Final Report for the Program Evaluation and Monitoring of the Community Networks to Reduce Cancer and Health Disparities Program

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1. PURPOSE OF THE EVALUATION

1.1 Type of Evaluation

- The national evaluation proposed is a process evaluation of Phase I of the Community Networks Program (CNP). The process evaluation will document and track activities implemented across sites to meet the Phase I objectives of the RFA from 2006-2009.

1.2 Purpose of Evaluation

The purpose of the proposed Phase I evaluation is to implement a full-scale process evaluation. A feasibility study was conducted in FY 2005. During FY 006, logic models and data collection tools were developed. The primary objectives of this Phase I evaluation are to:

(1) Collect and store Phase I core process evaluation data elements from each CNP, utilizing a Web-based data entry system already developed during the design stage of the evaluation;
(2) Analyze the Phase I process data to determine if the CNPs are implementing activities to meet the CNP Phase I objectives;
(3) Aid in the monitoring of each CNP to identify problems with program implementation and to propose possible solutions, as well as to identify model implementation strategies and characteristics that can be shared with other CNPs; and
(4) Provide technical support and training to CNPs, as needed, to assist them in collecting Phase I core data elements.

1.3 Timeliness of the Evaluation

- The CNP is a key component of the Center to Reduce Cancer Health Disparities (CRCHD's) answer to the challenge set forth by the Trans-HHS Cancer Health Disparities Progress Review Group (PRG) to: *Establish partnerships for and support the development of sustainable community-based networks for participatory research in areas of high cancer disparities* (DHHS, 2004a). The CNP also contributes to two of the 20 DHHS Department-Wide Objectives: 1) *emphasize faith-based and community solutions*, and 2) e*mphasize healthy living and prevention of disease, illness, and disability*. The CNP's community-based participatory research (CBPR) approach seeks to expand community partnerships to provide effective preventive, screening, and treatment health services. The CNP builds on the work of the well-recognized CRCHD Special Population Networks (SPN) program. Because no comprehensive national evaluation of this earlier program was conducted, the evaluation of the CNP is critical at this juncture to provide evidence of the effectiveness of community-based participatory education, research, and training to address cancer health disparities.

Phase I of this evaluation will have several purposes. It will serve as the basis from which to assess the linkage between CNP activities and outcomes documented in other Phases of the evaluation, such utilization of beneficial procedures and leveraging of funds. CRCHD also will use the Phase I process data in an evaluation feedback loop to inform modifications of the program throughout the award period.

Because Phase I data will be collected throughout the length of the program, CRCHD will have longitudinal process data. The data collected in 2006 will serve as a baseline for the evaluation. The quasi-experimental design will allow CRCHD to compare these baseline data to data collected in subsequent years, and will inform CRCHD about the evolution of the program's implementation.

- The evaluation of the CNP is timely because of its potential application to other NIH programs addressing health disparities. The National Center for Minority Health and Health Disparities (NCMHD) has recently launched its Community Participation in Health Disparities Intervention Research Program. This program includes infrastructure and community partnership components that are similar to the CNP. The CNP evaluation tools and results therefore will be beneficial to the NCMHD program.

1.4 Study Questions

- CRCHD has identified a series of questions corresponding to Phase I objectives, as listed below.

1. To what extent has a core organizational infrastructure been developed?
2. To what extent have partnerships been developed with communities experiencing cancer disparities and organizations that can aid in reducing their cancer disparities?
3. To what extent have collaborations been established with NCI Centers/Divisions/Offices to support other NCI efforts to reduce cancer disparities?
4. How has the utilization of beneficial interventions to reduce disparities in the community changed? (Phase II objective)
5. What kind(s) of non-CRCHD funding for community-based education and training activities directed at reducing cancer disparities have the Community Networks Programs obtained? (Phase III objective)

These questions will be addressed from the in the data collected on the CNP. The Background and Methods for data collection for the CNP are presented first. Then the questions and the data collected to show how the Program has moved to create the responses are presented.

2. BACKGROUND

- In May 2005, CRCHD awarded 25 cooperative agreements for a period of 5 years in response to the Request for Applications (RFA-CA-05-012), *Community Networks to Reduce Cancer Health Disparities through Education, Research and Training (Community Networks Program [CNP])*. Approximately $95 million in 5-year grants was made available for the program.

- The purpose of the CNP is to assist communities and populations experiencing a disproportionate share of the cancer burden by conducting community-based participatory education, training, and research among these racial and ethnic minorities (e.g., African Americans, Hispanics, Asians, Pacific Islanders, and Native Americans/Alaska Natives) and underserved populations (e.g., Appalachian, rural, low-socioeconomic-status, and other underserved communities). Community participation is expected to increase the relevance, cultural appropriateness, and effectiveness of disparity reduction efforts.

- The program's primary aim is to test the efficacy of community-based participatory research (CBPR) as a strategy to increase access to and utilization of beneficial cancer interventions in communities with cancer health disparities and to provide a cadre of well-trained researchers who will continue to reduce disparities in communities.

2.1 The Three Phases of the CNP

- The CNP is to be implemented in three phases:

Phase I of the program is to establish an infrastructure and systems to support community-based participatory education, research, and training to reduce cancer health disparities. Because CNP infrastructure and systems will continue to evolve throughout the life of the program, Phase I activities continue throughout the 5 years of the program.

Phase II focuses on developing community-based participatory research and training programs to reduce cancer health disparities. These activities extend from year 2 (September 1, 2006, to August 31, 2007) through year 5.

In Phase III, the 25 grantees—the local Community Networks Programs (CNPs)—are charged with implementing strategies to establish the credibility and sustainability of CNP activities.

- The focus of report is the CNP grantees' progress in achieving Phase I and Phase II goals and objectives, and the beginning of Phase III activities from 2005 to 2009.

- Table 2-1 outlines the goals and objectives, established by CRCHD, for each phase of the CNP program.

Table 2-1. Goals and Objectives for Each Phase of CNP Implementation

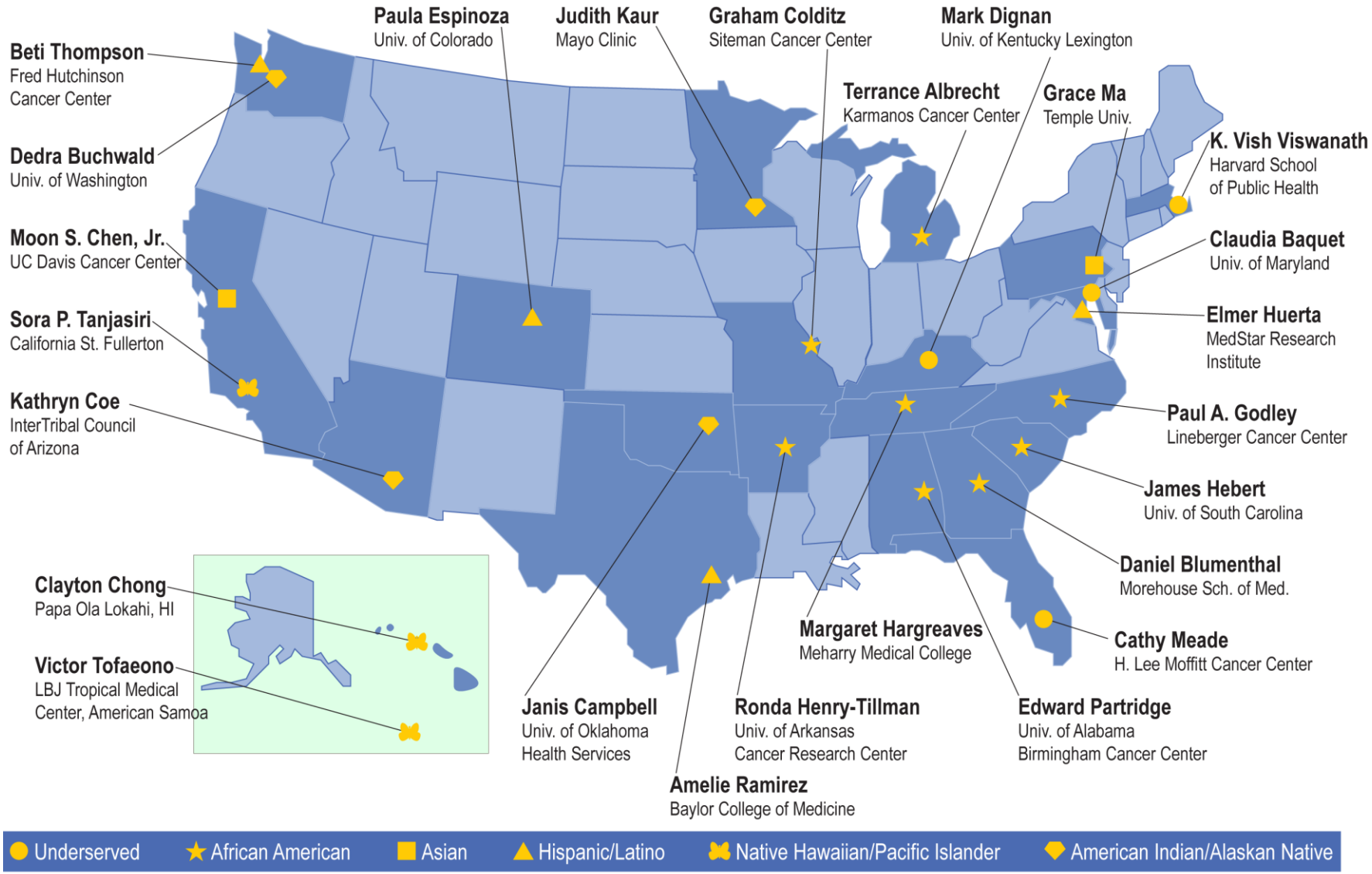
Phase I Goal	Develop and increase capacity building to support community-based participatory education, research, and training to reduce cancer health disparities.
Phase I Objectives	1. Develop a core organizational infrastructure for the local CNP. 2. Create partnerships with communities experiencing cancer health disparities and with organizations working to reduce cancer disparities in these communities. 3. Form at least four collaborations with other NCI Centers/Divisions/Offices. 4. Conduct cancer education activities. 5. Obtain non-CRCHD funding for community-based participatory education and training to reduce cancer health disparities.
Phase II Goal	Develop community-based participatory research and training programs to reduce cancer health disparities.
Phase II Objectives	1. Perform community-based participatory research to reduce cancer health disparities. 2. Increase utilization of beneficial interventions. 3. Develop and implement pilot projects using community-based participatory research to develop efficacious community-based participatory interventions to reduce cancer health disparities. 4. Train researchers in community-based participatory research to reduce cancer health disparities, particularly researchers from racial/ethnic minority and underserved populations.
Phase III Goal	Establish credibility and sustainability of CNP activities that reduce cancer health disparities.
Phase III Objectives	1. Increase participation in primary and secondary prevention procedures in order to reduce cancer health disparities at the community level in the short term and decrease disparities in the long term. 2. Leverage CNP resources to obtain non-CRCHD funding for research proposals on reducing cancer health disparities. 3. Provide evidence-based information on reducing disparities to local, State, and Federal policymakers.

- By August 31, 2009—the end of year 4 of operation—all 25 CNPs had implemented Phase I and reported on their progress in meeting the Phase I goal and objectives. In addition to focusing on Phase I, this report documents the progress that some of the CNPs report in implementing the Phase II goal and objectives, and beginning Phase III activities.

2.2 A Follow-on to SPN

- The CNP program is a follow-on to the Special Populations Networks (SPN) program, a precursor program conducted by the CRCHD. Although the programs share similar goals, the CNP places greater emphasis on community participation and, in particular, community-based participatory approaches to research, education, and training to reduce cancer disparities. Thirteen institutions that received a CNP award had previously participated in the SPN program. In the findings presented in Section 4 of this report, we examine differences in implementation progress between those CNPs that were formerly funded as SPNs and those that were not SPN awardees. The 25 CNPs cast a wide geographic net across the United States and its territories, as illustrated in Figure 2-1.

Figure 2-1. Map of Community Networks Program Sites



Source: CNP Project Listing, Center to Reduce Cancer Health Disparities Community Networks Program (CNP), National Cancer Institute, U.S. National Institutes of Health.
Available at : http://crchd.cancer.gov/cnp/cnp-project-listing.html.

2.3 A Diverse Cross Section

- The 25 institutions with CNP awards vary widely in size, complexity, and geographic dispersion. For example, the Asian American Network for Cancer Awareness, Research, and Training, which serves approximately one-third of all Asian Americans residing in the United States, conducts community-based participatory education, training, and research by, for, and with Asian Americans in Sacramento, San Francisco, Los Angeles, Seattle, and Honolulu. Building on existing community partnerships, the National Black Leadership Initiative on Cancer III: Community Network Program utilizes its core infrastructure of four regional research offices and 45 volunteer community coalitions in 30 States to address cancer health disparities among African Americans. The Appalachia Community Cancer Network addresses cancer health disparities in the Appalachian areas of Kentucky, West Virginia, Ohio, Pennsylvania, New York, Maryland, and Virginia—home to some of the most medically underserved and economically disadvantaged people in the United States. The American Samoa Community Cancer Network focuses on reducing cancer health disparities in the U.S. territory of American Samoa. The CNP for Older, Underserved African American Adults tackles cancer health disparities among the population it serves in Detroit's socially and economically challenged urban neighborhoods. The Tampa Bay Community Cancer Network (TB-CNN): A Model for Reducing Health Disparities addresses cancer health disparities among the medically underserved, low-literacy, and low-income populations in selected areas of three Florida counties. Redes En Accion, the National Latino Cancer Research Network, built a network of researchers and health professionals that operate nationally; they have regional sites located in California, Florida, New York, Washington, D.C., and Texas.

- Table 2-2 presents a complete list of the 25 programs, and identifies the principal investigator, institution, population served, and whether the site participated in the SPN program.

Table 2-2. Community Networks to Reduce Cancer Health Disparities: Program Sites

Project Title	Principal Investigator/Institution	Population Served	Activity*
The American Indian/Alaska Native Initiative on Cancer	Kaur, Judith S. Mayo Clinic College of Medicine	American Indian/ Alaska Native	Yes
American Samoa Community Cancer Network	Tofaeono, Victor T. Williams Lyndon B. Johnson Tropical Medical Center	Samoan/Pacific Islander	No
Appalachia Community Cancer Network (ACCN)	Dignan, Mark B. University of Kentucky Research Foundation	Underserved	Yes
Arkansas Cancer Community Network (ARCCN)	Henry-Tillman, Ronda S. University of Arkansas Research Center	Underserved	Yes
Asian American Network for Cancer Awareness, Research & Training (AANCART)	Chen, Moon S. Jr. University of California, Davis Cancer Center	Asian	Yes
ATECAR: Asian Community Cancer Network	Ma, Grace X. Temple University	Asian	Yes
Carolina Community Network	Godley, Paul A. Lineberger Cancer Center, University of North Carolina, Chapel Hill	African American	No
CNP for Older, Underserved African American Adults	Albrecht, Terrance L. Karmanos Cancer Center	African American	No
The Colorado Front Range Latino Community Network	Espinoza, Paula A. University of Colorado at Denver and Health Sciences Center	Hispanic	Yes†
Deep South Network for Cancer Control	Partridge, Edward E. University of Alabama at Birmingham Cancer Center	African American	Yes
Hispanic Community Network to Reduce Cancer Disparities	Thompson, Beti Fred Hutchinson Cancer Research Center	Hispanic	No
Imi Hale: Native Hawaiian Cancer Network	Chong, Clayton D.K. Papa Ola Lokahi	Native Hawaiian/ Pacific Islander	Yes
Latin American Cancer Research Coalition	Huerta, Elmer E. MedStar Research Institute	Hispanic	Yes
The Maryland Regional Community Network Program To Eliminate Cancer Health Disparities	Baquet, Claudia R. University of Maryland School of Medicine	Underserved	Yes
Massachusetts Community Networks to Eliminate Cancer Health Disparities Through Education, Research, and Training (MASS CONECT)	Viswanath, K. "Vish" Harvard University School of Public Health	Underserved	No
Meharry Medical College-Community Health Centers Network	Hargreaves, Margaret Meharry Medical College	African American	No
National Black Leadership Initiative on Cancer III: Community Networks Program	Blumenthal, Daniel Morehouse School of Medicine	African American	Yes‡
Program for the Elimination of Cancer Disparities	Colditz, Graham A. Siteman Cancer Center, Washington University	African American	No
Redes En Acción: National Latino Cancer Research Network	Ramirez, Amelie G. Baylor College of Medicine	Hispanic	Yes
Regional Native American Community Networks Program	Buchwald, Dedra S. University of Washington	American Indian/ Alaska Native	No
South Carolina Cancer Disparities Community Networks	Hebert, James R. University of South Carolina Research Foundation	African American	No
Southwest American Indian Collaborative Network	Coe, Kathryn Intertribal Council of Arizona	American Indian	Yes§
Tampa Bay Community Cancer Network (TB-CCN): A Model for Reducing Health Disparities	Meade, Cathy D. H. Lee Moffitt Cancer Center & Research Institute, Inc.	Underserved	No
University of Oklahoma Community Networks Project (OUCNP)	Campbell, Janis University of Oklahoma Health Services	American Indian/ African American	No
WINCART: Weaving an Islander Network for Cancer Awareness, Research, and Training	Tanjasiri, Sora Park California State University Fullerton	Pacific Islander	No

* Former SPN or Other NCI Special Population Activity

† Latino/a Research and Policy Center

‡ National Black Leadership – Cancer Control, Research and Training Network (NBL-CCRTN)

§ American Indian Initiative in Arizona

3. METHODS

- This section presents the study goals for the national evaluation of the Community Networks Program (CNP), the conceptual framework that has guided the national evaluation, core data elements and data collection tools, and methods used to analyze the data reported by the grantees—the 25 Community Networks Programs (CNPs).

3.1 Goals of the Evaluation

- The national evaluation is attempting to measure the efficacy of community-based participatory research as a strategy for reducing cancer health disparities. It is guided by the CNP's programmatic goals and objectives (see Table 2-1). The evaluation tracks each CNP grantee's progress in meeting the three goals of the program—(1) the establishment of a program infrastructure and effective community partnerships, (2) the conduct of community-based participatory research and training programs to reduce cancer health disparities, and (3) the sustainability of CNP research programs.

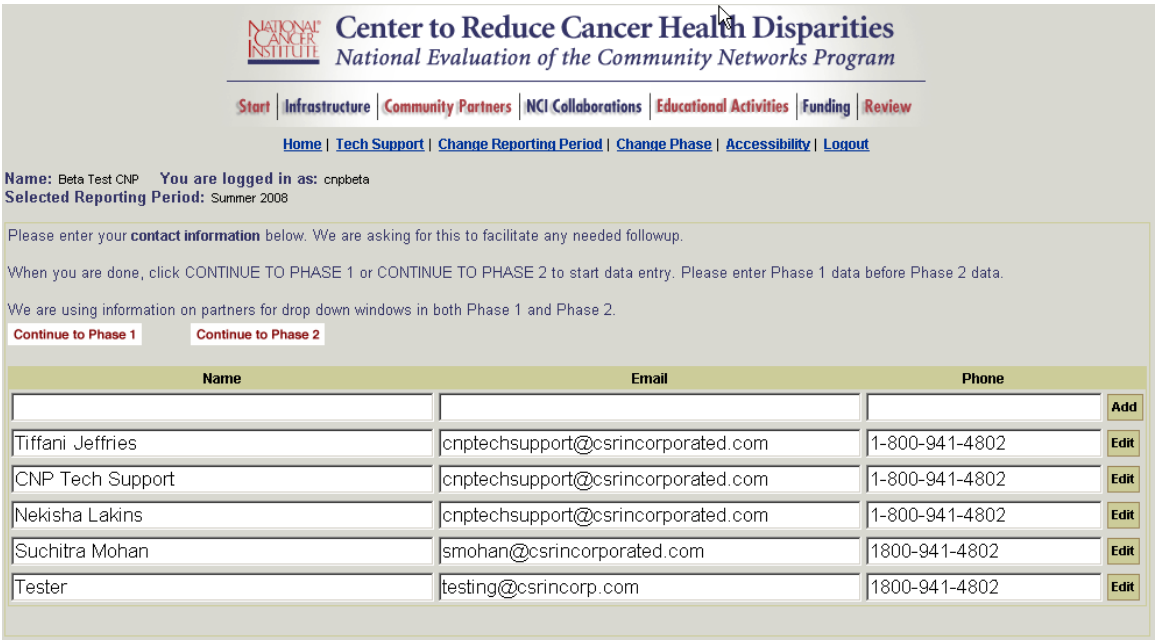
3.2 Conceptual Framework and Logic Models

- The national evaluation is grounded in a conceptual framework that CRCHD developed during a feasibility study in 2004, and in phase-specific logic models developed during years 1 and 2 of the CNP national evaluation. The framework shows the relationships between program objectives; program building blocks; the focus of activities; and short-term (process), intermediate, long-term, and ultimate outcomes (impact) (see Appendix A).

3.3 Core Data Elements and Data Collection Tools

- CRCHD and CNP PIs identified core data elements to be collected online with a Web-based tool developed by CSR. The Phase I data elements and Web-based data collection systems were finalized in year 2. After fall 2007 data collection, several CNP PIs and data managers informed CSR that their accomplishments would be more accurately reflected if they could report increases in cancer-related knowledge and awareness and other intermediate outcomes. CSR added fields to allow the reporting of intermediate outcomes. CSR also added drop-down lists for reporting needs assessments and education activities associated with intervention outcome studies. Figure 3-1 presents screenshots of the home page and the contact information page for the Web-based tool. Appendix C includes the data collection instruments for Phases I and II. The data collection instruments for Phase III will be completed early in year 5.

Figure 3-1. Screenshots of the Home Page and Contact Information Page



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3.4 Web-Based Data Collection

- In year 4, CSR continued to use the Web-based system developed in year 1. CSR uses IIS/ColdFusion/SQL Server Web architecture for this site. A single URL (http://www.cnpeval.org) was maintained with links to the Phase I and Phase II tools and, from these, to the different sections of each tool. Navigation aids were included to help users progress through data entry.

- The site opened for the fall 2008 cycle in November 2008, following extensive internal testing by CSR staff, and it closed in February 2009. Because there have been no major changes to the tools during 2009, CSR staff performed limited internal testing before the site was opened for data collection in May 2009.

- One training tutorial on data entry was held via conference call in November 2008. CSR staff provided technical assistance through a dedicated technical support e-mail address and a toll-free telephone line when the Web tool was open for data collection. Staff responded to all questions within 2 business days and, most often, within several hours. In April 2009, CSR staff, in conjunction with CRCHD staff, held a webinar conference call to address data reporting by CNP grantees and steps toward future data collection. PIs, program managers, and other essential staff members participated in the call, and 15 CNP grantees were represented.

3.5 Qualitative Data Collection—Site Visits

- CSR's qualitative data collection for the national evaluation includes telephone interviews with CNP PIs and staff, as well as site visits. In spring 2008, two CSR staff members visited three CNPs to observe program facilities and operations and to discuss the degree to which the community network model facilitates program success. CSR staff met with PIs as well as other key informants identified by PIs, including staff, partners, and clients.

- In addition to collecting qualitative data through the telephone interviews and site visits, two CSR staff members reviewed CRCHD files to collect data on pilot studies. Summaries included data on pilot study research topics, progress, and findings.

- Research topics for pilot projects ranged from needs assessment studies and intervention research to policy assessments. CSR collected qualitative and quantitative data on awarded pilot projects and projects already in progress. CSR staff members recorded the score the project received, the target population, the outcome category, and targeted outcomes. When the data were available, staff members indicated specifics about the proposed outcome measures and any available outcomes indicated.

3.6 Data Quality Control

- Data quality control measures put in place during year 1 of the contract were maintained through year 4. These included built-in validation checks within the Web-based system to ensure that certain data elements were reported correctly. For example, respondents were required to use a specific date format to report dates of meetings or activities. The start date of a data collection effort had to be earlier than the end date. Study or intervention titles and data sources were required for some questions. Frequent communication with respondents who contacted CSR for technical assistance also helped ensure that these CNP staff members provided the correct information to answer the questions.

- Once each data submission period ended, CSR analysts and database specialists reviewed the data submitted and identified data responses that needed to be verified with the CNPs to appropriately clean the data set for analysis. CSR developed a comprehensive list of data items to discuss with each CNP and contacted CNP staff as needed. There is a page in the Web-based tool to collect contact information (name, phone number, and e-mail address) for each CNP. The person performing data entry usually is listed as the contact person.

This feature in the Web-based tool facilitated quick and easy followup. For example, CSR contacted nine CNPs to seek clarification as well as additional information after the end of the data submission period.

3.7 Data Analysis

- All data were downloaded into Access, Excel, and the statistical software package SAS v.8. For text data, CSR analysts developed coding schemes to identify themes and summarize findings across CNPs.

- CNPs were categorized by size according to funding level. Table 3-1 presents the categories. Six CNPs were awarded $1 million or more (identified as Group 1), 8 received awards of $700,000 to $950,000 (Group 2), and the remaining 11 received $350,000 to $520,000 (Group 3). Stratified analyses by funding level were conducted for select variables. In addition, for select variables, CNPs that received previous SPN awards (see Table 2-2) were compared with those that did not receive such an award to gain an understanding of how the earlier program contributed to the CNP implementation process.

- CNPs were asked to provide updates on Phase I components already reported in years 1, 2, and 3. These included information on CNP staffing; committees; partnerships with non-clinical and clinical entities; collaborations with non-CRCHD centers, divisions, or offices; and leveraging of non-CRCHD funding. For these components, data shown in this report reflect activities and status to date—e.g., current staffing levels, or clinical partnerships established to date—rather than only changes that occurred in year 4.

- Phase II data reporting began in the summer of 2007. As was the case in the year 3 report, for those CNP-sponsored interventions that reported both the number served and the size of the target population, we could calculate a beneficial cancer utilization rate (UBI) showing the proportion of the target population utilizing a particular intervention. However, the utilization rate continues to be very sensitive to changes in the size of the reported target population for a given intervention. As was noted in year 3, the size of the reported target population appears to change, sometimes dramatically, from one reporting period to the next. As a result, the utilization rate over time appears to be somewhat unstable, rising and falling sometimes dramatically from one year to the next. This problem is ameliorated to some degree when utilization rates are calculated using pooled time-series data. Just as in year 3, while the utilization rate is still useful, it should be interpreted with some caution as a measure of performance. Thus the year 4 report concentrates on the year-to-year changes in the number of individuals served using beneficial cancer interventions. This outcome measure is presented using observed data and adjusted data reflecting annual differences in the number of beneficial cancer interventions.

Table 3-1. CNP Categorization by Funding Level

CNP PI	CNP Project Title
Group 1 Category/Funding Range: $1 million–$1.4 million	
Kaur, Judith S.	The American Indian/Alaska Native Initiative on Cancer
Chen, Moon S.	Asian American Network for Cancer Awareness, Research, and Training
Partridge, Edward E.	Deep South Network for Cancer Control
Blumenthal, Daniel	National Black Leadership Initiative on Cancer III: Community Networks Program
Dignan, Mark B.	Appalachia Community Cancer Network
Ramirez, Amelie G.	Redes En Acción: National Latino Cancer Research Network
Group 2 Category/Funding Range: $700,000–$950,000	
Godley, Paul A.	Carolina Community Network
Coe, Kathryn	Southwest American Indian Collaborative Network
Ma, Grace X.	Asian Community Cancer Network
Huerta, Elmer E.	Latin American Cancer Research Coalition
Hargreaves, Margaret	Meharry Medical College–Community Health Centers Network
Henry-Tillman, Ronda S.	Arkansas Cancer Community Network
Buchwald, Dedra S.	Regional Native American Community Networks Program
Chong, Clayton D.K.	Imi Hale–Native Hawaiian Cancer Network
Group 3 Category/Funding Range: $350,000–$520,000	
Colditz, Graham A.	Program for the Elimination of Cancer Disparities
Tofaeono, Victor T. Williams	American Samoa Community Cancer Network
Campbell, Janis	University of Oklahoma Community Networks Project
Thompson, Beti	Hispanic Community Network to Reduce Cancer Disparities
Hebert, James R.	South Carolina Cancer Disparities Community Networks
Espinoza, Paula A.	The Colorado Front Range Latino Community Network
Albrecht, Terrance L.	CNP for Older, Underserved African American Adults
Meade, Cathy D.	Tampa Bay Community Cancer Network: A Model for Reducing Health Disparities
Viswanath, K. “Vish”	Massachusetts Community Networks to Eliminate Cancer Health Disparities Through Education, Research, and Training
Baquet, Claudia R.	The Maryland Regional Community Network Program To Eliminate Cancer Health Disparities
Tanjasiri, Sora Park	WINCART: Weaving an Islander Network for Cancer Awareness, Research, and Training

- To address data problems during the period this report covers, CSR analysts contacted CNP grantees to discuss intervention outcome reporting. During these discussions, CNP staff described their research agendas and results, the status of intervention outcome studies, issues with obtaining data required to infer CNP effects, and potential approaches to working with the national evaluator to address these issues.

- Summer 2009 data submissions allow CSR to summarize the status of intervention outcome research. Given the status of the current outcome data, it is possible to compare and contrast outcome data in year 4 with similar data in year 3. These findings, along with descriptions of Phase I and II accomplishments and Phase III activities, are the focus of Section 4 of this report.

4. FINDINGS

1, Evaluation Question: To what extent has a core organizational infrastructure been develop?

4.1 Phase I: Establish an Infrastructure and Systems To Support Community-Based Participatory Education, Research, and Training To Reduce Cancer Health Disparities

- Phase I addresses the development of the CNP infrastructure, including staffing and establishment of committees to guide decisionmaking and implementation of the activities. We present updates from year 4 of the CNP, including any relevant comparisons with previous years.

4.1.1 *Phase I, Objective 1: Infrastructure Development*

- This objective focuses on developing a core organizational infrastructure with the development of a core staff and the creation of advisory committees.

4.1.1.1 *Staffing*

- Since year 2, the majority of CNP professional staff members have had a master's degree or higher. In year 4, over 40 percent had a Ph.D. or M.D. Another 25 percent had master's degrees. The remaining staff had a bachelor's degree or less.[1] Between years 3 and 4, the largest net increase in staff was among medical doctors with a second advanced degree (see Table 4-1).

[1]It should be noted that for roughly 18 percent of CNP professional staff, there was no reported degree or education.

Table 4-1. CNP Staff by Educational Attainment Years 2–4

Type of Degree	No. of Staff Members Year 2	Percent	No. of Staff Members Year 3	Percent	No. of Staff Members Year 4	Percent	Change in No. of CNP Staff Year 2 to 4
Associate or LPN	7	2	6	2	6	2	-1
Bachelor's	49	13	50	13	50	13	1
M.D. or other medical degree	35	10	36	10	36	9	1
M.D. with master's or other non-medical doctoral degree	25	7	28	7	40	10	15
M'P.H,/M.S.P.H or other master's degree	73	20	72	19	85	22	12
No degree	5	1	4	1	7	2	2
Ph.D. or other doctoral degree	97	26	95	25	95	25	-2
R.N.	3	1	3	1	3	1	0
R.N., master's, or doctorate	10	3	10	3	12	3	2
Student–graduate	4	1	3	1	2	1	-2
Missing/Not Indicated	60	16	70	19	47	12	-13
Total*	**368**	**100**	**377**	**100**	**383**	**100**	**18**

*Totals do not add to 100 due to rounding.

- The total number of staff members across all CNP grantees increased slightly—by 6—from year 3 to year 4 (see Table 4-2). However, growth in staff was related to whether a CNP grantee had participated in the SPN initiative and the initial funding group from CRCHD. Former SPN grantees had an average decline of about 1 percent in the number of staff, while those that had not participated in the SPN on average saw the number of staff increase by 5.6 percent—an improvement over year 3 (see Table 4-2).

Table 4-2. Number of CNP Staff Members by SPN Status and Funding Group

CNP Attributes	Year 2	Year 3	Year 4	% Change Year 3 to 4
Affiliation with SPN Initiative				
Former SPN	214	234	232	-0.9%
Non-SPN	154	143	151	5.6%
Funding Group				
Funding Group 1	113	131	128	-2.3%
Funding Group 2	137	147	148	0.7%
Funding Group 3	118	99	107	8.1%
Total	**368**	**377**	**383**	**1.6%**

- CNP grantees in Funding Groups 1 and 2, the two groups with the largest grants, experienced either a decline or very modest growth in staff—2.3 percent and 0.7percent, respectively—from year 3 to year 4 (see Table 4-2). At the same time, CNP grantees in Funding Group 3—the group receiving the smallest grants—experienced an average 8.1 percent increase in the number of staff between years 3 and 4 (see Table 4-2).

- The trend in the average number of staff per CNP shows that from year 3 to year 4, there was almost no change in the average number of staff per grantee. From year 3 to year 4, the average number of staff of CNP grantees taking part in the SPN initiative did not change, while during the same period, the average number of staff of non-SPN grantees increased from 12 to 13. When the change in average number of staff per CNP grantee is examined by funding group, grantees in Funding Group 1 saw their average number of staff decline by 1. On the other hand, grantees in Funding Groups 2 and 3 experienced an increase of 1 in their average staff sizes (see Table 4-3).

Table 4-3. Average Number of CNP Staff Members by SPN Status and Funding Group

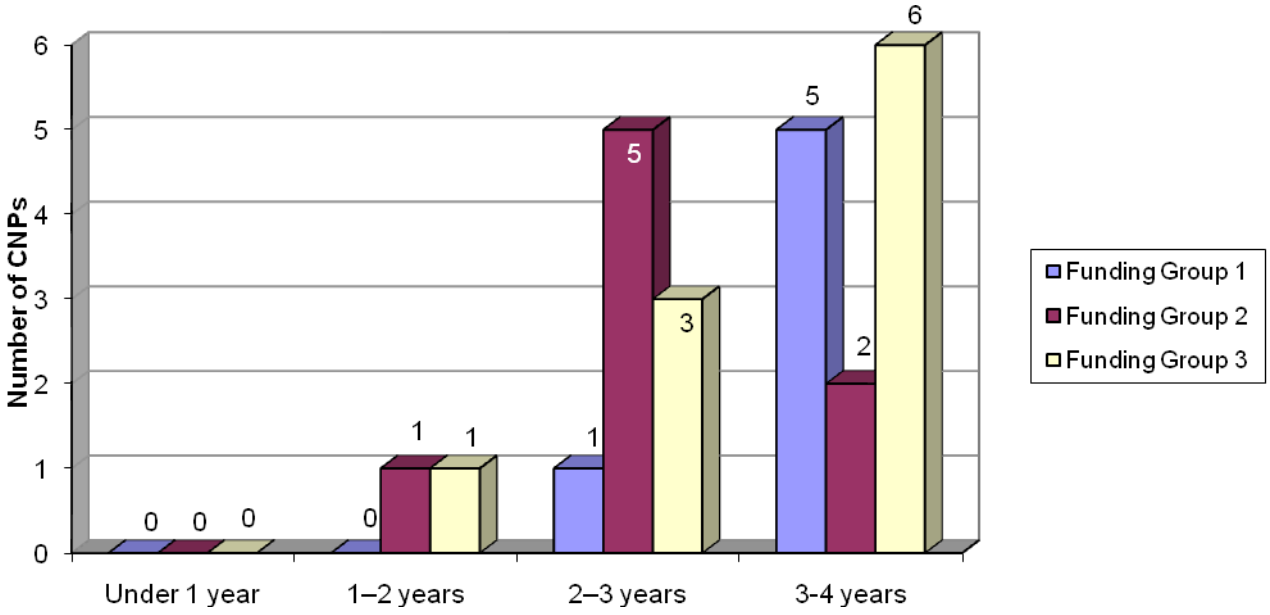
CNP Attributes	Year 2	Year 3	Year 4	Year 3 to 4 Change
Affiliation with SPN Initiative				
Former SPN	16	18	18	0
Non-SPN	13	12	13	1.0
Funding Group				
Funding Group 1	19	22	21	-1.0
Funding Group 2	17	18	19	1.0
Funding Group 3	11	9	10	1.0
Weighted Average*	**14.7**	**15.1**	**15.3**	**0.2**

*Numbers are rounded.

- Between years 3 and 4, the change in total CNP staff size and in the average number of staff per CNP grantee appears to be modestly associated with SPN status and funding level. That is, the relationships between average number of staff and SPN status and funding group have remained unchanged since year 1. SPNs tend to have more average staff than non-SPNs, and the number of average staff is positively related to the size of the NCI grant. (See Tables 4-2 and 4-3.) It is unclear, however, whether there is a relationship between SPN status and funding level and rate of change in both the total and average staff size from year to year. Indeed, compared with the change between years 2 and 3, these relationships appear to have reversed between years 3 and 4—non-SPNs and grantees in Funding Group 3 seem more likely to have increased their staff sizes than former SPNs and grantees in Funding Groups 2 and 3. One possible explanation is that staff in non-SPN grantees or grantees in Funding Group 3 managed to increase their job tenures relative to staff in former SPN grantees or grantees in Funding Groups 1 and 2. If this were the case, the greater tenure might lead to less staff turnover and an overall increase in staff size.

- When examining only the difference between funding groups, there does appear to be some difference in the average staff tenure between CNP grantees. In year 4, across all three funding groups, the average tenure for staff in the majority of CNP grantees was 3 to 4 years (see Figure 4-1). However, grantees in Funding Groups 1 and 3 were more likely than those in Funding Group 2 to have staff that had been working on the CNP initiative for 3 to 4 years (Figure 4-1). This may suggest a slightly higher turnover rate for CNP grantees in Funding Group 2 than in Funding Groups 1 and 3.

Figure 4-1. Average Length of Time Staff Members Remain on the CNP as of Year 4



- One other possibility that may contribute to better understanding changes in staff size is the relationship between the growth in staff and the fundraising success of CNP grantees. If non-SPN participants and CNP grantees in Funding Group 3 were more successful in their fundraising efforts during year 4 than were former SPN participants and CNP grantees in Funding Groups 1 and 2, this could help to explain the observed changes in staff sizes across CNP grantees. However, this does not appear to be the case for SPN versus non-SPN, though it does appear to be the case for funding level. Non-SPNs actually saw a percent decline in their fundraising from year 3 to year 4 when compared with SPNs. On the other hand, compared with Funding Groups 1 and 2, Funding Group 3 had the largest percentage increase in new funds raised from year 3 to year 4.

4.1.1.2 *Steering Committee*

- The CNP Steering Committee serves to guide and oversee program operations. The RFA states that steering committee members should be representatives from the community, academia, and research and NCI. By year 3, all 25 CNP grantees reported having a steering committee. This also was the case in year 4 (see Table 4-4.). However, between years 3 and 4, the number of CNP grantees with all required members as specified by CRCHD guidelines[2] declined from 22 to 19.

Table 4-4. Number of CNP Steering Committees Meeting CRCHD Guidelines for Member Affiliations

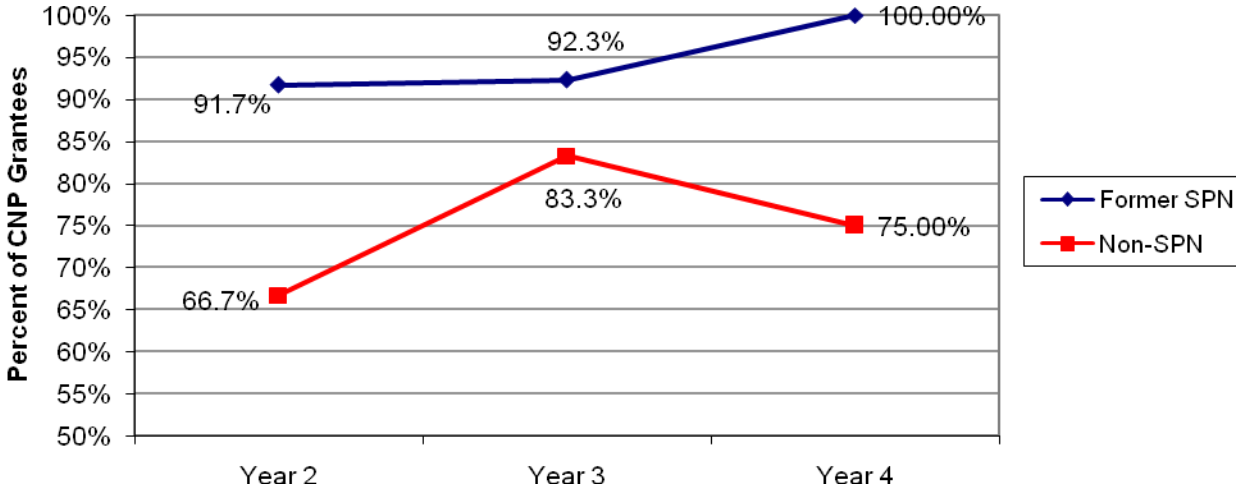
Number of Required Sectors Represented	Year 2	Year 3	Year 4
Number of CNP committees with members from	1	1	2

[2] CRCHD program guidelines for the Community Network Program require each steering committee to have representatives from academia, the target community, and NCI.

only one required sector			
Number of CNP committees with members from only two required sectors	4	2	4
Number of CNP committees with members from all required sectors	19	22	19
Number of CNP Grantees with Steering Committee	**24**	**25**	**25**

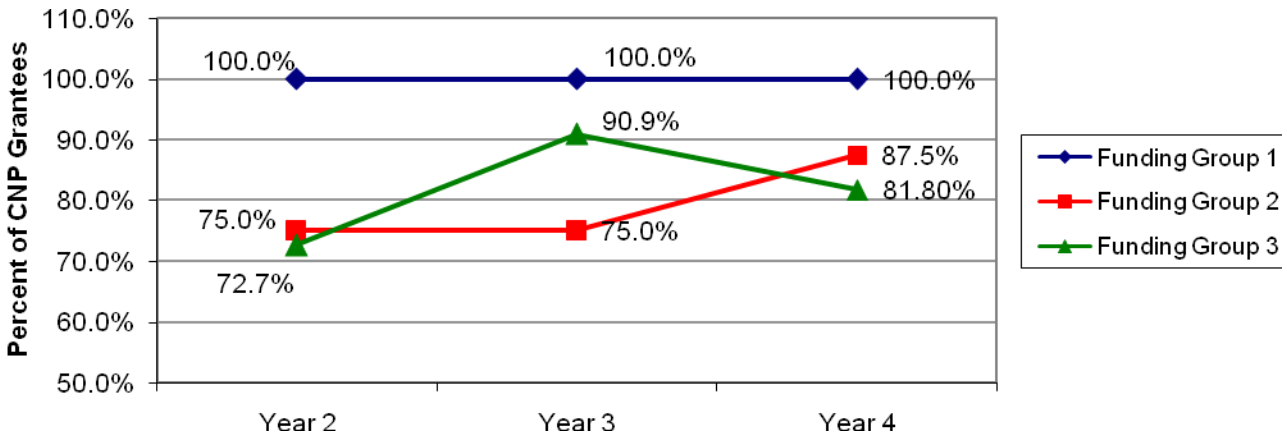
- SPN affiliation and funding group appear to be associated with whether CNP steering committees have representation from all required sectors. Non-SPN grantees are less likely than those that were involved with the SPN to have met the required representation (see Figure 4-2).

Figure 4-2. Change in Percent of CNP Grantees With Steering Committees Representing All Required Sectors by SPN Status



- Similarly, the level of CNP funding also seems to have a relationship to steering committee composition. In years 2, 3, and 4, all CNP grantees in Funding Group 1 (the largest grants) had representation from the community, academia, research, and NCI. During year 4, 88 percent of CNP grantees in Funding Group 2 had steering committees with the required representation, an increase from year 3. In year 4, grantees in Funding Group 3 (those with the smallest grants) showed a decline in the number of groups meeting the requirements for representation—82 percent in year 4 compared with 91 percent in year 3 (see Figure 4-3).

Figure 4-3. Change in Percent of CNP Grantees With Steering Committees Representing All Required Sectors by Funding Group



- The steering committees for 11 CNP grantees reported meeting 19 times during year 4. The average attendance was roughly 12 people per meeting. Minutes were created for 18 of the 19 meetings, and they were shared at 17 of the meetings. An average of two meetings a year were conducted, the largest number of meetings being five.

4.1.1.3 *Community Advisory Group*

- The RFA requires grantees to assemble a Community Advisory Group (CAG) of leaders in the local community. CAGs provide a formal link between the communities where CNP grantees provide services, and they serve as a liaison to CNP staff. CAGs offer advice on activities and help to disseminate information. CRCHD advises CAGs to meet at least twice a year.

- The number of CNP grantees that reported having at least one CAG increased from 23 to 24 from year 3 to year 4. However, 1 of the 25 CNP grantees does not yet have a formal CAG (see Table 4-5). The organizations participating in the CAGs focused on a wide range of issues (see Table 4-5). In year 4, 23 CNP grantee sites reported meeting with their CAGs. On average, CAGs met 5 times during the year, with an average attendance of 14, a maximum of 30, and a minimum of 3. Minutes were created and shared at every minute during year 4.

Table 4-5. Number of Community Advisory Group Organizations by Focus Area

Focus Area	Year 2		Year 3		Year 4		% Change Year 2 to 4
	No.	Percent	No.	Percent	No.	Percent	
One or more specific race/ethnic groups	525	76	563	78	620	78	18
One or more specific age groups	410	59	435	61	483	61	18
Underserved populations	481	70	549	76	603	76	25
One or more specific cancers	375	54	400	56	448	56	19
Faith-based strategies	195	28	216	30	233	29	19
Cancer education, outreach, advocacy, media relations	392	57	446	62	516	65	32
Policy-related	159	23	176	24	206	26	30

Access issues	245	36	313	44	361	45	47
Survivorship	199	29	223	31	247	31	24
Training/technical assistance	166	24	180	25	207	26	25
Alternative/complementary medicine	24	3	25	3	28	4	17
Prevention	362	52	401	56	449	56	24
Screening	273	40	318	44	354	45	30
Treatment	155	22	167	23	179	23	15
Other	55	8	58	8	69	9	25
Total CNP Grantees	**21**		**23**		**24**		**14**
Total CAG Organizations	**690**		**719**		**795**		**15**

Note: Numbers do not add to total because organizations focus on more than one issue.

4.1.1.4 *Regional Advisory Committee*

- The RFA specifies that multisite CNP grantees may form Regional Advisory Committees (RACs) to function similarly to the steering committee. A total of 10 CNP grantees reported having an RAC in year 3 and no new RACs were reported in year 4.

- Optimally, RACs include members from community-based organizations and academic or research institutions. Nine of the 10 CNP grantees that reported having an RAC have representatives from both affiliations. Similarly, 9 CNP grantees reported meeting during year 3, and on average they convened more than 19 times a year. When minutes were created, they were shared 98 percent of the time with RAC affiliates

2. Evaluation Question: To what extent have partnerships been developed with communities experiencing cancer disparities and organizations that can aid in reducing their cancer disparities?

4.1.2 *Phase I, Objective 2: Community Partners*

- Community partnerships, both clinical and non-clinical, are viewed as an essential element in the CNP logic model. Collaborating with local groups allows CNP grantees to better understand their communities and thereby work more effectively to address cancer disparities.

4.1.2.1 *Non-Clinical Partners*

- CNP grantees have formed a wide range of partnerships. Since year 2, the number of these partnerships has increased (see Table 4-6.) These collaborations include health advocacy groups, such as the American Cancer Society, local colleges and universities, faith-based organizations, and other influential community groups. Non-clinical partners provide a myriad of services, with most CNP grantees partnering with organizations that provide cancer education and advocacy and services to underserved populations (Table 4-6).

Table 4-6. Numbers of Non-Clinical Partners by Services Provided, Years 2 and 3

Services Provided	Year 2	%	Year 3	%	Year 4	%	% Change Year 2 to 4
For Specific Race/Ethnicity Groups	246	26	342	29	418	31	70
For Specific Age Groups	128	13	162	14	174	13	36
Alternative/Complementary Medicine	30	3	43	4	43	3	43
Cancer Education and Advocacy	430	45	531	45	616	46	43
Cancer Survival Support	197	21	231	20	266	20	35
Policy Related	185	19	208	18	244	18	32
Referral to Health Provider	233	25	286	24	321	24	38
Research/Clinical Trials	180	19	213	18	237	18	32
Related to Specific Cancers	225	24	295	25	333	25	48
Training/Technical Assistance	213	22	246	21	274	20	29
For Underserved Populations	371	39	530	45	618	46	67
Working with Faith-based Organizations	188	20	243	21	286	21	52
Other	132	14	181	15	207	15	57
Total	**949**	**100**	**1,171**	**100**	**1,346**	**100**	**42**

Note: Number of services is greater than total because partners can provide more than one type of service.

- Between year 2 and year 4, there was an increase in the number of non-clinical partners serving all racial and ethnic groups served by CNPs (see Table 4-7).

Table 4-7. Number of Non-Clinical Partners by Race and Ethnicity of Population Served

	Year 2		Year 3		Year 4		% Change Year 2 to 4
	No.	Percent	No.	Percent	No.	Percent	
Race of Populations Served							
Asian	265	28	304	26	346	26	31
White	338	36	364	31	385	29	14
Black or African American	477	50	508	43	537	40	13
American Indian or Alaska Native	244	26	237	20	246	18	1
Native Hawaiian or Other Pacific Islander	240	25	230	20	233	17	3
Multiracial	445	47	497	42	520	39	17
Ethnicity of Populations Served							
Hispanic or Latino	398	42	520	44	603	45	52
Not Hispanic or Latino	394	42	553	47	687	51	74
Total CNP grantees	**25**		**25**		**25**		**0**
Total partners	**949**		**1,171**		**1,346**		**42**

- In year 4, CNP grantees reported a total of 1,346 non-clinical partners, compared with 1,171 reported in year 3 (see Table 4-8). In year 4, the most prevalent type of agreement between CNP grantees and non-clinical partners was something other than a memorandum of understanding or letter of agreement. This is in contrast to year 3, when memorandums of understanding were the most likely form of agreement between CNP grantees and non-clinical partners. (See Table 4-8.)

Table 4-8. Total Number of Agreements With Non-Clinical Partners

25 CNP Grantees	Year 2	Year 3	Year 4	% Change Year 2 to 4
Memorandum of Understanding	493	520	528	7
Letter of Agreement	185	182	198	7
Other Agreement	260	447	575	121
No Agreement	11	22	45	309
Total Non-Clinical Partners	**949**	**1,171**	**1,346**	**42**

4.1.2.2 *Clinical Partners*

- While non-clinical partners are a crucial part of the community research process, in order to design and deliver cancer intervention services, CNP grantees must form healthy partnerships with potential clinical partners in their target communities. By year 4, CNP grantees reported having a total of 354 clinical partners providing primary and secondary prevention services—an increase of 51 over year 3 (see Tables 4-9 and 4-10). In years 2–4, CNP grantees appeared to be somewhat more likely to have partnerships with clinical partners that offer secondary prevention services—in particular, breast cancer and cervical cancer screening (see Table 4-9).

Table 4-9. Provision of Clinical Services by Type of Service and Number of Clinical Partners for Years 2, 3 and 4

Type of Clinical Services	No. of Partners Providing Services, Year 2	Percent of Clinical Partners Providing Services (N=268)	No. of Partners Providing Services, Year 3	Percent of Clinical Partners Providing Services (N=303)	No. of Partners Providing Services, Year 4	Percent of Clinical Partners Providing Services (N=354)
Primary Prevention						
Diet Management	82	30.6	97	32.0	106	30
Exercise Management	71	26.5	81	26.7	89	25
Hepatitis B Vaccine	70	26.1	83	27.4	85	24
Smoking Cessation	84	31.3	94	31.0	98	28
Other	52	19.4	55	18.2	62	18
Secondary Prevention						
Breast Cancer	191	71.3	221	72.9	255	72
Cervical Cancer	165	61.6	183	60.4	205	58
Colorectal Cancer	148	55.2	171	56.4	198	56
Prostate Cancer	139	51.9	154	50.8	168	47
Other	49	18.3	45	14.9	50	14
Total Number of Partners	**268**	**100.0**	**303**	**100.0**	**354**	**100.0**

- CNP grantees reported that, from year 2 to year 3, the number of clinical partnerships serving all racial/ethnic groups either decreased or remained unchanged. However, from year 2 to year 4, the number of clinical partners serving all racial/ethnic groups increased, with the exception of those serving American Indians or Alaskan Natives and Native Hawaiians and Pacific Islanders (see Table 4-10).

Table 4-10. Number of CNP Clinical Partners by Race and Ethnicity of Populations Served

	Year 2		Year 3		Year 4		Percent Change Year 2 to 4
	No.	Percent	No.	Percent	No.	Percent	
Race of Populations Served							
Asian	76	28	73	24	88	25	16
White	125	47	123	41	128	36	2
Black or African American	126	47	126	42	132	37	5
American Indian or Alaska Native	82	31	71	23	77	22	-6
Native Hawaiian or Other Pacific Islander	57	21	48	16	52	15	-9
Multiracial	183	68	181	60	195	55	7
Ethnicity of Populations Served							
Hispanic or Latino	161	60	197	65	228	64	42
Not Hispanic or Latino	140	52	166	55	204	58	46
Total CNP grantees with clinical partners	**25**		**25**		**25**		**0**
Total partners	**268**		**303**		**354**		**32**

- Compared with the year 2–3 period, the number of memorandums of understanding remained stable between year 3 and year 4. However, their relative importance in formalizing partnerships between CNP grantees and clinical partners actually declined. The largest percent increases were in the use of no formal agreement, followed by the use of letters of agreement and other types of less formal agreement instruments (See Table 4-11).

Table 4-11. Total Number of Agreements With Clinical Partners by Type of Agreement (Years 2, 3, and 4)

25 CNP Grantees	Year 2	Year 3	Year 4	% Change Year 2 to 4
Memorandum of Understanding	139	144	144	4
Letter of Agreement	36	45	65	81
Other Agreement	86	102	132	53
No Agreement	7	12	13	86
Total	**268**	**303**	**354**	**32**

3, Evaluation Question: To what extent have collaborations been established with NCI Centers/Divisions/Offices to support other NCI efforts to reduce cancer disparities?

4.1.3 *Phase I, Objective 3: NCI Collaborations*

- The RFA requires that CNP grantees form at least four collaborations with NCI centers, divisions, or offices other than CRCHD, including one with the Cancer Information Service (CIS). CNP grantees were allowed to count as an NCI collaboration a formal collaboration set up with an NCI-funded institution implementing a major NCI initiative, such as the Transdisciplinary Tobacco Use Research Centers (TTURC) or the Transdisciplinary Research on Energetics and Cancer (TREC) program. CNP grantees also were required to enter into a formal agreement with these NCI collaborators, completing an agreement document developed by CRCHD.

4.1.3.1 *Non-CRCHD Collaborations*

- Overall, all CNP grantees indicate that they have developed or are currently developing a formal collaborative agreement with non-CRCHD NCI offices, with an overall increase of 31 such collaborations from year 3 to year 4 (Table 4-12).

Table 4-12. Non-CRCHD NCI Collaborations

Status of Agreement	Year 2	Year 3	Year 4	% Change Year 2 to 4
Completed	23	45	66	187
In Progress	44	54	61	39
Not Yet Initiated	3	10	13	333
Total	**70**	**109**	**140**	**100**

- The number of collaborations appears to be related to CNP grantees' funding levels. However, that relationship appears to be complex. CNP grantees in Funding Group 1, those with the largest grants, had the greatest number of collaborations in years 2, 3, and 4 (see Table 4-13). In year 2, the relationship between funding groups and non-CRCHD collaborations appears linear, with grantees receiving the largest grants reporting the largest number of collaborations (see Table 4-13). However, in years 3 and 4, because of the rapid growth in collaborations among grantees in Funding Group 3, those grantees reported the second largest number of collaborations (see Table 4-13). An interesting question is what is driving the rapid growth in non-CRCHD collaborations among the smaller grantees in Funding Group 3. The year 3 and year 4 data provide no definitive information about what might be driving these patterns.

Table 4-13. Change in Number of Non-CRCHD Collaborations by Funding Level

	Year 2	Year 3	Year 4	% Change

				Year 2 to 4
Funding Group				
Funding Group 1	31	46	56	81
Funding Group 2	22	25	35	59
Funding Group 3	17	38	49	188
Total	**70**	**109**	**140**	**100**

- While important, the number of collaborations is only part of the story. The number of collaborations is the sum of three stages in the development of a partnership: (1) the number of interactions that have emerged into a formal collaboration—that is, where the CNP grantee has completed the collaboration; (2) interactions where the grantee and the potential collaborator are in the process of finalizing the partnership; and (3) interactions where the CNP grantee and the potential collaborator are still exploring a partnership. While each of these elements could be analyzed separately, the grantees' success in completing the collaboration provides a useful benchmark for understanding the success of the collaboration process.

- In years 2–4, when non-CRCHD collaborations are analyzed by funding level, the percentage of completed collaborations is positively related to grantee funding, with Funding Group 1 having the largest percentage of completed collaborations and Funding Group 3 the smallest (see Table 4-14). However, compared with the other two funding groups, Funding Group 3 also had the greatest increase in the percentage of completed collaborations between year 2 and year 4 (see Table 4-14).

Table 4-14. Change in Percentage of CNP Grantees That Completed Non-CRCHD Collaborations by Funding Level

	Year 2 (%)	Year 3 (%)	Year 4 (%)	% Change
Funding Group				
Funding Group 1	42	50	57	15
Funding Group 2	32	40	49	17
Funding Group 3	18	32	35	27
Weighted Average	**33**	**41**	**47**	**14**

4. Evaluation Question: How has the utilization of beneficial interventions to reduce disparities in the community changed?

4.1.4 *Phase III, Objective 1: Reduce Cancer Health Disparities at the Community Level*

- Reducing cancer disparities involves increasing the number and proportion of individuals in underserved communities who utilize beneficial cancer interventions over time. Eventually this increase in both the absolute and the relative use of beneficial interventions should lead to reductions in cancer disparities. CNP grantees are reporting trend data on the number of individuals from their target communities served by a cancer intervention resulting from the CNP initiative. This section will focus exclusively on cancer screening interventions.

- A key objective of the CNP initiative is to move from community needs assessments to the development of evidence-based cancer interventions. The 25 CNP grantees are at different stages of intervention development. The majority of reported interventions focus on some form of cancer screening activity (see Table 4-30). From 2006 to 2008, CNP grantees increased the overall number of interventions reported. However, from 2008 to 2009, the number of reported interventions fell. One reason for the decline is that the data for 2009 reflect only half of the year. (See Table 4-30.)

Table 4-30. Interventions by Cancer Health Issue

Cancer Health Issue	2006	2007	2008	2009
Cancer Screening				
Breast Cancer—Mammography	5	14	12	8
Breast Cancer—Clinical Breast Exam	3	6	7	4
Cervical Cancer—HPV	–	1	2	2
Cervical Cancer—Pap Smears	3	8	9	4
Colorectal Cancer—Colonoscopy	4	5	7	3
Colorectal Cancer—FOBT	7	8	4	–
Colorectal Cancer—Sigmoidoscopy	–	1	2	1
Prostate Cancer—Digital Rectal Exam	3	2	4	2
Prostate Cancer—PSA Testing	3	8	6	3
Other Cancer—Skin Cancer, Cancer Knowledge	1	1	2	–
Primary Prevention				
Diet/Nutrition	3	5	13	4
Hepatitis B	–	–	2	1
Physical Activity	1	–	8	2
Smoking Cessation	6	4	14	4
Total Interventions	**39**	**63**	**92**	**38**

- Table 4-31 presents the annual number of individuals receiving services in a CNP cancer intervention—by cancer health issue, intervention type, and race and ethnicity. Two types of numbers are presented. For each year, the actual number observed and the number receiving services across all the interventions

for a particular cancer health issue are presented. There is a column for each year that indicates the number of interventions serving the target community for a particular cancer health issue. In addition to the observed number receiving services and the number of interventions, there is a column presenting an adjusted figure for the number of individuals served. This latter figure is an attempt to control for differences in the number of interventions each year and for differences in the length of the time periods measured. For example, under mammography, in 2006 there were only five interventions, but in 2009, there were eight. In addition, years 2006, 2007, and 2008 each cover a 12-month period, while 2009 covers only a 6-month period. The adjustment recalculates the 2006, 2007, and 2008 interventions using the number of interventions from 2009. Finally, the 2009 observed number is adjusted to make it a 12-month period.

- The adjusted number of individuals receiving services in a given year is calculated by dividing the observed number of individuals served that year by the number of interventions conducted for that year. This calculation will give the average observed number of individuals served per intervention per year. To get the adjusted number of individuals served for each year, the results are multiplied by the total number of interventions in 2009.

(Number served/number of interventions) x No. 2009 interventions = Adjusted Number Served

- These adjustments allow us to compare across time periods. As we did in the year 3 report, we are using 2006 as the baseline. We do not include reported numbers prior to 2006. We also have not included observed numbers that the grantees in their reporting indicated were baseline numbers. This is because each CNP uses a different starting period and, sometimes, a different definition of what constitutes a baseline. Essentially, the data reported provide a trend analysis of the number of individuals served for each type of cancer health issue by a given type of intervention, using 2006 as the starting point.

Table 4-15. Numbers Served by CNP Beneficial Cancer Interventions, by Cancer Site and Intervention Type, Observed vs. Adjusted (2006–2009)

Cancer Health Issue	Intervention Type	2006			2007			2008			2009		
		No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served
Breast Cancer	Mammography	5	11,778	18,845	14	15,083	8,619	12	17,183	11,455	8	3,106	3,106
Breast Cancer	Clinical Breast Exam	3	267	356	6	1,717	1,145	7	1,862	1,064	4	1,055	1,055
Cervical Cancer	HPV DNA Testing	–	–	–	1	865	1,730	2	991	991	2	601	601
Cervical Cancer	Pap Smears	3	12,104	16,139	8	16,205	8,103	9	11,033	4,904	4	1,985	1,985
Colorectal Cancer	Colonoscopy	4	4,716	3,537	5	5,018	3,011	7	961	412	3	488	488
Colorectal Cancer	FOBT	7	3,461	1,978	8	5,388	2,694	4	4,570	4,570	–	–	–
Colorectal Cancer	Sigmoidoscopy	–	–	–	1	55	55	2	331	166	1	182	182
Prostate Cancer	Digital Rectal Exam	3	84	56	2	67	67	4	449	225	2	549	549
Prostate Cancer	PSA Testing	3	1,293	1,293	8	3,306	1,240	6	1,375	688	3	627	627
Other Cancer	Skin Cancer, Cancer Knowledge etc	1	59	118	1	52	104	2	37	37	–	–	–

Cancer Health Issue	Race/Ethnicity	2006			2007			2008			2009		
		No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served
Breast Cancer—Mammography	American Indian/Alaska Native	2	4,495	6,743	3	3,001	3,001	4	2,059	1,544	3	98	
Breast Cancer—Mammography	Asian	–	–	–	1	9	9	–	–	–	–	–	–
Breast Cancer—Mammography	Black/ African American	1	23	69	4	2,492	1,869	3	2,599	2,599	3	1,611	
Breast Cancer—Mammography	White	–	–	–	2	116	116	1	30	30	–	–	–
Breast Cancer—Mammography	Multiple races	1	6,833	13,666	4	9,465	4,733	3	12,227	8,151	2	1,397	

Cancer Health Issue	Race/Ethnicity	2006			2007			2008			2009		
		No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served
Breast Cancer—Mammography	Multiracial	–	–	–	–	–	–	1	268	268	–	–	–
Breast Cancer—Mammography	Race not specified	1	427	–	–	–	–	–	–	–	–	–	–
Breast Cancer—Mammography	Hispanic/ Latino	1	427	854	3	5,462	3,641	2	5814	5,814	2	1,397	
Breast Cancer—Mammography	No Hispanic/ Latino	2	3,570	7,140	6	4,992	3,328	7	4,236	2,421	4	1,667	
Breast Cancer—Mammography	Ethnicity not specified	2	7,781	7,781	5	4,629	1,852	3	7,133	4,755	2	42	
Breast Cancer—CBE	American Indian/Alaska Native	1	125	125	–	–	–	2	231	116	1	22	22
Breast Cancer—CBE	Black/ African American	–	–	–	1	10	30	3	1,301	1,301	3	1,033	1,033
Breast Cancer—CBE	White	–	–	–	3	117	117	1	42	42	–	–	–
Breast Cancer—CBE	Multiple races	2	142	142	2	1,590	1,590	–	–	–	–	–	–
Breast Cancer—CBE	Multiracial	–	–	–	–	–	–	1	288	288	–	–	–
Breast Cancer—CBE	Race not specified	–	–	–	–	–	–	–	–	–	–	–	–
Breast Cancer—CBE	Hispanic/ Latino	–	–	–	2	1,444	722	1	317	317	–	–	–
Breast Cancer—CBE	No Hispanic/ Latino	1	1	3	2	98	147	5	1,345	807	3	1,033	
Breast Cancer—CBE	Ethnicity not specified	2	266	133	2	175	88	1	200	200	1	22	
Cervical Cancer—HPV	American Indian/Alaska Native	–	–	–	1	865	865	–	–	–	–	–	–
Cervical Cancer—HPV	Black/ African American	–	–	–	–	–	–	2	991	991	2	601	601
Cervical Cancer—HPV	Race not specified	–	–	–	–	–	–						
Cervical Cancer—HPV	Hispanic/ Latino	–	–	–	–	–	–	–	–	–	–	–	–

Cancer Health Issue	Race/Ethnicity	2006			2007			2008			2009		
		No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served
Cervical Cancer—HPV	No Hispanic/ Latino	–	–	–	1	865	1,730	2	991	991	2	601	601
Cervical Cancer—HPV	Ethnicity not specified	–	–	–	–	–	–	–	–	–	–	–	–
Cervical Cancer—Pap Smears	American Indian/Alaska Native	2	11,236	11,236	2	11,973	11,973	2	7,449	7,449	–	–	–
Cervical Cancer—Pap Smears	Asian	–	–	–	–	–	–	1	606	606	–	–	–
Cervical Cancer—Pap Smears	Black/ African American	–	–	–	3	3,968	3,968	3	2,852	2,852	3	1,778	1,778
Cervical Cancer—Pap Smears	White	–	–	–	1	91	91	1	43	43	1	207	207
Cervical Cancer—Pap Smears	Multiple races	–	–	–	2	173	173	2	83	83	–	–	–
Cervical Cancer—Pap Smears	Race not specified	1	868	868	–	–	–	–	–	–	–	–	–
Cervical Cancer—Pap Smears	Hispanic/ Latino	1	868	868	–	–	–	–	–	–	1	207	
Cervical Cancer—Pap Smears	No Hispanic/ Latino	2	11,236	16,854	7	16,046	6,877	8	10,883	4,081	3	1,778	
Cervical Cancer—Pap Smears	Ethnicity not specified	–	–	–	1	159	159	1	150	150	–	–	–
Colorectal Cancer—Colonoscopy	American Indian/Alaska Native	2	4,642	4,642	2	4,289	4,289	2	33	33	–	–	–
Colorectal Cancer—Colonoscopy	Black/ African American	1	14	28	1	655	1,310	3	653	435	2	410	410
Colorectal Cancer—Colonoscopy	White	–	–	–	1	55	55	1	69	69	–	–	–
Colorectal Cancer—Colonoscopy	Multiple races	–	–	–	1	19	19	1	206	206	1	78	78
Colorectal Cancer—Colonoscopy	Race not specified	1	60	60	–	–	–	–	–	–	–	–	–
Colorectal Cancer—Colonoscopy	Hispanic/ Latino	1	60	60	2	74	37	1	69	69	–	–	–
Colorectal Cancer—Colonoscopy	No Hispanic/ Latino	2	3,362	3,362	3	4,944	3,296	5	686	274	2	410	410
Colorectal Cancer—Colonoscopy	Ethnicity not specified	1	1,294	1,294	–	–	–	1	206	206	1	78	78

Cancer Health Issue	Race/Ethnicity	2006			2007			2008			2009		
		No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served
Colorectal Cancer—FOBT	American Indian/Alaska Native	2	3,347	1,674	2	4,399	2,200	1	3,694	3,694	–	–	–
Colorectal Cancer—FOBT	Black/ African American	1	9	18	3	917	611	2	807	807	–	–	–
Colorectal Cancer—FOBT	White	–	–	–	1	48	48	1	69	69	–	–	–
Colorectal Cancer—FOBT	Multiple races	1	16	32	2	24	24	–	–	–	–	–	–
Colorectal Cancer—FOBT	Race not specified	3	89	89	–	–	–	–	–	–	–	–	–
Colorectal Cancer—FOBT	Hispanic/ Latino	1	74	74	2	57	29	1	69	69	–	–	–
Colorectal Cancer—FOBT	No Hispanic/ Latino	1	3,313	9,939	6	5,331	2,666	3	4,501	4,501	–	–	–
Colorectal Cancer—FOBT	Ethnicity not specify	5	74	74	–	–	–	–	–	–	–	–	–
Colorectal Cancer—Sigmoidoscopy	Black/ African American	–	–	–	–	–	–	1	262	262	1	182	182
Colorectal Cancer—Sigmoidoscopy	White	–	–	–	1	55	55	1	69	69	–	–	–
Colorectal Cancer—Sigmoidoscopy	Hispanic/ Latino	–	–	–	1	55	55	1	69	69	–	–	–
Colorectal Cancer—Sigmoidoscopy	No Hispanic/ Latino	–	–	–	–	–	–	1	262	262	1	182	182
Colorectal Cancer—Sigmoidoscopy	Ethnicity not specified	–	–	–	–	–	–	–	–	–	–	–	–
Prostate Cancer—DRE	American Indian/Alaska Native	2	62	31	1	17	17	–	–	–	–	–	–
Prostate Cancer—DRE	Black/ African American	1	22	44	–	–	–	3	427	285	2	549	549
Prostate Cancer—DRE	White	–	–	–	–	–	–	1	22	22	–	–	–
Prostate Cancer—DRE	Multiple races	–	–	–	1	50	50	–	–	–	–	–	–
Prostate Cancer—DRE	Hispanic/ Latino	–	–	–	–	–	–	–	–	–	–	–	–
Prostate Cancer—DRE	No Hispanic/ Latino	1	9	18	2	67	67	4	449	225	2	549	549

Cancer Health Issue	Race/Ethnicity	2006			2007			2008			2009		
		No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served	No. of Inter-ventions	Observed Number Served	Adjusted Number Served
Prostate Cancer—DRE	Ethnicity not specified	2	75	75	–	–	–	–	–	–	–	–	–
Prostate Cancer—PSA	American Indian/Alaska Native	2	1,284	642	1	1,340	1,340	–	–	–	–	–	–
Prostate Cancer—PSA	Black/ African American	1	9	27	3	1,156	1,156	4	558	419	3	627	627
Prostate Cancer—PSA	Multiple races	–	–	–	3	537	358	2	817	817	–	–	–
Prostate Cancer—PSA	Race not specified	–	–	–	1	273	273	–	–	–	–	–	–
Prostate Cancer—PSA	Hispanic/ Latino	–	–	–	–	–	–	–	–	–	–	–	–
Prostate Cancer—PSA	No Hispanic/ Latino	1	1,264	3,792	4	2,496	1,872	4	558	419	3	627	627
Prostate Cancer—PSA	Ethnicity not specified	2	29	29	4	810	405	2	817	817	–	–	–
Other Cancer	American Indian/Alaska Native	–	–	–	–	–	–	1	30	30	–	–	–
Other Cancer	White	–	–	–	–	–	–	1	7	7	–	–	–
Other Cancer	Multiple races	1	59	59	–	–	–	–	–	–	–	–	–
Other Cancer	Race not specified	–	–	–	1	26	26	–	–	–	–	–	–
Other Cancer	Hispanic/ Latino	–	–	–	–	–	–	1	7	7	–	–	–
Other Cancer	No Hispanic/ Latino	–	–	–	–	–	–	1	30	30	–	–	–
Other Cancer	Ethnicity not specified	1	59	59	1	26	26	–	–	–	–	–	–

- The year-to-year trend shows that while the cumulative numbers served have been increasing over the 4 year period, on average, the year-to-year utilization across all cancer interventions has been declining by about 13 percent annually. However, the trends differ depending on which cancer health issues and which intervention type is examined. For example, utilization of mammography declined over the study period, while the utilization of clinical breast exams has increased. It may be that CNPs have shifted in their use of these two approaches. Or, it may indicate that because grantees have been successful in reaching their target populations in the first few years, fewer members of their communities require the screening activity.

- There are similar findings with colorectal and prostate cancer. For colorectal cancer, the utilization of FOBT and Sigmoidoscopy increased over the study period, while the use of colonoscopy declined. CNP community members increased their utilization of digital rectal exams to screen for prostate cancer, while slightly slowing their use of PSA testing (see Table 4-31).

- When the utilization trends for screenings are looked at by race and ethnicity, similar variations are found. African Americans appear to be generally increasing their utilization of cancer health screenings, while Native Americans and Alaska Natives appear to be trending down in their utilization of CNP cancer health interventions. In general, with the exception of mammography, CNP screening interventions appear to be having only a modest effect on Hispanics in terms of utilization (see Table 4-31).

Table 4-32 presents the trends in the utilization of beneficial cancer interventions by CNP grantee and by individual interventions from 2006 to 2009. The data in this table are only reported for CNP interventions that reported the number of individuals using a particular cancer health intervention. For this table, 2006 should be considered baseline data. The data suggest a great deal of variation in the number of individuals reached by any given intervention and the consistency of providing that intervention across time. For example, no CNP grantees have provided any one type of intervention in each year of the 4-year study period. The data also show that as a group, grantees are more likely to establish screening interventions for colorectal cancer than for any other type of cancer. The second most likely intervention type for a CNP grantee is mammography screening, followed by screening for cervical cancer. However, CNP grantees are serving more people through their mammography screening then through any other type of approach.

Table 4-16. Utilization of Beneficial Cancer Interventions by CNP, Cancer Health Issue, and Cancer Intervention Type (2006–2009)

			2006		2007		2008		2009	
			No. of Inter-ventions	Observed Number Served	No. of Inter-ventions	Observed Number Served	No. of Inter-ventions	Observed Number Served	No. of Inter-ventions	Observed Number Served
1	Breast Cancer	Mammography			1	3,754				
2	Breast Cancer	Mammography			1	9				
3	Breast Cancer	Mammography			3	2,482	3	2,599	3	1,611
4	Breast Cancer	Mammography							1	40
5	Breast Cancer	Mammography	1	6,833			1	6,619		
6	Breast Cancer	Mammography					1	268		
13	Breast Cancer	Mammography	3	4,518	2	2,501	1	1,507		
14	Breast Cancer	Mammography							2	42
17	Breast Cancer	Mammography					1	38		
18	Breast Cancer	Mammography			4	394	2	92		
19	Breast Cancer	Mammography			1	4,018	1	5,546	1	1,357
20	Breast Cancer	Mammography			1	1,425				
24	Breast Cancer	Mammography	1	427						
25	Breast Cancer	Mammography			1	500	2	514	1	56
3	Breast Cancer	Clinical Breast Exam					3	1,301	3	1,033
6	Breast Cancer	Clinical Breast Exam					1	288		
13	Breast Cancer	Clinical Breast Exam	2	261						
14	Breast Cancer	Clinical Breast Exam							1	22
17	Breast Cancer	Clinical Breast Exam					1	31		
18	Breast Cancer	Clinical Breast Exam	1	6	5	292	1	42		
20	Breast Cancer	Clinical Breast Exam			1	1,425				
25	Breast Cancer	Clinical Breast Exam					1	200		
3	Cervical Cancer	HPV					2	991	2	601
13	Cervical Cancer	HPV			1	865				
2	Cervical Cancer	Pap Smears					1	606		
3	Cervical Cancer	Pap Smears			3	3,968	3	2,852	3	1,778
9	Cervical Cancer	Pap Smears							1	207
13	Cervical Cancer	Pap Smears	2	11,236	2	11,973	1	7,299		
18	Cervical Cancer	Pap Smears			3	264	3	126		
24	Cervical Cancer	Pap Smears	1	868						
25	Cervical Cancer	Pap Smears					1	150		
3	Colorectal Cancer	Colonoscopy			1	655	3	653	2	410
7	Colorectal Cancer	Colonoscopy								
9	Colorectal Cancer	Colonoscopy			1	55	1	69		
13	Colorectal Cancer	Colonoscopy	3	4,656	2	4,289	1	10		
17	Colorectal Cancer	Colonoscopy					1	23		
19	Colorectal Cancer	Colonoscopy			1	19	1	206	1	78

			2006		2007		2008		2009	
			No. of Inter-ventions	Observed Number Served	No. of Inter-ventions	Observed Number Served	No. of Inter-ventions	Observed Number Served	No. of Inter-ventions	Observed Number Served
24	Colorectal Cancer	Colonoscopy	1	60						
3	Colorectal Cancer	FOBT			3	917	2	807		
6	Colorectal Cancer	FOBT								
9	Colorectal Cancer	FOBT			1	48	1	69		
13	Colorectal Cancer	FOBT	3	3,356	2	4,399	1	3,694		
18	Colorectal Cancer	FOBT	3	31	1	15				
19	Colorectal Cancer	FOBT			1	9				
24	Colorectal Cancer	FOBT	1	74						
3	Colorectal Cancer	Sigmoidoscopy					1	262	1	182
9	Colorectal Cancer	Sigmoidoscopy			1	55	1	69		
24	Colorectal Cancer	Sigmoidoscopy								
3	Prostate Cancer	DRE					3	427	2	549
13	Prostate Cancer	DRE	3	84	1	17				
18	Prostate Cancer	DRE			1	50	1	22		
3	Prostate Cancer	PSA			3	1,156	3	549	3	627
13	Prostate Cancer	PSA	3	1,293	1	1,340	1	9		
18	Prostate Cancer	PSA			2	324				
19	Prostate Cancer	PSA			2	486	2	817		
9	Other Cancer	Skin Cancer, etc.					1	7		
18	Other Cancer	Skin Cancer, etc.	1	59	1	52				
25	Other Cancer	Skin Cancer, etc.					1	30		

5. *Evaluation Question: What kind(s) of non-CRCHD funding for community-based education and training activities directed at reducing cancer disparities have the Community Networks Programs obtained?*

4.1.5 *Phase I, Objective 5: Leveraging Non-CRCHD Funding and Support*

- Over a 4-year period, CNP grantees leveraged nearly $369 million from non-CRCHD sources (Table 4-18). Over that period, the awards-to-applications ratio increased on average by 7.3 percent annually, a decline from the 3-year average in years 1–3 (see Table 4-18).

Table 4-17. Cumulative and Average Non-CRCHD Grant Awards for CNP Grantees, Years 1–4

	Year 1	Year 2	Year 3	Year 4	Annual Growth (%)
Total Funding Applied For	**$158,226,988**	**$247,867,422**	**$413,463,082**	**626,758,224**	**58.2**
Denied Funding	$37,661,771	$52,491,357	$60,345,217	$96,931,756	37.0
Awarded Funding	$65,712,992	$101,528,391	$249,619,538	$368,601,749	77.7
Pending Awards	$54,852,225	$93,847,674	$103,498,327	$161,089,002	43.2
Total Number Applied For	**207**	**347**	**540**	**681**	**48.7**
Number Denied	20	42	63	85	62.0
Number Awarded	140	244	407	496	52.4
Number Pending	47	61	70	100	28.6
Awards-to-Applications Ratio for Awarded and Denied Funding	**0.64**	**0.66**	**0.81**	**0.79**	**7.3**
Average Funding Applied for per Application	**$764,381.58**	**$714,315.34**	**$765,672.37**	**$917,655**	**6.3**
Denied Funding	$1,883,088.55	$1,249,794.21	$957,860.59	$1,140,374	-15.4
Awarded Funding	$469,378.51	$416,099.96	$613,315.82	$743,149	16.6
Pending Awards	$1,167,068.62	$1,538,486.46	$1,478,547.53	$1,610,890	11.3
Average Awards-to-Applications Ratio for Awarded and Denied Funding	**0.20**	**0.25**	**0.39**	**0.39**	**24.9**

- SPN status and funding group, however, seem to be related to both the size of the grant award and CNP grantees' success in turning grant applications into grant awards. Former SPN participants had a larger number of grants and higher awards-to-applications ratios than non-SPN grantees for each year from years 1–4 (see Table 4-19 and Figure 4-5). In years 1–3, CNP grantees in Funding Group 1 had a higher average number of grants and awards-to-applications ratios than grantees in Funding Groups 2 or 3 (see Table 4-18 and Figure 4-6). However, while grantees in Funding Group 1 had the largest number of applications and the most grant awards on a dollar basis, the awards-to-applications ratios for all three funding groups was roughly the same in year 4 (see Table 4-19). In general, there appears to be a positive relationship between grant awards and CNP funding levels. The larger the CNP funding, the larger the number of non-CRCHD grants and the more successful CNP grantees

were in competing for non-CRCHD grants, as measured by the awards-to-applications ratio.

Table 4-18. Cumulative Applications-to-Awards Ratio for Awarded and Denied Non-CRCHD Funding by SPN Status and CNP Funding Level, Years 1–4

	Year 1	Year 2	Year 3	Year 4	Annual Growth %
Affiliation with SPN Initiative					
Former SPN					
Award-to-Awarded and Denied Applications	0.90	0.89	0.91	0.87	1.1
Number of Awarded and Denied Grants:	141	219	363	442	46.4
Non-SPN					
Award-to-Awarded and Denied Applications	0.68	0.72	0.73	0.80	5.6
Number of Awarded and Denied Grants:	19	67	107	139	94.1
Funding Level					
Funding Group 1					
Award-to-Awarded and Denied Applications	0.90	0.89	0.90	0.85	-1.9
Number of Awarded and Denied Grants:	105	167	286	346	48.8
Funding Group 2					
Award-to-Awarded and Denied Applications	0.86	0.83	0.85	0.86	0.0
Number of Awarded and Denied Grants:	36	70	104	123	50.6
Funding Group 3					
Award-to-Awarded and Denied Applications	0.79	0.76	0.78	0.85	2.5
Number of Awarded and Denied Grants:	19	49	80	112	80.6
Average					
Average Award-to-Awarded and Denied Applications	0.88	0.85	0.87	0.85	-1.2
Total Number of Awarded and Denied Grants:	**160**	**286**	**470**	**581**	**53.7**

Figure 4-4. Average Non-CRCHD Cumulative Grant Awards for CNP Grantees by SPN Status

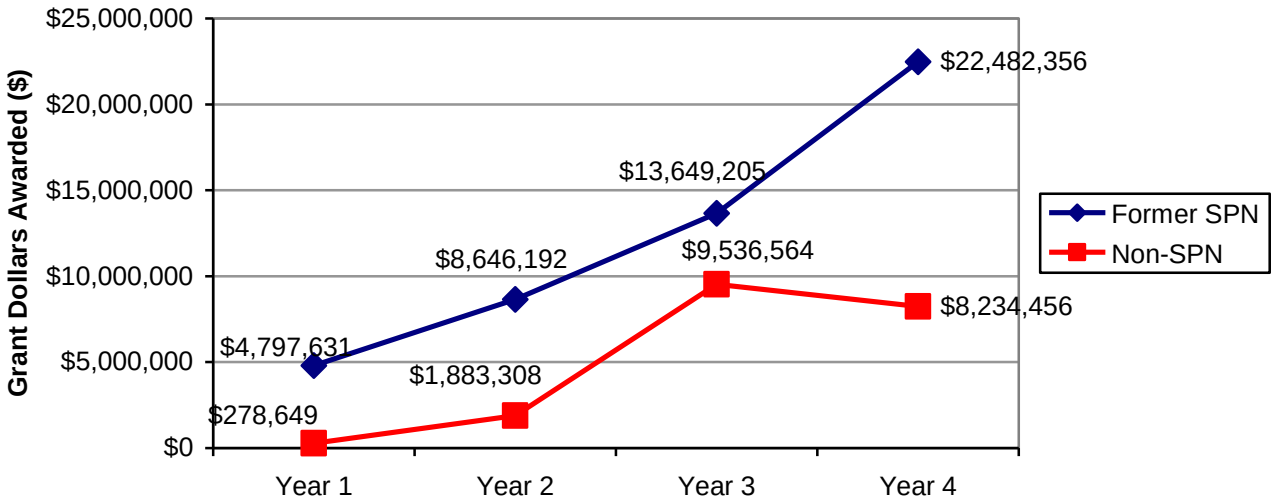
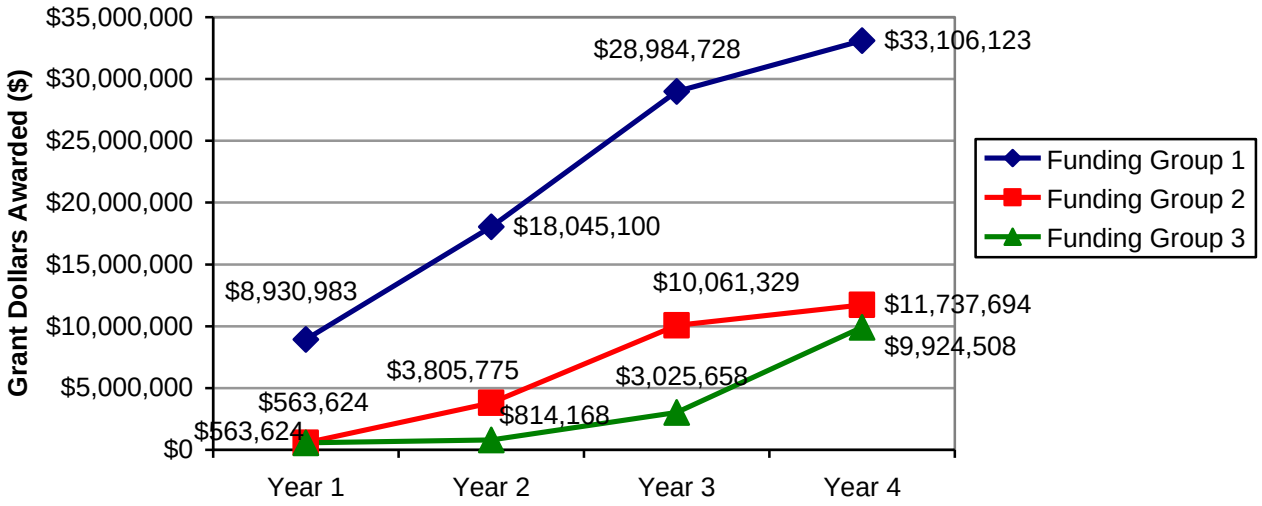
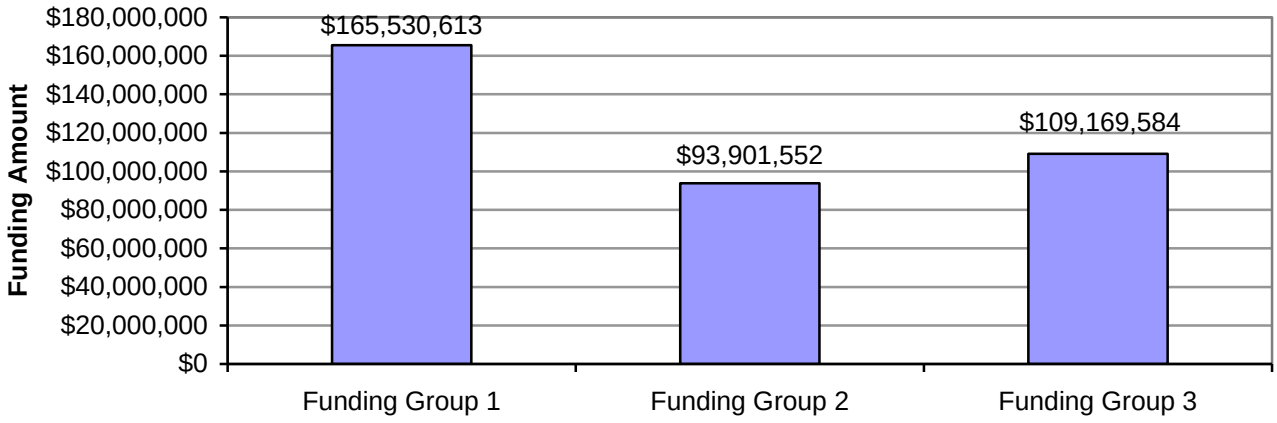


Figure 4-5. Average Non-CRCHD Cumulative Grant Awards for CNP Grantees by Funding Group



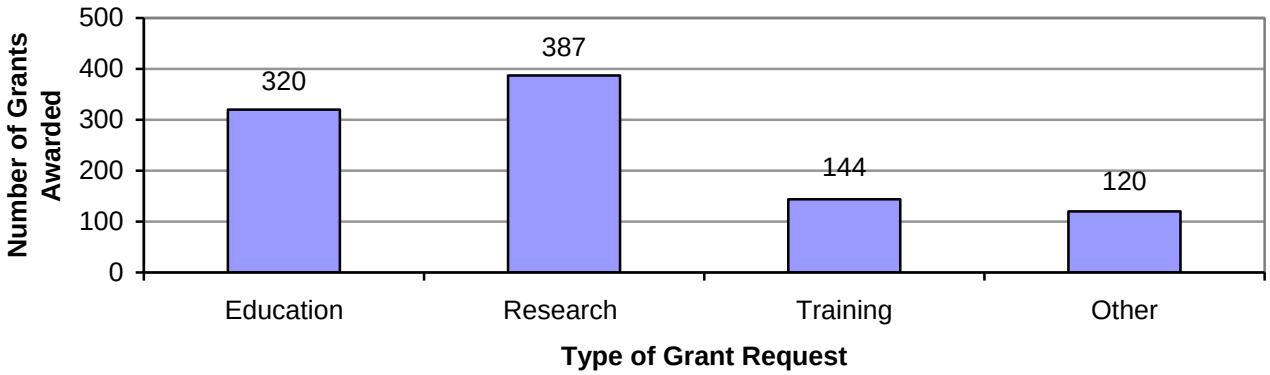
- CNP grantees also managed to use their initial CRCHD funding to leverage additional funds. An examination of grantees by funding level indicates that by year 4, those in Funding Group 1 had raised more than $165 million above their original CNP grants. Over 4 years, grantees in Funding Groups 2 and 3 were able to leverage roughly $94 and $109 million, respectively (see Figure 4-7). Taken together, this provides strong evidence that the CNP grantees are building a solid foundation to sustain their efforts beyond the current CNP initiative.

Figure 4-6. Amount of Non-CRCHD Funding Leveraged by CNPs by Funding Group in Year 4



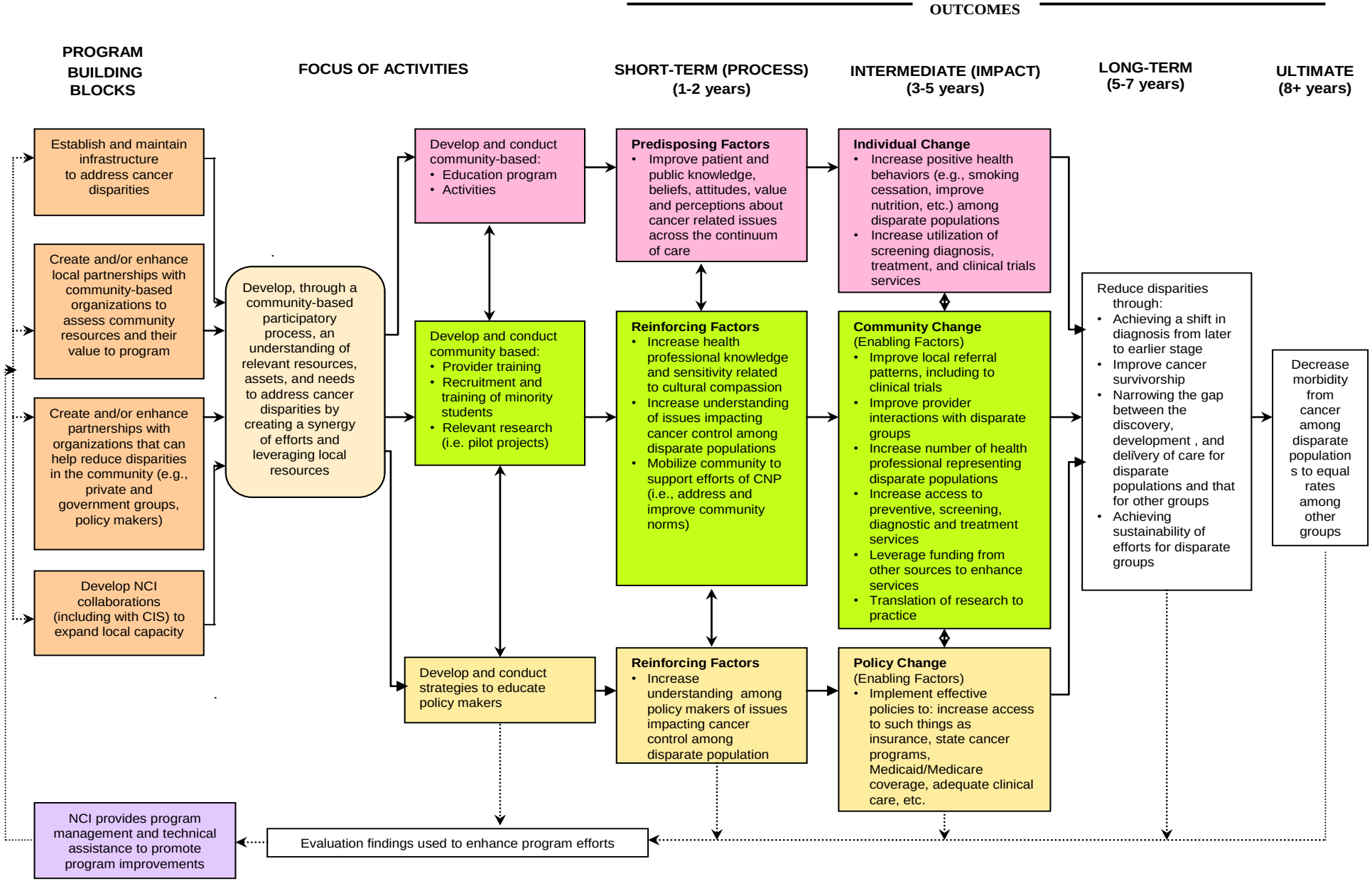
- Finally, CNP grantees were able to find non-CRCHD funding in a variety of areas. Most non-CRCHD grants were awarded to support either research or education, but a sizable share was awarded for training activities (see Figure 4-8).

Figure 4-7. Non-CRCHD Grants Awarded to CNPs, by Type* in Year 4



* Total awards in this figure will not match totals from Table 4-18 or Table 4-19. A single grant is often given for multiple purposes.

Appendix A


OUTCOMES
PROGRAM BUILDING BLOCKS
FOCUS OF ACTIVITIES
SHORT-TERM (PROCESS) (1-2 years)
INTERMEDIATE (IMPACT) (3-5 years)
LONG-TERM (5-7 years)
ULTIMATE (8+ years)
Establish and maintain infrastructure to address cancer disparities
Create and/or enhance local partnerships with community-based organizations to assess community resources and their value to program
Create and/or enhance partnerships with organizations that can help reduce disparities in the community (e.g., private and government groups, policy makers)
Develop NCI collaborations (including with CIS) to expand local capacity
Develop, through a community-based participatory process, an understanding of relevant resources, assets, and needs to address cancer disparities by creating a synergy of efforts and leveraging local resources
Develop and conduct community-based:
• Education program
• Activities
Develop and conduct community based:
• Provider training
• Recruitment and training of minority students
• Relevant research (i.e. pilot projects)
Develop and conduct strategies to educate policy makers
Predisposing Factors
• Improve patient and public knowledge, beliefs, attitudes, value and perceptions about cancer related issues across the continuum of care
Reinforcing Factors
• Increase health professional knowledge and sensitivity related to cultural compassion
• Increase understanding of issues impacting cancer control among disparate populations
• Mobilize community to support efforts of CNP (i.e., address and improve community norms)
Reinforcing Factors
• Increase understanding among policy makers of issues impacting cancer control among disparate population
Individual Change
• Increase positive health behaviors (e.g., smoking cessation, improve nutrition, etc.) among disparate populations
• Increase utilization of screening diagnosis, treatment, and clinical trials services
Community Change
(Enabling Factors)
• Improve local referral patterns, including to clinical trials
• Improve provider interactions with disparate groups
• Increase number of health professional representing disparate populations
• Increase access to preventive, screening, diagnostic and treatment services
• Leverage funding from other sources to enhance services
• Translation of research to practice
Policy Change
(Enabling Factors)
• Implement effective policies to: increase access to such things as insurance, state cancer programs, Medicaid/Medicare coverage, adequate clinical care, etc.
Reduce disparities through:
• Achieving a shift in diagnosis from later to earlier stage
• Improve cancer survivorship
• Narrowing the gap between the discovery, development , and delivery of care for disparate populations and that for other groups
• Achieving sustainability of efforts for disparate groups
Decrease morbidity from cancer among disparate populations to equal rates among other groups
NCI provides program management and technical assistance to promote program improvements
Evaluation findings used to enhance program efforts