement a comprehensive TV, radio and print campaign. This will be done with				

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
	assistance from marketing/media firm • The media campaign will consist of three branches: breast & cervical, colorectal and a Spanish-language campaign which combines all three services • Educate target population and general public about program services. This will be done with assistance from contractors **PROVIDERS** • Contact medical providers in Delaware who provide breast, cervical and colorectal				

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
	health services • Educate providers regarding program eligibility and reimbursement guidelines • Enroll clinicians and practices as SFL providers • Create, maintain and disseminate an up-to-date list of all eligible providers				

2. Domains, Goals & Objectives and Evaluative Questions

SFL Domain	Goals & Objectives	Key Evaluative Questions
I.1 Breast Screenings	80% of the SFL-eligible women 50-64 years of age will obtain age-appropriate cancer screenings in FY2007	What percent of eligible women were screened? What are common characteristics of women who were not screened? How satisfied were clients with services?
I.2 Cervical Screenings	80% of the SFL-eligible women 50-64 years of age will obtain age-appropriate cancer screenings in FY2007	What percent of eligible women were screened? What are common characteristics of women who were not screened? How satisfied were clients with services?
I.3 Colorectal Screenings	80% of the SFL-eligible men and women 50-64 years of age will obtain age-appropriate cancer screenings in FT2007	How many were done by test type? What types of populations were reached? How many tests were the first such screening tests for a client? How satisfied were clients with services?
I.4 Provider Reimbursing	100% of invoices with appropriate screening data will be paid within 30 days of receipt	How many claims were received weekly? What is average number of claims automatically processed for payment bi-weekly? How many claims required manual adjustments? How many claims were denied and

		for what reasons?
I.5 Client referrals	100% of clients will receive appropriate referrals for diagnostic and treatment services?	What percentage referred to Medicaid Breast and Cervical Cancer Program? What percentage referred to DCTP? What percentage referred to CHAP? What percentage referred to other resource, e.g., hospital charity care?
I.6 Coordination of ancillary services	95% of the men and women who require follow-up services will obtain the appropriate diagnostic and treatment services	What percentage of women with complete follow-up for each cancer. What percentage of men with complete follow-up for CRC? What percentage lost to follow-up? What percentage refused?
I.7 Management of screening and diagnostic data	90% of screening and diagnostic data will meet or exceed CDC Minimum Data Elements Data Quality Standards	What percentage of the data met or exceeded the CDC breast and cervical indicators?
I.8 Cancer data surveillance	100% of records for clients diagnosed with breast, cervical or colorectal cancer will include complete cancer date surveillance	What number of screenings with a final diagnosis of HSIL, CINII or CIN III/CIS? What number of screenings with a final diagnosis of invasive cervical cancer? What percentage of screenings with time between final diagnosis and treatment > 90 days? What numbers of women were diagnosed with invasive breast cancer?

J. Division of Public Health Administered Programs – Delaware Cancer Registry

LOGIC MODEL
Delaware Cancer Registry (DCR)

Planned Work ***Intended Results***

			Outcomes		
Inputs	**Activities**	**Outputs**	**Initial**	**Intermediate**	**Longer-term**
In order to accomplish our activities we need the following:	*In order to achieve the program goals we will take the following actions:*	*We expect that once achieved these activities will produce the following evidence/service delivery:*	*We expect that if the program meets target goals it will lead to the following changes within 1-2 years:*	*We expect that if the program meets target goals it will lead to the following changes within 3-5 years:*	*We expect that if the program meets target goals it will lead to the following changes within 6-10+years:*
• CDC funding in the amount of $322,273 for cancer registry operations annually for the past two years • Delaware Health Fund funding in the amount of $220,000 in Year 2, $219,000 in Year 3, and $253,000 in	• Upgrade DCR data system capabilities • Upgrade DCR hard copy storage capacity • Train registrars • Conduct assessment of treatment data • Conduct assessment	• Enhanced capacity to perform quality studies, e.g., stage III colorectal cancer treatment study • Integration between health care providers, including hospitals, and the DCR • Web-based cancer case submissions • Routine feedback	• Maintain gold status per national organization criteria • Increase % of cases entered correctly/timely • Enhanced capture of cases from non-traditional reporters • Enhanced capture	• Continue to achieve highest NPCR rating, i.e., gold status • Use DCR data to monitor treatment data for quality purposes employing selected/sampled validation criteria • Enhanced ability to produce timely, comprehensive standard/routine	• Assurance that DPH DCR is capturing all cancer cases • Decrease in cancer mortality rate statewide • Established capacity to support public inquiry and research

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
Year 4 for cancer studies and registry operations • Tangible support from State leadership (Governor Minner, Lt. Gov. Carney, and the General Assembly) • Leadership, guidance and strategic direction from the Delaware Cancer Consortium (DCC) Chair, Advisory Council, Quality committee of DCC, Delaware Cancer Registry Advisory Committee (DCRAC) and Division of Public Health • State contractor for registry-ORC Macro	of demographic data • Submit timely to the ACS and NPCR • Expand QA and CQI activities • Develop DCR informational / promotional brochures/pub-lications to inform public/ others of value of DCR • Expand reporting by free-standing surgi-centers/ other non-traditional reporters • Submit requisite paperwork to enable NDI data capture • Explore alternate means of case finding, e.g., scrutiny of insurer claims data • Develop	to health care providers with updates • Informative brochure on DCR's mission, purpose, value, etc. • Periodic death match against National Death Index (NDI), i.e., lost to follow-up cases • Increased security for DCR data • Increased capacity to store greater volume of hard and electronic data • Enhanced ability to disseminate cancer-related data/information to the public and to researchers • Established capacity to support on-line queries of public use data	of treatment data • Enhanced ability to implement studies for DCC and DPH • Submission of initial finder file to NDI for lost-to-follow-up death data capture • Completion of first SSDI data search for lost-to-follow-up death data capture • Completion of informational DCR brochure • Established capacity for geo-mapping cancer data • Completion/pub-lication of public use data file definitions, and of data access policies/procedu res	reports for stakeholders • Improved electronic communications between DCR and health care providers • Implementation of basic geo-mapping of cancer data • Routine case capture from all providers • Routine production of mapped cancer data • Provision of requested public use files within 10 business days of complete/valid request • Provision of customized research files within 15 business days of protocol approval	

Inputs	Activities	Outputs	Initial	Intermediate	Longer-term
• DPH Director • Deputy Director • Health Promotion &Disease Prevention Section Chief / Chronic Disease Bureau Chief • Cancer Director • Chronic Disease Epidemiologist • DPH Vital Statistics • Delaware residents • Vendors and contractors	standard “public use” file definitions and data release policies/proce-dures • Enable web-based queries of “public use” data				

2. Domains, Goals & Objectives and Evaluative Questions

DCR Domain	Goals & Objectives	Key Evaluative Questions
J.1 Compliance with Requirements	85% of the reporting institutions will comply with the Delaware Cancer Registry reporting requirements in FY2007	To what degree do providers comply with requirements?
J.1 Compliance with Requirements	To support and enhance the population based Registry, meeting NPCR objectives and standards	To what degree do providers comply with requirements? What are common issues in compliance?
J.2 Completeness of Information collected	To enhance quality assurance program	To what degree is there integration between central registry, hospitals and other reporting agencies? How does this impact the accuracy of demographic and treatment reporting?
J.4 Certified Tumor Registrars (CTRs)		How many CTRs were employed in DE from 2002-2006? What are the trends? Are they employed/volunteering currently in this position? Are there unfilled position openings for registrars?
J.5 Registrar training	To enhance education programs	How many people have been trained?

IV. Impact Evaluation Methodology

Impact evaluation is taken to mean short term outcomes (Timmreck, 2003) which should be measured frequently and early in a project. It is important to note that while Delaware is also proposing to conduct impact outcomes evaluation (Timmreck, 2003), which links resources used to benefits achieved, it is recognized that such a methodology (e.g. cost effectiveness analysis) is rigorous and ambitious and merits an important investment in order to be effective. It is Delaware's intent to be a leader in using this methodology in cancer control evaluation.

A. Impact Qualitative Analyses

With respect to impact outcomes, the primary units of measure are adoption of protective health behaviors and rates of cancer incidence and mortality. Protective health behaviors include smoking cessation, cancer screening and environmental exposure risk reduction. It is proposed that key informant interviews be conducted to elicit changes in knowledge, attitudes and beliefs of target populations, providers (Timmreck, 2003) as well as systems (vís a vís policy changes) that resulted in short term outcomes that are relatively easy to discern. For example, on the individual level, the focus of this part of the evaluation would be changes in knowledge, attitudes and beliefs that led to getting a screening or led to changes in lifestyle as a result of screening. This would be in contrast to the process qualitative focus of how someone perceived they were treated during the screening or how easy it was for them to schedule an appointment.

B. Cost Effectiveness Analysis

Delaware is proposing a modest, yet important, investment in cost-effectiveness analysis as a part of its overall Comprehensive Cancer Control evaluation plan proposal.
The Agency for Healthcare Quality and Research, the federal agency which supports research to improve quality of care through cost efficiency while addressing patient safety and medical errors, notes "…the central purpose of cost effectiveness analysis is to compare the costs and the values of different health care interventions in creating better health and longer life." (Agency for Healthcare Research and Quality, 2001) Cost effectiveness analysis should not be confused with cost benefit analysis. According to Rossi et al, (Rossi et al., 2004) "Both cost-benefit and cost-effectiveness analyses are means of judging the efficiency of programs…In cost benefit analyses, the outcomes of the programs are expressed in monetary terms; in cost effectiveness analyses, outcomes are expressed in years of life. Delaware acknowledges the framework proposed by Teutsch (Teutsch, 1992) as one important possible framework for this proposed evaluation. Further, the work of Andersen et al in establishing cost effectiveness of cancer screening promotion would help inform the design of this proposed work.

Delaware proposes that this challenging evaluation technique be used in order to help strengthen the evidence base for cancer control in general and provide substantive feedback to stakeholders and policy makers in Delaware. Indeed, Delaware's

prioritization of cancer treatment payment is of national significance and should be evaluated accordingly.

V. Evaluation Dissemination Plan

A. Giving Meaning to Data and Findings

The watch-words for the comprehensive cancer control program in Delaware have been participative process and partnership. Just as full and open discussion informed the development of DCC's programming, so must it also inform the evaluation of its programs. Evaluation is not truly complete until the constituencies involved in or served by the program have the opportunity to learn of and dialogue around the findings of the evaluation. A facilitated dialogue can accomplish many objectives:

- Create a shared meaning for data
- Uncover possible errors in interpretation
- Identify new evaluation questions
- Stimulate new ideas for programming
- Motivate new champions
- Recruit new partners

Further, as is posited in the CDC Framework for Program Evaluation in Public Health (Centers for Disease Control and Prevention, 1999) it is vital that the sources of standards by which program performance will be assessed are established prior to the assignment of meaning to findings. As per this CDC reference document, selected possible standards may include needs of participants; community values; absence of harm; resource efficiency; or, institutional goals.

B. Public Access

Delaware believes that public access goes far beyond a document being posted on a web-site. The tenets of health literacy apply also to evaluative data – easy to understand data are as important as plain language. DCC proposes to engage with all partners in such a manner that they become ambassadors for sharing the results of their shared work. Media outlets can be effective partners in sharing the results of our collective work. Even the internet can help create an active, not passive, presence by the incorporation of interactive components into evaluation findings.

C. Taking Action: A Proposed Communication Plan

Health communication models are generally thought of more in terms of program planning, as opposed to sharing of findings, Delaware understands that the sharing of evaluation results can and should feed into and support its health communication strategies. Indeed, the model described here in Figure 3, "Circles of Influence" is based in both community organization and diffusions of innovations theory. This section

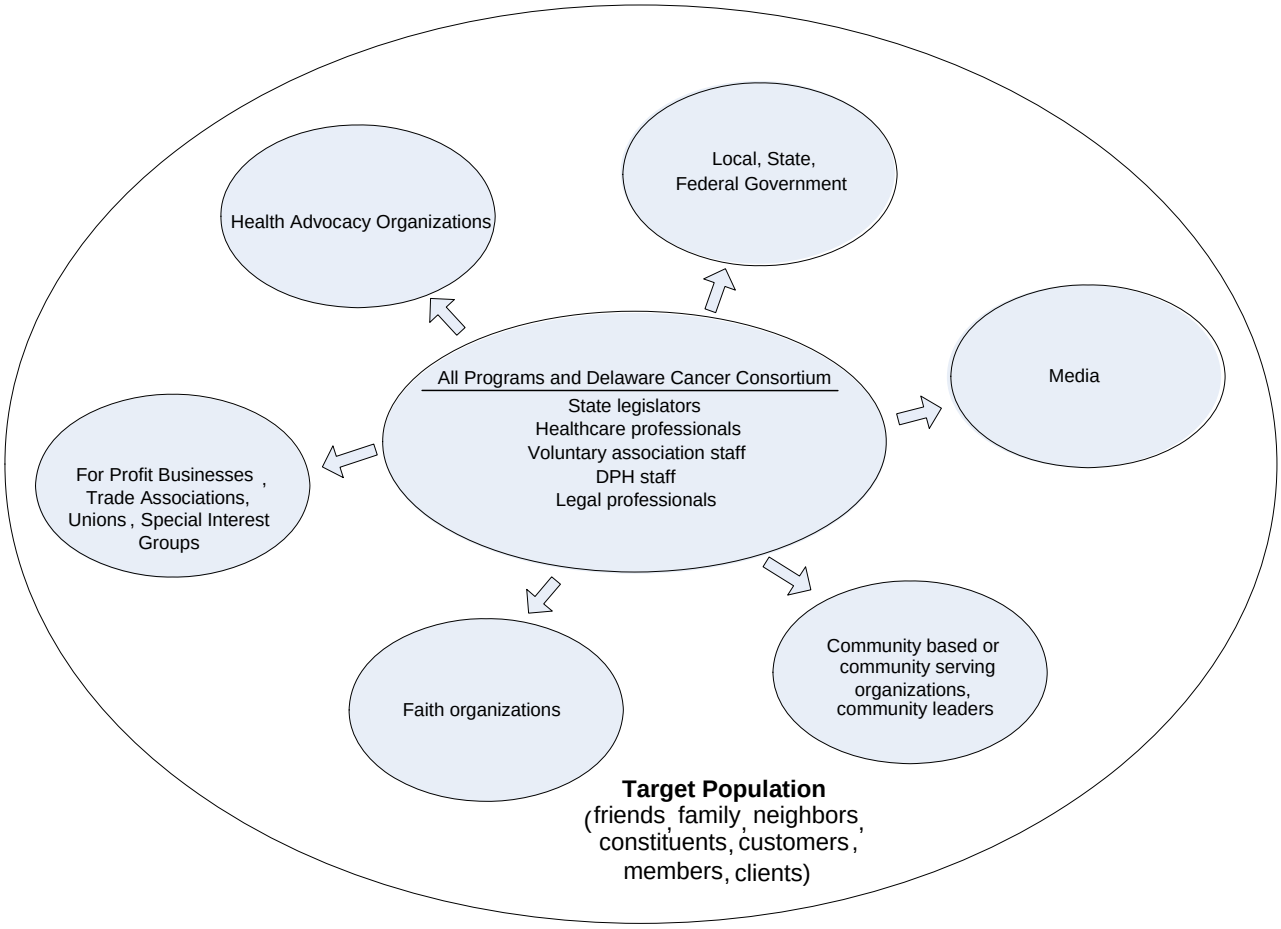
describes how Delaware proposes to incorporate dissemination of evaluation findings into its overall Comprehensive Cancer Control Plan effort.

DPH will contract with a vendor to implement the steps outlined in this plan. In its administrative role, DPH will guide the day-to-day activities of evaluation. Once findings are deemed ready for review (e.g., data are validated, all descriptions of programs are checked for accuracy), a systematic roll-out of the findings, including facilitated dialogue around the meaning of the data, will ensue. Specifically, the evaluation findings will be shared and discussed with these important audiences, or "Circles of Influence" (see figure 3):

- Governor and key Legislators, federal partners such as Region III Offices of Minority Health and Women's Health
- Local, State and Federal Government
- Consortium Members
- Media
- Community Based or Community Serving Organizations
- Advocacy oriented organizations
- For Profit Businesses, Trade Associations, Unions, Special Interest Groups

Due to the intense nature of its planning and implementation work, the structure of the DCC is comprised of representatives from these types of organizations: state legislature; healthcare systems, voluntary health associations; Division of Public Health staff; and, legal professionals. In order to broaden the Consortium's reach, various other sectors will need to be tapped as the Consortium seeks to broaden its base of support. All of the populations targeted by these programs have multiple roles in their daily lives. The more ways in which the DCC messages are disseminated, the more chances the individuals who would most benefit from DCC programs will be moved to *take action*.

Figure 3. Circles of Influence



VI. Recommendations

DPH plans to issue a Request for Proposal in October 2006 to conduct the evaluation of the Comprehensive Cancer Control Program. DPH anticipates awarding the contract in time to begin the evaluation in January 2007. This evaluation plan provides the primary considerations, theoretical frameworks and defines the scope for the evaluation. A small group of representatives from the DPH and the DCC will work closely with the selected contractor to ensure full access to information, validity of conclusions and timely, thorough execution of contracted work. With respect to normal evaluation activities, it is proposed that each of the working committees of the Consortium identify one person to serve as a liaison with the evaluators of the Comprehensive Cancer Control Program. This will facilitate the sharing of accurate information, increase access to key participants and promote acceptance of the evaluation strategy. The evaluators will consult with liaisons on an individual basis or convene them via teleconference calls, as appropriate. Likewise, as committees develop questions or concerns, they may

engage in discussion with the evaluation team and management staff. This model is being used by the Commonwealth of Pennsylvania with positive results.

DPH recognizes that the beginning of this phase of the Cancer Control Program is a good time to examine cross-cutting system issues which may affect multiple initiatives and individual outcomes. Cultural and linguistic competency is perhaps the most critical cross-cutting component of the Cancer Control Program. Culture and language are as important in outreach, education, prevention, and early detection as in treatment.

A review of recent literature reveals that biases and socio-economic status can adversely impact patient health outcomes due to differences in screening practices, diagnosis decisions, medication use and follow-up care recommendations. Perhaps one of the most notable recent reports was commissioned by the Centers for Medicare and Medicaid Services to ascertain what sorts of trials they should pilot with respect to cancer and minority elders. This report, "Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities" was released in 2003 and has salient conclusions based on an exhaustive review of literature and extensive case studies. The evidence is rather strong with respect to cultural and linguistic factors being associated with success of prevention and treatment efforts; therefore, Delaware is proposing to enhance its current Cancer Control Plan including evaluation to meet this critical need.

Perhaps one of the most recognized foundational documents reflecting a national consensus process across many constituencies in the cultural and linguistically competency arena is the Culturally and Linguistically Appropriateness Services, known as CLAS Standards; see Appendix A for a listing of the fourteen (14) proposed standards.

There are two important dimensions of cultural and linguistic competency that Delaware wishes to consider. First, there are issues relating to access and quality of care for populations for whom English is a second language. Second, are concerns that Comprehensive Cancer Control Plan materials and media messages are formulated in a way that promotes ease in understanding, especially for those whose literacy levels are low.

Just as communication in clinical contexts is crucial to positive outcomes, so it is for health education, health promotion and understanding/compliance with regimen instructions. The ability to understand health messages is generally referred to as "health literacy." The Institute of Medicine (IOM) defines health literacy as follows:

> *Health literacy is defined as the degree to which individuals have the capacity to obtain, process and understand basic information and services needed to make appropriate decisions regarding their health. At some point, most individuals will encounter health information they cannot understand. Even well educated people with strong reading and writing skills may have trouble comprehending a medical form or doctor's instructions regarding a drug or procedure.(Nielson-Bohlman, Panzer, & Kindig, 2004)*

IOM then recommends:

> *…that health care systems should develop and support programs to reduce the negative effects of limited health literacy….” Still further, IOM supports the inclusion of people who will be using the materials in the process of creating the materials.*

In conclusion, evaluative strategies will need to be attuned to cultural and linguistic issues not only in how the strategies are constructed and executed, but also in terms of how the data are interpreted.

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