

**Evaluation and Performance Measurement Plan**

**Program Title: Georgia Initiative to Mobilize Partnerships for Prevention and Action for Cancer, Tracking, and Registration**

**Program 2 (Georgia Comprehensive Cancer Control Program)**

**Project Period: 6/30/2018 – 6/29/2019**

**Submission Date: 11/29/2018**

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The GACCCP acknowledges valuable input from members of the GACCCP Evaluation Stakeholder Workgroup, the Regional Cancer Coalitions of Georgia and the Georgia Cancer Control Consortium.

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1. **Introduction**

**1.1 Background**

Cancer is the second leading cause of death in Georgia (McNamara, Bayakly & Ward, 2016). Every year, about 48,850 Georgians are diagnosed with cancer and nearly 17,280 die from the disease (American Cancer Society (ACS), 2017). While the burden of cancer is shared by all Georgians, cancer incidence and mortality are disproportionately greater among men, minority, medically underserved populations and older age groups. Black men in Georgia are 14 percent more likely to be diagnosed with cancer and 31 percent more likely to die from the disease than white men (Georgia Comprehensive Cancer Registry (GCCR), 2010-2014). Black women were less likely than white women in Georgia to have received recommended breast or cervical cancer screenings (Behavioral Risk Factor Surveillance System (BRFSS), 2010). Moreover, while white women have higher breast cancer incidence rates than black women, black women are more likely to die of breast cancer. Still, many cancers can be prevented. Nearly half of cancer deaths can be linked to modifiable risk factors such as tobacco use, excess body mass, physical inactivity and alcohol use. Smoking is responsible for about 4,500 cancer deaths each year in Georgia (Chung, Lavendar & Bayakly, 2015). Regular screening exams by a health care provider can result in early detection of many cancers, when treatment is more likely to be successful. Screening for early cancer detection can dramatically reduce mortality rates.

Because of advances in cancer diagnosis and treatment, cancer survivors in Georgia are living longer than ever before. As the population of the United States and Georgia continues to age overall, cancer care and support for cancer survivors have increasing importance. Increased access to treatment in accredited cancer care facilities and support and care for survivors over their lifetimes is needed in Georgia. Georgia has a high burden of chronic conditions, and along with being at risk for secondary cancers and cancer reoccurrences, cancer survivors are among those impacted most by chronic conditions. Recent data show that 16.8 percent of cancer survivors report being current smokers and almost 31 percent report no leisure time physical activity (Georgia Department of Public Health (GA DPH), 2015). Almost 13 percent of cancer survivors in Georgia report they had been diagnosed with angina or coronary heart disease which is significantly higher than the statewide coronary heart disease rate of 4.5 percent (GA DPH, 2015). In addition, one in five cancer survivors in Georgia had been diagnosed with diabetes which is significantly higher than the Georgia diabetes rate of 9.9 percent (GA DPH, 2015). Moreover, approximately 31 percent of all cancer survivors in Georgia report being obese, slightly higher than the statewide obesity rate of 29 percent (GA DPH, 2015).

**1.2 Program description**

The GACCCP is part of a national effort launched by the Centers for Disease Control and Prevention (CDC) aimed at reducing cancer-related morbidity and mortality. The GACCCP aims to provide oversight in implementing a statewide cancer plan, perform program activities, and enhance partnerships among key stakeholders to reduce cancer-specific morbidity and mortality. Key priority areas of the GACCCP are primary prevention, screening and early detection of cancer, and cancer survivorship. The GACCCP logic model shows program inputs, strategies, and activities, and describes how these inputs and outputs relate to anticipated short-term, intermediate, and long-term outcomes (**Figure 1**).

Stable, experienced, and effective program management and leadership

**OUTCOMES**

**INPUT**

**OUTPUTS**

Short-term Intermediate Long-term

Strategies and Activities

• Increased healthy lifestyle behavior among priority populations

• Reduced cancer risk

• Increased quality of life among cancer survivors

• Increased early detection

• Reduced cancer morbidity and mortality

• Reduced cancer disparities

• Increased appropriate cancer screening and surveillance of priority populations

• Reduced structural barriers and improved access to cancer care and preventive services

• Increased evidence-based cancer care plans that include all stages of cancer survivorship

• Enhanced knowledge and attitude toward cancer prevention (e.g., HPV vaccination, tobacco cessation/ prevention, healthy eating) and screening among priority populations

• Improved healthy lifestyle behavior

• Improved healthcare provider practices and systems to support cancer prevention and screening

• Increased chronic disease self-management support

• Increased use of evidence-based interventions to support cancer prevention and screening

• Enhanced methods to identify and describe needs and health disparities among cancer survivors

**Strategy 1: Program Collaboration** • Partner with other programs in GA DPH e.g. GBCCP, GCCR, GA Tobacco Use Prevention Program, GA Immunization Program, Division of Communications

**Strategy 2: External Partnerships**  • Maintain and collaborate with GA Cancer Control Consortium (Consortium), Regional Cancer Coalitions of GA (RCCGs), GA CORE and other external partners

**Strategy 3: Cancer Data and Surveillance** • Create and disseminate cancer burden and surveillance reports

**Strategy 4: Environmental Approach** • Implement group education about breast cancer screening • Promote physical activity among cancer survivors

**Strategy 5: Community-Clinical Linkage** • Promote GA Tobacco Quit Line • Educate African Americans about tobacco cessation by using Pathway to Freedom curriculum •Utilize GA Immunization Registry • Reduce barriers to cancer screening • Enhance methods to identify and describe health disparities

**Strategy 6: Health Systems Change** • Implement provider assessment and feedback, client reminders, and small media to increase HPV vaccination • Implement colorectal cancer radio campaign

CDC

GA DPH

Consortium

RCCGs

GA CORE

GA Health Policy Center

Public Health Districts

External Partners

E

Georgians affected by cancer

**Strategy 7: Program Monitoring and Evaluation**

**1.3 Overview of evaluation plan**

The Georgia Comprehensive Cancer Control Program (GACCCP) evaluator will perform a comprehensive evaluation to monitor progress and assess outcome measures of the GACCCP in accordance with the CDC Framework of Program Evaluation (1999). Ms. Janet Shin, an internal GA DPH staff, will lead the planning and implementation of the GACCCP evaluation activities. The purpose of this evaluation is to monitor how ongoing activities are implemented as planned and determine the program effectiveness. The evaluation is focused on the following areas: 1) partnership; 2) statewide cancer plan; and, 3) implementation of evidence-based interventions (EBIs). The evaluation will use a mixed methods approach that involves quantitative and qualitative methodologies.

1. **Stakeholder engagement**

Key stakeholders of this evaluation and their engagement plan is described in **Table 1**. Major stakeholders include the CDC, the GACCCP staff, the Georgia Cancer Control Consortium (Consortium), the Regional Cancer Coalitions of Georgia (RCCGs), and other partner organizations. The GACCCP evaluator will work collaboratively with the GACCCP director, the Consortium Data and Evaluation Subcommittee and other key stakeholders by convening on an as-needed basis throughout the project duration.

**Table 1.** Stakeholder assessment and engagement plan

|  |  |  |
| --- | --- | --- |
| **Stakeholder Name** | **Interest or Perspective** | **Role in the Evaluation** |
| CDC Project Officer | Monitor program deliverables, requirements and performance measures | Provide technical assistance, participate in consensus building exercises and planning discussions if major programmatic changes are recommended |
| GA DPH Comprehensive Cancer Control Program (GACCCP) staff | Monitor program goals, objectives, funding, reports and data, Provide oversight and coordination of collaborative activities among key stakeholders | Guide design and implementation of evaluation activities, inform program planning and quality improvement |
| GA DPH, Chronic Disease Prevention Section, Reporting and Evaluation Unit | Collect, analyze and report program specific data | Develop and implement evaluation activities, provide recommendations from findings, disseminate findings |
| \*Georgia Cancer Control Consortium (Consortium) Steering Team and Work Groups | Develop and implement statewide cancer plan priority areas, objectives and strategies | Guide evaluation design, data analysis and interpretation, provide recommendation on dissemination strategies |
| Regional Cancer Coalitions of Georgia (RCCGs) | Implement statewide cancer plan strategies and activities, including Survivorship Project | Collect, analyze and report project specific data, provide data, use findings for program planning and quality improvement |
| Georgia State University Health Policy Center (GHPC) | Implement statewide Cancer Plan | Evaluate statewide Cancer Plan implementation, collect and analyze data |
| Georgia Center for Oncology Research and Education (GA CORE) | Implement statewide cancer plan strategies and activities; lead cancer survivorship activities of statewide Cancer Plan | Collect, analyze and report project specific data, guide development of assessment tools |
| GA DPH, Related Programs (e.g., Tobacco Use Prevention Program, Immunization Program, Epidemiology Section) | Collaborate and coordinate with GACCCP staff to streamline chronic disease prevention efforts | Use findings to implement and enhance performance of respective program |
| National African American Tobacco Prevention Network (NAATPN) | Implement program activities | Collect, analyze and report project specific data, use findings for program planning and quality improvement |
| I Will Survive (IWS) |
| Cancer Pathways |
| Logan Wilkes Foundation |
| Georgians affected by cancer | Participate in GACCCP activities | Provide data |

*\*Georgia Cancer Control Consortium Workgroups include Data and Evaluation Subcommittee, Early Detection and Screening Workgroup, HPV Prevention Workgroup, Palliative Care Workgroup, Survivorship Workgroup, and Diagnosis Staging and Treatment Workgroup*

1. **Evaluation Focus**

Both process and outcome evaluations will be conducted. Evaluation types, evaluation focus, key evaluation questions and relevant measures are described in **Tables 2** and **3**. These evaluation questions were selected and prioritized based on programmatic needs and selected evaluation purpose. The evaluator will collaborate with program stakeholders and refine these evaluation questions during the project duration.

**Table 2. Process Evaluation Focus**

|  |  |  |
| --- | --- | --- |
| **Evaluation Focus** | **Evaluation Questions** | **Primary Process Measures** |
| Partnership function and contribution | 1. How strong is the GACCC partnership (e.g. Consortium members)? | Structure of the Consortium, Extent to which the partnership is active and meets regularly |
| 1. How satisfied are Consortium members? | Satisfaction of the Consortium members about membership, planning and implementation, and leadership and governance |
| Statewide cancer plan | 1. To what extent are goals in the statewide cancer plan being implemented as intended? | Progress from partners for the cancer plan |
| Implementation of evidence-based interventions (EBIs) | 4a. To what extent are EBIs in the annual plan being implemented as intended to address cancer burden in the general population? | RCCGs’ utilization of epidemiological data findings, lessons learned |
| Number of “Someone You Love” documentary screenings, number of participants, number of HPV Provider Champions recruited, lessons learned |
| 4b. To what extent are EBIs in the annual plan being implemented as intended to address cancer burden in the target population? | Number of leaders trained by NAATPN, number of participants in tobacco cessation education, number of participants in breast cancer education, number of Georgians received colorectal cancer screening |
| 1. What are facilitators and barriers in implementing interventions? How can we reduce these barriers? | Facilitators and barriers in program implementation, plans to reduce barriers |

**Table 3. Outcome Evaluation Focus**

|  |  |  |
| --- | --- | --- |
| **Evaluation Focus** | **Evaluation Questions** | **Primary Outcome Measures** |
| Implementation of interventions | 1. To what extent did EBIs lead to expected outcomes? | Knowledge/attitude toward cancer prevention and screening among priority populations, knowledge/attitude toward healthy lifestyle behavior, healthcare provider practices and systems to support cancer prevention and screening, cancer risk (e.g., HPV vaccination series completion rate), appropriate cancer screening and surveillance of priority populations, body mass index among cancer survivors |
| 1. What are unanticipated outcomes resulting from the program implementation? | Unanticipated outcomes |

1. **Data collection**

Program activities and progress will be monitored by using Catalyst, a statewide reporting system. **Table 4** describes the performance measures, data sources, data collection method, and assessment frequency. Previous GACCCP evaluation reports demonstrate that it is feasible to continuously collect the existing databases. The proposed evaluation plan is feasible to collect new performance measures.

**Table 5** describes the data management planregarding data collection and analysis by the GACCCP staff. All datasets will have participant names and contact information removed, with a unique identifier allowing linkage if the need arises while maintaining confidentiality. Four RCCGs that implement the CDC-funded survivorship exercise program will collect and submit raw datasets to the GACCCP. Raw datasets related to other data sources, including reports from the RCCGs, the Georgia Tobacco Quit Line (GTQL) reports, the Georgia Immunization Registry (GRITS), Teletask data, Assessment, Feedback, Incentives, and eXchange (AFIX) vaccination comparison report, Communications report, BRFSS, the NAATPN reports, the IWS reports, the Cancer Pathways reports, the Logan Wilkes Foundation reports, and Survivorship Care Plan survey and focus group data will be managed by the respective partner program or organization, and aggregated data findings will be submitted to the GACCCP.

**Table 4. Data Collection**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Performance Measures** | **Data Description** | **Data Sources** | **Collection Method** | **Assessment Frequency** |
| Structure of the Consortium, extent to which the partnership is active and meets regularly | | Reports from GHPC | GHPC staff will submit reports to GACCCP. | Bi-annually |
| Number of meetings held, number of participants in meetings | | Meeting notes and agendas for Consortium Steering Team, Consortium Workgroups, and RCCGs | GHPC staff and GACCCP staff will document these measures during meetings. | Monthly, quarterly |
| Facilitators and barriers in program implementation, plans to reduce barriers | | Meeting notes,  reports from RCCGs | GACCCP staff will document the meeting notes. RCCG staff will submit reports to GACCCP. | Quarterly,  bi-annually |
| Satisfaction of the Consortium members about membership, planning and implementation, and leadership and governance | | Partnership functioning survey, reports from GHPC | GHPC staff will collect the survey data and submit reports to GACCCP. | Bi-annually |
| Progress from partners for the cancer plan | | Reports from GHPC | GHPC staff will submit reports to GACCCP. | Bi-annually |
| Utilization of epidemiological data findings, lessons learned from dissemination activities | Utilization of epidemiological data findings, why/why not the findings were not useful, strategies to improve the dissemination activities | Dissemination survey | GACCCP staff will administer a web-based survey to RCCG staff by using Qualtrics platform. | Annually |
| Chronic disease self-management support among tobacco users | Number of people utilized the GTQL | GTQL report | Optum (i.e., GTQL vendor) staff will collect the data. | Annually |
| Number of community leaders trained by the NAATPN, number of African American participants in tobacco cessation education | | NAATPN report | NAATPN staff will collect data and submit a report to GACCCP. | Annually |
| Knowledge/attitude toward healthy lifestyle behavior | Knowledge about tobacco cessation, attitude toward tobacco cessation, African American participants’ overall experience in the Pathways to Freedom educational sessions |
| Healthcare provider practices and systems to support cancer prevention and screening | Number of report cards that were distributed, average coverage rate for providers who received the report cards | GRITS | GA Immunization Program staff will use GRITS and develop a report card. | Annually |
| Number of AFIX conducted | AFIX vaccination comparison report | GA Immunization Program staff will generate AFIX vaccination comparison reports. | Annually |
| Use of evidenced-based programs to support cancer prevention and screening | Number of text-message client reminders about HPV vaccination delivered | GRITS, Teletask data | GA Immunization Program staff will collect GRITS. Teletask (i.e., GACCCP vendor) will collect Teletask data. | Annually |
| HPV vaccination completion rate | HPV vaccination completion rate among clients who received text-message reminders, HPV vaccination completion rate by demographics (e.g., sex, age) |
| Number of “Someone You Love” documentary screenings, number of participants, number of HPV provider champions recruited, lessons learned | | Event log, Meeting notes, Survey | GACCCP manager will track the measures. | Annually |
| Use of evidenced-based programs to support cancer prevention and screening | Number of participants in breast cancer education | IWS report | IWS staff will collect data and submit a report to GACCCP. | Annually |
| Number of participants reached by colorectal cancer radio campaign | Communications report | Division of Communications staff will collect data. | Annually |
| Appropriate cancer screening and surveillance of priority populations | Percent of adults over age 50 who ever had a sigmoidoscopy or colonoscopy | BRFSS | GA DPH Epidemiologists will collect data. | Annually |
| Intention about cancer prevention and screening among target populations | Intention to stay up-to-date with breast cancer screening, participants’ overall experience in breast cancer educational sessions | IWS report | IWS staff will collect data and submit a report to GACCCP. | Annually |
| Use of evidenced-based programs to support cancer prevention and screening | Number of participants in cancer prevention education | Cancer Pathways report | Cancer Pathways staff will collect data and submit a report to GACCCP. | Annually |
| Intention about cancer prevention and screening among target populations | Intention to change cancer risk behaviors (e.g., tobacco and vaping prevention/cessation, sunscreen use, health eating, and HPV vaccination) |
| Use of evidenced-based programs to support cancer prevention and screening | Number of participants in healthy eating cancer prevention project | Pre- and post-test, Logan Wilkes Foundation report | Logan Wilkes Foundation staff will collect data and submit a report to GACCCP. | Annually |
| Knowledge/behavior about cancer prevention and screening among target populations | Knowledge about healthy food choices and snacks, amount of healthy foods consumed |
| Evidence-based cancer care plans that include all stages of cancer survivorship | Patients’ adherence to the survivorship care plans, patients’ socioeconomic status, health risk behaviors, and chronic conditions, use and usefulness of survivorship care plans | Survivorship care plan survey and focus group | Consortium Survivorship Work Group members will oversee data collection. | Annually |
| Needs and health disparities among cancer survivors | Physical, psychological, practical, and spiritual concerns of cancer survivors, availability and access to support services, and whether these services are meeting cancer survivors’ needs | Cancer survivorship needs assessment survey in English, Spanish, Korean, Chinese, and Vietnamese | GA CORE staff and Emory University Prevention Research Center staff will oversee data collection. | Annually |
| Body mass index among cancer survivors | Weight and height among cancer survivors | Fitness assessment data, reports from RCCGs | RCCG staff will collect data and submit reports and data to GACCCP. | Pre-intervention, mid-intervention, post-intervention |
| Quality of life among cancer survivors | Quality of life (e.g. pain, satisfaction, mood, daily function, mobility, self-rated health status), Wellness meter (e.g., depression, fatigue) | Quality of life survey, Wellness meter, reports from RCCGs |
| Unanticipated outcomes | | Reports from RCCGs | RCCG staff will submit reports to GACCCP. | Bi-annually |

**Table 5. Data Management Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Sources** | **Storage** | **Access** | **Archival/ Preservation Plan** |
| Dissemination survey, meeting notes and agendas, event log | Stored in secure the GA DPH server in compliance with the HIPPA guidelines | Restricted access to the GACCCP staff only | Stored in the GA DPH server indefinitely |
| BRFSS | Restricted access to the GA DPH chronic disease epidemiologists only |

1. **Analysis and interpretation**

Both quantitative and qualitative methodologies will be applied to analyze the various datasets. The GACCCP evaluator will compile, clean, code, analyze and interpret data from multiple data sources. The GACCCP evaluator will summarize and highlight the key findings from the progress reports and final annual reports submitted by RCCGs and GA CORE in Catalyst reporting system. Survey data will be analyzed by performing descriptive data analysis, t-test, chi-square test, and/or McNemar’s test. Qualitative responses in the survey data and various documents, such as meeting notes, will be analyzed by conducting thematic analysis. The evaluator will present the preliminary findings to the Principal Investigator, GACCCP staff and other stakeholders for programmatic interpretation.

1. **Dissemination and use of evaluation findings**

The GACCCP evaluator will collaborate with the Principal Investigator, the GACCCP director, the GACCCP epidemiologist, the RCCGs, the Consortium and other key stakeholders to ensure that the evaluation findings will be thoroughly used for continuous quality improvement. The GACCCP evaluator will submit an annual evaluation report to the CDC via Chronic Disease Management Information System (CDMIS). Findings from the GACCCP evaluation activities will be disseminated to program stakeholders via multiple communication methods, such as presentations at meetings, academic and professional conferences, and written documents, such as evaluation reports. The evaluation findings will also be disseminated through web-based channels, such as GA DPH website. The GACCCP evaluator will share the lessons learned with other NCCCP evaluators through conference calls and webinars.

1. **Evaluation timeline**

Timeline of evaluation activities that will be performed during this project period is outlined in **Table 6.**

**Table 6.** Timeline for evaluation activities

|  |  |
| --- | --- |
| **Timeframe** | **Evaluation Activities** |
| Year 2 1st Quarter:  July 2018 – September 2018 | * Review workplans from grantees * Provide technical assistance and guidance to grantees about revising workplans as appropriate * Collect data and reports (e.g., annual reports submitted from grantees through Catalyst) * Synthesize progress data and annual report findings from grantees * Develop annual evaluation report, and refine Year 2 evaluation plan |
| Year 2 2nd Quarter:  October 2018 – December 2018 | * Finalize annual evaluation report and Year 2 evaluation plan * Disseminate annual evaluation report to CDC and stakeholders * Teleconference in December 2018: each grantee will report on their progress and barriers/facilitators to implementation * Collect data and reports (e.g., biannual progress reports submitted from grantees through Catalyst) |
| Year 2 3rd Quarter:  January 2019 – March 2019 | * Review and revise evaluation and performance measurement plan as appropriate * Synthesize biannual progress data and report from grantees * Develop and submit annual performance report and Year 3 continuing application to CDC * Teleconference in March 2019: each grantee will report on their progress and barriers/facilitators to implementation * Provide technical assistance to grantees about data collection, analysis and reporting as appropriate |
| Year 2 4th Quarter:  April 2019 –  June 2019 | * Teleconference in June 2019: each grantee will report on their progress; barriers/facilitators to implementation; and barriers/facilitators to data collection/entry/submission * Provide technical assistance to grantees about data collection, analysis and reporting as appropriate |
| Year 3 1st Quarter:  July 2019 – September 2019 | * Review workplans from grantees * Provide technical assistance to grantees about revising workplans as appropriate * Collect data and reports (e.g., annual reports submitted from grantees through Catalyst) * Synthesize progress data and annual report findings from grantees * Develop annual evaluation report * Disseminate annual evaluation report to CDC and stakeholders |