

# Reaching Women for Mammography Screening



## Successful Strategies of National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Grantees



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention



**Suggested citation:**

Centers for Disease Control and Prevention. *Reaching Women for Mammography Screening: Successful Strategies of National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Grantees*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1997.

*This document was prepared for the Centers for Disease Control and Prevention (CDC) by Macro International Inc., under contract number 200-93-0696.*

# Reaching Women for Mammography Screening

Successful Strategies of  
National Breast and Cervical Cancer  
Early Detection Program  
(NBCCEDP) Grantees

1997

Centers for Disease Control and Prevention  
National Center for Chronic Disease Prevention  
and Health Promotion  
Division of Cancer Prevention and Control



# Contents

<b>Introduction</b> .....	1
Background .....	1
Methods .....	3
Limitations and Caveats .....	5
<b>Inreach</b> .....	7
Introduction .....	7
Direct Inreach to Clinic Populations .....	8
Direct Educational Strategies .....	8
Tracking and Reminder Systems .....	8
Incentives .....	12
Staff Development and Training .....	13
Physician Education .....	14
Training and Recruitment of Nurses and Midlevel Practitioners .....	18
Radiologic Technician Training .....	20
All-Staff Training .....	21
Reaching Nonphysician Providers .....	23
<b>Public Education</b> .....	25
Introduction to the Health Communication Process .....	25
Using Multiple Media Channels .....	32
Television .....	33
Radio .....	39
Print .....	42
Environmental Media .....	46
Billboards .....	46
Signage .....	47
Special Events .....	48
Additional Resources .....	52
<b>Outreach</b> .....	57
Introduction .....	57
The Transtheoretical Model .....	58
Stages of Change .....	59
Processes of Change .....	60

<b>Outreach (continued)</b>	
Invitations to Seek Screening	60
The Medium	60
Timing	61
Identifying the Women	61
Lesbian Outreach	63
Corporate Sponsorships	65
Pharmacy Partnerships	66
Discount Stores	66
Outreach to and Through Religious Organizations	68
Hotlines	71
Mobile/Portable Mammography	72
Comprehensive Screening	73
Wellness Programs	74
Outreach Workers	75
Lay Outreach Workers	76
One-to-One Outreach Using Public Health Workers	83
<b>Policies and Procedures</b>	85
Introduction	85
Policy Planning	86
Program Organization	86
Selecting the Target Population	87
Clinical Staffing Standards	89
Setting Policies	90
Fee Structures	91
Implementing Policies and Procedures	92
Policies as Implementation Priorities	92
Mechanisms to Inform Local Providers	92
Clinical Procedures	94
Policies and Contracts	95
Monitoring Policies	96
Computer Systems	96
Audits	96
Evaluation	98
Payments Linked to Performance	98

<b>Coalition and Partnership Development</b> .....	101
Introduction .....	101
How Coalitions and Partnerships Are Formed .....	103
Coalition and Partnership Members .....	105
Partnerships .....	106
Measuring Outcomes .....	107
Coalition and Partnership Costs .....	108
Barriers and Strategies to Overcome Them .....	109
Factors in Coalition and Partnership Successes .....	110
Summary: Steps in Forming a Coalition .....	112
 <b>Appendix: List of NBCCEDP Grant Programs</b> .....	 119





# Introduction

## Background

Scientific evidence through clinical trials has shown that mammography screening reduces the mortality and morbidity associated with breast cancer. Many studies have demonstrated the benefits of regular screening in detecting early tumors in women of all ages.<sup>1,2</sup> Some research suggests that screening programs that include mammography can produce up to a 31% reduction in breast cancer mortality.<sup>3,4</sup> To achieve the national goal of reducing morbidity and premature death from breast cancer, more complete coverage of mammography screening is needed among older women in every community across the United States. While scientists and public health professionals agree that women 50 years and older should receive mammography screening every 1 to 2 years, similar agreement about how to increase the percentage of older women in the community who receive appropriate screening is lacking.<sup>5</sup> Programmatic recommendations for increasing screening are needed by both public and private sector organizations. For example, managed care organizations (MCOs) are eager to learn successful strategies for motivating older women in their patient population to seek mammography screening. As MCOs begin to serve more women who participate in Medicaid or Medicare, through Medicaid and Medicare risk contracts, it is critical to both the MCOs and the women that the women seek the mammography screening available to them. It is important to recognize that these women face barriers to mammography screening that present new challenges for MCOs.

Public and private organizations that provide mammography screening have considerable programmatic experience that could be shared in a mutual partnership. Public health departments, particularly those participating in the Centers for Disease Control and Prevention's (CDC's) National Breast and Cervical Cancer Early Detection Program (NBCCEDP), have been addressing the demands of reaching

---

<sup>1</sup>Chu KC, Smart CR, et al. Analysis of breast cancer mortality and stage distribution by age for the health insurance plan clinical trial. *Journal of the National Cancer Institute*. 1988;26:562-568.

<sup>2</sup>McClellan GL. Screening and early diagnosis of breast cancer. *Journal of Family Practice*. 1988;80:1125-1132.

<sup>3</sup>Shapiro S, Venet W, et al. Ten to fourteen year effect of screening on breast cancer mortality. *Journal of the National Cancer Institute*. 1982;1:829-1832.

<sup>4</sup>Tabar L. Reduction in mortality from breast cancer after mass screening with mammography; *Lancet*. 1982;1:829-832.

<sup>5</sup>*Building a National Cancer Control Program: Program Review*. Atlanta, GA: Centers for Disease Control and Prevention, Division of Cancer Prevention and Control; 1994.

underserved and special populations, such as communities of color and women with low incomes, low literacy, or cultural or language barriers. These departments are more experienced in traditional public health functions, such as community assessment and health planning, outreach to high-risk population groups, public education, community-based coalitions, professional education, population-based surveillance and tracking systems, and partnership development. In contrast, MCOs have more experience in the delivery of clinical services, including diagnosis and treatment, and have the advantage of a defined patient population for conducting evaluation research. A shared partnership between public health departments and managed care organizations would benefit women in the community by leveraging the assets of each partner.

The U.S. Public Health Service developed the National Strategic Plan for the Early Detection and Control of Breast and Cervical Cancer to ensure that targeted women receive regular screening for breast and cervical cancer with prompt follow-up, if necessary. Enactment of the Breast and Cervical Cancer Mortality Prevention Act of 1990 authorized CDC to implement program activities recommended in the National Strategic Plan through partnerships with state and local health agencies and other organizations. In response to this congressional mandate, CDC established the NBCCEDP.

Currently, 5 territories, 13 American Indian tribes, and all 50 states are funded by CDC to establish and manage comprehensive breast and cervical cancer screening services for women. The fiscal year 1997 appropriation of \$102 million enables CDC and its grantees to establish greater access to screening and follow-up services, increase education programs for women and health providers, improve quality assurance measures for mammography and cervical cytology, and improve evaluation of activities through surveillance systems. Efforts give priority to women who are minorities, low-income, and 50 years of age or older.<sup>6</sup>

Although mortality from breast cancer is higher among older women, they seek mammography screening less frequently because of barriers such as fear and anxiety; lack of awareness, provider recommendation, or time, for working women; limited access due to cost or transportation; and language, literacy, or cultural barriers.<sup>7</sup> Because of these multiple barriers, it is an ongoing challenge for public health departments to develop and replicate successful intervention strategies to

---

<sup>6</sup> *Announcement Number 474: 1994 National Breast and Cervical Cancer Early Detection Program.* Washington, DC: Department of Health and Human Services; 1994.

<sup>7</sup> Haynes SG, Mara JR, eds. *The Picture of Health: How to Increase Breast Cancer Awareness in Your Community.* Bethesda, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute; 1993. NIH publication no. 94-3604.

reach underinsured older women for mammography screening. In the changing health care environment, there are numerous opportunities and incentives to build productive partnerships between NBCCEDP grantees to coordinate and collaborate with MCOs in the delivery of mammography screening and breast cancer early detection services to older women. However, the extent to which they currently work together varies widely.

In February 1996, the NBCCEDP commissioned Macro International Inc. to develop a guide to identify those activities that, in the opinion and experience of grantees, have been most effective in bringing targeted women in for screening and rescreening. The purposes of such a guide are to provide background and explain needed infrastructure to aid the field in (1) identifying the best strategies to increase mammography screening rates in selected populations and (2) developing collaborations (especially between public sector organizations and MCOs) to implement these strategies.

This guide fulfills several purposes, including inventorying and assessing strategies as a gross measure of progress in NBCCEDP grant programs after 5 years of operation; profiling good strategies in a format useful for broader dissemination; and developing a resource for those trying to replicate these strategies elsewhere and especially for those trying to do so through collaborations between the public and private sector.

## Methods

The guide was developed in close consultation with NBCCEDP staff and with the assistance of a small advisory committee of representatives from grantee programs and other technical assistance resources.

In consultation with the advisory committee and NBCCEDP's team of project consultants, the project identified states that seemed to have the most activity under way in the areas under investigation. The initial pool of states included the 12 original comprehensive grantees; to this list were added any state recommended by a project consultant and any state that, after review of grantee files, appeared to have substantial and innovative activities under way. This process resulted in a pool of 23 states.

### ADVISORY COMMITTEE MEMBERS

- Pat Hilton, Assistant Project Manager, ROW Sciences, Rockville, Maryland
- Donna Gugel, Senior Program Specialist, ROW Sciences, Rockville, Maryland
- Jane Moore, Program Director, Health Promotion and Chronic Disease Prevention Branch, Oregon Health Division, Portland, Oregon
- Nancy Nowak, Program Consultant, Program Services Branch, Division of Cancer Prevention and Control, NCCDPHP, CDC, Atlanta, Georgia
- Faye Wong, Chief, Program Operations Section, Program Services Branch, Division of Cancer Prevention and Control, NCCDPHP, CDC, Atlanta, Georgia

Unstructured telephone interviews were conducted with the project director for each state grant program. In the course of that discussion, the director identified discrete activities that fell into any of the following five categories:

- Outreach, including recruitment, tracking, and follow-up.
- Inreach and other clinic-based strategies, including staff development.
- Public education.
- Program policy, protocol, and procedures.
- Community development and mobilization strategies, including coalitions and partnership development.

As can be seen from this categorization, the project took a broad approach in identifying efforts that were likely to bring women in for screening and rescreening, including not only direct service activities but also infrastructural efforts such as changes in policies and procedures.

The project directors identified the staff members who were most familiar with the activities identified. Telephone interviews with these staff were unstructured but tried to elicit the following types of information for each activity:

- Nature of the activity.
- Target audience.
- Setting(s).
- Collaborators.
- Resources.
- Outcomes/effectiveness.
- Methods for measuring effectiveness.
- Facilitators of and barriers to success.

The goal of collecting this information was to identify and compare similar activities, extracting patterns and themes in successful ones that would help the staff of other organizations to replicate them. In the end, the project staff identified and profiled 113 activities across the five categories in the 23 states.

This guide describes findings from formally evaluated interventions. Findings that may not have been subjected to formal evaluations but whose effects were monitored (for example, through hotline call volume or return of action cards) are also emphasized. Finally, the guide reports patterns and themes in activities that were not evaluated but are widely regarded as successful by expert staff at multiple grantee sites.

## Limitations and Caveats

The guide is an ambitious undertaking and, unavoidably, has some limitations, notably the following three.

- The guide is based on the experience of primarily public sector agencies. Although much of their experience is relevant to all organizations trying to increase screening and rescreening, some issues of bureaucracy and policy may be unique to the public sector. Likewise, the target audience for these programs tends to be very specific—uninsured, and underinsured, hard-to-reach women in a narrow age range. Again, while much of this information is applicable to reaching any woman for screening and rescreening, and will become even more applicable as private organizations become increasingly involved in serving low-income women and women from vulnerable populations, the current strategies may have less utility for insured middle-income women who tend to form the bulk of the enrollees and patients of private organizations.
- Although the guide tries to emphasize strategies that have been tested in the field through formal evaluation or at least monitoring of indicators, in fact, most grantees place emphasis on delivery, not evaluation, of services. Many of the strategies described herein are based on the informed report of grantee staff. An effort was made to include only those strategies that were widely reported to be effective, but these have not always been subjected to rigorous evaluation.
- Although the project staff tried hard to identify all relevant strategies in each state, they were dependent on what was reported to them by their state contacts. It is likely that some states are conducting activities that are similar to those described in this guide but were not identified by the state contacts with whom the project staff spoke.

The body of the guide describes the successful strategies in more detail. A chapter is devoted to each of the five major categories—inreach, public education, outreach, policies and procedures, and coalition and partnership development. In each chapter, a short introduction of how that category fits into the overall strategy for bringing women into screening and rescreening facilities is followed by some detailed illustrations and lessons learned by sites conducting innovative strategies.



# Inreach

## Introduction

**F**or purposes of categorizing successful strategies in this guide, inreach activities are defined as those that target an established or captive audience with which the program or its network already has a relationship. For example, classic inreach strategies target patients coming to comprehensive clinics or other provider clinics, often for services other than breast and cervical cancer screening. These patients constitute a captive audience, and inreach strategies aim to minimize missed opportunities to reach these audiences with messages about breast and cervical cancer (BCC).

Although this chapter illustrates some activities that are unique to inreach, many of the strategies and the principles that make them successful resemble outreach. The term “inreach” implies a process that is similar to outreach. Rather than “reaching out” to various communities to find women who do not use or who underuse medical services, however, these activities “reach in” to an existing population of women who have already accessed the medical system. For example, a clinic may display a poster or show videotapes in waiting rooms that remind women of the need for regular clinical breast examinations and mammography and encourage them to discuss recommended breast cancer screening with their primary care physician.

Defined this way, the inreach category yielded the smallest number of innovative and successful strategies of all the general categories explored with grantees. Yet, in conversations with grantees, it was clear that inreach is considered an integral part of breast cancer prevention programs. Inreach has the benefit of being simple and effective, although grantees employ it less often than other strategies. In reality, grantees tend to use a much broader definition of inreach than the customary one. Grantees consolidate activities in staff education and provider training into inreach. For example, several grantees mentioned lectures on new screening technologies as both an inreach and a physician education activity, although the direct target audience was not the patient population. They reason that even though the target audience for these lectures is not the patient population, they result in an enhanced patient experience. Indeed, inreach from the grantees’ perspective was broadly defined as any activity during the patient’s *entire* experience within the provider setting, from checking in at the reception desk to follow-up with screening results, that would facilitate women getting screened according to guidelines.

Inreach, defined this way, may be less “glamorous” than successful outreach activities that bring many new women for screening. Instead, inreach comprises the little, incremental changes that day by day make the system flow more smoothly and thus, make the women more likely to return. Many of these activities are changes to policies and procedures, which are discussed in the chapter entitled “Policies and Procedures.” This chapter focuses on inreach directed to patient populations, staff development, and provider education. The first section describes activities that directly target women who are accessing medical services. The second section describes activities that are not directly targeted to the patient population but translate into improved services, communication, and interaction in the provider setting.

## **Direct Inreach to Clinic Populations**

Direct inreach is a set of three integrated strategies. Successful programs maximize opportunities for direct education of those women who are already clients. These educational opportunities are supported by tracking and reminder systems and incentives to encourage clients to seek services. This section provides some illustrations of all three strategies.

### **Direct Educational Strategies**

Almost without exception, programs conduct fundamental activities such as providing educational materials in waiting rooms and patient health education materials in appropriate languages. Posters, pamphlets, and videos on display in providers’ offices serve to alert patients to ask their physicians or other clinic staff about recommended screening procedures. These strategies are intended to heighten the awareness of the clinic patients to screening and rescreening issues before the interaction with the provider. The general consensus of grantees was that efforts that address both provider and patient result in the largest increase in numbers of patients screened.

### **Tracking and Reminder Systems**

Tracking systems are a key component of comprehensive breast cancer care, and programs use a variety of integrated systems.

#### **Cancer Screening and Tracking System**

Eleven states and two tribes use CDC’s Cancer Screening and Tracking System (CaST), a provider-based surveillance and reminder system developed by CDC to automate data collection and reporting for breast and cervical cancer screening



programs. The CaST system is used to track women who have normal examinations, generate reminders for rescreening, and track women who have abnormal examinations to help ensure appropriate follow-up. Basic data collection for the CaST system at the time of screening provides information for several software functions: a reminder component; an overdue report to identify study results that are past due; a quarterly data report for evaluating the outcome of a screening intervention; and a duplicate client report. An export function allows creation of text files and also compiles the minimum data set required of BCC grantees.

One of the most important uses of a tracking system is to keep women in the habit of being screened regularly. Programs have developed a variety of reminder systems either as components of tracking systems, such as CaST, or as discrete systems. Regardless of the type, grantees are convinced that reminder systems are effective. For example, Minnesota's BCC program found that the cumulative proportion of women 50 and older receiving repeat mammograms within 12 months was significantly higher among women who attended clinics with reminder systems in place (0.45 vs. 0.31,  $P = .04$ ).

Among the many kinds of reminder systems used, some target the physician who then reminds the client, others target the client directly. Some reminder systems are used to invite new women to seek their first screening (akin to the strategies described under "Personal Invitations" in the outreach chapter). More commonly, reminder systems target women in the existing patient population who have missed a screening appointment or are due for their annual rescreening.

### **Tickler Systems**

The most common reminder system is the tickler system, which can be either automated or, more commonly, manual. Tickler systems are tracking systems that monitor the patients' progress through the current stage in the system. The more sophisticated systems not only track women through the screening process, from referral to results, but also automatically generate reminder letters or postcards for missed appointments and rescreenings. Therefore, programs with an automated system can directly remind the patient, rather than depending on an intermediary physician or nurse.

Despite the advantages of the more sophisticated automated tickler systems, BCC programs typically use other methods. For example, most state programs do not provide reminder services themselves but do so through a network of contracted providers. Although it might be a great boon to the program to have a centralized reminder system, implementing this at the provider level, where software would have to be tailored to each office environment, would be expensive and time consuming.

### **Program Staff**

Some programs target the physician or nurse, by using different manual methods to designate charts and prompt the health professional to conduct a clinical breast examination and discuss breast cancer screening during the next office visit. Similarly, forms for breast cancer screening history that are completed in waiting rooms and given to the physician during the appointment can be used to remind both the woman and the provider to discuss screening schedules.

Although the physician's role in the reminder system is pivotal, grantees emphasized the role of other office staff. Office staff play a potentially important health educator role by delivering educational messages in the clinic setting. Though grantee sites were not involved, two National Cancer Institute (NCI) studies tracked the performance of programs that trained nursing assistants, medical assistants, and others who had direct patient contact to promote the three recommended steps to prevent breast cancer.<sup>8</sup> The training included role playing to help office staff overcome patients' barriers to following the screening recommendations. To prompt discussions with women, office staff in one program wore buttons that read "Ask Me About Project Example" in Spanish and English. The programs resulted in increased screening levels, in part because patients saw the office staff as more approachable "lay" people.

Often, staff in physicians' offices do not have the time or energy to maintain a reminder system; also, systems that capitalize on office visits by suggesting screening to a captive audience work only for women who are screened by their customary health provider or a facility in contact with their health provider. Women who are screened at facilities that do only mammography screening or who use a certain provider only for screening do not go to that office for other reasons, so reminder systems targeted directly to them are essential.

Several grantees have adapted to provide reminder services, either because the provider offices cannot assume responsibility for reminders or because many women are screened at dedicated facilities. Nebraska's Every Woman Matters (EWM) Program illustrates this different approach. The program collects a database of screened women from its network of providers. The screening coordinator at the state level identifies women in the program database who are due for an annual screening and oversees the entire reminder process. The women are sent packets containing a screening coupon, bill (on a sliding-fee scale up to a

---

<sup>8</sup>Haynes SG, Mara JR, eds. *The Picture of Health: How to Increase Breast Cancer Awareness in Your Community*. Bethesda, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute; 1993. NIH publication no. 94-3604.

\$5 maximum), an update form for demographic information, a medical release form, a flyer on breast self-examination, and a provider-clinic list. When women present for screening, the physician takes the coupon, documents the procedures conducted, and sends the coupon to EWM where it is entered into the system for tracking. The system also generates reminder postcards for women over 50 whose coupon does not enter the system within 4 months of the mailing of the packet. EWM program staff are conducting a controlled study to measure the effectiveness of the postcard. The cost of the reminder service, including postage, paper, printing, and staff time to generate materials and assemble packets per client, was \$0.60 per packet distributed and \$2.45 per client screened.

In Maryland, the BCC program also assumes responsibility for the reminder system but in collaboration with the provider offices in each of the state's 24 counties. Maryland's BCC program is decentralized and operates through county coordinators in each county who contract with private physicians to provide services to the target population. The reminder system, which began as a demonstration project modeled after Dartmouth's Cancer Prevention and Community Practice Program, was expanded to all counties. The manual system is dependent on office facilitators who are trained at the time the practice is recruited into the BCC program. Within each office, a prevention team is established and provided with patient assessment tools (e.g., health history, flow charts), patient reminder tools (e.g., daily diaries, reminder postcards completed by patients at a previous visit), and technical assistance from the county coordinator. The system is monitored routinely by baseline chart audits, 6-month follow-up assessments, and an evaluation of office participation in developing the systems and tools used. All materials are provided by the state as part of the grant, and there is no cost to the physician practice. The main costs to the state are the training manuals and tools, which range from \$80 to \$150 per year per practice, and the salary of the program coordinator who trains the facilitators, recruits practices, arranges team training, and provides ongoing supervision of facilitators. The reminder system has been evaluated and was determined to have increased screening rates by 33% since its implementation.

In communities of color and other special populations, cultural and language barriers further exacerbate the logistical barriers to effective reminder systems. In selected California counties, providers faced low screening and rescreening rates among Vietnamese women. The Vietnamese Breast Cancer Intervention Case Study, an NCI-funded multilevel intervention targeting both Vietnamese physicians and women, used a reminder system as part of the intervention. At the time of the patient's visit, a copy of the physician Cancer Prevention Reminder is attached to the medical record to "flag" the record for the physician and to remind the physician to do clinical breast examinations (CBE) and to discuss screening. A similar patient

reminder in Vietnamese is also given to the patient at each visit, which informs her of the recommended screening schedule and sets goals for screening. After the visit, the physician's notations on the reminder form are used to update the medical record, and provide information to the reminder system for the next office visit. This reminder system serves multiple purposes, including breaking down language barriers and motivating Vietnamese physicians, perceived by patients as emphasizing acute conditions, to do preventive screening. The project is still undergoing evaluation.

## Incentives

This section presents strategies that employ incentives as a method of encouraging women to seek screening. The grantees interviewed had mainly used incentives with existing client populations in provider settings. (The "Outreach" chapter discusses incentives as part of an outreach program.)

While several grantees use a coupon or voucher for the mammography itself, mainly as a means of tracking the client through a decentralized system (see Nebraska's EWM program above), some grantees offer coupons for gas, food, or other items to encourage women to fill out screening surveys or to keep their appointments. Gasoline coupons, in particular, serve two functions: reward and motivate the women to complete the mammography screening and reduce the cost of their transportation. Although BCC screening programs virtually eliminate the cost of the mammogram, low-income and vulnerable populations often experience transportation costs as a barrier.

In some states, the coupons are advertised and distributed in the reception area of the provider office. In this way, they are integrated into the normal appointment process. Some programs issue the coupon at the initial appointment, and the woman leaves with the incentive in hand, as a tangible reminder of what must be done. In these cases, the coupons must be validated by the provider of the future service before they are used, documenting that the mammography was done or the appointment was kept. In other states, the coupons are advertised and information is provided at the initial visit, but the coupon is issued at the time the future appointment is kept.

South Carolina tested the effectiveness of coupons in a pilot project conducted with provider offices and mammography facilities in all 12 regions of the state. State program staff posted signs in provider offices encouraging women to ask how to receive a \$5 coupon for groceries or, in one region, for food at Burger King. Women who were eligible for free screening services received a CBE screening and a referral to a mammography screening site. They received a two-part coupon at the

mammography appointment, kept the redeemable part, and wrote their name, address, and Social Security number on the stub, which the office kept for tracking purposes. The public education team used the Social Security data to monitor the ages of women being screened, the number of African American women, and the correspondence between client lists and Best Chance Network (BCN) enrollment data. More than 60 women received and redeemed coupons. The cost of the program was minimal (less than \$500), including the cost of printing the coupons, developing promotional materials, and reimbursing the participating food stores. The local supermarket monitored the rate of coupon redemption.

Many lessons were learned in conducting the project:

- The project wanted to offer gas coupons, but it was difficult to get gas vendors to collaborate because coupon redemption is not a customary practice in their industry.
- Bar codes printed on the coupons enhance the prospects for partnerships with supermarkets because they facilitate deducting the coupon amount from purchases.
- The time frame of the coupon promotion must consider that women may enter a BCC program at any time. To maximize the incentive, the time frame needs to be long enough to allow women to enter the program, receive the mammography services, and redeem the coupon.
- Providers and their office staff must be well informed and cooperative for the program to work. A good orientation for office staff is necessary. State staff should develop all promotional materials and information to make the program as effortless as possible for the office staff.
- Programs may find that other incentives are more powerful than grocery coupons, and should explore expanding the program to include other types of goods and services.

## Staff Development and Training

As discussed earlier, staff development and training are categorized as inreach strategies by most grantees, even though the client is not the target, because the effects of the strategy are to improve the service setting and increase the chances that the client will remain in the system for screening and rescreening.

A key insight of the discussions with grantees about staff development and training is that the whole service setting must be considered, from the client's initial contact with the receptionist or telephone operator of the service provider to the

data processing and billing that allow for swift results and accurate billing. This insight is especially true for communities of color or other special populations that may already be alienated from or fearful of traditional health care institutions and for whom normal logistic barriers are exacerbated by cultural ones. Some of these issues will be addressed later in the chapter on policies and procedures. This section focuses on training for key staff in the provider setting, such as physicians, radiologists, midlevel practitioners (including physician assistants and certified nurse practitioners), and paraprofessionals, and on interventions directed to the entire staff.

### **Physician Education**

Primary care physicians, including family and general practitioners, internists, and obstetricians/gynecologists, are the most common gatekeepers for breast cancer prevention, performing CBE, teaching breast self-examinations (BSE), and referring women for mammograms.

Prior research on attitudes, knowledge, and behavior of primary care physicians reveals a persistent reluctance to refer asymptomatic, healthy-appearing women for regular mammography. For example, when Nebraska's EWM program and the University of Nebraska Medical Center studied physician perceptions of mammography, they found that physicians feel responsible for educating and informing female patients on breast cancer but believe that ultimate responsibility lies with the patient. They attribute underutilization of mammography to patient factors. The study also found that physicians saw utility in screening guidelines but that risk assessment, personal bias, and their own personal or family experience with breast cancer take precedence over guidelines, especially for younger patients. Research such as this suggests the need for targeting training to physicians, and most state BCC programs have done so. As illustrated below, most programs find that many physicians are actively interested in training related to prevention and screening of breast and cervical cancer and that the simple act of reminding them of the role they can play in reducing cancer mortality is effective. For example, by using such a message, Rhode Island's BCC Program found their 1-night professionals' conference overbooked.

In addressing physician education needs, some states have started at the beginning of training. For example, South Carolina teaches medical students how to conduct CBEs and how to teach BSE. Other states focus their efforts on physicians already in practice. This section provides illustrations of both.

### **Continuing Medical Education (CME) Credits**

Continuing medical education (CME) interventions have proved successful in changing physician referral practices and women's behavior related to having

mammograms. For example, a New York (NCI-funded) study found that a CME intervention for physicians was followed by a reduction from 44% to 24% in the rate of women who reported they did not have a mammogram because their doctors did not recommend it and an increase from 28% to 44% in the number of women who said they received mammograms during the past year. Grantees use a variety of strategies to encourage their providers to update their breast cancer screening knowledge and practices. Meetings and conferences that last a few hours to several days are the most common vehicles for CME. Grantees indicated that the main factors associated with successful CME for physicians are minimal time commitment, location of the workshop or conference, and guest list and made the following points and suggestions:

- All-day events are not popular. If possible, training should be split into half days, even if doing so results in a several-day training.
- The setting should be comfortable and in a convenient location. If the training is longer than 1 day, include easily accessible perks, such as golf and family activities.
- Physicians prefer to be trained among other physicians rather than in multi-professional trainings with other medical staff, such as radiologic technicians and nurses.
- For partial-day conferences, evening conferences with dinner are preferred to daytime events.
- Conferences that are free are often less well attended. Even when the fees are not needed to cover the cost of the conference presentations, some BCC programs charge the fee anyway and use the proceeds to defray the catering costs.
- For smaller, more-focused events, it is wise to conduct a needs assessment in advance with potential attendees. For example, a recent North Carolina conference to update and improve the breast-imaging skills and knowledge of radiological (mammography) technologists (RT's) was sponsored by the Comprehensive Breast and Cervical Cancer Control Program and the University of North Carolina School of Medicine. The four and a half-day conference was held at Hilton Head, South Carolina, and illustrates the preferred mix of activities. The conference brochure highlighted the recreational opportunities of the area and encouraged attendees to bring guests or family. The conference included hands-on tutorials and lectures from 8:00 a.m. to 12:30 p.m. each day and earned the participants 15 CME category-1 credits. The fee of \$450 covered the course materials, syllabus, daily breakfast, break refreshments, and participant-faculty dinner.

### **Physician Clinical Breast Exam Training**

Many grant programs find that this training for physicians is among the most sought-out offerings and has the potential for significant, though hard to measure, effects on women's attitudes toward mammography screening. Maryland's BCC program, in collaboration with the American Cancer Society, the state medical society, and other professional organizations, offers a 2-hour course to build provider skills in clinical breast examination. Physicians are sent a recruitment letter signed by the head of the state medical society that includes endorsements by the American Cancer Society (ACS), local hospitals, and the BCC program. The

training is taught by physicians, offers CMEs, and, with the exception of the 45-minute opening lecture, is a practicum using patient surrogates. State staff indicate, based on participant feedback, that the use of patient surrogates, as opposed to video tapes of models, greatly enhances the effectiveness of the training. The surrogates are trained to offer feedback to providers on procedure and communication, which gives the physician insights into the effect of their actions.

### **DOCTOR/PATIENT COMMUNICATION IN THE CLINICAL SETTING**

A formative evaluation workshop conducted by Brown/ATPM staff while developing their training curriculum illustrates the many levels at which doctor/patient communication takes place and can be disrupted. Analysis of tapes of clinical encounters with standardized patients revealed several findings:

- Gender is a significant factor in counseling about sexually charged issues, not just in the physical examinations.
- Particularly when discussing sexual matters, the positioning of doctor and patient can have important consequences that will differ depending upon the gender of the physician.
- Periods of silence are important but may be difficult for inexperienced clinicians to handle.
- The nature and duration of eye contact when discussing sexual matters or performing exams are important.
- The physician's awareness of nonverbal expressions of discomfort or unease is especially important when discussing sexual matters and sensitive procedures with a patient.
- Physicians have to be aware of words that are emotionally, sexually, or otherwise laden with meaning and be alert to transmitting unintended meanings.

### **Communication Training for Physicians**

Dealing with sensitive subjects is not a typical part of physician training, and the resulting problem is exacerbated when providers and patients are of different genders. Two CDC-funded projects aim to enhance physicians' communication and counseling skills in breast and cervical cancer. Although the projects are not efforts of NBCCEDP grant programs, they are included here because the products will be available as a resource for private and public programs.

In conjunction with the Association of Teachers of Preventive Medicine (ATPM), educators at Brown University have been funded by CDC to develop a training curriculum for medical students and residents. The curriculum comprises eight modules and is presented in a combination of formats, including simulated patient-provider interactions using standardized patients. Some of the modules include communication, gender, and cultural issues



in the doctor/patient relationship, skills in cancer-prevention counseling, cultural issues in breast and cervical cancer screening, and disclosure of findings. The modules are being field-tested and evaluated at several medical school sites and target providers who are female or from communities of color. After field-testing, the curriculum will be available for all medical schools and other physician training programs.

A similar curriculum is being developed as a collaborative effort of the Educational Development Center, Inc., and Dartmouth Medical School. The curriculum is designed to boost rates of breast and cervical cancer screening by enhancing primary care physicians' knowledge and skills in building partnerships with their patients for cancer prevention. The program offers up to 6 hours of training. An initial 1-hour video-based didactic presentation is followed by four case-based interactive seminars and one 1-hour follow-up training on revising office systems to support cancer prevention. The curriculum is designed to combine clinical information, communication skills-building, and suggested office operations to support and sustain improvements in practice. The curriculum is designed for physicians who have completed training, and the field-testing targets MCOs. The curriculum is expected to be available in September 1997.

### **Special Issue Journal**

Nebraska's BCC program helped produce a special issue of the journal of the state medical association dedicated exclusively to breast cancer. It was the first time the journal had been devoted to one subject and offered options for CME for physicians and physician assistants. The issue, which was nominated for an award by the Medical Writer's Association, contained 11 articles authored by Nebraska physicians, nurses, psychologists, and social workers on topics such as breast cancer incidence, mortality, and screening; treatment options; imaging and early detection; physician-related barriers to screening; postmastectomy breast reconstruction; survivors' perspectives; effect of breast cancer on sexuality; and systematic adjuvant therapy for breast cancer. The issue was mailed to all physicians and residents in the state, practicing and student physician assistants, nurse practitioners, and clinics and mammography units associated with the BCC program. The authors developed questionnaires for physicians to answer and return to the BCC program for CME credit, along with an evaluation of the journal.

The special issue was a joint effort of the Nebraska medical association and the BCC program. The program suggested authors and topics and paid for the additional printing and mailing costs of the special issue, which was larger than usual and distributed to a larger mailing list; the medical association published the journal. The effort paid off for both groups, by increasing the credibility among

physicians of the BCC program's activities and exposing the medical association and its journal to a larger audience. The BCC program will soon replicate the joint effort with the Nebraska Nurses Association.

### **Training and Recruitment of Nurses and Midlevel Practitioners**

Several grantees see a direct relationship between the number of providers available and the number of women screened for breast cancer. Furthermore, the grantees' experience suggests that more of certain kinds of providers would further improve screening rates, in particular, minority providers, providers who speak the languages indigenous to a community, and female providers. Because such providers are underrepresented in the physician pool in many communities, many grantees have devoted resources to expand the types of providers trained in BCC interventions, especially registered nurses, certified nurse practitioners, and physician assistants. This section details some of these grantee activities. Efforts to expand duties vary widely from state to state and are influenced by the state's supply of different types of providers and the provisions of its nurse practice act.

Texas addressed a shortage of nurses involved in screening, especially in rural areas, by contracting with health care education organizations for professional education and clinical breast examination certification programs for registered nurses, certified nurse midwives, and nurse practitioners. Under these contracts, the health education organization develops the certification program and the BCC program pays the registration fees for the nurses.

Colorado chose a similar strategy because of a shortage of providers and because training in clinical breast examination was losing out to CME training in a competition for existing providers. Many physicians were reluctant to work with the hard-to-reach populations targeted by the BCC programs, and the clinical breast examination certification programs were competing with traditional CME programs offered for multiple days on more mainstream topics in attractive settings. The BCC program concluded it was better served by training nurses and midlevel practitioners who were already working with or were more inclined to work with the target population and who were interested in the training. An evaluation was built into the training; results indicated a 40% increase in posttraining test scores.

Michigan works to improve the quality of nonphysician screening personnel through an annual clinical skills conference focusing on breast and cervical cancer. Nurse practitioners, physician assistants, and occasionally other practitioners can earn accreditation by attending the conference.

West Virginia's BCC program experienced all of the challenges that Colorado and Texas experienced but also believed strongly that women needed to be screened by women providers, especially in Appalachian communities. New flexibility in the state's licensing law that permitted nurses to perform, not merely assist with, clinical breast examinations moved West Virginia's BCC program to contract with the Mary Babb Randolph Center in Morgantown to provide Public Health Nurse Physical Assessment Training (PHNPAT). Topics include breast self-examination, mammography promotion, and anatomy and physiology of the breast. After certification, the participants perform 50 monitored breast exams, half of them on women over 50 years of age, and are given feedback on each. The increase in trained and certified providers, and especially female providers, is expected to have a dramatic effect on the number of women who will follow through on referrals for mammography. The number should rise because the women will feel more comfortable with a female provider and, according to staff, are more likely to promote the recommended screening schedules. Texas and North Carolina have programs very similar to West Virginia's.

In addition to the efforts of NBCCEDP grantees, CDC is directly funding special projects relevant to the training and development of nurses. The American Nurses Association holds a cooperative agreement with CDC to develop a teaching module, recently field-tested, for undergraduate and advanced practice nursing students on how best to educate and teach low-income African-American women about breast and cervical cancer screening practices. The module is intended to foster community empowerment, is culturally sensitive, and is Afrocentric.

Using CDC funds, the Mayo Medical Center has developed and currently conducts a 40-hour training program for nurses who serve Native American women in two Indian Health Service areas of the state. The training is provided on-site because the program believes this will enhance the chances that change will become part of everyday operations. At the end of the training, the nurses are able to complete a clinical breast examination, teach breast self-examination, obtain a good Pap smear with minimal discomfort to the patient, use culturally specific and sensitive methods to recruit women to the screening sites, organize and maintain tracking systems, and use Continuous Quality Improvement (CQI) techniques to monitor the services. The intent of the program is to increase patients' access to screening in these outlying areas, where chronic physician shortages mean that nurse practitioners are often diverted to acute care activities. In addition, the program aims to reduce psychological barriers to screening by providing a pool of culturally sensitive screening personnel, many of whom are women.

## Radiologic Technician Training

In the experience of BCC grantees, with the exception of physicians, no professional is more crucial to the success of a breast cancer screening program than the radiologic or mammography technicians. They come in close contact with the women being screened, and it is often the performance of the technologist that a woman remembers most about her breast cancer screening experience. Therefore, grantees devote considerable resources encouraging mammography technologists to improve their screening techniques to make the experience as pleasant as possible for clients.

Grantees stressed that training of radiologic technicians, as in training of all health professionals, should begin with a needs assessment. Nebraska developed, distributed, and analyzed a training needs survey of its own technicians as well as radiologic technicians (RTs) in South Dakota, Iowa, and Kansas. The findings revealed their preferences regarding the type of training (hands-on workshops, videoconferences, and self-study programs), day (Saturday), duration (full day), and priority topics. The eight highest rated topics mentioned by both less experienced and more experienced mammography technicians were diseases of the breast, critique of films taken by the technicians, patients with special needs, mammographic appearances of benign and malignant processes, positioning guidelines, signs and symptoms of breast cancer, special projections in mammography, and staying motivated as a mammographer. The Nebraska programs are able to compare survey results with current training offerings and modify them to match the expressed preferences of technicians. The needs assessments include reasonably comprehensive demographic and practice sections so that needs specific to geographic, age, and experience subsegments of the target audience can be detected.

Other than time, cost is among the most frequently cited barriers to training for RTs. Two states had contrasting results such as when they offered stipends. South Carolina's Best Chance Network offered 78 stipends of \$100 to reimburse radiologic technologists for continuing education registration fees. Each member facility in the network received a memo, application forms, and a list of conferences. The facilities were limited to choosing two applicants and had to submit proof that continuing education credits were to be awarded. Fewer RTs than expected applied for reimbursement. Program staff concluded that applying for continuing education credits may have been an obstacle.

In contrast, Nebraska's EWM program offered scholarships for mammography technologists to attend a conference held by the University of Nebraska Medical Center. Member screening sites were allowed to choose one technologist to receive

reimbursement for registration fees and partial reimbursement of mileage, food, and hotel accommodations. In return, the selected technologists would present an in-service training to other technologists on their faculty. RTs were very responsive, and, in the end, the program was able to sponsor 16 technologists.

North Carolina also used a conference as a training site. In training its RTs, a 1-day specialized conference for RTs was added to the state's annual radiology conference. Although the conferences for the physicians and for the technicians were held the same weekend and at the same hotel, they were kept separate because staff believed that physicians were more inclined to attend a conference for physicians only. Topics included image evaluation, quality control for film processing, cleaning and maintenance, and positioning; a hands-on positioning workshop was also conducted. CME credit (8.0 category-1 credits) was offered and the registration was \$100. The conference was well received, but cost was still perceived as a barrier despite the low registration fee.

### **All-Staff Training**

Grantees uniformly agree that an effective provider education program targets all staff who come in contact with patients, not just the patient care staff. Even those staff involved behind the scenes need training to ensure that health messages are delivered consistently and to reduce the likelihood that clients will be lost to the system.

In addition to customary all-staff updates, orientation of new staff, and debriefing sessions with exiting staff, BCC programs may identify special topics for their training sessions. This section describes two programs that are inclusive in their staff training on special topics.

The first program is the "Lunch and Learn" program. An initiative of South Carolina's Best Chance Network, the program aims to provide on-site professional education to all BCN providers and providers serving the more than 400 clients in Companion Health Care, a health maintenance organization and a network partner. The program involves all office staff, reflecting the network's preference for a team approach to all stages of clinical care, including referrals for abnormal tests, annual reminders, and data completion necessary to validate state and national goals for mortality reduction. The program curriculum, usually presented by the cadre of program coordinators in 1- to 1.5-hour sessions during the lunch hour, covers breast and cervical health, how to teach women to perform breast self examinations, how to perform clinical breast examinations on clients, and inreach and follow-up techniques to attract women for screening and rescreening. The training is interactive and hands-on and encourages brainstorming sessions among all staff to

identify creative solutions. For example, a session on identifying eligible women for network services might yield strategies for physicians and nurses but also advocate that the receptionist take notice of women over 50 coming in for blood pressure screening.

Companion Health Care and the Best Chance Network adopted this curriculum after informal evaluation data from another program indicated that it resulted in significant increases in screening rates. Evaluation data on the current effort indicate that participants agree with the need for the training and think it has been effective. However, it is too early to tell if it has led to increases in screening.

A difficulty in all-staff training is the tendency of some groups of professionals, especially physicians, to see their training needs as unique. Although the network has widespread physician participation, on occasion the regional training coordinators have also hosted special physician trainings in locations where the physicians preferred not to participate in the all-staff training sessions.

The second program is Minnesota's Cancer Control Program, which offered an all-day media training for its staff. The impetus was the belief that all staff are performing public relations for the program and should know how the media work and how to deal with the media. The training focused on brainstorming story ideas that targeted women 50 and older, analyzing the results of a media campaign, and writing press releases and background materials. The training also addressed special topics, including working with cable TV, partnering with local businesses, and developing human interest stories.

In addition, when Massachusetts' BCC program conducted a needs assessment within the lesbian community (see the "Outreach" chapter for more details), one conclusion was the need for more providers who were sensitive to lesbian and bisexual women in the clinic setting. This conclusion resulted in the development of a provider sensitivity training program and training sessions planned for three locations around the state. The training aims to attract a broad array of staff from clinics, ENCORE<sup>plus</sup> programs,<sup>9</sup> and outreach workers. The workshops will be intensive and interactive, include panels of lesbians describing their experiences in the health care system, and pay special attention to inherent heterosexual biases in the system. A key principle of the training is that sensitizing the clinic setting means sensitizing all the staff—from staff in the waiting room staff to the data collection staff.

---

<sup>9</sup>YWCA's ENCORE<sup>plus</sup> program is a national staff training program to improve services for medically underserved women (see box in "Outreach" chapter, p. 77).

## Reaching Nonphysician Providers

Whereas grantees have several outlets for training physicians, these same outlets may be less effective with other types of providers. Often, these providers are harder to attract to distant, several-day conferences; therefore, programs are always searching for effective alternatives to the so-called stand-up training offered at these conferences. Continuing education can be provided in other settings by different methods, and BCC programs have used all of them at one time or another. This section describes the experiences of BCC programs in providing continuing education for nonphysician providers through videoconferences, video resource libraries, and publications.

### Videoconferences

Videoconferences are an attractive alternative to stand-up training on the surface but were given mixed reviews by grantees. Although they save on travel, accommodations, and per diem expenses, opportunities for interaction are nonexistent for some videoconferences and awkward for interactive ones. BCC program staff and attendees report a resulting loss of effectiveness.

Smaller interactive videoconferences permit interaction, but unless the number of participants is very high (which, in turn, limits the opportunities for interaction), the cost savings over stand-up training are not significant. Some programs report that the planning and coordination requirements for a video conference are so high that stand-up conferences at a central location are more feasible for annual events. Regardless of the cost-benefit relationships, however, videoconferences fill an important need for rapid dissemination of information to program providers. In addition, rural providers are very receptive to videoconferences.

One BCC program televised a satellite video conference for physicians, clinic nurses, and mammography technicians in 39 sites. The conference had several purposes: to discuss the results of focus group research on women's attitudes about mammography; to relate critical issues regarding diagnosis, treatment, and coping skills from the client's perspective; to review trends, incidence, and risk factors of breast cancer; and to discuss regional differences in providers' referral practices. Afternoon and evening sessions were offered in some sites; evening sessions were better attended. The program secured schools as sites at no cost. Evaluation forms were distributed to the attendees by volunteer facilitators at all satellite locations. The total cost was approximately \$10,500 and included fees for a nonprofit agency contracted to assist in coordination and in obtaining continuing education credits for nurses and mammography technicians.

### **Video Resource Library**

One BCC program used its affiliation with the medical school at the state university to build a library of tapes from the Health and Sciences Television Network, a main federal center for health education. The tapes are copied inexpensively without the need to obtain copyright permission and then distributed to BCC providers; some are broadcast statewide. The videos cover an extensive range of categories, are made by universities and other institutions across the country, and range from sophisticated productions to national teleconferences to simple broadcasts in hospitals. Examples of relevant videos are: *Physicians: Management of Nonpalpable Breast Lumps*, and *Management of Early Stage Breast Cancer: Asymptomatic Masses*. The program includes a self-mailing evaluation pertaining to breast cancer with all videos. Upcoming programs and new acquisitions are publicized through the program's statewide provider newsletter. Some, but not all, programs carry CMEs, which can be obtained by calling an 800 number to receive information on the program. As with videoconferencing, rural providers are very receptive to the video resource library, and the membership in the national network allows the program to build a large library without the cost of developing its own videos.

### **Publications**

Memos, briefs, newsletters, and handbooks are the most frequently mentioned means of disseminating information to the network of providers; some BCC programs are adding unique formats to the mix. Several have created and distributed pocket cards (that fit into a pocket on physicians' white lab coats) that contain reminders of guidelines and clinical breast examination techniques. For example, California has developed a diagnostic algorithm for physicians and a treatment guide for women referred for a breast biopsy. The algorithm provides physicians with up-to-date information that guides them when they consider treatment and referral options for their patients. Providers are required to offer the treatment guide to all women they refer for biopsy. The 30-page guide discusses the nature of breast cancer, diagnostic and treatment procedures, counseling, and even reconstructive options in the case of mastectomy. A glossary is provided at the back to help the patient understand the guide as well as her treatment team.

North Carolina has developed a pocket card that is inserted in a provider's guide published by the BCC program. The card depicts a flow chart of recommended procedures for women in three age groups (35 and younger, 35 to 49, and 50 and older) and the techniques used in breast palpation and clinical breast examinations.



# Public Education

## Introduction to the Health Communication Process

**F**or purposes of identifying and classifying successful strategies, this guide distinguishes between outreach and public education by classifying as outreach those strategies that addressed the target audience as individuals and classifying as public education those strategies that addressed the target audience as a mass audience. The boundary between these two is somewhat fuzzy, and many strategies cannot be easily distinguished. Nevertheless, most grantee programs are undertaking extensive programs that use mass media. This chapter addresses these strategies, illustrating the various uses of mass media, the audience addressed, and the elements of message construction. Clearly, issues of audience and elements of message construction are equally applicable to outreach and inreach strategies with the same target audiences. In addition, as is clear from discussions with almost all grantees, it is the rare program that undertakes only a public education strategy or an outreach strategy. Rather, both are part of an integrated whole—the public education component builds awareness with the target audiences that the individual outreach can then convert to active engagement in the system.

Public education components work to ensure that women are aware of the importance of screening and sources of care and understand the recommended screening guidelines and how to initiate the screening process. In addition, public education is key to improving overall understanding about breast cancer, reducing public fears, and promoting action toward early detection.

This chapter details the process for planning and developing public education programs by presenting a framework for viewing public education first and then illustrating successful strategies employed by grantees to increase screening and rescreening for breast cancer. The framework used here is the Centers for Disease Control and Prevention's 10-stage health communication process presented as a wheel (see box, p. 26).<sup>10</sup> Although communicating effectively about breast cancer screening, as well as all health issues, is a difficult task, the wheel guides the classification and elaboration of public education programs. CDC acknowledges that this is

---

<sup>10</sup>*Health Communication at CDC*. Atlanta, GA: Centers for Disease Control and Prevention; March 1994.

## THE TEN STAGES OF CDC'S HEALTH COMMUNICATION WHEEL

- Review background information.
- Set communications objectives.
- Analyze and segment target audience.
- Develop and pretest message concepts.
- Select communication channels.
- Create and pretest messages and products.
- Develop promotion plan.
- Implement communication strategies and conduct process evaluation.
- Conduct outcome/impact evaluation.
- Provide feedback to improve communication.

an idealized process that will often exceed the available resources of many programs. Programs can review these steps within the confines of their budgets to determine which ones are essential in developing their own health communications plans.

### Step 1: Plan the Foundation

This planning stage provides the foundation for the entire health communication process. Faulty decision making at this point can lead to the development of a program that is “off the mark.” Careful assessment of a problem in the beginning can reduce the need for costly midcourse corrections. Some key questions to ask in the planning stage are

- What resources are available for the project?
- What extra-organizational factors (social, political, economic, technological) bear upon the problem?
- Would the effort duplicate or compete with another effort already under way?
- Is there medical and public health consensus on what the message should be?
- Has a similar program been attempted in the past, and if so, what were its successful aspects?
- What are the current levels of consumer knowledge, attitudes, beliefs, and behaviors?
- How will the message serve the overall prevention program?
- Can the program build on existing programs or activities or profit from joint activities with other organizations? Collaborating with other programs and agencies that share common goals is the most efficient way to use often scarce resources.
- What benefits can the target audience expect to see from an effort at prevention?

**Step 2: Set Communications Objectives**

Once the background information has been collected and reviewed, the context is set for establishing a set of communication objectives. It is essential that clear objectives be formulated to focus all subsequent activities on the final goals. Objectives should be well defined in scope and time and be measurable and attainable. They should also reflect a synthesis of step one information in an optimal combination of methods and channels in pursuit of the overall goals. How much—of what outcome—is expected among whom and by when?

**Step 3: Analyze and Segment Target Audiences**

Communication activities should be based on a thorough understanding of the target audiences; few messages will appeal to everyone. Segmentation identifies large groups that share key characteristics that affect their attentiveness to a message. The most effective version of the message can then be developed and targeted to the various groups through the most effective medium. In addition, segmentation should consider those factors that are most important for the prevention program, such as gender, literacy, or media preference.

**Step 4: Develop and Pretest Message Concepts**

This step encompasses the following tasks: develop different message concepts; assess how the target audience reacts to the concepts and if the audience understands the message, recalls it, accepts its importance, and agrees with the value of the solution to the problem; determine the reaction of the audience to the chosen format; and revise the message concepts as needed.

In-depth interviews, literature reviews, and focus groups are examples of helpful research tools in identifying key message concepts. Message concepts must be scientifically valid and consistent with the communication objectives as well as linguistically and culturally relevant and appropriate to the needs of the target audience.

**Step 5: Select Communication Channels**

Information collected in the previous steps should be used to guide the selection of communication channels and materials that will be most effective with the target audience. Channels, in this context, refers both to the setting within which the message is presented (for example, worksite, home, face-to-face, or mass media) and the medium for presenting the message (for example, television, radio, or direct mail). In this step, programs, especially those with limited budgets, look for existing materials of their own or other materials that they can adapt for their audiences.

Target audiences, channels, and messages interact, in that certain messages and channels are the best ways to reach some segments of the targeted audience, whereas some channels are not appropriate for certain messages. While many state breast and cervical cancer programs see promoting mammography screening and rescreening among the general population of women as their charge, most accept that their primary mission is to women aged 50 and older, particularly to underinsured and underserved populations.

Although clearly defined, the target group of women over 50 is still potentially too broad a target audience for a public education campaign. For example, within the target group are significant segments, such as women of color, lesbian and bisexual women, and underinsured and uninsured women, that may have unique channels. Also, because they do not share a uniform lifestyle or priorities, the women may respond to different messages.

When selecting the medium to present the message, consider that each offers some trade-offs in terms of reach, price, and ability to convey complicated messages. In addition, consider that segments of the target population will invariably differ in the media they prefer. Table 1 summarizes the characteristics of the four most common media: television; radio; newspapers; and experimental media, such as billboards, bus signs, taxi signs, and even posters displayed throughout the community.

Several factors help programs choose which and how many media to use in reaching a specific target audience:

- **Appropriateness to the information and message.** Complicated messages are not easily conveyed in short public service announcements (PSAs) or environmental media.
- **Fit with program purpose.** Most media are probably appropriate for building awareness of the message within the target audience. Influencing attitudes and behavior, however, requires media choices that allow for more detailed and sophisticated presentations, such as direct mail or longer television and radio PSAs.
- **Cost.** For nonprofit and public screening programs, cost is often the critical deciding factor. Time frame and budget have to be considered. Programs must accept these as constraints at the start and adjust their messages and target audiences accordingly; a message should not be forced into an inappropriate medium to save money.

**Table 1. Characteristics of Four Media for Message Distribution**

Television	Radio	Newspapers	Environmental Media
<ul style="list-style-type: none"> <li>Offers the opportunity to include health messages via news broadcasts, public affairs/interview shows, and dramatic programming.</li> <li>The visual as well as the audio component make emotional appeals possible. Easier to demonstrate behavior on television.</li> <li>Can reach low-income and other audiences not as likely to turn to health sources for help.</li> <li>Has potentially the largest and widest range of audiences but not always at times when public service announcements (PSAs) are most likely to be broadcast.</li> <li>PSAs and public affairs programming are no longer regulated by the government, but stations are still interested in broadcasting them for community goodwill.</li> <li>Promotes passive consumption by the viewer; less than full attention is likely. Message may be obscured by commercial "clutter."</li> <li>Production of programs is expensive. Feature placement requires contacts and may be time consuming.</li> </ul>	<ul style="list-style-type: none"> <li>Various formats offer flexibility to target specific audiences: teens, women over 50, homemakers, and ethnic groups.</li> <li>Deregulation ended government oversight of station's broadcast of PSAs, and public affairs programming, but stations are still interested in community visibility.</li> <li>Offers opportunity for direct audience involvement via call-in shows.</li> <li>Audio alone may make messages less intrusive.</li> <li>Can reach audiences who do not use the health care system.</li> <li>Promotes generally passive consumption, although exchange with the audience is possible.</li> <li>Live copy is very flexible and inexpensive; PSAs must fit station format.</li> <li>Feature placement requires contacts and may be time consuming.</li> </ul>	<ul style="list-style-type: none"> <li>Can reach a broad audience rapidly; smaller audience than television or audience.</li> <li>Offers a variety of news "angles," including health, nonprofit, and volunteer activities.</li> <li>PSAs are virtually nonexistent in newspapers.</li> <li>Can convey health information more thoroughly than television or radio. Feature placements are possible.</li> <li>Are dependent on literacy level of audience.</li> <li>Elderly may have visual handicaps that limit use of newspapers.</li> <li>Many specialty newspapers make it possible to reach target audience.</li> <li>Short life of newspapers limits rereading and sharing with others, but newspapers can be reproduced and the contents can be quoted.</li> <li>Small papers may take public service advertisements.</li> <li>Coverage in large papers demands a newsworthy item.</li> </ul>	<ul style="list-style-type: none"> <li>Can reach a wide audience but may be fixed to specific locations.</li> <li>Limited potential for use of PSAs and donation of free space.</li> <li>Full content can be focused on health messages.</li> <li>Visual aspect can depict segments of the target population.</li> <li>Can easily reach audiences residing in target area and using public transportation.</li> <li>Extended life of environmental media allows for continued rereading and reinforcement of messages.</li> <li>PSAs are often accepted. Messages may remain posted until space is purchased for future use.</li> </ul>

Source: Haynes SG, Mara JR, eds. The Picture of Health: How to Increase Breast Cancer Awareness in Your Community. Bethesda, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute; 1993. NIH publication no. 94-3604.

## Step 6: Create and Pretest Messages and Products

The information collected in the previous steps is used to select messages and channels for pretesting. Each message concept may be represented in multiple messages and formats. It is best to keep the materials in draft form to allow changes to be made easily and inexpensively, if results of the pretests reveal helpful

improvements. Methods of pretesting include so-called intercept interviews with members of the target audience and controlled airing of commercials, keeping in mind the following:

### CHARACTERISTICS OF GOOD MESSAGES

- **Comprehension.** How clear is the message? How well will it be understood?
- **Acceptability.** Does the message contain anything that may be considered offensive or distasteful by the target audience? Does it reflect the norms and beliefs of the target audience? Does it contain language that might be construed by the audience as irritating or abusive?
- **Personal Involvement.** Will the message be perceived by the audience as directed to them or at someone else?
- **Persuasion.** Does the message convince the target audience to adopt the desired behavior?

- Communication materials must fit the format selected.
- The pretest design should allow for the measurement of intended as well as unintended effects.
- Pretest results should be used to revise messages and materials as needed before proceeding to the next step.

### Step 7: Develop Promotional Plan

A sound promotional plan is necessary to ensure that the messages reach the intended audiences. Developing a plan may involve public relations campaigns or media advocacy to draw attention to the communication message.

A comprehensive promotion plan should:

- Identify target audiences and channels.
- Describe activities and events to promote and broaden the communication effort.
- Describe methods to disseminate materials.
- Describe mechanisms to store and track quantities of materials used and those remaining.
- Describe logistical support for all of the above.
- Provide an implementation timetable.

**Step 8: Implementation**

The health communication process comes to fruition and is monitored in this step. The fully developed program is promoted and distributed through all the chosen channels. A mechanism for periodically tracking audience exposure and reaction to the program is also implemented so alterations can be made. The following questions are asked in this step:

- Is the message being spread through the intended channels of communication?
- Is the target audience paying attention and reacting?
- Should existing channels be replaced or new channels added?
- Which aspects of the program are having the strongest effect?
- Are changes needed to improve the effectiveness of the program?

This step encompasses process evaluation because it evaluates whether the message is making it through the system and being received as planned.

**Step 9: Assessing Effectiveness**

When the process evaluation determines that the message is being received as planned, this step becomes most crucial. Is the strategy having the effect intended? The program should be tracking the outcomes decided earlier throughout the duration of the project. Central to this step is an evaluation design that allows the program to determine if objectives were met and if outcomes are the result of the program, other factors, or both. The program also begins an assessment of how well stages of planning, implementation, and assessment were conducted.

**Step 10: Feedback to Refine Program**

Each step yields useful information about the audience, the message, the channels of communication, and the program's intended effect. Information gathered and processed at this step can inform the next cycle of program development, including why the program worked or did not work, and the lessons learned that can make future programs more successful.

Public education is a main thrust of BCC programs, and grantees are conducting activities related to mammography screening and rescreening that cover a broad spectrum of media and messages. Central to the public education campaigns of most states are efforts using several or all of the following media: commercial network, cable, and local access television; radio; print; and environmental media.

The remainder of this chapter describes how the steps of the health communication process are implemented in the real-life setting of public education for BCC programs. In particular, the discussion emphasizes how programs have used various forms of media to conduct these activities. Most of the discussion is based on the actual experiences of BCC programs in setting up public education as elicited in telephone interviews with key program staff. While all states noted varying uses of media campaigns for public education, 13 states highlighted these efforts in their telephone discussions. Publications and manuals developed by the programs supplement this information.

## Using Multiple Media Channels

The next sections discuss specific media channels individually, but grantees' media efforts rarely are confined to a single channel. Many state efforts use coordinated messages in multiple channels aimed at large, general audiences.

Colorado is an example of a state with a large media program that integrates several media channels. In 1995, the program developed television and radio spots and other media pieces to raise screening rates throughout the state. Television and radio stations and other media specialists were recruited to help make the program a success. The program measured success by the number of times the spots aired and by increases in screening rates and telephone calls after the airing of the ads. The spots aired 373 times during the time period of the study. Although the program did not include a formal evaluation, program staff indicated that both screening rates and telephone calls increased when the spots were aired.

In a statewide effort to increase use of a free mammography screening service (the Pathways project), California hired professional advertisers to develop television spots and purchase the time to air them. Related efforts using billboards, in-store promotions, and press events were also conducted. The television spot, entitled "The Time Bomb," describes breast cancer as a relentless time bomb and shows an 800 number for women over 40 to call to arrange for a free screening. The spot won several awards, and the project resulted in significantly increased numbers of calls to the 800 number as well as an increased percentage of minority callers.

The state BCC program in Maryland, in partnership with the state tobacco agency, has operated a dedicated hotline and aired television and radio advertisements since 1992. The advertisements, developed to raise awareness among the general population and designed with the assistance of outreach workers and contracted physicians, are funded by pooling BCC funds with similar funds from the state tobacco agency to develop a broader campaign.



A more limited campaign in Monroe County, New York, used video clips and bus cards. The campaign, conceived by a media consultant who was also a breast cancer survivor, focused on typical concerns and excuses for not being screened. The video clips were aired on a local cable network; the bus cards are still in use. The consultant donated her time and enlisted a corps of volunteer actors and film crew members.

### **SOUTHCENTRAL FOUNDATION**

Some Alaska Native languages have no word for cancer, because it was uncommon in native populations until the turn of the century. But now it is the number one killer of Alaska Native women. Southcentral Foundation, a nonprofit health corporation for Alaska Natives, is making the word and its meaning more visible through a multimedia campaign. They have developed two videotapes and a brochure featuring Alaska Native women; these materials are distributed throughout the country by the Alaska Division of the ACS. The program found that materials from other programs featured Caucasian women, leading the Alaska Native women, who could not relate to the images, to conclude that they were not at risk.

In designing the campaign content, the program staff were sensitive to cultural preferences. The brochures do not contain facts and figures, but convey human closeness interwoven with Alaska Native folklore. They were designed by a local Alaska Native artist who used animated illustrations of Alaska Native women. In the video, *The Gift of Health*, eight Alaska Native women seated around a kitchen table share experiences of having mammograms and breast exams. The atmosphere is homey and relaxed. In the next room, an elder tells a story to children about a friendship between a woman and a raven. It is clear that the woman learned many things from the raven, such as strength, survival, taking care of others, and helping others. A second video features Alaska Native women who are breast cancer survivors. The women are featured in their homes and are dressed diversely, some in traditional dress and some in jeans or business attire. The women talk about treatments that integrated both modern and traditional folk medicine.

## **Television**

Television offers the advantage of wide reach in a short time. Grantee public education efforts delivered through television include both advertising and public relations approaches. In advertising, while most programs are dependent on public service announcements (PSAs), some grant programs have been able to fund paid advertising. Public relations approaches offer grantees more opportunity for creativity and flexibility, and an innovative public relations strategy can result in extensive free coverage of grantee activities as local or even national news. Finally, with the advent of videocassette recorders (VCRs), television offers new opportunities to spread the BCC message through distribution of videotapes.

Grantees who were using both PSAs and paid advertising indicate that the content of the two varied minimally. That is, certain messages were not more likely to be picked up as PSAs than others. Indeed, virtually all BCC messages are deemed worthy by commercial stations for PSA circulation although most stations have policies regarding the type, content, and length of PSAs they are willing to accept. Content was not the deciding factor in the decision to pursue paid advertising. Instead, that decision invariably focused on the loss of control over placement and timing of PSAs. Programs with the funds to purchase air time can choose the programs and channels best suited to their target audience. Those with limited budgets, dependent on PSAs, must compete with a host of other organizations submitting PSAs; this affects both whether and when the station will air them. PSAs often fill the less popular, unsold, paid advertising slots, often late at night when the target audience is unlikely to be watching.

The choice between PSAs and paid advertising offers a trade-off among exposure to the target audience, frequency of exposure, and cost. PSAs are free, and good ones may run frequently, but they are likely to be shown at less than optimal times; the program has no control over the timing. Paid advertising, while providing control, may be so expensive for the optimal times that the program may be able to afford only a few exposures.

Although television is a mass medium, most states tended to focus the use of televised PSAs or paid advertising on specific subsets of the BCC target population. As described previously, such focus offers the advantage of permitting the design of messages and choice of channels that can best reach the target audience. In most cases, the targeting of the televised component reflects the emphasis of the overall public education campaign. Specific examples of targeted audiences include:

- Low-income women, aged 40 years and older, residing in four rural northeast counties (Minnesota).
- Communities of color in an outlying county (New York).
- Latina women (California).
- Vietnamese adults (California).

Grantees used a variety of mechanisms to create the televised messages. Some used spots initially developed by NCI. In other cases, the local television station worked with the program to produce a commercial, or the project staff collaborated with organizations in the community to produce the spots or videos. In a few cases, the television component was prompted by a community volunteer with media expertise who offered to produce PSAs; in one case, the volunteer was a breast cancer survivor.

In producing videos or television spots, programs must allow time for conceptual development, production, and pretesting and take into consideration the attendant costs. The time and costs may seem overwhelming to a program on a limited budget, but programs emphasized that there are potential local resources to examine. Sources of assistance have included the following for BCC programs:

- Local video production companies that are interested in becoming involved with the program or other community service activities.
- Grants or community programs that may have a public education component onto which production of BCC materials may be piggybacked.
- The audiovisual department of the local high school, college, or university that may be interested in developing the video presentation as part of a class project.

There are a variety of existing sources that can also be adapted to the needs of local programs. National cancer organizations such as the American Cancer Society (ACS) and NCI have video presentations for general audiences, but also for specific target audiences. Programs have used these without alteration; others have appended a locally produced prologue or epilogue to provide more local connection.

All communication methods using visual media present challenges and barriers. For example, some programs find that the cost of producing videotapes for distribution is not justified by the amount of exposure. Providers' offices and community centers are the normal venues to which the tapes are distributed. While careful selection of settings can increase the likelihood that the target groups will see it, the volume of people coming through these settings does not justify the expense. Also, the videotapes are usually too long to receive good exposure as PSAs. Programs conclude that it is better to use nationally distributed videotapes and to put their own resources into producing shorter, higher quality advertisements and purchase of air time.

Programs that had examined nationally produced television spots for either PSAs or paid advertising found that the spots often focus on too broad a target population or highlight individuals to whom the local target population may not be receptive. While an ideal solution is to develop only local spots using readily recognized individuals, a less expensive solution is to adapt the national spot by integrating local segments.

While television offers the advantage of its geographic reach, general information on the need for screening is rarely sufficient to motivate women to go for screening. Given the cost of producing televised spots and purchasing air time,

programs prefer to promote specific clinics in their advertising. They have found that this has led to an increased volume of screens.

The following paragraphs highlight some ways that BCC programs are currently using PSAs and other video presentations to reach their target audiences.

A component program of Minnesota's BCC Control Program targets the rural northern part of the state. Because the target area is extremely large, the program has seen an advantage in the geographic reach of television and uses local media as a channel for its public education. The program airs PSAs and longer stories related to breast cancer issues, especially on cable stations. Based on their experience, the program staff offer the following insights on using television, especially cable television, as an outlet:

- The reach of cable television is deceptively large. Spots may be more widely broadcast than one realizes. Typically, through links between stations, the spots are passed to other cable stations. Programs can find out in advance the communities with which this link exists and use this expanded reach more effectively.
- Messages are typically run several times a day over the course of a defined time frame. It is essential to track when the spots are run. Over time, as the program develops a relationship with a local cable station, there may even be opportunities to help determine when they are aired.
- The produced spot belongs to the program, not the station. Thus, the opportunities for additional exposures are numerous. The spot can be "shopped" to other stations, added to the video collection of local libraries, or distributed to or scheduled for showing with women's groups or others with a natural interest in the topic.
- When using or excerpting from spots produced by other organizations, be sure to obtain permission first, and, as discussed previously, consider adding a local tagline to connect the spot to the local area.
- In developing the content, emphasize personal stories. In designing the spot, limit the use of graphics, especially charts and graphs, to only a few and ensure that the graphics and the message are synchronized. In general, faces are better than graphics, and the faces should resemble the target group as much as possible.

Like Minnesota, Kansas needed to reach older, rural women. The Kansas video, called *Our Mothers, Our Daughters, Ourselves* was distributed through counties to local libraries, extension services, cancer groups, and others. The video shows

highlights of presentations at a 1994 conference on breast cancer, supplemented by a narrative. Over 1,000 copies of the tape have been distributed and more have been requested.

Addressing the need of a new immigrant group that faced both language and cultural barriers to health care, California developed a 12-minute videotape in Vietnamese that was used in multiple ways. *Chan Troi Moi: Phuong Cach Giup Tim Ung Thu Vu* (A New Horizon: Breast Cancer Screening Methods) tells the story of an older woman (who has already adopted the practice of regular screening) who persuades a younger woman, aged 50, to get a mammogram. The younger woman struggles with fear and embarrassment. Finally, with the support of her older friend, she agrees and receives a breast exam and instructions in breast self-examination from her doctor, who then refers her for a mammogram. At the radiologist's office, she receives a mammogram as the doctor explains the procedure. Her test results are negative. The final scene shows the entire extended family enjoying themselves at a barbecue.

NCI funded development of this video, and the BCC project paid to air the video on local Vietnamese television. In return, the station aired news items about the project, including interviews with staff about project activities and educational objectives. Also augmenting the video presentation were six 30-second commercials that were aired on a regular basis. Again, the program paid for the broadcast time. These spots encouraged women to make appointments for breast exams and mammograms and, as with the video, highlighted culturally appropriate themes. These themes included the importance placed on screening by family members who depend on the woman.

### **CULTURE-SPECIFIC VALUES ENHANCE COMMUNICATION**

California's Vietnamese Community Health Promotion Project illustrates the issues and opportunities in using materials across cultures. In developing the video, the California staff recognized both the cultural- and language-specific issues of Vietnamese women. Rather than simply dubbing an English-language video into Vietnamese, the staff chose to use Vietnamese actors and to incorporate themes that would resonate with the target women:

- The older woman is the initiator, reflecting the cultural acknowledgment of the wisdom of older people; this view contrasts with that in many western videos, in which younger people have to convince older people to adopt new technologies.
- The video emphasizes the importance placed on early breast cancer detection by children who love and depend on a mother.
- The emphasis on the examination process not only addresses fears about what might happen at the health clinic, but, by highlighting that the results are negative, dispels a sense of fatalism about cancer that is common in traditional cultures.
- The final scenes highlight the importance of extended family, a fundamental characteristic of Vietnamese culture.

Evidence to date of project effectiveness is only anecdotal, although related activities have been more thoroughly evaluated (see “Outreach” chapter). Providers in the targeted area have noted an increase in Vietnamese women coming in for screening, and indicate that a significant number have said they saw one or more parts of the campaign.

Some areas in Ohio also chose paid advertising as the most appropriate route for public education of targeted populations. Local network affiliates, independents, and cable television stations identified the time slots with the most women viewers over 50 years old. The program purchased advertising slots and aired NCI-produced spots that target African-American women and women over 50. At the same time, the program arranged with the Lifetime Network, which was already airing PSAs on breast cancer, for its local cable distributors to add tag lines referring women to the local BCC project. Lifetime was happy to accommodate the local tag line, which was then credited to the local cable affiliate’s community service contribution.

The program partnered with the Junior League of Toledo, which covered the cost of the air time. The total cost of air time on local television was approximately \$1,500 per month for 22 broadcasts of the spots. Adding the local tag lines cost the program approximately \$500 per ad. The staff was careful to choose the times and shows that were most likely to reach the target audience. Consequently, the cost per spot varied widely depending upon when the ad was broadcast.

Oregon’s program has developed an 11-minute videotape of survivors of breast or cervical cancer who share their experiences from diagnosis to the present. Targeted to a multiethnic population, the video includes Caucasian, American Indian, and Hispanic women. The video allows, and the state program encourages, each community to overwrite information at the end of the video that focuses on local resources and special events.

Production of this video was cofunded by the BCC program and a video production company. Besides assisting with the funding and production of the video, the production company also assumed responsibility for marketing it, at a cost of \$10 to \$20 per copy.

As part of its EWM program, Nebraska produced a television and radio spot, *A Few of the Little Things You Might Miss*. The “little things” are two young children standing in a cornfield. The theme and content drew directly on results of focus groups with women from the over 50 target population to determine the messages needed for a statewide media campaign. Feedback from the focus groups, which were conducted by the Nebraska Medical Association (NMA) under contract with the program, indicated that these women are very focused on taking care of their

family members, but often neglect their own health. The media spots appeal to the women's desire to care for their families; the concluding message is that the screening is a gift that a grandmother can give to her grandchildren.

Few projects used formal methods to assess the effectiveness and impact of televised public education efforts. Most rely on anecdotal evidence or on recall by women coming into clinics for CBE or mammography. States that ask new patients where they heard about the BCC program find that television is an important source. Indeed, a formal evaluation of a California program focusing on rural populations found that 15% of all callers to the 800 telephone line identified television as the source of their information about the project. The project also identified a relationship between screening volumes and media interventions by comparing volumes in months with and without media interventions.

## Radio

Like television, radio reaches a wide audience. The enormous number of radio stations and specialty stations means that the opportunities for targeting specific populations at relatively low cost are numerous. BCC programs are using radio in ways similar to their use of television. Radio efforts include a variety of PSAs and paid advertising as well as appearances by staff on radio talk shows.

The issues related to purchasing air time or pursuing PSAs on the radio are identical to those related to television; however, radio stations historically have provided more opportunities for PSAs and offered greater flexibility in the air time available for both PSAs and commercial time. For example, in cases where BCC programs have paid for air time, some local radio stations have been willing to match the paid spots with an equal number of complimentary spots.

Television and radio also face similar issues of targeting and content development. As with television, a number of national organizations have developed radio PSAs and paid advertising spots that can be used for public education. Because there are so many radio stations, the stations are more likely to pursue a "niche" strategy than are television stations; and they are likely to have extensive ratings information that documents the demographics of their listening audience. While many radio stations, like their television counterparts, exhibit a "herd" mentality by competing for lucrative, younger listeners with more disposable income, BCC programs are more likely to find radio stations that target older audiences than they are television stations. Furthermore, radio stations that target communities of color and cultural and language subgroups are numerous in most states, even if these stations do not directly target older women with most of their programming.

Whether to use more radio or television will vary with who is being targeted and the available public education budget of the program. Among lower-income populations, some women may not have a television set and will almost certainly not have cable television, except in rural areas. Most women who work outside the home are in environments that may permit radio listening during working hours, but rarely television viewing. In some cultures, radio is even better than television for reaching women at home. As noted in a national teleconference by the coordinator for a Latina outreach program for one of the nation's largest organizations for breast cancer survivors:

*Radio is the most effective [Spanish language medium]. When you go to radio, it's incredible the amount of calls that we receive. And it's because a lot of people are isolated. They don't go outside. They don't have children in the school, or they are working. Then if you go to the workplace, you will see the radio is on, and most of the time it is in Spanish. And they got the information through that.<sup>11</sup>*

While the radio format certainly can accommodate longer information pieces, PSAs and radio commercials are generally 30 to 60 seconds in length. The time limit is a challenge for programs; it does not provide enough time to both address the importance of screening and present the necessary referral information. One way of extending the message is to have the announcer or disk jockey provide a telephone number or address for further information at the end of the message. This is also a useful technique for integrating nationally produced spots into local campaigns. Even more effective is timing the radio spots so that they cluster near a staff appearance on a talk show, so the tag line can refer the listener there for more information.

The following paragraphs present examples of ways that BCC programs are using radio to deliver public health messages.

A California program demonstrates an effective use of multiple media in a targeted campaign. As part of a local campaign aimed at the Latina community, *Pathways for Early Cancer Detection for Latinas: En Achene Contra el Cáncer*, the local BCC program and the local radio station collaborated to produce a monthly radio talk show and 14 PSAs that were aired by a Spanish-language station in the San Francisco Bay Area. The talk shows and PSAs reinforce messages provided in biweekly television news segments; they include testimonials of women who are cancer survivors, families of survivors, physicians, community leaders, and women

---

<sup>11</sup>*Building Partnerships for Breast Health Outreach: A National Teleconference*. April 24, 1996. Avon Breast Cancer Awareness Crusade.



who have had breast and cervical cancer screenings. California also developed several short PSA messages and distributed them to local BCC programs, which were to use volunteers to get the PSAs placed on local radio stations.

Several states have been successful in involving radio personalities (and, through them, their radio stations) in BCC public education efforts. In South Carolina, the state's Best Chance Network has developed a network of contacts with local radio personalities. BCN uses these contacts to place the organization's community educators and clinical providers as guests on talk shows to discuss the program, breast cancer, and the importance of early detection and screening. The relationship with a single radio personality has broadened into more significant station involvement in at least one case. One local station serves as a drop-off and distribution for ribbons and information cards for the state's Pink Ribbon Sunday campaign (see "Outreach" chapter, p. 57) and airs promotional messages for the statewide awareness campaign. This association has led other stations, which compete with their peers for community service visibility and wish to demonstrate community involvement, to request PSAs for their stations.

Similarly, a program in Connecticut built a relationship with a credible, visible, local disc jockey to reach their African American target audience. The director of the program at New Haven's St. Raphael's Hospital is a regular guest on three local radio stations. The program and the director have a special relationship, however, with a specific disc jockey who is a powerful opinion leader in New Haven's African American community and has proven an effective advocate for the program. In addition to hosting the project director, the disc jockey gives weekly updates on the total number (both cumulative and weekly) of patients who have received mammograms at St. Raphael's program and urges women to support the program to keep it funded and in the community. The station has gotten involved in other ways. It ran a contest in which callers who mentioned the BCC program were entered into a raffle for door prizes supplied by the station. The disc jockey discussed the criteria for eligibility with callers, referring eligible ones to the program. When the station ran a promotion at a local community center in a low-income area, it allowed the BCC program to distribute flyers and hosted an on-site interview with the BCC program director.

### **BCC PROGRAMS INSIGHTS FOR USING RADIO EFFECTIVELY**

- Involve radio personalities who will take up BCC as "their" cause. This involvement lends visibility and credibility to program efforts, especially if the personality is an opinion leader in the community.
- Contact the radio station and provide information on a regular, predictable schedule to maintain visibility with the station.
- Since turnover at radio stations is high, use the initial contact to establish a network of contacts within the station. These contacts will ensure that program-related efforts will continue even if a key person leaves.

The relationship between St. Raphael's and the radio stations grew out of the BCC program's interest in developing and broadcasting PSAs. The hospital's public relations person was effective in reaching the stations and getting the program director placed on talk shows. Just as importantly, the public relations staff are diligent about keeping the station updated, providing, for example, the weekly statistics that the disc jockey announces on the show. While no formal evaluation of this single effort has been done, the program indicates that intake information at the clinic frequently lists radio as the source of information about the program.

In nearby Bridgeport, Connecticut, the local chapter of Planned Parenthood, which has a limited budget for promotion, clusters its PSAs and radio contacts around its specific screening dates. The case manager calls radio stations every 2 to 3 weeks with a list of free screening dates, provides them with updated PSAs about the program, and arranges appearances on radio talk shows to discuss breast cancer risk, the importance of screening, eligibility criteria, and how to make an appointment. Promotion costs have been minimal because the staff have been aggressive about seeking free air time.

The evaluation approach of the Bridgeport effort resembles that of its peer programs. Although the radio promotions have not been formally evaluated, program staff do track the number of new screening clients or 800 callers who identify the radio promotion as their source of information. Most programs using radio believe that it complements other forms of public education and outreach; in many cases, increases in the number of calls and enrollment in program activities clearly coincide with the timing of radio campaigns. But because the radio campaigns are often part of larger media campaigns, it is often hard to separate the contribution of radio alone. Moreover, radio is not effective in all cases. In one program, only 5% of callers to the 800 number identified radio as their information source.

Even though radio time is much less expensive than television time, the cost of air time is still the most significant challenge for public education staff. As mentioned earlier, the most successful strategy for addressing this barrier has been to negotiate matching free air time from the radio stations.

## Print

Newspapers offer still another way to reach a wide audience with information related to mammography screening and rescreening. Although the number of mass circulation newspapers has declined in most areas, this decline has been offset by a proliferation of specialty and geographically targeted newspapers, such as neighborhood newspapers and free or "alternative" weeklies. Therefore, as with

radio, it is likely that programs will have a variety of choices, including some that may specifically target the same population as the BCC program. In addition, print media offer a wider range of opportunities for public relations efforts than television or radio. News releases and other printed stories are more likely to be adopted as news or editorial content in print media than in broadcast media. This is fortunate because newspapers, which are very dependent on advertising revenue, almost never accept PSAs.

Most states were able to cite successful strategies using newspapers, whether major metropolitan dailies, local papers, or specialty weeklies. Programs offered insights about using newspapers for advertising, but even more about getting BCC information into the news or editorial content. Many had been successful in placing special inserts on breast and cervical cancer in their local newspapers. Indeed, many programs saw newspapers as among their more effective vehicles for bringing women in for screening. In California, for example, a rural program indicated that 40% of all women coming in for screening cited newspaper advertisements as their information source. And the program can demonstrate specific increases in the number of women calling the program and coming in for screening in the first 3 months following print media campaigns.

Print media are so successful for BCC programs because print is best for conveying complex information and because newspapers provide a permanent record and reminder to which the woman can refer later. Programs reported that newspaper ads and articles were most successful when they included information on services offered, income and other program eligibility, and the telephone number for an appointment.

The following paragraphs illustrate how some programs are using print media for both advertising and public relations. Because most programs prefer to design comprehensive campaigns employing multiple media, some of the examples are from programs that have been cited previously in the discussions of television and radio strategies.

The Vietnamese community in Santa Clara and Alameda Counties has a well-developed network of Vietnamese-language newspapers. The newspapers are distributed free and are widely read in the community, especially by those with limited English language skills. Because the BCC program targets older women, who are less likely to read English than younger women, a partnership with these papers made sense. The editors have agreed to publish at no cost articles written by program staff that explain breast cancer screening, the types of tests, and the sites for low-cost or free services. In addition to these general information articles, the staff provide interviews with Vietnamese breast cancer survivors.

Programs also purchase advertising space in these papers. As with other media campaigns directed to this community (see the “Television” section, p. 33), advertisements use images and themes that will resonate with the targeted women. Ads feature profiles of Vietnamese women who were early participants in breast cancer screening, using photographs and information to personalize the ads. The information includes dates when the women arrived in the United States, their favorite recipes, favorite singers, and plans for obtaining breast cancer screening.

The approach used with the Vietnamese community is applicable to any population with limited English proficiency and a network of local papers with small or limited staffs. Invariably, cities with large communities with limited English proficiency have newspapers or newsletters in the native language. And, as indicated previously, older individuals, who are most often the target of BCC efforts, are those most likely to have limited proficiency.

Small papers, regardless of the language in which they are written, have small staffs; that limitation offers community programs like BCC unique opportunities to place articles. Indeed, so long as the program pays attention to length and clearly indicates where the article can be cut to make it shorter, local papers will almost always be receptive to program submissions.

South Carolina’s BCN developed newspaper ads that targeted African-American women over 50 years old who were uninsured or underinsured. The newspaper effort was timed to coincide with an environmental media campaign. Unfortunately, the program was not able to secure free ad space in the state’s major metropolitan dailies and was also unable to purchase this space. However, these metropolitan papers did agree to provide general coverage of the program by printing stories about BCN activities during the campaign. In addition, the program was able to purchase ad space in small newspapers, where the advertising rates were not prohibitive.

In Bridgeport, Connecticut, the Planned Parenthood case manager is as diligent about keeping the local papers informed about free screening dates as she is the local radio stations (see “Radio” section, p. 39). The project has successfully made the screening calendar a permanent feature of the senior page of weekly town circulars. In a rare departure from common practice, the *Connecticut Post* also donated free advertising space. This donation was the culmination of a long process. Key to the success was developing a relationship with the editor of the “WomanWise” section. When that editor printed the screening calendar in her section, and five new screening clients indicated they had seen the information in the *Post*, the case manager sent a thank-you note to let the editor know that the information had been effective in reaching people. This exchange developed into routine updates every 2

weeks; and it has led to more extensive coverage of the program, including a general news article on women's health that featured information on where to call for screening services.

Minnesota's BCC program in the Twin Cities area illustrates perhaps the most extensive single use of print media, successfully arranging for a special supplement in the magazine section of the mass-circulation Sunday newspaper. This is prime placement for articles on BCC, since the Sunday newspaper is the most widely read, and the magazine section, in particular, attracts women readers.

The Minnesota supplement, entitled *Beating Breast Cancer: A Woman's Guide to Diagnosis, Treatment, and Resources*, included articles on

- Breast cancer: what you need to know.
- Lowering your risk.
- Race for the Cure events.
- Mammography: what you need to do.
- Breast self-examination.
- Survivors: what you should remember.

The supplement also contained a comprehensive list of breast cancer resources, including organizations and hospitals that assist women coping with breast cancer. The special insert was produced by the staff of the magazine section as a special advertising section. Articles were provided by the local BCC program. The magazine section staff and the newspaper's advertising staff assumed responsibility for selling advertising to hospitals, providers, and related businesses and organizations. All costs of production were covered by advertising revenue.

Michigan's BCC program, in conjunction with the state ACS, develops a "working draft" newsletter three times a year. The draft is made available to local health departments, which customize and distribute it to previously enrolled women to encourage it to return for rescreening. The drafts contain articles and citations in a format that the local agencies can use either as presented or to complement their own material in an expanded newsletter.

## PRINCIPAL LESSONS LEARNED IN BRIDGEPORT

- Be persistent in building a broad network of newspaper contacts. The program's case manager mass-mailed the screening schedule to all local editors and was not even aware that the WomanWise editor had published it.
- Document the impact of the print coverage and share the results with the newspaper. News media like to know that they are reaching the public.
- Cultivate a single relationship with a single contact; this effort can often open doors to others. Although the program's relationship with the WomanWise editor was fortuitous rather than planned, it would have been a likely place to start. Such relationships can provide access to other editors for general news coverage, or even open doors to competing newspapers.
- Be diligent and timely about updating your contacts. The screening calendar has become a regular feature because the newspaper can count on timely updates.

## Environmental Media

A final form of media employed in the public education efforts of BCC programs is a polyglot of efforts that are grouped under the generic banner “environmental media.” This category encompasses billboards, signage on the outside or inside of buses and taxis, bus shelter and bench advertising, and posters placed in various locations in the community. Environmental media are not as widely used as other forms of media for public education, for a variety of reasons that are sometimes specific to the site. A common criticism is that environmental media exposures are often too brief—the time it takes to pass a billboard, for example—to convey complex information. Although it was rare for environmental media to be cited as an information source by women seeking screening, sites using environmental media felt its use did contribute to recruiting women for screening by building awareness of a campaign slogan or the program’s phone number.

Because the exposure to the message is so brief, good, catchy graphics are essential in environmental media. They are also expensive, and programs should look for high-quality materials that have already been developed, perhaps by a national organization such as NCI.

### Billboards

Three states used billboards as part of their media mix for public education on screening and rescreening. Oregon, which used an NCI-produced graphic, *Spread the Word*, erected a billboard in the month of October in northeast Portland, the location with the largest concentration of African American women, the target group.

South Carolina also used billboards to reach African-American women, this time as part of an overall media campaign targeting women over 50 years old who were uninsured or underinsured.

California’s NCI-funded Vietnamese Community Health Promotion Project (in Alameda, Santa Clara, Los Angeles and Orange Counties) erected a billboard in the intervention community. The billboard featured a head-and-shoulders photo of a Vietnamese breast cancer survivor with Vietnamese copy that read, “A breast exam saved my life. Make an appointment with your doctor today.”

This California project also erected several signs. The NCI-funded project received additional assistance from the state health department and local providers, who helped identify the best locations and make local adjustments to the text.

The cost for billboard space varies widely depending upon location and size. Sometimes, billboard companies offer free board space. Even when programs must

pay for space, the company will generally keep the message posted until the billboard is resold. The least expensive or free billboards generally are those in the least popular locations. For programs like BCC with a specific target audience, however, these locations may be preferable.

## Signage

Programs using environmental media post signs and posters at myriad locations. These programs report that signs on the outside or inside of buses and taxis are the most successful form of environmental media. Public transportation is the most common mode among women in the BCC target population. Programs that post messages in buses and taxis believe they gain widespread exposure in the target community because of the large numbers of these vehicles.

Though the format is somewhat limiting, bus and taxi signage offers opportunities to convey basic messages and referral information. Signage on the outside of buses needs to adhere to the same principles as successful billboards. The exposure is almost instantaneous and an attention-getting graphic and brief message are best. In contrast, placards inside the bus offer more flexibility. Passengers are in transit for extended periods of time. If the space allows for print large enough to be read from the seat, this signage can convey extensive information; or the same information can be conveyed in multiple languages.

For example, California's local provider in Santa Monica found signs to be the most successful and cost-effective intervention. Signs in both Spanish and English contained descriptions of program services and eligibility requirements along with an appointment telephone number. The signs were developed by the state; information specific to the Santa Monica site was added at minimal additional cost. The program purchased space for a 2-month period, but transit officials have continued to post them as a public service. Assessment of the intervention determined that the signs have generated approximately nine calls per month for screening appointments.

In two states, the public education campaign included promotional posters that were placed in locations where the target population is likely to gather. Nebraska's posters used images and information from their *A Few of the Little Things You Might Miss* media spots to reinforce messages in those commercials. As part of the statewide campaign, posters were placed in providers' offices to remind women, who may have seen or heard the media spot on television or radio or at community locations, to inquire about the need for a mammogram. Nebraska's program tracks the source of enrollment at screening and found that up to one-quarter of the women had responded to the media campaign or called the 800 number. In

Bridgeport, Connecticut, posters and flyers were placed at senior centers, government assistance offices, post offices, bus stations, and beauty parlors as part of the program's multiple media campaign to advertise the availability of free screening clinics. Since the posters and flyers were part of a more comprehensive campaign, specific data on their impact were unavailable.

## Special Events

The category of special events includes a wide variety of performances and exhibits that serve the multiple purposes of raising awareness of BCC and, in the case of performances or other activities for which an admission is charged or products are sold, generating revenue for the BCC program. This section features illustrative special events being undertaken by selected programs and the role these play in outreach efforts.

### **Hats Off to Health**

Arkansas' "Hats Off to Health" is a humorous two-person show that names and counters excuses women often give for not having breast and cervical cancer screening. The pair portray a multitude of characters with appropriate names ("Hesitant Harriet," "Penny Pinching Pearl," and "Busy Bessy") who discuss reasons for avoiding yearly mammograms. Then the last character, "Wise Willie," dispels many myths about breast cancer screening with a humorous monologue. Pretests and posttests of approximately 600 women who have attended the program found that the play reduced perceived barriers to mammography. The BCC staff are videotaping the performance to expand the coverage of the program. Interpreting the results of the pretesting and posttesting, the staff believe that dramatic and comedy performances may be effective health promotion tools because women see themselves in characters portrayed. In addition, the staff believe that "Hats Off to Health" demonstrates the potential of a humorous approach to breast cancer screening as opposed to the more traditional fact-based or scare-tactic approaches.

### **Quilt Exhibit**

The Columbia County Women's Cancer Control Task Force in Portage, Wisconsin, invited group or individual quilters to bring quilts with a personal message of hope for exhibition. The result was "Piecing Together Hope," a quilt show that reached 130 participants and thousands of spectators and was prominently featured in the local media. Each quilt was accompanied by a dedication story, which made each a unique health promotion message. Women read the dedications as part of the show. Several quilts were donated to the Columbia County group for display at all public events. In addition, the group conducted a quilt block (square) contest



in conjunction with the show; these entries are being used to make another quilt, which the group will enter in a national BCC competition in May 1997. Effectiveness was assessed mainly through verbal and written feedback from participants and visitors, press coverage, and the large number of women who submitted quilts and blocks. Additional anecdotal evidence of success included several letters from women who were screened as a result of the show and were diagnosed with breast cancer. One of the insights gained from this program was that women may be more likely to internalize cancer prevention messages and seek screening themselves if they are participants in the promotion activity.

### **Gallery of Courage**

To celebrate National Breast Cancer Awareness Month, the New York State Department of Health sponsored an exhibit of portraits of breast cancer survivors. The survivors were women from various counties across the state; each woman's story was displayed on a placard underneath her portrait. Following a press conference and ribbon cutting, the exhibit traveled to various locations around the state during the month. Photography was donated by J. C. Penney and Wal-Mart portrait studios, and a black-and-white copy of each photo was sent to survivors' hometown newspapers with bibliographic information and a description of the project. The effectiveness of the exhibit has been measured only anecdotally; again, the program received letters from many women who were moved by the personal testimonies to seek screening themselves.

### **Breast Cancer Awareness Day**

On the same day in October of 1995, every county in the state of West Virginia unveiled and displayed wreaths with a pink ribbon motif, made by county extension service homemakers. The project was a collaboration of the BCC program and ACS, the American Association of Retired Persons (AARP), the NCI Cancer Information Service, the Southern Appalachian Leadership Initiative on Cancer (SALIC), and the state's Cooperative Extension Service. NCI provided the pamphlets and other materials, the extension service homemakers made the wreaths and planned the ceremonies, ACS provided mobile units and some treatment funding, AARP staffed the events with volunteers, and SALIC provided support for the activities.

The statewide campaign was created on a shoestring budget. Through effective use of volunteers and donations, the program spent in all about \$1,000. Some of the chief expenses were \$100 to print the press kit that extension women used with local media; \$600 to advertise the event; and \$100 to reimburse some of the homemaker clubs for materials.

The program expects to see an increase in the number of Appalachian women screened as a result of the active participation of the extension service homemakers; the program is monitoring the women's response through traditional means such as the source-of-referral data on the intake form. An unexpected measure of the campaign's success came in January, when the legislature earmarked \$250,000 for breast cancer treatment funds, a major victory in a state where charity care at hospitals had been the only option for poor women. The massive press coverage and the overwhelming public response to Breast Cancer Awareness Day were cited as major factors in sensitizing legislators to the issue.

California worked with local affiliates of different advocacy groups, such as the National Association of Breast Cancer Organizations, to organize a special Breast Cancer Awareness Day. The California State Department of Health Services helped fund a rally at the state capitol that involved senior state executives and culminated in tying a pink ribbon around the state capital dome.

## **OTHER SUCCESSFUL SPECIAL EVENTS**

### **Race for the Cure**

Numerous states have a Race for the Cure, a well-known fundraising event started by the Susan G. Komen Foundation. BCC programs are usually active in many aspects of organizing and conducting this event. Proceeds support a host of grantee and other activities. For example, the Junior League of Omaha, Nebraska, organized a race, and a large amount of money was raised to be used for public education and diagnostic procedures.

### **Breast Cancer Awareness Stamp Unveiling**

Several states have issued stamps in conjunction with Breast Cancer Awareness Month. For example, post offices throughout Michigan displayed information produced by the health department on breast cancer prevention, and all employees wore pink ribbons for the unveiling of the breast cancer awareness stamp.

### **Women's Health Week Screening Blitz**

During Women's Health Week in October, a breast cancer partnership made up of a Catholic hospital, the ACS, local radiologists, and women's clubs in Genesee County, New York, staged a screening blitz. Incentives, like bags of gifts donated by local business, were distributed to the first 100 women who were screened. Last year, at least 100 women were screened through this effort.

### **Women's Wellness Days**

The CDC, in conjunction with the Cherokee Nation's "Health Nations" program, sponsored six Women's Wellness Days at various locations in the month of October. The Wellness Days consisted of several educational booths manned by resource staff. The booths emphasized a variety of health concerns, including BSE. Cherokee Nation health representatives provided child care on site.

### **State Fair Booth**

Wisconsin's BCC program combined several outreach strategies by staffing a booth at the state fair. Nearly 100 volunteers staffed this year's booth, which displayed quilts from BCC projects. The quilts and the booth were publicized through a partnership with the Piggly Wiggly supermarket chain, which described the program and booth in its weekly circulars and printed special bags to be distributed at the booth. The program used raffle entries to collect information on the number and the characteristics of women who visited the booth. After the drawing, the entries were sent to the appropriate counties for tracking and follow-up. As a result of the booth, 1,500 women received one-on-one counseling, and a much larger number picked up information. To date, 15 mammography referrals can be tracked directly to the booth.

The program concluded that state fairs were an inexpensive way to reach a large number of women, even if directly-attributable screenings were few. Total costs for renting and staffing the booth were \$1,200; the quilts and materials were donated. A special activity such as the quilts increased the likelihood that women would visit the booth, compared with a more traditional booth offering only health information.

Some general themes that seem to cross the special events categories are the following:

- Projects such as quilting draw on the findings that people are more likely to internalize messages from activities that require hands-on involvement.
- Programs should explore opportunities to provide the BCC message in a range of media.
- Programs should test the effectiveness of a range of tones, from humor to drama to traditional, and objective, fact-based approaches.
- For programs on small budgets, the cost of effectively evaluating a special event often exceeds the cost of the event itself. Therefore, if the programs are to have more than anecdotal evidence, they need to find partners to undertake the evaluation component.
- Special events offer opportunities both to spread the BCC message and to generate revenues for program activities.
- Statewide events work best when the state program delegates control to groups such as local service clubs or county extension service groups. The local connection generates community support and local media coverage and creates momentum at the community level.

## Additional Resources

The previous sections highlight public education strategies employed by BCC programs and identified in telephone discussions with them. In addition, many programs have produced public education and promotion manuals that offer guidance on (1) how to develop and implement comprehensive public education campaigns and (2) how to integrate public education, outreach, and inreach into an organized multifront effort to increase screening numbers. Five were mentioned by programs during telephone discussions:

- **Outreach and Promotion Guide.** Wisconsin Women's Cancer Control Program, Wisconsin Department of Health and Social Services.

This guide is intended to assist local communities with outreach and public education efforts. It includes information about involving communities and working with the media as well as outreach plans for priority populations. The boxed material that follows presents tips from the guide about working with the media.

- **Education and Publicity Manual.** Minnesota Breast and Cervical Cancer Control Program, Minnesota Department of Health.

The Minnesota manual assists local programs in developing and promoting site-specific materials. It provides ideas, examples of publicity materials that are available free from the state program, and examples of other educational materials on breast and cervical cancer that are available from other sources. Materials presented in the manual were selected for their focus on breast and cervical cancer screening; other selection criteria were the inclusion of early detection information, readability, cultural appropriateness, clarity, and free or low-cost materials. The manual addresses developing and distributing messages and includes excerpts from the department's promotion kit. It also provides information, strategies, and examples of publicity materials for reaching women over 50 years old and women who are African American, Latina, American Indian, and Asian-American. A list of top 10 tips for reaching each special population is provided along with examples of available materials.

- **Your Message Counts: A Guide for Community Leaders.** National Migrant Resource Program.

This bilingual (Spanish and English) guide helps community leaders plan communication strategies for breast and cervical cancer prevention in Hispanic communities. The guide is divided into five sections: (1) "Getting Organized" describes how to research the issue; define goals, objectives, and

target audiences; and develop organizational materials, a budget, and a timeline. (2) “Identifying Your Channels” discusses what media can and cannot do for you as well as the temporary use of each media outlet to deliver the messages. (3) “Promoting Your Message” discusses identifying your media angle, contacting media, media options that provide opportunities for coverage. (4) “Evaluating” presents types of evaluation and evaluation methods. (5) “Spanish-Language Media” provides an overview of and tips for working with the Spanish-language media. The following boxed material presents tips from the guide about working with the media.

- **Making Health Communication Programs Work.** Office of Cancer Communications, National Cancer Institute.

This manual, based on more than a decade of experience, describes a logical framework for classifying and elaborating the process of public education. The framework divides the health communication process into the following stages: (1) selecting channels and materials, (2) developing materials and pretesting, (3) implementation, (4) assessing effectiveness, and (5) feedback to refine program. Programs can review these stages to determine which ones are essential in developing their own health communication plans, given the confines of their budgets.

- **Public Education Campaign: Public Service Media Placement Guide.** California State Department of Health Services, Breast and Cervical Cancer Control Program.

This publication was developed by the California BCC program with the help of media consultants to provide information for local BCC programs on PSA development for print, radio, television, and outdoor media. Professional media marketing tips designed to maximize the impact and visibility of public service announcements are included.

## TIPS ON WORKING WITH THE MEDIA

Wisconsin's *Outreach and Promotion Guide* offers insights into working with the media that serve as a good summary of the lessons learned by the programs whose efforts have been illustrated in this chapter.

### Step 1. Put Together Your Media List

Begin preparing your media list now by contacting the local newspapers and television and radio stations in your area. Check with your public health educator or hospital public relations person to see if they have a list you can update.

Try to find out which reporters and editors are most interested in your area of service. For example, many larger newspapers have health reporters or women's issue reporters. Send news releases directly to that person. Smaller newspapers and radio stations usually do not have specialized reporters. Direct your information to the editor of the newspaper, the news director of the radio station, or the assignment editor of the television station. Develop relationships with these people. They'll soon come to rely on you as their source for cancer screening information.

Find out who the public service director is. This will be the person you contact to place television and radio PSAs.

### Step 2. Designate Your Spokesperson(s)

Decide who you want to talk to the media. Remember, this doesn't have to be one person. You can be the spokesperson for your program. Perhaps a local physician can be the spokesperson advocating the benefits of cancer screening. A local cancer survivor can speak about personal examples and the benefits of screening. Make sure the team you put together is briefed on the issues surrounding your program and has enough information to answer questions. It's always a good idea to go with a volunteer when they do an interview. That way, you can serve as backup if there's a question the volunteer doesn't know how to answer.

### Step 3. Develop a Plan

Decide what you want the public to know over the next year. Determine what's newsworthy.

Does your program have new hours? Will you be holding a special event this summer? Will your local spokesperson be speaking at the Kiwanis next month? Have cancer rates in your area changed significantly? Do you know someone with a story to tell about how she survived cancer? Is there a new advertising campaign about to be launched? These are all items of news and your local reporters and editors should hear about them.

Spread out your news releases, feature stories, events, and speeches over the year to guarantee the most publicity. Of course there will be times when an unplanned issue or event comes up. Be ready to contact the media when the unexpected happens.

### Step 4. Implement Your Plan

For each phase of your publicity plan, decide what media is best to use. Send out news releases as well as any other supporting information you might have. Make sure you follow up with reporters to try to arrange an interview or to answer any questions they might have.

Let the public service directors of the television and radio stations know when you'll be launching a new public service campaign. Try to get their commitment to run the PSAs. Also, find out if there is a free on-air community billboard at the local television station. If so, ask that information about your cancer program be displayed.

**Step 5. Follow-up and Thank You**

Reporters like to know they've done a good job. When a newspaper, or radio or TV station helps you promote your program, thank them. Continue to send them information. They may become one of your biggest advocates.

**Step 6. Record Your Media Contacts**

Keeping a record of your media contacts will help you remember who is interested in what information. It also will help you remember their deadlines and the best time to contact them. You can also use the information to evaluate your outreach efforts.





# Outreach

## Introduction

Perhaps no term connotes a wider array of activities to more people than “outreach.” If grantees have learned anything, they have learned that outreach must be defined broadly and comprehensively. “Passing out pamphlets is not outreach,” emphasized more than one, even though distributing pamphlets is often the first activity the neophyte organization undertakes.

Instead, grantees see outreach as making *meaningful* contacts with women on *their* terms in *natural* settings within well-defined communities, while also providing any service that facilitates entry into the screening cycle. Almost by definition outreach means leaving the confines of the health department to take messages and services to the people who need them.

For programs just starting breast cancer screening, grantees offered four helpful hints:

- The most appropriate approach will vary greatly from locality to locality, depending on the service system, the cultural characteristics, and the active organizations in each area. Consequently, while an organization can hope to centralize its outreach system to a degree, perhaps offering common infrastructure, the frontline program needs to be allowed to respond to local conditions and populations.
- New programs are lulled into a false sense of security by the early response to outreach efforts. Especially when a program is one of the newer efforts to address screening and rescreening, even rudimentary outreach yields good responses. Programs should not assume that screening will go on indefinitely with similar rates. The first and even the second wave of women who come into the program represent the easy-to-reach populations. In contrast, finding and recruiting the third wave of difficult-to-reach women requires intensive, tailored outreach.
- Rescreening presents its own set of challenges. Often these challenges closely resemble the challenges faced with the hard-to-reach population (even with women who were easy to bring into screening initially).

- Whether screening or rescreening, whether targeting the easy-to-reach or the hard-to-reach, programs must know their community. Especially at the outset, knowing the existing actors and infrastructure can mean the difference between success and failure. For example, targeting the hard-to-reach by parking a mobile mammography unit in a visible location is rarely successful without concomitant strategies to meet the people in the community, especially those working with agencies that are already in touch with the target population, providing related services. Forming partnerships with organizations that are respected in your community will increase the screening program's visibility and strengthen the program's ability to find hard-to-reach women for screening.

This chapter discusses general categories of outreach activities. The sections include both general descriptions of the kinds of activities conducted by the states interviewed and specific program descriptions and keys to success.

Two distinctions clarify, in general terms, the content and organization of this chapter. First, some outreach strategies tend to overlap public education ones; this chapter describes initiatives that make a personal, as opposed to a mass media, contact with a woman. (As will be seen, the outreach is often combined with or follows an areawide public education strategy.) Second, the early sections of the chapter discuss strategies related to screening; rescreening is discussed later.

## The Transtheoretical Model

While outreach is usually viewed as a one-to-one approach, it is also, essentially, an effort to alter a person's behavior. The transtheoretical model has proven especially useful to public health efforts to help people adopt healthier beliefs and behaviors. Many of the interventions mentioned here are based in part upon the application of this model.

The transtheoretical model conceptualizes how people change their behaviors, viewing the process as a set of cognitive stages that people pass through as they attempt to alter a problem behavior. The model is based on research of Prochaska and DiClemente in which many systems of psychotherapy and behavior change were synthesized into a single system.<sup>12</sup>

---

<sup>12</sup>Prochaska JO, DiClemente C, Norcross JC. Search of how people change: applications to addictive behaviors. *American Psychologist*. 1992;47:1102–1107.

## Stages of Change

- **Precontemplation.** There is no intention to change the behavior in the foreseeable future. The person may be unaware of or in denial about the consequences of a risky behavior. An example of a precontemplator would be a woman who has not considered getting a mammogram. She may not consider herself at risk or able to afford one. Demonstrating that there is a risk and that mammography is an effective preventive measure would help move precontemplators into the next stage.
- **Contemplation.** The person is aware of the consequences of the problem behavior, but has not yet made a commitment to take action in the near future. A contemplator may know she is at risk for breast cancer but consider mammograms too painful, expensive, or inconvenient. Efforts to dispel incorrect notions or to lower cost and access barriers would be especially effective in bringing in these women.
- **Ready-for-action.** The person intends to change the behavior and may have taken some action in the past. A woman who has had mammograms before is an example of someone who is ready for action. She may feel she does not need a mammogram regularly or that her risk is not great enough to warrant another. Education that emphasizes the need for regular mammograms or programs that permit easier access will help these women consolidate their gains.
- **Action.** The stage at which the person has modified her behavior, but only recently or inconsistently. A woman who has had mammograms in the past and plans to keep getting screened regularly in the future is in this stage. Efforts to encourage or facilitate planning will help such women into the next stage.
- **Maintenance.** The point at which the person is working to prevent relapse. Women who get regular mammograms are in this group. Efforts should focus on keeping women in this stage. Reminders in the mail or participation in an annual screening drive are possible measures.

Since its formulation, the model has found extensive application in behavior change programs and in the measurement of behavior change. Behavior change programs have been adapted to focus efforts on certain stages and tailor efforts for different stages. The model has been particularly useful in devising interventions for individuals. The effectiveness of programs has been measurably improved when resources could be focused where they would do the most good. Measurement of behavior change has been adapted to determine a person's location in the model, to determine how best to influence their behavior.

The pace of transition from stage to stage may vary greatly among individuals and behaviors. Individuals may move back and forth between stages. Effective interventions help people move steadily through the stages toward a goal behavior.

### Processes of Change

The transtheoretical model also suggests that individuals rely on 10 distinct processes as they move from one stage to the next (see box). Not all processes are applicable to all behaviors, nor are they all appropriate for all stages. The processes encompass cognitive, behavioral, and emotional components.

## Invitations to Seek Screening

While personal invitations, such as birthday cards or postcards, are the mainstay of rescreening efforts, they also play a significant role in bringing women in for their initial screening. As screening initiatives, however, these invitations are only as good as the mailing list, and the mailing lists are often “shots in the dark.” By contrast, the

rescreening lists include individuals whom the organization has already “qualified,” through individual and previous contact, as a screening client. Nevertheless, grantees have found personal invitations a significant and useful tool for reaching women for initial screening, when combined with other efforts.

### The Medium

Direct mailing was the medium most commonly used for personal contact. However, in almost all cases, the personal direct mail invitation was preceded by a public awareness campaign that included posters or public service announcements in a variety of media. The campaigns were timed so that the public education efforts would raise awareness of screening, while the individual invitation would “make the sale.”

No grantees had experimented with other media, such as telephone calls, for the initial screening invitation. Grantees leaned against

### PROCESSES OF CHANGE

- **Consciousness raising**—increasing information about self and problem.
- **Self reevaluation**—assessing how one feels and thinks about oneself with respect to a problem.
- **Environmental reevaluation**—assessing how one’s problem affects the physical environment.
- **Self liberation**—choosing and committing to act or belief in ability to change.
- **Social liberation**—increasing one’s alternatives or access to the nonproblem behaviors available in society.
- **Counter-conditioning**—substituting alternatives for problem behaviors.
- **Stimulus control**—avoiding or countering stimuli that elicit problem behaviors.
- **Reinforcement management**—rewarding oneself or being rewarded by others for making changes.
- **Dramatic relief**—experiencing and expressing feelings about one’s problems and solutions.
- **Helping relationships**—being open and trusting about problems with someone who cares.

the use of telephone for the initial contact because of the unreliability of the list, lack of information on the home situation of the client, and expense.

In Minnesota, a collaboration between the BCC program and the local Professional Review Organization is testing the effectiveness of a direct mail and media campaign in recruiting Medicare-eligible women to mammography screening. Target women are randomly assigned to one of three groups: direct mail only, direct mail plus press release exposure, and press release exposure only. The ultimate outcome measure is the number of women exposed to the campaign who come in for screening. Preliminary information indicates that the intervention is having some success. June 1996 data indicate that 13 of the target women had received screenings through BCC; only 1 of these was from the control group (press release exposure only).

### **Timing**

Holidays such as Mother's Day and birthdays were the most commonly used trigger for mailing, but written invitations were not confined to holidays. The advantage of tying personal invitations to holidays is that women are perhaps more sensitized to making changes and positive efforts at these times. Grantees who chose Mother's Day or New Year's Day as opposed to birthdays did so because it allowed for a single mass mailing and less individual tracking, and the single date could more easily be combined with an areawide mass media campaign.

### **Identifying the Women**

Strategies for identifying women fell into two clusters. First, most programs obtained (or, on occasion, purchased) relevant lists. Second, some programs chose to reach the women through an intermediate contact, such as a relative or friend.

Programs that used lists most often relied on motor vehicle or voter registration lists. These had the advantage of being inexpensive or even free (for other public sector agencies) and, depending on the state, could be sorted by birth date or another demographic factor that would allow for rudimentary targeting of the list. There are benefits and drawbacks to any mailing list. Many programs reported that motor vehicle and voter registration lists were not helpful in identifying the women targeted by grantees (mainly uninsured or underinsured, older, and hard-to-reach women) and did not result in good response rates. A combination of factors seemed to undermine the effectiveness, but most notably, programs sensed that their target population was underrepresented on these lists.

## SOME INVITATION STRATEGIES

In West Virginia, the BCC program collaborated with Family Dollar stores to create a special event for the month preceding Mother's Day. One of the items at a BCC booth in stores was a Mother's Day card with a message about mammography. Customers could take the cards, write additional messages of their own, and send them to their wife, mother, grandmother, aunt, etc.

Two states using motor vehicle lists had different experiences. In New York, a "stuffer" was added to the driver's license renewal notices sent by the Department of Motor Vehicles (DMV) to any woman over 40 years old in the state. The DMV stored, sorted, and inserted all of the notices, which the BCC program had designed and printed. The only restriction placed on the insert was that it fit the envelope and not add significantly to the weight. The insert reached approximately 1.7 million women. State officials reported that they experienced an increase in calls to their 800 number. Conversely, when West Virginia used a similar strategy, they did not experience an increase in responses. In addition to suspected underrepresentation of the target population in the DMV lists, state respondents believed that their strategy of choice—to send the card on each woman's fortieth birthday—may have been counterproductive in that it reminded her of her age and of its attendant health risks. New York's more successful strategy had been to target all women over 40 with a mass mailing, rather than to link it to the individual's birthday.

In Cleveland, Ohio, a message about mammography was placed in bills by the gas company at no charge. The mailing reached 1.1 million addresses in Cleveland and surrounding counties, and the grant program determined from its intake information that 100 women were enrolled in the program as a direct result of the campaign. The only cost incurred was postage for mailings sent to women who were determined to be eligible.

An alternative was to use a general population mailing such as inserts in a utility bill. However, these mailings are so untargeted that the number of "hits" for the number of distributed inserts are often not worth the effort. Even when the utility company does not charge for the inserts, the cost of printing a sufficient volume for the general population is prohibitive.

An alternative to using mailing lists to distribute personal invitations is use of an intermediary relative or friend. For example, several sites set up tables in malls close to Mother's Day. Shoppers were encouraged to choose from a selection of Mother's Day messages that encourage screening, address the card, and enclose a personal message. This strategy ensures that the address is correct and has the added salience of a personalized message from a relative or friend. California developed Mother's Day cards with a breast cancer message and distributed them to community agencies and churches, which in turn distributed them to their members.

Grantee programs had these insights to pass on to others distributing personal invitations for the first time:

- Choose the list carefully and consider whether the target population is likely to be included.

- Be sure that you have calculated all costs for conducting this initiative, including printing, stuffing, screening responses, and referral of eligible women who respond. Cost is an important factor in the choice of mailing list: printing and screening costs escalate rapidly with a poorly targeted general population list that produces many inquiries from ineligible women and few inquiries from eligible women.
- Build into the campaign an evaluation component before reminders go out, to ensure that you will be able to show effectiveness. While few programs have the resources to devote to a true scientific evaluation, actions as simple as monitoring the number of calls to the 800 line or providing a mail-back card or other “call to action” help determine if the activity is worth repeating in the future. For those with access to DMV or other lists, more sophisticated ways to test the effectiveness of the intervention include targeting the inserts to some but not all regions of the state and monitoring differences in responses from the regions.
- If a phone number is presented, consider printing a local number as well as an 800 number on all materials. The local connection is important for all women, and rural women in particular may not make 800 calls or even have access to 800 service.
- Keep the language on cards or inserts simple, especially if the invitation includes statistics on breast cancer risk.
- If women are to be depicted on the materials, use photographs. Painted or drawn images are risky because women may not relate to them or may find them less personalized.
- Printing the invitation on high-quality stationary and including the letterhead of your program lends more credibility to the message.

## Lesbian Outreach

Lesbians and bisexual women present unique issues for breast and cervical cancer programs. Many lesbians and bisexual women are medically underserved; some program directors referred to them as “invisible” populations. They may encounter numerous barriers to health care services and, as a result, have low rates of mammography screening. While, on the surface, strategies that bring all women in for screening and rescreening would seem to apply to lesbians and bisexual women as well, research and the experience of programs has led to the conclusion that this is a special population that needs to be targeted with specialized strategies.

Results from surveys, focus groups, and individual interviews conducted with lesbians by several state programs suggest the following modifications to screening and service delivery programs:

- Create lesbian-sensitive and lesbian-targeted materials.
- Modify intake and other medical forms so they do not assume heterosexuality.
- Create a more welcoming service delivery environment by addressing homophobia among clinic personnel generally, not just the direct caregiving staff.

The BCC programs in several states responded to this type of research by developing resource directories and consumers' guides for the lesbian and bisexual community. Massachusetts' BCC Initiative worked through the Lesbian Education and Health (LEAH) Program, a project of the Family Planning Council of Western Massachusetts. The BCC Initiative provided financial support for LEAH to develop a guide and resource directory of lesbian-sensitive health providers in the local county. In addition, the BCC program provided financial support to this family planning council and a community health center in Boston to conduct needs assessments in the local lesbian and bisexual community. The purpose of this survey was to determine optimal strategies for increasing screening and to provide sensitivity training for all BCC program providers and health department staff. It is hoped that such training will counter assumptions that may alienate lesbians who seek screening.<sup>13</sup> In Washington State the BCC program coordinated the first screening effort directed at lesbians in Seattle-King County, the Lesbian Breast and Cervical Health Project (LBCHP).

States reported a host of other strategies that, while not formally tested, were believed to be effective in outreach to lesbians and bisexual women. Ultimately, most felt, effective outreach required a one-on-one personal contact with lesbian women. A comprehensive strategy might include

- Partnerships with the lesbian press for announcements, special event coverage, and sponsorships. This heightens the visibility and credibility of the BCC program with the target audience.
- Cultivating and involving visible, respected, and vocal members of the local lesbian community. This leads to good word-of-mouth recommendations throughout the community.

---

<sup>13</sup>This topic is discussed in more detail in the Staff Development and Training section of the "Inreach" chapter, page 13.



- Enlisting these leaders or other lesbian women for home parties that result, among other things, in referrals of women to providers for screening.
- One-on-one contact at lesbian-oriented events, such as pride marches, music events, and lesbian sports leagues.
- Transportation vouchers that provide inexpensive access to lesbian-friendly providers.

Most outreach efforts to lesbians and bisexual women are in their early stages, and formal evaluations are not underway. Most intend to measure success by number of contacts made and the number of self-identifying lesbian or bisexual women who come in for screening. Washington State's screening efforts through the LBCHP yielded 10 new screenings, 7 of which were from the target population. At press time, Massachusetts was about to begin evaluation of its collaborative efforts with the family planning councils and community health centers.

To assure that strategies will be appropriate and effective, state programs that work extensively with lesbian and bisexual populations make the following recommendations:

- Create an advisory committee of women from the target population to provide guidance and direction.
- Minimize "reinventing the wheel" and missed opportunities for screening by actively collaborating for outreach with community organizations and programs that serve or have access to lesbians and bisexual women. These organizations may be able to serve as screening sites or, at a minimum, be able to share effective information and strategies for reaching lesbians and bisexual women.
- If older lesbians are the target group, then try to recruit older lesbians as outreach workers.
- Pay attention to enabling services such as transportation to broaden access to lesbian-friendly providers.

## Corporate Sponsorships

While partnerships are discussed more extensively later in the chapter on coalition building, a host of corporate partnership and cosponsorship activities are directed at specific, usually outreach, activities. These arrangements with local businesses and corporations range from direct mailing agreements between utility companies and BCC programs to commitments of employee staff time and shared sponsorship of programs. This section groups activities by the type of entity with whom the BCC program is partnering.

## Pharmacy Partnerships

Nebraska's EWM program works actively with pharmacists and pharmacy students to involve them in encouraging mammography. The level of involvement differs with the pharmacist and may range from merely displaying BCC program information and packets within their stores to referring customers to providers in the area.

New England and Michigan have more active pharmacy collaborations than other areas. In Rhode Island, Connecticut, Massachusetts, and New York, Stop & Shop Companies, Inc. partnered with the state programs to provide community health education to its customers. For example, all 17 of Rhode Island's Stop & Shop stores set up booths near the stores' pharmacies and printed special flyers, bags, and weekly circulars to promote the BCC prevention program. In addition, Stop & Shop conducted a raffle, eliciting food and beverages from vendors and donating fruit baskets as incentives to visit the information table. The BCC program supplied the volunteers—110 who provided more than 500 hours of staff time. They were recruited from the state's volunteer network, public education task force, and regional resource centers to staff the booths, answer questions about the program, hand out information, and refer eligible women for free screening. The process evaluation of the effort showed that the partnership reached 3,791 women with written materials, responded to 1,410 women with questions, made 263 referrals for screening, and made 15 appointments for eligible women.

In a similar effort, the Michigan Department of Community Health partnered with selected pharmacy divisions of Kmart Corporation to conduct a mammography sweepstakes campaign. Kmart funded a media consultant who collaborated with the state's advertising agency to plan the sweepstakes campaign and produce in-store notices as well as tag lines for the state's mammography ads for television, radio, and print materials. Kmart donated space and staff time and arranged for the donation of prizes. Women aged 40 years and older who had gotten a mammogram were eligible to enter. The state printed the sweepstakes coupons and made educational materials available to over 7,500 entrants. Michigan was later able to follow up on its success with Kmart by conducting a similar program with Rite Aid Corporation.

## Discount Stores

The West Virginia BCC Program partnered with Family Dollar Stores, Inc., as part of the program's business outreach plan. Family Dollar provided 75 employees, whom the BCC program trained to be BCC representatives during their normal working hours for the month before and the week of Mother's Day. Employees shared what they learned with other employees and with customers

during normal working hours. The BCC program contributed funds to advertise the joint effort and supplied staff for booths at all stores, offering promotional materials on mammography, Mother's Day cards, children's coloring cards, and posters. The program also arranged with its program providers for on-site or nearby mammography equipment at nine of the store locations.

As with the Stop & Shop partnership, this effort met Family Dollar's desire to be seen as a concerned and responsive community partner with a key customer segment, older women in the community. The partnership yielded a corps of trained volunteers for the BCC program at little cost. Total costs were minimal, consisting of printing costs for posters, cards, brochures, and advertising, because program providers did the screening and Family Dollar provided release time for staff training.

California worked with the Safeway supermarket chain in a project that included printing mammography screening messages on 2 million grocery sacks. The 800 number was also part of the message. Local BCC programs were able to do the same with milk cartons in that state.

Lessons learned from corporate partnership efforts include the following:

- Partnerships work best that address the needs of both partners. Stop & Shop was looking for a way to present itself as a community-responsive provider and its pharmacies as a community resource. The partnership with BCC met both needs.
- Similarly, target "natural" partnerships with corporations whose staff and clients are part of the target population and would benefit from collaboration.
- Sometimes the best way to enlist the cooperation of a corporation is to work through a relevant department, such as the pharmacy. Pharmacists are effective catalysts because of the health orientation of their profession and the one-on-one interaction the profession demands. In addition, Nebraska found that pharmacies that served as preceptors for students were even more receptive, because students had an active interest in disease prevention.
- Even employees from health professions, such as pharmacists, may need a crash course in breast health and mammography if they are to serve as credible representatives.
- Within a supermarket or department store, choose a booth location that relates to the outreach and allows interaction with women. The pharmacy section was an ideal location on both counts. It is consistent with a health education outreach, and women often wait in the area for prescriptions to be filled.

- When partnering with a chain or department store that draws from a large area, be sure to include an 800 number on all materials to ensure that women who live at a distance can access follow-up information.
- Don't restrict the targeting to urban or chain franchises. Although there is more "bang for the buck" in engaging all stores in an area through the regional office, some programs find that the rural and nonchain stores are more receptive to community involvement. Nebraska found that the rural and nonchain pharmacies were more likely than others to participate fully in mammography efforts.
- Assertive, outgoing volunteers are essential in supermarket situations to distinguish the booth from more typical merchandising efforts. If the booth is staffed with passive volunteers, customers may assume it is one more booth where products are being sold.
- Use BCC partnerships as an opportunity to develop a more comprehensive relationship with corporate partners. For example, Michigan found that K-Mart is willing and interested in partnerships with Michigan Department of Community Health, not just breast and cervical cancer.

## Outreach to and Through Religious Organizations

Outreach to churches, synagogues, and other religious organizations is a strategy frequently employed by state BCC programs. Religious congregations offer a ready audience that meets at a regular time and place in an environment perceived as nurturing, caring, and having the best interests of the individual in mind. Religious congregations are well-connected to the local community, especially in the case of communities of color; are popular with the key target group of older women; and encompass a natural structure of lay and clerical leaders who can serve as opinion leaders in engaging members of the congregation. In addition, many denominations and local congregations have seen health as integral to their mission of serving the needs of their congregants and community and have, for example, established parish nurse programs. Often, "selling" mammography alone is not successful. Presenting it in the context of health and faith is often a more fruitful approach. This section presents some of the principal strategies employed by programs in partnership with religious organizations.

In Minnesota, a partnership of agencies, churches, and corporations has developed National Multicultural Cancer Awareness Week, which culminates in Cancer Awareness Sunday, the fourth Sunday in April. This is a church-based educational event to "break the silence" associated with cancer, address women's

fears, and encourage the African-American community to get screened and, if necessary, treated. This year, 38 churches participated, a 50% increase from 1995. Working in partnership with the churches are the Minnesota Department of Health, the ACS, and numerous community organizations. The Medtronic Foundation supports the development of a guide to help churches conduct the program. At the congregation level, eligible women are identified and signed up, and YWCA outreach workers call them back to provide referrals.

South Carolina's Pink Ribbon Sunday is a similar effort. Church members are encouraged to wear ribbons made and distributed by staff and volunteers of the state's Best Chance Network. BCN works in advance to recruit the churches, distribute to local churches and organizations Pink Ribbon request cards designed to recruit a contact person, and determine the number of ribbons to be distributed. Volunteer groups cut the ribbons and assemble packages. The American Cancer Society funds the manufacture of the ribbons and pins and the development of the attachment card. The card includes South Carolina-specific statistics on breast cancer deaths, the three steps to detecting breast cancer, BCN's 800 number, and the ACS number.

A guide to help churches conduct Pink Ribbon Sunday encourages them to approach breast cancer as a family issue rather than a women's issue. For example, the attachment card presents the number of families that have buried a family member who died of breast cancer, rather than the number of women who died. BCN Pink Ribbon Sunday efforts encourage churches to host mother-daughter breakfasts and have survivors conduct the worship service.

A total of 50,000 ribbons was distributed in the first year of the program, 1995. This number increased threefold in 1996. BCN saw a significant increase in calls to the 800 number in 1996 and is tracking to see if this translates into increases in enrollment.

A key to the success of Pink Ribbon Sunday is that it is the culmination of a series of "wraparound" events that give it prominence and visibility. For example, in 1995 South Carolina's First Lady read a "Breast Cancer Awareness Proclamation" signed by the governor that proclaimed October as Breast Cancer Awareness Month, October 15 as Pink Ribbon Sunday, and October 19 as Mammography Day. The press conference and seminar were well attended by survivors, advocates, supporters, and the press and set the stage for the Pink Ribbon Sunday event.

In Wisconsin, Pink Ribbon Sunday has been expanded to a 7-day Pink Ribbon Week to ensure that congregations that do not meet on Sunday are included and to encourage multiple exposures to messages conveyed in the special programs and

bulletins. The campaign was based on recommendations from a committee of the Wisconsin Department of Health and Family Services' BCC staff; the ACS Comprehensive Cancer Center; and parish nurses, ministers, and deacons. The state developed materials for county coordinators to use with congregations and parish nurses in their area. In addition, the state provided pink ribbons for distribution, which were cut and assembled by BCC volunteers, Girl Scouts, and sewing groups.

A guide was developed that included sermon topics and suggested songs, prayers, special service ideas, and press releases so the congregations did not have to develop their own materials. However, some congregations augmented the materials, inviting survivors to speak and planning additional activities to support awareness. Only 600 congregations were expected to participate, but 1,500 joined the campaign. Each local coordinator worked with 10 to 40 congregations. The success of the campaign was measured mainly in terms of the numbers of women reached with prevention messages. The program staff also noticed an increase in screening in October and November, but is not certain if this was due solely to Pink Ribbon Week.

Programs working with religious congregations need to remember the following to be successful:

- Church campaigns need to be part of a larger effort that increases the communitywide visibility of issues such as breast and cervical cancer. Isolated church campaigns are less likely to be successful.
- Churches have limited resources and many demands on their time, staff, and volunteers. Efforts such as Pink Ribbon Sunday compete with the ongoing ministry of the church. BCC programs are more likely to be successful if they include guides or other resources that the church can use or easily adapt.
- Despite their popularity, ribbons are a very labor-intensive and time-consuming premium. Pins similar to those distributed at museums are much cheaper to produce than ribbons. If ribbons must be used, try to enlist other volunteer organizations, such as the Girl Scouts, to assemble them. Or consider distributing the cut ribbons to the churches and asking the members to assemble them.
- All materials must be sensitive to church-state issues and to differences in the theological orientation of congregations. Denominations may differ widely in the degree to which they see involvement with the community and partnership with the state on health issues as integral to or consistent with their theological mission.

## Hotlines

Because this chapter defines outreach as any one-to-one effort directed at eligible women, hotlines logically belong under the rubric of outreach. In reality, however, no state uses hotlines as a major form of outreach. More commonly, the hotline is the principal mechanism for the “call to action” that the outreach and the public education campaigns attempt to engender. The advantages of an 800 hotline are obvious and several. An 800 number provides centralized and consistent dissemination of information, reduces the cost barrier, and perhaps more importantly, provides a direct link to providers for eligible callers. Also, tracking 800 calls has emerged as a key tool for evaluating the effectiveness of interventions and determining how women find out about BCC programs.

South Carolina’s 800 hotline number, which is printed on all material and mentioned in all PSAs, serves as an information resource, screener for enrollment into the program, referral system, indicator of the effectiveness of BCN public education campaigns, and quality assurance system to track provider receptiveness. The Cancer Information Service (CIS), supported by the National Cancer Institute, has a regional office serving North Carolina, South Carolina, and Georgia. The BCN program contracts with CIS to provide the 800 services rather than staffing a separate number itself. CIS logs all calls and referrals, while BCN monitors the number of enrollees who indicate that they used the 800 number.

In addition to serving as the recipient of calls prompted by the “call to action” and as a source of evaluation data, a hotline can be used for quality assurance and patient advocacy. Feedback from the 800 line can be used to tailor provider education or monitor provider performance. For example, in South Carolina, women who encounter difficulties in making an appointment or experience poor service from a clinic are instructed to contact CIS. CIS acts as a central clearinghouse to forward the information to the appropriate provider coordinator at BCN, who helps the woman find an appropriate site and follows up with the “problem” clinic. This gives the woman an outlet for controlling her care and gives BCN a ready source of information on problems in the system.

States disagreed about the utility of 800 lines in dealing with rural populations. Many felt they were essential, because they reduced the cost barrier for women in rural areas, where long-distance calling is often expensive. However, others felt that the local connection was essential for reaching rural women. In the latter states, both a state and a local number are offered on materials.

## Mobile/Portable Mammography

Mobile vans and portable units are an obvious form of outreach, and most state programs were using them. However, programs were quick to point out that while mobile and portable mammography surmount physical access issues, these are only a small portion of the reasons that women, especially the hard-to-reach women who are the focus of the program, do not seek screening. In and of itself, mobile mammography is not an effective strategy; but it is a very useful tool in a more comprehensive strategy.

Mobile vans and portable units increase screening rates by increasing physical access to screening, literally bringing the service to the community's doorstep. They are especially effective as part of special events where the program wishes to capitalize on the interest generated in a captive audience, or with populations that have barriers to access due to distance or infirmity. For example, several states target mobile screening for elderly women in assisted living situations, who may face extreme transportation barriers. Other special populations for whom this approach has been successful are women in rural areas, which almost always have a paucity of screening facilities (Kansas has just initiated such a program), migrant farm workers who are transient and are unlikely to have an established relationship with a provider, and users of Indian Health Service clinics, which may not have the capital to provide this equipment at all sites. Mobile mammography units are one of California's main BCC outreach efforts to its rural populations. While few programs have been formally evaluating the effectiveness of mobile mammography, staff of the Portland, Oregon, program, which does a periodic screening circuit in outlying rural areas, indicated that they provided 86 mammograms in 3 or 4 days during a recent screening effort.

The Women's Wellness Center of the University of Medicine and Dentistry of New Jersey and the YWCA of New Jersey collaborate on a program that combines outreach and portable screening. Program staff make monthly visits to senior housing complexes and other settings such as beauty parlors and supermarkets. The site visits include an educational program targeted to women of color over 50 years of age. During the visit, the staff schedules mammography appointments for their portable mammography unit, which then visits the site 2 weeks later.

The program has exceeded its numerical goal, and staff attribute its success to a variety of factors besides reducing physical access barriers. Women of color are often more reluctant to use the medical care system than other women. The portable unit provides the service in a comfortable, nonmedical setting, reduces the wait for a mammogram, and is less conspicuous than a mobile unit. In addition, the staff emphasize personalized contact with the women, including follow-up visits a month after screening to encourage regular screening.



Programs using mobile and portable screening had these insights to offer:

- An advantage of mobile and portable units is that they provide screening in nonmedical settings. But this advantage is compromised if the units look like “clinics on wheels.” Try to put women at ease by decorating the unit in soft colors and avoiding an institutional look.
- Mobile and portable units often capture hard-to-reach women who cannot be reached in other ways. Therefore, it is important not to miss the opportunity. Programs should use onboard processing that allows for checking the quality of the mammogram before the woman leaves the unit.
- Most programs cannot dedicate staff to mobile screening and must use clinic staff for this purpose. Coordinating four schedules—the physician, technician, health educator/nurse, and the woman to be screened—is time-consuming and fraught with difficulty. Many programs have found it most feasible to designate specific days of the week for mobile screening in a particular community.
- It is often helpful to advertise the service ahead of time in rural areas. Simply reducing travel to a reasonable distance will effectively eliminate this barrier for most of the population. Also, making local women aware of the service schedule and location increases program efficiency. New York mailed announcements of van availability to rural women. In the San Francisco Bay area, local health departments advertise the availability of a mobile unit on “Breast Health Day.”

## Comprehensive Screening

Offering comprehensive, multipurpose screening through health fairs is a successful strategy to promote clinical breast examinations and self-exams and to refer women to mammography. The strategy is successful for two reasons. First, pairing BCC services with others brings in women who might not inquire about BCC alone. For example, New Mexico’s Breast Cancer Prevention program found that combining blood pressure and cholesterol screening with information sessions on breast cancer drew their target population of older women. California combined screenings with flu shots. Second, organized correctly, the health fair operation can minimize the time barrier for most women. Women prefer the convenience of picking up literature, getting screened for other chronic diseases, and scheduling mammography appointments all in one day, or in some cases, obtaining mammograms.

Three states, Arizona, North Carolina, and Massachusetts, are receiving special CDC funds to test various models for integrating breast and cervical cancer screening into more comprehensive care for women. The goal of these efforts is to reduce preventable morbidity and mortality from chronic disease in uninsured and underinsured older women who do not have regular access to health screening and interventions.

The Massachusetts Well Woman Program (MWWP) is a 2-year demonstration project for comprehensive, chronic disease screening and intervention among uninsured and underinsured women aged 50 years and older in selected community-based sites throughout Massachusetts. The project, a collaboration of the Massachusetts Department of Public Health, community sites, and several academic institutions and advocacy organizations, adds important basic health education and prevention services, such as cholesterol and blood pressure screening, to the comprehensive services already offered by the state's BCC program. Key MWWP activities include baseline, 6-month, and 12-month screenings and specifically target multilingual women in the Latina, Southeast Asian, and Portuguese communities. Participating sites include hospitals, community health centers, and visiting nurse associations. The sites were randomly designated as "usual care" sites, offering cholesterol, blood pressure, chronic disease risk factor, and breast and cervical cancer screening, referrals, and follow-up care; or as "special intervention sites," offering all usual care services plus educational interventions and activities as well as support through individual and group counseling and telephone contacts. An expanded chronic-disease risk factor screening is being used in all sites to capture information on risk factors such as physical inactivity, poor nutrition, smoking, and stress levels. An important part of the project is evaluating the effectiveness of the interventions in changing blood pressure and cholesterol levels.

Each site was responsible for enrolling 150 women from the target group; to date, the project has reached 1,600 women. The evaluation phase is not yet under way but will monitor changes in risk factors and differences in the amount of change in usual care and special intervention sites.

## Wellness Programs

Most programs that have been operating in communities for extended periods of time learn that other health concerns may overshadow breast health, especially in low-income or other vulnerable populations. Therefore, the way to get BCC messages across often is to piggyback them or integrate them into other efforts or for the BCC program itself to conduct a more comprehensive health education effort. Integrating the BCC message with other, broader health education messages may

allow the BCC staff to save resources by sharing responsibility with the staff of other programs. But, more importantly, the BCC message is spread more widely because the array of topics attracts eligible women to the booth who might not be attracted by information on BCC alone.

New Mexico's BCC Prevention and Control Program conducted Senior Wellness days in senior centers throughout a rural southeastern district. About half of the 30 centers in the district agreed to schedule the four-member health promotion teams for a wellness day. Most importantly, the most rural, medically underserved locations were more likely to participate and to send notices to their local media promoting the team. The wellness day itself was geared to the interests of both men and women. Three hours of presentations and screening were offered, including blood pressure and blood sugar screenings, "nutrition as we age," stretching exercises, and a discussion of fitness in the later years. Then, the men left the room and breast and cervical cancer prevention information was discussed, a short evaluation form was distributed, and visual aids and pamphlets were offered to the participants. The program reached 170 women; the staff will be tracking these names to see how many of the contacts result in subsequent screenings. Because this was a rural population, the more comprehensive approach offered several advantages. First, in these ranching areas, women may be traveling several hours to retail centers. A comprehensive screening is probably perceived as higher value for the time invested. Second, many families may share a single vehicle. Offering services for both males and females made it attractive to both members of the couple. And third, the addition of popular topics such as nutrition, fitness, and blood pressure probably attracted many women who would not have attended a session on BCC alone.

## Outreach Workers

For purposes of this strategies guide, outreach has been defined as any strategy to bring in women based on one-to-one, as opposed to mass audience, interaction. Consequently, at the core of most programs' outreach efforts is an array of interpersonal strategies employing cadres of professional, paraprofessional, or volunteer staff. The ways in which these staff are deployed varies widely, depending on the needs of the program. In some cases, they are employed in one-to-one interactions. In many others, they represent the BCC program or spread the BCC message to groups of women. This section presents some illustrations of effective uses of either professionals or volunteers in group or individual strategies and the insights of programs about the types of activities and individuals that are most likely to be successful.

## **Lay Outreach Workers**

Programs use lay outreach workers in a wide variety of volunteer outreach activities. Although programs had specific insights to offer about each strategy, there were some general insights about using volunteers:

- It is helpful to have job descriptions for volunteers or lay health workers to clearly outline expected duties as well as to present their roles as jobs that are as important as salaried positions.
- Rather than developing your own cadre of volunteers, consider collaborating with an existing organizational network like extension service members. These members are likely to be interested, dependable, and well-connected in their community.
- Regardless of the job being performed by the volunteer, acknowledgments and incentives are important to show appreciation and to motivate them. For example, special certificates for volunteers undergoing training is an inexpensive way to publicly recognize their time and effort and their resulting expertise.
- Offer program materials in as many languages of the target community as possible. Consult community women to determine appropriate images for materials.
- Redefine “outreach” in Requests for Proposals or agreements to encourage creativity. Too many respondents are likely to define it in traditional terms such as distributing information.
- If the outreach involves agreements with other agencies, be sure to institute monthly reports to monitor their performance.

## **Outreach to Groups of Women**

Strategies aimed at groups of women are diverse in approach, but these efforts have a few things in common: They are organized by the women or others in the community; they tend to be held in informal and social settings; and they may integrate breast and cervical cancer messages into a larger or more comprehensive topic.

In Rhode Island’s Woman to Woman program, trained local volunteers organize talk groups for women over age 40 in their community. The BCC program trains the volunteers in breast and cervical health, gives them effective strategies for bringing the message of cancer prevention to the community, and provides a manual of talking points to use in the group discussions. These points include who

is at risk, three techniques to detect breast cancer, barriers to using these techniques where mammograms are available, payment for services, and steps to take with a positive diagnosis. The program collaborates with ACS to certify those trained with “Special Touch” certificates. A similar Colorado program with 50 trained and certified lay health speakers reached more than 2,000 women in 1995 in small, interactive, group discussions designed to promote knowledge of risk factors and to create positive attitudes toward screening. Programs such as these measure effectiveness through pretest and posttest measures of knowledge, attitudes, and beliefs. The Colorado program demonstrated a significant change in participants’ knowledge, attitudes, and beliefs about breast cancer screening. The program has not yet been able to track whether participants act on their stated screening intentions.

### **YWCA’ S ENCORE<sup>plus</sup> PROGRAM**

The Office of Women’s Health Initiatives of the YWCA hosts a health advocacy and outreach program in 27 states called ENCORE<sup>plus</sup>. A national ENCORE<sup>plus</sup> training corps provides regional trainings to YWCA professionals to impart the knowledge, skills and cultural sensitivity necessary to develop and implement programs for ENCORE<sup>plus</sup> clients, medically underserved women. Trained YWCA professionals form working relationships with state health departments to recruit women for early detection services.

Programs such as these had many insights to share with others about how to conduct these efforts:

- Volunteers should always work in their own communities. This enhances the chances of organizing successful groups as well as the credibility of the message. The point is especially true for communities of color or other special populations that may distrust traditional institutions.
- Talks should be no longer than 1 hour, especially if the BCC message is being woven into another event.
- The optimal group size is 5 to 10 women, to permit enough personal interaction, active group discussion, and attention to issues of individual group members.
- Evaluation of these efforts is difficult after the fact. It is important to collect individual profiles from each participant during the discussion group, to permit less cumbersome tracking later.
- Incentives or acknowledgments of volunteer efforts are crucial and much appreciated. These need not be expensive or elaborate; an example is the “Special Touch” certificates used in Rhode Island. The nature and timing of the incentive or acknowledgment should be decided in advance.

### **Home Health Parties/Health Circles**

A slight variation on the group discussion theme, home health parties and health circles piggyback BCC messages in a structured, familiar setting. For example, home health parties are organized in neighborhood homes much like Tupperware or other sales parties and are structured similarly. Health circles also use an existing social structure to teach about BCC. Integrating BCC into these familiar settings enhances the receptiveness of the participants to the message and reduces the fear that may attend discussion of these sensitive topics.

In New Mexico, home health parties were truly a homegrown strategy, arising out of a woman's request for a BCC staff member to speak in her home to family and friends about cancer prevention and treatment options. The current program (Pass it On) targets rural areas and uses a snowball strategy, relying on word of mouth at one party to recruit hosts for additional parties. New Mexico currently uses BCC staff for the presentations, in part because the strategy is to integrate BCC messages into more comprehensive presentations on women's health; however, all other aspects of the home health parties are done by the community host. And the program is being modified to train lay health advisors to do presentations at the parties. The hostess receives a stipend for her time and effort; speakers in the modified program will also receive a stipend. These stipends have been important incentives in rural New Mexico, which is a poor area.

The party begins with discussion about women's health in general, then shifts to breast cancer, inviting all participants to be screened and recruiting hosts for other home health parties. Although the department recruits hosts with fliers, newspapers, and radio messages, word of mouth at parties has been the best recruiting strategy.

Three-month follow-up surveys are being mailed to determine if participants have been screened, but results are not yet available. To increase survey completion rates, completed tracking surveys are entered into a raffle for a larger incentive.

Home health parties and health circles have proven especially effective in outreach to communities of color and other special populations because they offer the flexibility to adjust the style, message, setting, and approach to accommodate cultural preferences.

Minnesota recently adopted a model similar to New Mexico's for outreach efforts to Native Americans in the Fond du Lac Tribe. A previous emphasis on presentations at public sites has been converted to a home visiting program. Coordinators had concluded that Native American women in this region are

generally not receptive to large group activities. As in New Mexico, the BCC program is using paid staff to deliver the messages—public health nurses who, they have found, are preferred and well-respected by this target audience. Modifying the message to fit cultural attitudes, the program emphasizes the importance of taking care of oneself in order to be able to take care of one's family. In Oregon, a coalition was developed that represents nine Native American tribes and include elders and women from the tribe with a history of breast cancer. The coalition works in collaboration with the YWCA to conduct "talking circles" in the community, using a moderator from the community.

Massachusetts' Breast and Cervical Cancer Initiative partners with community agencies that are already active in communities of color and immigrant communities to conduct outreach using a health circle model. Groups meet in spaces that are familiar, accessible, and comfortable for the specific community, including homes, Buddhist temples, and, on occasion, familiar local agencies (such as immigration offices). The health circle model has proven especially successful with older Southeast Asian women (Vietnamese and Cambodian). Health circle groups of 6 to 12 Southeast Asian immigrant women, conducted by the Vietnamese-American Civic Association in Dorchester and Boston, discuss anatomy, nutrition, and general health, then move into discussions of the early detection of breast and cervical cancer. Women are empowered to choose topics that are of concern to them. In the weeks after the program, the agencies follow up with participants and give referrals for appropriate screening services. The program is undergoing more formal evaluation, but the anecdotal evidence of effectiveness is powerful. Several local providers who reported that they had never seen a Vietnamese patient for breast cancer screening services suddenly scheduled 10 to 15 women in the weeks following this initiative.

The Art and Wellness Program in New Mexico employed an interesting variation on the health circle model. In addition to discussions of health concerns, the groups of Native American (primarily Navajo) women collectively created a group clay pot, each woman contributing a coil. Lay health speakers, trained by the program's regional health educators, conduct the circles in the native tongue. Breast health issues are integrated into a larger discussion of health issues of particular concern to the Navajo community. In the first year, more than 800 women participated in health circles, and 200 of those entered the system to receive services.

Based on the first year's experiences, the program has been slightly modified. Clay pots have been supplemented with individual projects such as tote bags and mugs that women can take with them as tangible reminders of the circle and that do not need to be fired by a professional potter.

### **Survivors as Witnesses**

Although the use of lay outreach workers in general is an effective strategy, among the most effective of these workers are survivors or families of survivors. Most states indicated that they recruited and used survivors as much as possible in their lay outreach efforts, but Arkansas' Witness Program is among the most well known. The Witness Program started with four survivors who began to network with churches to witness, that is, to give verbal, emphatic testimony about the experiences. Word of mouth spread the word about the witnesses, and other churches and organizations began to contact the group to visit their congregations and members. The number of survivors who participate in the program has grown from 4 to 35 witnesses in a short period of time. Currently, the program is developing a witnesses video that will increase the reach of the activity. In reviewing the activity, state staff emphasized that it is important to use teams of witnesses to avoid perpetuating a "token" survivor perception. Also, it is important to give credit to the women for sharing their story; always keep the attention on the survivors. Finally, because the witnesses are operating in the field, it is important to make them feel a part of the larger effort through meetings, newsletters, and updates to encourage active participation and support.

### **One-to-One Outreach**

Although many of the most visible efforts deploy lay outreach workers in group settings, programs have a variety of interesting strategies under way that use lay workers in one-to-one outreach.

South Carolina's BCN comprises 14 paid outreach workers who live in the communities they serve and work out of their homes. Each serves a two- to three-county area that has been selected based on mortality rates. The outreach workers resemble other members of the communities from which they come, and most do not have postsecondary education. BCN's 5-day training teaches the outreach workers how to recruit women, assist in making clinical appointments for clinical breast exams, do reminder calling, collect quality assurance data from clients after the mammogram, and do follow-up calls 1 year later to check whether the provider recommended an annual mammogram and the client sought it. All of this information is recorded in a log, carbons of which are shared with the BCN office. Outreach workers are asked to recruit 1 woman a day, or 20 women per month. The one-to-one efforts of the outreach workers are integrated with BCN's group education activities, which are conducted by community educators in each region.

North Carolina operates a similar program, targeting older African-American women. An outgrowth of "Save Our Sisters," a collaborative effort of NCI and the University of North Carolina in the Wilmington area, the program proved so



effective at attracting into the health system women who were traditionally alienated by health care institutions that the health department made it a statewide effort. Community health advisors are chosen from the community and, as noted, closely resemble those they are targeting. They are trained in medical terminology, completing forms, access issues, Medicaid billing, and providing emotional support. They can provide transportation and often accompany women to the mammogram. Because they were active community members before their new role, the advisors know most residents and attend local reunions, revivals, and festivals to recruit. The advisors work in collaboration with the local health departments, who receive money for this program from the state. Some local health departments pay their lay health advisor a stipend; others have concluded that a paid stipend would alter the community's perception of the advisor.

Maryland's Outreach Worker program is based on a diffusion-of-innovation model. Training of outreach workers emphasizes getting out into the community and collaborating with community agencies and sites with a natural population of women, such as laundry facilities and hair salons. Outreach workers answer questions and give women referrals to providers who are part of the program. Evaluation data are anecdotal thus far, but providers in these communities report that most new screens can be attributed to the efforts of the outreach workers. West Virginia has a similar program in which volunteers distribute information and a survey, which they later collect, to friends and family. The volunteer signs a contract to distribute at least five packets, but she may seek additional contacts or may pass out packets at another volunteer function, such as at a health fair booth. In any event, the contract is easy to complete and of short enough duration that the program has few problems getting volunteers to complete it. In a Santa Monica program directed at lower-income women over 50 years old, volunteers who were recruited from senior peers, seniors trained as physiologists, and providers have collaborated with local hospitals to improve all aspects of care for these women.

Two other California programs recognize the importance of community workers to ensure that outreach interventions are consistent with the linguistic, cultural, and social context of the community. One California program uses lay women as peer advisors and role models to disseminate screening messages in Latina communities. By using community women, the program ensures that interventions are more likely to counter fatalistic attitudes that may predominate among older women in these communities. Called "promotoras," the lay advisors are paid \$500 for their 6-month commitment to teach breast self-examination and refer women to screening sites. Program staff emphasized the necessity of paying and training the promoters. Staff also found that involving community physicians increased the credibility of interventions.

Another program that addresses screening in Vietnamese communities had to deal with challenges among providers as well as the target women. Most adults are foreign-born and screening rates are very low. Vietnamese women tend not to use the institutional health care system, and Vietnamese providers tend to have low rates of screening, treating acute problems first. The project realized it needed to work on both fronts simultaneously. The program is actively recruiting “access advocates” who speak Vietnamese and can guide women through the health care system. Meanwhile, it is developing posters in a traditional Vietnamese poetry style as well as pamphlets and calendars. These were distributed to providers, English classes, salons, herbalists, and other places the community gathers. Video and other messages emphasize the importance of extended family.

A New York program takes a slightly different approach to one-to-one outreach. The Adopt/Sponsor a Woman outreach program in the Hudson Valley area is based on personal networks, not on training a cadre of volunteers. Volunteers from local women’s organizations identify an unserved and unlikely-to-be-served woman and, using whatever methods they care to, encourage her to be screened. Data indicate that every woman selected was ultimately screened.

Minnesota’s Friend to Friend program is similar, although it includes extensive training as well as a variety of materials. For programs interested in replicating this type of effort, the BCC staff have broken down the costs for each component of the program and have disaggregated the recruitment and evaluation data by recruitment site.

Programs using volunteers for one-to-one outreach had the following insights:

- The closer the volunteer is to the target population, the better. Gaps in knowledge and education can be filled by training and are more than compensated for by the access and credibility that using community volunteers affords.
- Outreach workers who are also survivors are the most successful in recruiting women.
- The role and relationship of the volunteer will vary with the community. Programs should consider carefully whether to “credential” their volunteers and whether to pay a stipend. In some communities, this is necessary to recruit and retain volunteers or to increase their credibility in the community or both. In other cases, it vastly alters (usually for the worse) the perception of the volunteer in the community.
- Establish goals for outreach workers to work toward.

- Community-sensitive design is more important than rapid implementation. Develop an advisory board to oversee training, recruitment, and follow-up activities; do not rush to set up the program at the expense of effective planning.
- Before a program is instituted, ensure that the local screening facilities are prepared to accommodate increased demand. The number of women seeking screening often increases significantly, especially early in the program. Outreach efforts that result in long waits for screens may alienate women and create negative word-of-mouth in the community.
- Because the lay health advisor has established a relationship with the women, it is often more effective to have the advisor, rather than the provider, send reminders of screening dates. The personal relationship is important for bringing new women into care who may be frightened or mistrustful of the system.

### **One-to-One Outreach Using Public Health Workers**

While this chapter has emphasized the use of volunteers, some states are also deploying professionals in a variety of outreach roles.

Kansas has recruited and stationed nurses in three clinics across the state to coordinate outreach, inreach, and public education activities. The clinics were selected on the basis of their history of serving the indigent. The nurses establish a network of local providers to perform services, and they spread the word on where to go for screening. Providers who are enrolled receive special training at meetings held throughout the state. The program is scheduled to add three more outreach positions in the near future.

Maryland's St. Raphael's Hospital in New Haven received a grant to operate a program called "Sister-to-Sister." A health educator was hired to recruit women in the community into the program. The educator visits local churches, health fairs, beauty salons, and grocery stores to set up booths and distribute information on breast and cervical cancer. The program focuses primarily on the African-American community, where St. Raphael perceived the greatest need. The initial grant was for a 6-month period, but the Hospital hopes to extend the funding.



# Policies and Procedures

## Introduction

Often the role of policies and procedures in the success of breast cancer screening programs is overlooked. Well constructed policies and procedures facilitate program development by creating an infrastructure for creative and innovative activities, while ensuring that women receive adequate and appropriate services. Vague or poorly constructed policies and procedures provide minimal direction for program activities and little assurance that quality services are delivered. During this study, some states specifically cited policies and procedures as key factors in the success of their breast cancer screening and services programs. Many other state staff described successes that are built on effective policies, but did not credit the policies themselves, suggesting that a strong infrastructure is often taken for granted by those operating within it.

Policies communicate a program's mission and goals to the people who will implement the program. Procedures are mechanisms defined to ensure appropriate program operation. Together policies and procedures create a framework for program activities and performance expectations.

In the CDC-funded breast cancer screening program, states are the administrative bodies that set policies and develop procedures. These policies and procedures create guidelines for service-delivery providers to use in implementing the program at the local level. The programs and activities described throughout this report are formed on the backbone of policies and procedures, and virtually every choice or decision described has policy implications. Policies and procedures establish the standards for program performance, such as who will be served by the program, what types of services will be provided, who will provide the services, how and when services will be provided, and how service provision will be tracked and monitored.

The flexibility of a good infrastructure is also often undervalued. Throughout this report, innovation and creativity are common themes. Unique programs and initiatives mean that something was done differently, and therefore the policies and procedures had to be flexible enough to permit such innovation. For example, a policy that limits a health department's interactions with commercial enterprises may protect the integrity of the use of public funds, but that policy may also limit the health department's involvement with a major public education event. It is

essential that policies be flexible, and that permission to alter policy be given under appropriate circumstances. In these cases, flexibility in policies can have important impacts on the success of the program.

Throughout this section, ideas for developing policies and procedures that promote the goals of the breast cancer screening program are described. In particular, the guide focuses on three areas:

- Policy planning.
- Effective implementation strategies to apply policies and procedures to operations at the local level.
- Monitoring implementation and policy effects.

## Policy Planning

All types of programs, including breast cancer screening programs, must have a comprehensive infrastructure that enables the program to operate. For the breast cancer screening program, CDC has provided guidelines from which policies are developed. CDC staff also provide technical assistance to the states to help define and revise policies so operations clearly reflect program goals. The first step in the policy development process is planning. Planning effective policies requires information about the environment in which the program will be operating.

## Program Organization

Much of the infrastructure for a program is dependent on how the program—its policies and procedures—is established administratively. The structure of the agency that administers the grant has profound policy implications. A program developed within a unit, within an agency, within a department, will have a very different relationship with the internal bureaucracy than will a special office that reports directly to top management. These constructs will have profound effects on how programs get their job done. Respondents report that both effective and ineffective breast cancer screening programs operate within these different administrative constructs; however, failing to adequately assess and plan for the effects of the internal structures will almost certainly create program difficulties or limit effectiveness unnecessarily. For example, a breast cancer screening program that is structurally within a general cancer screening unit but creates entirely new policies and procedures is both reinventing the wheel and limiting the program.

Once a breast cancer screening program's role in its greater organization is established, the fundamental policy decisions on program organization must be made. Should operations be centralized or decentralized? Who should make which

levels of administrative decisions? Who should perform the various functions associated with the program? Because the breast cancer screening program does not operate in a vacuum, the policies and procedures created by the state must be shaped to fit within or relate well to community constructs already existing in the area served by the program.

Throughout conversations with representatives involved in breast cancer screening programs, they emphasized that one of the key factors to success was building on the strengths of the existing system. In states with strong county-based health systems, like Michigan and Wisconsin, the women needing services already know and trust the county health facilities and systems; they seek a variety of health services at their local county-run clinic. The policies of effective breast cancer screening programs capitalize on this strength by giving much policy authority to the local systems. In contrast, in areas with strong state-based health systems, like West Virginia and Colorado, state-driven policies are most effective. In other areas, such as New York and Kansas, community-based organizations are seen by many women as their key health care provider. To capitalize on this existing pattern and build on existing trusts, the states developed a grant process that invites the organizations to develop innovative locally based programs.

The development of the managed care system in Oregon is an excellent example of how the policies of breast cancer screening programs must be flexible enough to adapt to the changes occurring in an overall health policy structure. In Oregon, a statewide movement to expand health care coverage developed. Nineteen managed care organizations were contracted to provide care for the state's Medicaid clients. To ensure that the breast cancer screening program would be effective, state administrators worked with the managed care organizations to plan program policies. To assess this form of program organization, surveys of newly enrolled women were conducted to compare their experience with screening before enrollment in the plan and while on the plan. The results of this telephone survey are used by the state in working with the organizations to remedy problems. Further, the planning process has served to build a relationship between the managed care organizations and the state. State breast cancer screening staff serve as members of the quality assurance committees of managed care plans, addressing policy issues such as who is coming in and what services are provided.

### **Selecting the Target Population**

Selecting the target population for any program is a major policy decision. For breast cancer screening programs, there are many issues to be faced. Should the program be open to all women, or just women who have no other insurance coverage? Should women be screened at 40 years of age (as ACS recommends) or at

50 (where other studies show significant impact)? If resources are scarce, who should be given priority? All of these questions must be answered through policies.

Within the CDC guidelines, states must develop policies to determine who should be served by the breast cancer screening program. Breast cancer screening programs must assess their overall population and select a target population, based on the characteristics of their communities. Factors such as demographics, other breast cancer screening programs operating in the community, population distribution, and service availability are typically factored into the selection of a target population and into policies to prioritize certain groups within the target population.

Typically, a needs assessment is done to determine what needs exist in the community and among which populations. Most state-level staff and many community-level program representatives mentioned reviewing a needs assessment as part of the planning process done before their program development. Frequently, needs assessments show extensive, and often specialized, needs among certain populations, such as minority groups. For this reason, policy initiatives for breast cancer screening have been developed to address the needs of minority populations. Many of these programs are described elsewhere in the report.

In some service areas, a parallel breast cancer screening program exists and provides services to needy women. In states such as Michigan, California, and New York, program policies can coordinate these programs and expand services or they can divide the programs, such that they are in effect competing with each other. Staff from breast cancer screening programs in each of these states have worked closely with the parallel program. Each has developed policies to ensure that the target populations of the programs complement each other to reach more women.

Catchment areas that include sovereign tribal nations also face major policy questions. Providing services to women in need often requires, in effect, that international treaties be developed. Michigan learned that to work effectively with tribal leaders, the history of programs had to be learned. Many programs had been misrepresented to tribal peoples, so honesty was crucial in negotiations. Understanding this history created a common ground for negotiation among the program leaders and the tribal officials. Once trust was built, state and tribal leaders were able to develop effective programs for Native American women. Michigan now has a very high rate of screening for this target population, exceeding the rates for other demographic groups.

Ohio is an excellent illustration of how policies setting a target population can fundamentally affect the entire breast cancer screening program in a state. Staff in



Ohio's program consider their policy directive about who should receive services as one of the keys to their ability to serve women most in need.

Recognizing that program resources would be scarce, Ohio established a global policy that targeted women who would best be served by the program. Ohio's policy targets low-income and minority women and permits women over 40 years old to receive CBEs, but only women over age 50 to receive mammograms through the program. Ohio recognized that in many states, resources were depleted in serving those who were less at risk. It was estimated that over 100,000 women needed to be served, but resources would permit only about 13,000 women to be served. Policies to ensure that resources were targeted were considered essential.

To ensure that all women seeking services receive them, Ohio established a partnership with ACS and others. Through this partnership, women seeking services who are not part of the target population are referred to other partners operating parallel service programs. Similarly, women in the target population who seek services through the other partners are referred to the state program. Thus the overall service population has been increased.

### **Clinical Staffing Standards**

One of the functions of state government is setting policies on medical licensure and credentials. State policies determine who can conduct what procedures and who can provide which services. These policies have implications throughout the health care systems in a state. Several innovative policies and procedures were cited by respondents for clinical staffing standards.

Some respondents cited the importance of changing clinical staffing standards in improving effectiveness. Permitting an expanded role for paraprofessionals is often seen as a key policy initiative. One of the profound effects of these policies has been to permit nurses and nurse practitioners—who are often women—to provide breast cancer screening services. Research and practical experience has shown that many women prefer to be screened by women providers, and representatives from many of the most successful programs report that much of their success can be attributed to the use of women as service providers.

As discussed previously in this report, many states have allowed paraprofessionals, who are often women, to be credentialed to provide services. Changing policies was a way to qualify more women service providers. Further, some states, especially rural states, reported that by changing these policies they were able to develop a larger supply of providers and improve access to services.

Another benefit of developing policies permitting the use of paraprofessionals was also reported. Policies that limited service provision to professionals with high-level credentials created a severe time constraint for the professionals. The physician could not spend more than a few minutes with the women because other patients were waiting. Because many successful programs report that women respond positively to longer times with the service providers, this type of policy has an unintended negative effect. Policies permitting paraprofessionals to be service providers increases the amount of time providers are able to spend with the client.

In many areas, changing staffing policies may be easy. State legislatures and licensing directors may be concerned with expanding access to services and welcome such revisions. In some areas, however, such changes are not seen positively. Paraprofessionals are seen as providing lesser services, or lower quality services, than doctors. In these areas, different types of clinical staffing options have been successfully pursued.

Some states, while not changing their credentialing policies, have set procedures that establish a case manager role in clinics. Typically, each woman receiving services is assigned a case manager who provides information and tracks the woman's progress through the system. Case managers ensure that adequate time is spent with a client and that no woman feels rushed or unimportant. Ancillary needs, such as the need for transportation and appointment setting, are attended to by the case manager. Case managers also ensure that services are provided in a timely manner and that follow-up services are provided.

Another option that is considered successful is to change the professional education standards required for credentialed providers. In several places, policies have been set that require professionals to meet standards for client sensitivity. These policies have directly affected the training and professional education systems in the state.

## Setting Policies

One of the most frequently mentioned keys to success in developing effective breast cancer screening policies and policy implementation is collaboration between those setting policies and those who will carry out the policies. As explained earlier, policy flexibility is essential to program development and improvement. To tap the expertise of the local service providers in improving policies and procedures, many states have developed systems to obtain local input.

While these systems are often informal, some states have developed formal review structures. Michigan's advisory boards are an example. The breast cancer

screening program has (among other advisory boards in the state) a board to review policy initiatives and help form policy directives. This board meets three to four times per year, and has 20 to 25 members, mostly from local health departments and other interested parties such as the ACS, hospital association, nurses association, and private providers. This board advises the state on what will work in the field and how to make policies and set standards that will help get the job done. Typical decisions involve contract requirements for the local health departments, how to use state funds, minimum standards for the operation of the protocol (the health care protocol itself was set by an expert panel), and how facility operation and billing should work.

The board was formed before the program began so even the initial policies would have some provider input. Members of the Michigan Association of Public Health and representatives from local health departments that “were probably” going to join the program attended the initial meeting. For subsequent meetings, invitations to attend were announced in the program’s newsletter and at professional meetings throughout the state. The meetings were interactive and addressed policy issues as they arose. In the past year, the advisory board addressed tobacco tax issues, the sliding fee scale, how to cope with changing eligibility requirements, and data collection. Issues that require extensive deliberations were given to ad hoc committees.

Although the state staff ultimately sets the policies, the advisory board’s role is essential in ensuring buy-in from the providers and anticipating many problems before they arise.

## Fee Structures

Research has shown that cost is a major barrier to women obtaining screening services. One of the hallmarks of the National Breast and Cervical Cancer Early Detection Program has been that no woman will be refused services because of the inability to pay. Grant funds are used to directly fund services for underserved women. While all states have policies and procedures to direct the use of grant funds for services, several states have unique policies on fee structures that are credited with program success.

Several states have developed the policy and set procedures for using a sliding fee scale to have women share the cost. These programs are considered successful because even token fees illustrate the value of the service to the client. Programs typically report that women come to appointments more often when a small fee is charged, such that the “no show” rate is reduced.

Women often ask more questions and expect more follow-up when even a small payment for services has been made. Further, these fees supplement program resources.

In other programs, sliding fees are not considered effective. For example, in the state of Nebraska, a sliding fee scale for payment of mammograms was used. Some women in the top income bracket (set at 200% to 225% of poverty level) were still responsible for fees of \$100 for the exam and, consequently, were not coming in for screening. Under a new policy, mammograms are either free or the woman pays \$5 for all screening services in a year.

In Michigan, women were required to pay low sliding scale fees for service. Although these token fees were not seen as a barrier to service, Michigan recently made the policy decision not to charge any eligible women fees for services. Cost-benefit analysis showed that the costs of administering the sliding fee program were greater than the revenue generated by the fees.

## **Implementing Policies and Procedures**

Once policies are set, they must be applied to the day-to-day operation of the screening program. Procedures are the mechanisms that implement policies at the local level. These are the operational guidelines that programs operate under. Within the breast cancer screening program, effective procedures promote and ensure that quality services are delivered to the clients. Many respondents cite their policies and procedures as the cornerstone of their quality assurance efforts.

### **Policies as Implementation Priorities**

One of the interesting implications of policy initiatives is how procedures affect priorities at the local level. One state representative described how the state saw that not enough women were being enrolled in the program. To remedy this situation, many procedures for enrolling women in the screening program were established. Local providers followed the detailed procedures and enrolled many women. However, the local providers assumed that the new procedures implied an emphasis on screening only: women were enrolled and screened, but virtually no follow-up was performed with women who needed additional services. The procedures were revised to ensure that all services were performed as needed.

### **Mechanisms to Inform Local Providers**

To implement procedures, the local providers must be aware of the procedures and trained in applying them. Respondents cited many successful ways of informing providers of procedural requirements.

One of the most common ways to inform providers of new policies and procedures in the breast cancer program is through the dissemination of manuals or guides. The Ohio and California programs provide written guidelines explaining policies and procedures to providers who then use them to determine eligibility. An example of the use of a guide to ensure mass awareness of policies and procedures occurred in Oregon. To publicize policies and distribute procedures, the state mailed an article on the new screening guidelines in Oregon to approximately 50,000 health providers and consumer groups throughout the state. To address the differing needs for information by the two different audiences, two versions of the guide were created. The first version contained consumer guidelines and was given to local groups and state consumer and business groups to clear up confusion about insurance coverage (such as Medicaid, Medicare, private insurance, and coverage by out-of-state insurers). The second guide was sent to the 20,000 health care providers in the state. It explained the background and context of screening for health care providers and detailed the procedural expectations of the program. By tailoring the information to the respective target audiences, everyone received needed information in a handy format.

Some programs report great success with the use of provider manuals. Ohio, for example, used a specially developed manual to support their policies and inform provider-participants about program expectations. The state produced a booklet of program guidelines based on new policy. All service providers received the guidelines before joining the state program. This booklet establishes how providers determine eligibility by age and defines low-income as a self-reported family income at or below 200% of poverty.

California has a state-level coalition of consultants and specialists who provide review and guidance on policies in addition to their other activities. This activity has proven helpful in building support among coalition members and others for legislation and policy changes.

Other commonly cited methods for disseminating new program procedures are conference sessions, training sessions, and direct mailings. Most states have regular, often annual, conferences for service providers. During these conferences new policies are explained and the related procedures are distributed, enabling providers to ask questions directly of administrative staff. Specific training sessions to explain policies and procedures are common in many states. West Virginia, for example, holds training sessions in regional centers throughout the state. In addition to these methods, many states often use newsletters and letters to disseminate minor changes in policies and procedures.

Many respondents reported that one of the keys to successful implementation of the procedures for the breast cancer screening program is the availability of technical assistance. Administrative staff must be available to help providers implement procedures. Many times this help can be done over the telephone, but often on-site visits are needed. Providers may need to have their hands held as the new procedures are going into effect. Providing intensive technical assistance when needed is reported to be very successful both in ensuring compliance with procedures and in maintaining positive relationships with providers. This assistance need not be a formal program. Many states reported that their BCC staff routinely provide technical assistance to providers as an integral part of their diverse job description.

One of the most important lessons learned by program administrators is to provide information in a format the target audience will use. One state reported developing extensive policy manuals and guides. Later visits to the programs showed that virtually none of the local programs were implementing the policies. When asked why, the local providers reported they never had time to look at the manual and believed that in-person training would have been held if the information was important. The state revised its information dissemination strategy and now consults with providers before developing informational materials.

## Clinical Procedures

Developing clinical procedures that support implementation of policies has been an effective way to improve breast cancer screening programs. Several respondents cited the development or adaptation of clinical operational procedures as tools for ensuring that policies are implemented. For example, clinics are given forms or checklists that staff follow, which walk them through the standards set by policies.

The state of Washington has carried this idea even further. General health clinical procedures have been adapted to help ensure that women receive screening services. All 330 health clinics in the state have procedures that inform all women over the age of 40 about screening services regardless of the reason for their clinic visit. Other procedures for providing clinical services also reinforce the need for breast cancer screening, such as an integrated medical chart that records important service milestones.

## Policies and Contracts

Many breast cancer control programs, like other programs, use the contracting process as a mechanism to ensure policy adherence. Typically, procedural guidelines are written into contracts made with service delivery providers, thus creating a legally binding agreement that the policies and procedures will be followed by the contracted entities. Several states reported systems that linked the ability to meet policy procedural requirements with contract awards. Texas and Colorado further require, for reimbursement, documentation that services were performed.

Several states have used the contract process to ensure that quality of care standards are met. Texas's contracts with providers illustrate how service requirements can be linked to contracts. A few years ago, analysis of follow-up records of women served by the breast cancer screening program showed a problem occurring in some places: some providers were only working to increase the number of women screened, and were not providing follow-up services to women who had abnormal screenings. Some women's records showed a 2-year time lag between screening and diagnosis, and many other women were lost to the program. To address this problem, state staff examined existing case-management service protocols used by clinics and providers. This examination showed that case-management systems were important factors in improving the timeliness and coordination of follow-up services.

These results were used to help state staff draft policies and procedures that would be written into provider contracts. To use the contractors' experience in delivering services and to promote cooperation with the policies among contractors, draft policies were shared with them. The contractors, who typically are local health departments, Planned Parenthood groups, private hospitals, and universities, worked with state staff to develop a case-management protocol and set standards for the program.

This protocol was then written into contracts for the 50 contractors throughout the state. It specifies the length of time between screening and diagnosis, the number of allowable refusals for follow-up, and a standard for the number of "lost" cases. The policies and procedures require documentation of timely client contact and monthly submission to the state of information about follow-up medical procedures.

One of the important lessons learned was to balance program requirements with operational flexibility. The Texas protocol, for example, requires a detailed level of service, but contractors are given freedom to implement the program in a variety of ways. To give one example, the protocol requires multiple contacts with a client, but the contractor has the discretion to determine how these contacts are made.

## Monitoring Policies

Monitoring ensures that programs are in compliance with the established policies and procedures. Respondents described a variety of monitoring systems that are considered effective ways to ensure that programs comply with the state policies and women receive appropriate services.

### Computer Systems

Computer systems are one of the key ways states ensure that services are being provided to the women enrolled in the program. The CDC guideline requires the collection of a wide range of data elements for use in program monitoring and development. These data requirements have caused all states to develop some type of computer-based management information system.

Typically, program managers determine their data needs: are the mandated data elements sufficient for this program or are other data needed for other purposes? They then assess the resources available to them. In some places, computer equipment and programming resources exist and can be easily tapped. In other places, these resources are not available. Depending on this assessment, the program manager will choose one of two options—contracted and in-house data systems—both of which are considered effective practices.

In some states the advantages of using contracted computer systems are extolled. Under these systems, local providers submit data directly to the contractor who processes the data and submits reports directly to the state. These contracted relationships are described as cost effective and efficient.

In other states, perceived data needs preclude the contracting out of services. In these states, such as Colorado, data are used for a variety of purposes, including policy development and scientific research. Colorado also wanted to link breast cancer screening information to other health services information maintained in the state. For these reasons, Colorado has designed a specific management information system and has several dedicated full-time employees supporting the system. Although costly, the system enhances data collection and provides virtually instant information to answer policymakers' questions.

### Audits

Audits are the traditional method of ensuring compliance with program procedures. In most states, trained staff go to service providers and review client records to ensure that services are rendered at or above the minimum standards set by policy and that procedures are followed. South Carolina's BCN is an example of



how states successfully use an audit process to ensure compliance with policies. All 134 initial screening sites associated with the program are contractually required to adhere to state policies and participate in a formal audit process.

Contracts with providers specify criteria for breast and cervical services that include standards for quality, effectiveness, and efficiency; screening mammograms; consistency of reported data; and procedures for screening, follow-up, and referrals. These criteria were developed by program staff. Compliance with the criteria is audited after the first year of the contract and then re-audited as follows, depending on the previous audit results: 1) after 2 years if they met 80% or more of the audit criteria; 2) within 1 year if they met 70% to 80% of the criteria; or 3) within 6 months if less than 70% of the audit criteria were met. To ensure that everyone is aware of the process and understands the expectations, audit standards are clearly written into the individual site contracts.

The audit is performed by the state staff and typically takes less than half a day per site. The designated coordinator at the site randomly pulls together medical records that have been chosen from the computerized listing of reporting and billing forms received from providers. Typically, audits are completed on 10% of all client records or a minimum of 15 records within a specified time period (typically 12 months). The state staff person uses a valid and reliable standardized form that covers 22 different criteria to review patient records.

The audits are viewed as constructive because there is no immediate financial penalty for noncompliance. Initially, however, some sites were wary of any type of review. To overcome this, the audit process is structured as a consultation and learning process, rather than an evaluation. The goals of the audit are to provide constructive feedback to the sites and to improve staff and program performance. When the audit identifies problems, education and retraining are typically provided. If less than 80% of the criteria are met, a corrective action plan mandates follow-up trainings and a second audit. This audit process has been very useful in solving problems and improving overall program efficiency. For example, the audit process can—and did—show general problems with documentation errors, as distinct from errors with procedures. To improve compliance with documentation requirements, a screening checklist was created for physicians so that they can document their findings on a single form during the clinical examination.

California performs audits, but also has developed a self-audit tool for providers and agencies. The agencies appreciate the opportunity to identify ways to fine-tune their program.

Overall, the audit process has been successful in ensuring provider compliance with state policy. The state program assumes that 90% of providers will meet 80% of the established criteria. The audits enable administrative staff to evaluate the clinical components—to see that the providers are meeting the contracted requirements and that the clinical services are up to standard.

Many other states report success with less formalized audit processes. On-site visits and random record reviews were cited as effective monitoring tools.

## **Evaluation**

In developing monitoring procedures, each program must set its standards for evaluating effectiveness. For most programs, effectiveness is evaluated by the number of women receiving screening or rescreening services. Successful programs increase these numbers, unsuccessful procedures have little or no impact. Typically, trial and error is used rather than scientifically designed evaluation practices. Many respondents, however, cite the use of these methods as interim practices rather than long-term policy strategies. Often respondents said their program was “too new to be evaluated” and that they planned more evaluation as the program grew and developed.

## **Payments Linked to Performance**

A key way states have found to ensure compliance with policies and procedures is to link payments for services with adherence to the requirements. In these states local providers do not receive payments for services until they submit completed information on the services provided to the clients. For example, the state of Texas, in an effort to both ensure the quality of care for its clients and improve reporting practices, incorporates a requirement for documentation in its contracts. Providers do not receive any payments for services until the state receives a complete record showing that the women enrolled in the program met eligibility requirements, received appropriate screenings in a timely manner, and received follow-up as necessary based on the results of the screenings. Incomplete records are returned to the provider and must be resubmitted before payments are made.

Although this process may seem severe, compliance with the standards is reported to be very high: most women in the state receive services in accordance with the established procedures.

Because all aspects of a breast cancer screening program have cost implications, a successful breast cancer screening program, compared with a less successful one, provides more services to more women for a given amount of financial resources. A key criterion in policy decisions is cost control.

The policy framework for paying providers fees for their services is a rapidly changing field. Once, virtually all providers of any type of medical service were paid for the entire cost of the service. This fee-for-service structure unintentionally encouraged providers not to be concerned about costs. In the overall health care arena, the breast cancer screening program emerged when the fee-for-service model was being revised to include cost-containment mechanisms.

Several states have implemented cost-containing or risk-based systems for paying providers. In these systems, a set fee is paid to providers for meeting certain goals within the procedural guidelines established by the state. Michigan and Colorado are examples of how such a structure can work effectively. In both states, local providers are paid a set amount for each woman served. Each year, the local providers work with the state to set a target number of women who will be served by the program. This estimate, multiplied by the historical standard fee (adjusted for inflation), becomes the program's operating budget. If the local provider is able to serve more women, it receives more money than was budgeted. If fewer women are served, the local provider receives less money. This outcome-based system places the responsibility of the financial risk on the local providers, but also gives them incentives to enroll women. In addition, local providers are given control of the funds. These service-based minigrants are seen as opportunities for local providers to flexibly use funds to meet the needs of the community. Administratively, Michigan has found that the flat-fee system has streamlined paperwork and improved program management.



# Coalition and Partnership Development

## Introduction

As the previous chapters make clear, effective breast cancer prevention is complicated, requiring action at multiple levels and using numerous approaches targeted to the needs of individuals and communities. Stakeholders involved in the fight against breast cancer acknowledge their interdependence. And, as more efforts are targeted to special linguistic and cultural groups and hard-to-reach and underserved populations, the need for joint efforts to identify and mobilize these communities is apparent. Although community organizations themselves may attempt to empower individuals and influence social change, the magnitude of the forces that create many community problems often is so great that community organizations alone do not have enough impact. Joint efforts to pursue common goals allow the participants to share the work load and costs and integrate their respective competencies, thus accomplishing more through joint efforts than the sum of their individual efforts could achieve. Coalitions and partnerships are but two of many approaches. Distinguishing between the two is often difficult. The terms are sometimes used interchangeably, and often partnerships will generate coalitions; or, conversely, coalitions will result in the creation of specific partnerships.

*Coalition* is a broad term, encompassing a variety of ways in which groups of community organizations and stakeholders join together to combat a common problem. Generally, the impetus for coalition building is a salient issue or some impetus in the environment related in some meaningful way to a group of individuals.<sup>14,15</sup> Community mobilization through coalition development is increasingly an instrument used by communities to take action against high rates of cancer, abetted in part because funders' grant guidelines often require such coalitions.

---

<sup>14</sup>D'Aunno TA, Zuckerman HS. A life-cycle model of organizational federations: the case of hospitals. *Academy of Management Review*. 1987;12:534-545.

<sup>15</sup>Gray B. Conditions facilitating interorganizational collaboration. *Human Relations*. 1987;38:911-936.

Coalition goals may be long-term, global, and somewhat diffuse. While the coalition may assume responsibility for undertaking some activities itself, often it is the coordinating body or sounding board for the activities of its component members singly or jointly. Frequently, coalitions start without a formal structure. However, as coalition members discuss and plan to act on a problem or need, formal ties and plans emerge.

By contrast, *partnerships* are somewhat more focused, representing the efforts of a limited number of organizations (or individuals and organizations) to accomplish a goal or implement an activity within a defined period of time. Previous chapters, especially the Outreach chapter, discussed numerous partnerships initiated or participated in by BCC programs. Some of these examples will be used later in this chapter to illustrate the range of ways in which NBCCEDP grantees have partnered with organizations and individuals to work together for cancer control. A series of CDC-funded conferences are being conducted this year by ACS using Arthur Himmelman's continuum of four "working together" strategies (see box) as a

### HIMMELMAN'S CONTINUUM OF "WORKING TOGETHER" STRATEGIES

- **Networking** means exchanging information for mutual benefit and is the most informal of the interorganizational linkages. *For example, a hospital and community clinic might exchange information about cancer screening and follow-up services.*
- **Coordinating** means exchanging information and altering activities for mutual benefit to achieve a common purpose. It requires more organizational involvement than networking and involves more time, higher levels of trust, and some access to each others' turf. *For example, a hospital and community clinic might share information about cancer screening and follow-up services and decide to alter service schedules so they can better meet the needs of common clients.*
- **Cooperating** means exchanging information, altering activities, and sharing resources for mutual benefit to achieve a common purpose. Shared resources may encompass knowledge, staff, physical property, money, access to people, and others. The sharing may involve written or legal agreements. *For example, a hospital and community clinic might exchange information about cancer screening and follow-up services, decide to alter service schedules, and agree to share physical space and funding for cancer screening and follow-up services.*
- **Collaborating** means exchanging information, altering activities, sharing resources, and enhancing each others' capacity for mutual benefit and a common purpose by sharing risks, responsibilities, and rewards. The key is willingness to enhance each other's capacity, to help partners become better at what they do. *For example, a hospital and community clinic might exchange information about cancer screening and follow-up care, decide to alter services, share physical space and funding for cancer screening and follow-up services, and provide professional development training for each other's staffs in areas of special expertise so they can better meet the needs of common clients.*

Source: Himmelman A. *Collaboration for a Change: Definitions, Models, Roles, and a Guide to the Collaborative Process*. Minneapolis, Minn: Himmelman Consulting Group; May 1996.

framework for building these types of partnerships to address the needs of underserved populations.<sup>16</sup>

What follows are lessons learned by state coalitions addressing breast and cervical cancer, and by state health agencies engaged in partnerships with public and private organizations and individuals to prevent breast and cervical cancer. While the lessons are founded on the experience of public sector organizations, the insights are transferable to any organization or individual that sees itself as a major community stakeholder on breast and cervical cancer issues and is open to joint efforts to address the problem.

## How Coalitions and Partnerships Are Formed

CDC's NBCCEDP has as its primary goal establishing, expanding, and improving community-based screening services for women at risk. While a number of routes to these goals have been identified by the NBCCEDP, CDC strongly encourages the creation of state-level cancer control coalitions that include representation from key public, private, and voluntary organizations affecting the early detection process. At the time of the interviews conducted for this study, the 18 state health agencies that first received comprehensive funding from CDC were well under way with coalition development. With the recent expansion of the comprehensive program to include all states and territories and several tribes, many others are in various stages of coalition building.

<sup>16</sup>This series of five conferences will bring together regional representatives of government, nonprofit, and community organizations to develop collaborative action plans to better address the needs of underserved populations.

### FORMING COALITIONS

NCI has published a guide on forming coalitions that stresses three main points that sponsors of coalitions should keep in mind:

First, coalition sponsors need to be able to assess the interests of community organizations and agencies and how their interests relate to the coalition. Although organizations may have different reasons for wanting to join the coalition, their reasons must provide motivation enough to spark commitment to the coalition's ultimate goals.

Second, coalition sponsors must be able to articulate to potential member organizations the unique contributions the coalition will make. If they do not successfully do so, organizations with similar goals may feel competition from the forming coalition and work to undermine its efforts.

Third, coalition sponsors need to recognize the important characteristics of a true organization and foster these in a coalition. Organizations have a history, mechanisms for conducting business and making decisions, a cohesion or connection among members, and a pattern or cycle through which all these features unfold to make the organization unique. Because coalitions are made up of many organizations, sponsors must take care to accept for membership only fully operating organizations. Otherwise, the coalition will spend a great deal of time focused on internally maintaining itself rather than on developing or acting upon the issues around which it was formed.

Source: National Cancer Institute. *Sowing Seeds in the Mountains: Community-Based Coalitions for Cancer Prevention and Control*. Couto R, Simpson N, Harris G, eds. Washington, DC: National Institutes of Health; 1994:145–147.

One of the best developed coalitions is SALIC, a consortium of representatives of state-level organizations in multiple states with Appalachian populations. SALIC was one of four consortia funded by the NCI in 1992 to implement projects to reduce cancer incidence and mortality in the 13-state Appalachian region. In Georgia, North Carolina, and South Carolina, cooperative extension services, state universities, and the Greenville (S.C.) Hospital System formed SALIC to identify, develop, and assist county and community coalitions in adapting and using existing resources and state-of-the-art approaches to improve cancer control efforts. Its sponsors believed that coalitions would gain momentum in individual counties, that the cancer prevention and control activities conducted in those counties would increase, and that member organizations would thereby be able to educate and empower those people targeted through the programs. The members of this consortium have benefited from its formation in that they are able to conduct far more comprehensive programs by working together than any of them could have done on their own.

At the other end of the size spectrum is a small coalition between the Oregon BCC program and a local chapter of the Komen Foundation. The formal coalition grew out of informal involvement of the two organizations in each others' meetings and support activities. Jointly, they have been able to conduct leadership summits on breast and cervical health and operate the Race for the Cure, using funds generated by the race to pay for mammography for women who do not qualify for BCC funds. In Portland, this coalition also developed a partnership with the migrant farm workers' clinic. The coalition provides benefits to all sides. The BCC program gets access to community volunteers and providers to whom the Foundation is linked. By contrast, the Foundation, which is completely volunteer run, receives data, expert technical assistance, and additional resources to conduct activities it may not have been able to accomplish on its own.

In Colorado, a group of community coalitions evolved from informal contacts between the members of various community organizations who participated in each other's activities. The coalition consists of 20 local coalitions that are community-based partner organizations. They meet monthly to coordinate a speaker's bureau and public education events and to review evaluation data. All coalition activities work toward the common goal of decreasing the incidence of invasive breast and cervical cancer in their communities.

Another small coalition (between ACS and the Oregon BCC) produced a manual for ACS directors. In addition to the manual, this coalition has also worked to develop a list of resources for women concerned about breast and cervical cancer, a Tell-a-Friend cancer outreach program, and various support services.



As is apparent, there are patterns in how coalitions form. Although SALIC was motivated by a grant mandate, the others all grew organically from informal interactions and from a recognition of the need for joint activity to pool limited time, funds, and expertise. While work was already being conducted by the individual organizations, the participants recognized that their ability to make a difference by working together was far greater than the sum of what they could accomplish working separately.

## Coalition and Partnership Members

The coalitions and partnerships examined include many different collaborators. For one coalition, the focal member is the cooperative extension service. For another, the Komen Foundation has been a strong member organization. But in other coalitions and partnerships, the key players may include the health department, hospitals, senior citizen centers, mental health support groups, ACS (which is very visible in many communities), the minority health council, industry, the local media, women's clubs, AVON, support groups for survivors, family resource centers, the U.S. Postal Service, churches, and schools. Indeed, the ACS conferences on creating partnerships to address cancer control in underserved communities used a matrix of 29 different organizations to measure the extent of current networking and collaboration.

Perhaps surprisingly, grantees that have initiated coalitions and partnerships report little difficulty in getting other organizations to sign on as members. No real incentives were offered by any of the groups involved. In fact, the opportunity to become part of something bigger than one organization was repeatedly mentioned as sufficient motivation for the approached groups to join.

Many find that the best strategy is to get one central, visible organization to commit before approaching the others. Often this lends credibility to the effort that may be enough to bring a wavering participant on board. The choice of that central organization will vary from community to community. Often, it is ACS. In other places, especially where the coalition needs to build a provider network, it is the county medical society or the state medical association. For one program, as mentioned previously, it was the Cooperative Extension Service. Once they were involved, the other partners were not hard to convince, because the extension service's activities with community women (in this case a series of homemaker clubs) were well known and visible with the target population of older women.

## Partnerships

Partnerships, too, have an ability to meet larger goals than those possible through single efforts. As mentioned earlier, partnerships tend to be program driven. They generally result from the desire of one organization to see a certain program be a success. Partnering activities with businesses, workplaces, and corporations range

### **PARTNERSHIPS AND COALITIONS: EXAMPLES FROM THE REAL WORLD**

- Nebraska's EWM program works actively with pharmacists and pharmacy students to become actively involved in encouraging mammography.
- The Stop & Shop Companies, Inc., in cooperation with Rhode Island, Connecticut, New York, and Massachusetts, distributes materials from booths in its local pharmacies.
- Kmart and Rite Aid Corporation in Michigan distribute coupons and hold promotional events for the BCC program.
- Family Dollar Stores, Inc. donated employee time to the West Virginia BCC program to staff booths and distribute information.
- New York maintains a partnership mailing list that serves the state as a pool of consultants, experts, and helpers for the statewide program. Appropriate members review surveys, consult on plans, and assist with other needs.

from limited participation, such as agreements by utility companies to include BCC information flyers in their monthly bill mailings, to organizational commitments of employee staff time and shared sponsorship of programs. Examples of the development of specific partnerships and the experiences their representatives share may prove informative and helpful to any group working with others to advance the cause of breast and cervical cancer prevention, but especially to those trying to form relationships with the same type of partner. The boxed material includes some good illustrations of partnerships in which state BCC programs have been engaging. Many of these activities were profiled earlier in the Outreach chapter. However, they are presented again here in summary form to demonstrate some key aspects of forming these types of relationships.

The Michigan BCC program illustrates one very successful worksite partnership. The partnership began when a representative of the state Nursing Home Association realized that nursing home patients did not need the state program's services because of comprehensive Medicare benefits, but

that nursing home employees, who are often low-income, middle-aged women, were likely to need and be eligible for program services. Under the partnership, BCC program staff acted as a broker to link nursing homes with their local health department, which often arranged a special day for enrolling employees. Now, 20% to 30% of nursing homes in the state participate in the program. Several of the nursing homes also offer paid time off for their staff to be screened.

## Measuring Outcomes

Measuring effectiveness in any community-level intervention is difficult. Interventions typically are multifaceted, and concurrent activities make it difficult to attribute effectiveness to one specific activity. Measuring the impact of coalitions and partnerships is compounded by the fact that the goals are often infrastructural, diffuse, and long-term. While coalitions and partnerships clearly want to be effective and desire to demonstrate impacts, measuring outcomes challenges them both to define success and to identify ways to measure it.

Most coalition representatives interviewed conceptualized “success” for the coalition as either the success of the component programs or success in implementing preliminary or infrastructural efforts that allow for more successful individual interventions. In the first case, no evaluation of coalition efforts per se may take place. In the second, the coalition will focus not on ultimate outcomes such as number of women screened, but on intermediate or process outcomes that demonstrate that the system is changing. For example, one coalition monitored the number of cancer control activities occurring at the community level, comparing levels of activity before and after the establishment of the coalition. While the group anticipates an increase in numbers of women screened, this is a long-term goal that, even if it is achieved, will be hard to attribute solely to coalition efforts.

Another coalition used minutes, logs, and plans of the partnership meetings as a way to monitor. This information helped track time spent on particular issues, progress of proposed projects, and fulfillment of goals for certain programs, focusing more on efficiency than effectiveness.

In Colorado, an annual training program for coalition members includes an evaluation of progress by surveying members on their perceptions of the coalition’s efforts and the effectiveness of the training summit. Data from the survey are analyzed and used to plan subsequent meetings.

Because the efforts of partnerships are often more time-limited and focused than those of coalitions, more opportunities exist for evaluation of their programs. For example, one group’s program trained cancer teams in “Tell-a-Friend,” an ACS strategy in which team members call their friends, ask questions about mammograms, and encourage them to have one. The program’s impact was measured in multiple ways: contacts made, friends’ intent to have a mammogram and BSE, and actual number of screens.

Another coalition is measuring the effectiveness of its post office campaign. Ten post offices in the area unveiled a new stamp during a 2-hour kick-off ceremony, distributed educational materials during a 4-month period, sponsored BSE training and CBE at post office sites, and made referrals for mammograms. Like most multifaceted programs of its type, the evaluation will combine process measures such as the number of women reached with outcome measures such as increases in numbers screened.

An important lesson of experienced coalitions is not to despair if effects on individual outcomes cannot be directly measured or attributed to coalition efforts. The effects of joint activity are often unexpected and fortuitous. For example, one coalition was able to attribute legislation establishing a breast cancer diagnosis and treatment fund to activities connected with its Breast Cancer Awareness month. Although the goals of the day were general awareness, and legislative advocacy was not an expressed intent, press coverage of the activities raised public awareness and built support for the bill introduced in the legislature.

## Coalition and Partnership Costs

As with evaluation, coalitions are more likely to track the cost of specific programs undertaken by the coalition or its component members than the cost of implementing and maintaining the coalition itself. And, in general, coalitions are not costly, consisting mostly of the time committed to meetings by the representatives of the member organizations and, perhaps, funds to support a few paid staff, if the coalition is lucky enough to have staff dedicated to it.

Even when coalitions sponsor specific programs and activities, the costs to the coalition may be minimal, because the joint efforts include all members sharing the workload and costs and bringing their unique expertise to the project. For example, one group noted that no more than \$1,000 was spent on any one program because virtually everything was carried out by the communities involved. Some costs included printing a press kit for members to use when communicating with local media, \$600 for advertising, and \$100 for reimbursements to homemaker groups for materials.

In general, the primary source of funding for partnerships and coalitions is the participating organizations themselves. These participants usually pool funds to support sponsored activities. Generally, there are agreements to supply in-kind support for one another's projects, be it funding, goods, or services. But there are other funding sources for coalitions as well, and some grantees have been successful in tapping them or melding many sources into a patchwork of support. For

example, one coalition combined health department grants, a mini-grant from ASSIST, donations, and funding from ACS. In several areas where the coalition includes the Susan G. Komen Foundation, proceeds from the Race for the Cure, which are significant in some locations, are often used to support community coalition activities.

In some cases, public funding is available to get local coalitions involved in BCC prevention programs. Kansas and New York have made funds available in the form of grants to coalitions to coordinate public education efforts, recruit providers, and recruit women for screenings.

## Barriers and Strategies to Overcome Them

Few barriers were identified by grantees initiating or participating in coalitions and partnerships. In the few cases where barriers were mentioned, grantees had strategies to suggest to overcome them.

Because coalitions are consortia of independent organizations, they move as quickly as their slowest member. Coalition activities must often be secondary to the core activities of each organization and compete with these activities for time and resources. This becomes a problem when conducting any group activity because the efforts of one coalition member may often depend on the timely completion of responsibilities by another. There is no easy answer to this problem except to ensure that the planning time frame includes a cushion to allow for delays in follow-through by members.

Related to this problem is the amount of time needed for planning events when multiple groups are involved. Almost a full year was needed to plan the program attempted by one coalition. Members of this coalition spanned the state, and they also found that media coverage differed for those in the metropolitan areas versus those in the smaller counties. To overcome this barrier, the coalition plans to attempt closer connections with media representatives in larger cities in the future. As for the barrier of increased planning time, the only strategy seen as an aid in overcoming it is attempting to stick to meeting agendas and make more efficient use of group meeting time.

In formal coalitions, the amount of paperwork can be an obstacle—the paperwork needed to cement relationships among the organizations and the paperwork necessitated by the reporting requirements of funding sources. Some groups have handled the challenge by distributing these responsibilities across the member organizations.

## **BARRIERS TO FORMING COALITIONS**

Underdeveloped organizations can pose problems for coalitions. But very well-developed organizations have the potential to cause problems as well. Community coalitions are sometimes in danger of being dominated by one or two powerful organizations. A representative from a large business entity or a lead agency with a large budget can essentially control the coalition agenda. This is particularly difficult if the dominant organization has leverage over other organizations in the coalition. In the formation stage, coalition sponsors need to weigh the benefits and costs of extending invitations to disproportionately powerful organizations.

Another issue for coalition sponsors to consider is which individuals to select as representatives from their chosen organizations. Those who are most successful tend to be leaders who have a constituency: those who know the stories of people who live in the community and can provide concrete examples of how an issue affects families in the area. This ensures accountability between the coalition and community members, producing more support for coalition efforts. When coalition representatives are not so strongly tied to their communities, community residents frequently ignore those coalitions.

---

Source: National Cancer Institute. *Sowing Seeds in the Mountains: Community-Based Coalitions for Cancer Prevention and Control*. Couto R, Simpson N, and Harris G, eds. Washington, DC: National Institutes of Health;1994:145-147.

Finally, coalitions with a broad array of participants are likely to encompass some who see themselves within a system they wish to change and others who see themselves as either excluded from or actively hostile to the system. These different perspectives may both color relationships between members of the coalition and lead to conflict within the coalition. While no strategy is guaranteed to overcome these problems, intensive coalition activity in the early stages is likely to build personal bonds between the individual representatives that may supersede their differences in philosophy.

## **Factors in Coalition and Partnership Successes**

Grantees were able to identify factors contributing to successes as well as barriers. One coalition attributes its successes to actively sharing credit among the members, sharing control over the planning among the participants, and not interfering with the relationships already built between the homemakers and other women's clubs in the communities. These factors are considered transferrable to other programs because division of labor and sharing praise are endeavors that should be possible in any setting.

Other grantees relate success to the use of volunteers in program activities. Besides reducing the workload of the paid staff, the volunteers have a multiplier effect in the community, spreading their experience and the knowledge gained to family and community settings of which they are also a part.

Involving a committed and visible group like the Cooperative Extension Service aids in the initial formation of the coalition and gives its activities credibility with the community.

In addition, literature on health care coalitions notes challenges that successful alliances overcome. Three problems face all community organizations working on health issues:<sup>17</sup> First, successful involvement of people through community organizations requires that individuals understand the linkage between their organization's activities and a fundamental issue in people's lives. When people use the health care system infrequently, it is difficult to involve them in health issues. Second, those most affected by health care issues, the elderly and the acutely ill, are least able to participate in community activities. Third, health issues are extremely individualized. Environmental and systemic forces contributing to poor health are more difficult to perceive; therefore, it is more difficult to mobilize broad-based community participation around these issues.

Finally, the Oregon BCC program underscored the important relationship it has with the Susan G. Komen Foundation and offered advice to other programs for developing collaborations with national organizations:

- It was important for the Oregon BCC to recognize it was the “new kid on the block.” The Komen Foundation has a strong history and future.
- Programs should be respectful of the relationships that participating organizations have already built.
- Early in the coalition building process, it is good to develop a set of “working principles”—a philosophy of screening principles—that will help in resolving problems/issues and building dialogue.
- Organizations considering forming coalitions should try to be involved in other groups' activities and boards. These contacts will aid both in determining which groups to extend invitations to, and in enticing those groups that have received invitations to join.

---

<sup>17</sup>Lipsky M, Lounds M. Citizen participation in health care. *Journal of Health Politics, Policy and Law*. 1976; 23:85–111.

## Summary: Steps in Forming a Coalition

The following steps to forming a coalition are taken from a work on community-based cancer control coalitions (*Sowing Seeds in the Mountains*). Although it focuses on coalitions, it also provides a great deal of helpful advice for groups forming partnerships to accomplish program goals. The steps summarize much of what has been discussed in this segment by describing issues to consider when community groups attempt to form alliances.

1. Research coalition models. Study the ways in which community-based coalitions are formed and structured and how they function.
2. Develop coalitions with members from diverse local community groups. Be sure that coalition members have links to all organizations and groups essential to the successful implementation and conduct of coalition activity.
3. Recognize the different categories of coalition member organizations, especially advocacy-oriented organizations and service-oriented organizations.
4. Be realistic about the time and effort coalition members can devote to coalition activities.
5. Create linkages of coalition members with hospitals, schools, businesses, social service agencies, and government agencies to better address adverse local environmental and social conditions. Design a more comprehensive approach. Provide greater access to community residents and increase community ownership and participation in coalition activities.
6. Keep in mind the context factors of any cancer prevention and control coalition, such as increasing use of the health care system, enabling elderly and acutely ill persons to access community resources, and identifying the environmental and systemic forces contributing to poor health.
7. When recruiting coalition members, clearly articulate the needs your coalition seeks to address and the unique contribution it can make; focus on how its goals affect prospective coalition members; and identify the benefits of coalition membership to each organization or agency.
8. Recruit coalition members who know the stories and histories of people who live in the community and who have an in-depth knowledge of how certain issues affect the residents of the area.



9. Consider the stability and capacity of the organizations that coalition members represent. Be sensitive to resource constraints such as staff, equipment, and budget levels. Be aware that different levels of participation can result from different amounts of resources.
10. Identify coalition leaders who are able to deal effectively with problems such as distribution of power, turf issues, and conflicts of interest or who have unique skills such as the ability to articulate and share the coalition's vision and potential for success.
11. Clearly define the coalition's purpose and member roles to build the trust and cooperation necessary to address issues effectively.
12. Make clear initially and continue to review the four factors of coalition maintenance: domain consensus, ideological consensus, work coordination, and evaluation.
13. Use coalitions to identify the needs of the at-risk populations they serve.
14. Involve the at-risk populations in cancer prevention and control efforts.
15. It is often critical to the success of a coalition-forming effort to search for and include the local affiliates of national organizations as members. National organizations (such as the National Breast Cancer Coalition, the National Alliance of Breast Cancer Organizations, or the Susan G. Komen Foundation) will often provide connections or information through their affiliates that can advance the purpose of the coalition.

Despite the difficulty involved in forming partnerships or coalitions to effect community change, this route is a fruitful one. With hard work and strong spirits, alliances of this sort hold much promise for producing social change. Their ability to link community organizations, social service agencies, and community institutions gives hope that the power needed to bring breast and cervical cancer under control may be within reach.



# Conclusions

**T**his guide has presented successful strategies for reaching women for mammography screening, especially low-income women, underserved and uninsured women, and women from communities of color. Identifying these strategies has several purposes. First, it shares information among NBCCEDP grantees, who may be interested in what their peer programs have found successful. As importantly, identifying these successful activities helps private sector and other organizations that may be assuming increased responsibility for breast cancer prevention among hard-to-reach groups. The activities of NBCCEDP grantees may serve as a model for these organizations or, better still, encourage health care providers and health plans to actively collaborate with these grantees in activities to address enrollees or the community at large. While the five categories of strategies—inreach, public education, outreach, policies and procedures, and coalition and partnership development—are quite different, there are some general themes that underlie all of them.

- Organizations need to think broadly about partnerships to reach underserved and hard-to-reach populations. Because health care is not the top concern of people with complicated lives, providers cannot assume that these women will seek care. Aggressive outreach may be necessary to work with agencies and individuals who are most frequently in contact with the women. And strategies must aim to break down barriers of cost and culture that may not be experienced by insured and middle-class women.
- In thinking about successful strategies, organizations should consider their infrastructure, not just direct outreach, as ways to bring women in. In particular, health care organizations or health plans with a designated group of clients will find inreach more productive than outreach in the short-term. Yet, even inreach strategies such as reminder systems and flagging charts will be ineffective unless policies and procedures such as hiring practices, payment policies, and hours of operation are modified to meet the needs of the clients.
- Similarly, while the tendency is to focus on the interaction between the direct caregiver (especially the physician) and the women, the chances that women will return for rescreening and adhere to follow-up recommendations are greatly enhanced when the creation of a welcoming environment is an office-wide undertaking.

- The successful strategies make clear that there are diverse resources available for programs, but they must be innovative in putting together the partnerships. And, in particular, they must look beyond traditional partners in the public and advocacy sector.

The rapidly changing health care environment offers both opportunities and challenges for public and private sector programs. Clearly, breast cancer prevention is a goal all share, and the needs and lifestyles of hard-to-reach women require a communitywide approach. These are some of the ways in which the sectors can work together.

- **Outreach.** While private sector organizations will use inreach strategies first, in time they will need aggressive outreach to increase their screening rates. NBCCEDP grantees are experienced at identifying, reaching out to, and successfully recruiting hard-to-reach women. These are the women who will be least likely to seek care in response to traditional inreach approaches.
- **Inreach and staff development.** Most NBCCEDP grantees have formed networks of providers in all sectors. While these providers may have contracts with the grant program, they are not accountable to the grant program in the way that employees are. Therefore, grantees have had to create new ways of establishing consensus on guidelines and approaches. Health care organizations and health plans might benefit from the models employed by NBCCEDP grant programs. Increasingly, staff- and group-model health maintenance organizations are being supplanted by independent-practice models in which individual physicians may contract with multiple health plans.
- **Public education.** Messages must be tailored to the psychological state, salient needs, and culture of the target audience. Grantees have an inventory of tested materials that have proven effective with women from a variety of cultures. As private health care organizations assume responsibility for these women, they would do well to draw on this inventory. In return, grant programs should be able to enlist monetary and other resources from private sector organizations to support communitywide public education efforts.
- **Policies and procedures.** In this area, as with inreach, NBCCEDP grant programs have already trod the path that private health care organizations and health plans are starting down. Issues of hours, payment policies, effective use of nonphysician providers, and monitoring implementation of procedures have been raised and, in many cases, successfully addressed. These can serve as models for the private sector, especially for those who will be operating in decentralized environments.

- **Community coalitions and partnerships.** The target populations of NBCCEDP grant programs are the women most likely to be transient, to fall in and out of eligibility for financial assistance, and to move among health care insurance plans. A communitywide approach to caring for these women is needed. The increased involvement of private sector organizations with these women offers opportunities to broaden coalitions and partnerships.
- **Surveillance and data collection.** NBCCEDP tracking systems, such as CaST, offer models for private sector organizations and health plans that are used to collect data for enrollment and billing, but may not know how to use existing data bases to support epidemiological or case management goals. Helping them identify high-risk women, track women through care, and use the data for communitywide surveillance is technical assistance that will be welcomed by most private sector health organizations and health plans.

In short, the future offers opportunities as well as challenges. Wise grant programs will aggressively assume the role of community convener on issues of breast cancer prevention. Wise private sector health care organizations and health plans will actively seek the counsel and expertise of established grant programs.



# Appendix

## LIST OF NBCCEDP GRANT PROGRAMS

**T**his guide, *Reaching Women for Mammography Screening: Successful Strategies of National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Grantees*, provides an overview of sample grantee activities, not an exhaustive list of every activity of every state program. This appendix provides a directory of key staff members of the NBCCEDP grant programs.

### CDC's National Breast and Cervical Cancer Early Detection Program Contact List—Summer 1997

#### **Alabama**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1996.*  
Viki L. Brant, MPA, Director  
Cancer Control Division  
Alabama Department of Public Health  
Bureau of Health Promotion and Information  
434 Monroe Street  
Montgomery, AL 36130-3017  
(334) 206-5535  
Fax (334) 206-5534

#### **Alaska**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1994.*  
Jeanne Roche, RN, MPH, CTR  
Program Director  
Barbara Berner, ANP, EdD  
Program Coordinator

Dept. of Health and Social Services  
Breast and Cervical Cancer Program  
Division of Public Health  
Epidemiology Office  
3601 C Street, Suite 540  
PO Box 240249  
Anchorage, AL 99524-0249  
(907) 269-8000  
Fax (907) 561-1896

#### **American Samoa**

*CDC funding for a capacity-building program began in 1994.*  
Diana Tuimei, Program Director  
Department of Health Services  
American Samoa Government  
Pago Pago, AS 96799  
011 (684) 633-4606  
Fax 011 (684) 633-5379

**Arizona**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1995.*

Bobbie O'Neil, BSN, MSHA  
Program Director  
Women's Cancer Control Project  
Arizona Department of Health Services  
1400 West Washington, Suite 330  
Phoenix, AZ 85007  
(602) 542-7534  
Fax (602) 542-7520

**Arkansas**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1995.*

Lynda Lehing, BSN, MBA  
Program Director  
Breast and Cervical Cancer  
Control Program  
Arkansas Department of Health  
4815 West Markham Street, Slot #11  
Little Rock, AR 72205  
(501) 661-2231  
Fax (501) 661-2009

**California**

*CDC funding for a comprehensive program began in 1991.*

David Ginsburg  
Program Coordinator  
Breast and Cervical Cancer  
Control Program  
California Department of Health Services  
601 North Seventh Street, MS-434  
PO Box 942732  
Sacramento, CA 94234-7320  
(916) 327-0761  
Fax (916) 445-2536

**Colorado**

*CDC funding for a comprehensive program began in 1991.*

Sharon Michael  
Program Director  
Colorado Department of Public Health  
and Environment  
Cancer Prevention  
Building A, Fifth Floor  
4300 Cherry Creek Drive  
South Denver, CO 80222-1530  
(303) 692-2505  
Fax (303) 782-0095

**Connecticut**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1995.*

Christine Parker, MPH  
Program Director  
Connecticut Department of Public Health  
Cancer Early Detection Program  
410 Capitol Avenue, MS#11HLS  
PO Box 340308  
Hartford, CT 06134-0308  
(860) 509-7804  
Fax (860) 509-7854

**Delaware**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1996.*

Robert Jackson, MD  
Acting BCCEDP Director  
Division of Public Health  
Delaware Department of Health and  
Social Services  
655 Bay Road Blue Hen Corporate Center  
Suite 4H  
Dover, DE 19901  
(302) 739-3033  
Fax (302) 739-6617



**District of Columbia**

*CDC funding for a capacity-building program began in 1994. Funding for a comprehensive program began in 1996.*

Barbara Baldwin  
Program Coordinator Breast and Cervical  
Cancer Prevention  
PHSA/CPH  
800 Ninth Street, Southwest, Third Floor  
Washington, DC 20024  
(202) 645-5573

Kurt Brandt, MD  
Program Director  
Deputy Administrator of Preventive  
Health Services Administration  
(202) 673-5573  
Fax (202) 645-4533

**Florida**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1994.*

Margo C. Blake  
Program Manager  
Florida Department of Health and  
Rehabilitative Services  
HSFHG  
1317 Winewood Boulevard, Building 5  
Room 404  
Tallahassee, FL 32399-0700  
(904) 414-5638  
Fax (904) 922-9321

**Georgia**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1994.*

Carol B. Steiner, RN, MN  
Program Director  
Division of Public Health  
Georgia Department of Human Resources  
Cancer Control Section  
2 Peachtree Street, NE, Sixth Floor Annex  
Atlanta, GA 30303  
(404) 657-6606  
Fax (404) 657-4338

**Hawaii**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1996.*

Lolani Jameson  
Hawaii Department of Health  
838 South Beretania Street, Room 205  
Honolulu, HI 96813-2498  
(808) 587-3900  
Fax (808) 587-3911

**Idaho**

*CDC funding for a capacity-building program began in 1994. Funding for a comprehensive program began in 1996.*

Minnie Inzer  
Breast and Cervical Cancer  
Early Detection Program  
Idaho Department of Public Health  
450 West State Street, First Floor, Suite 1  
PO Box 83720  
Boise, ID 83720-5450  
(208) 332-7311  
Fax (208) 334-6573

**Illinois**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1995.*

Doris Garrett, Program Director  
Division of Health Promotion  
Illinois Department of Public Health  
535 West Jefferson Street, Second Floor  
Springfield, IL 62761  
(217) 785-2060  
Fax (217) 782-1235

**Indiana**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1996.*

Dena L. Watts, Program Director  
Breast and Cervical Cancer

Early Detection Program

Indiana State Department of Health  
2 North Meridian Street, Sixth Floor  
Indianapolis, IN 46204-1964  
(317) 233-7901  
Fax (317) 233-7127

**Iowa**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1995.*

Lorrie Graaf, Chief  
Bureau of Health Promotion  
Iowa Department of Public Health  
Lucas State Office Building  
321 East 12th Street  
Des Moines, IA 50319-0075

(515) 281-7739  
Fax (515) 281-4535

Sandra Crandell, Program Coordinator  
(515) 281-4909

**Kansas**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1995.*

Paula Marmet, Director  
Bureau of Chronic Disease and  
Health Promotion  
Department of Health and Environment  
Lardon State Office Building  
900 Southwest Jackson, Room 901N  
Topeka, KS 66612-1290

(913) 296-8126  
Fax (913) 296-8059

Julia Francisco, Director  
Breast and Cervical Cancer Initiative  
(913) 296-1233

**Kentucky**

*CDC funding for a capacity-building program began in 1994. Funding for a comprehensive program began in 1996.*

Greg Lawther, Program Director, Manager  
Paula Alexander, RN, MS

Program Coordinator, Nurse Consultant  
Adult Health Branch

Kentucky Department for Public Health  
Commonwealth of Kentucky  
275 East Main Street  
Frankfort, KY 40621-0001  
(502) 564-7996  
Fax (502) 564-4553

**Louisiana**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1995.*

Ann Foltz, DNS, Program Director  
Chronic Disease Control Section  
Office of Public Health  
Louisiana Department of Health  
and Hospitals  
234 Loyola Avenue  
New Orleans, LA 70112  
(504) 599-1095  
Fax (504) 599-1075

**Maine**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1994.*

Barbara A. Leonard, MPH  
Program Director  
Maine Breast and Cervical  
Health Program

Maine Department of Human Services  
11 State House Station  
151 Capitol Street  
Augusta, ME 04333-0011  
(207) 287-5387  
Fax (207) 287-4631

**Maryland**

*CDC funding for a comprehensive program began in 1992.*

John W. Southard, MD, MPH, Director  
Office of Chronic Disease Prevention  
Maryland Department of Health  
and Mental Hygiene

Maryland Breast and Cervical  
Cancer Program

Local and Family Health Administration  
201 West Preston Street  
Room 306, Third Floor  
Baltimore, MD 21201

Main Office (410) 225-5281  
(410) 767-6787  
Fax (410) 333-7279

Ginny Gaumer, RN, Program Director  
(410) 767-5281 or 767-6728  
Fax (410) 333-7279

**Massachusetts**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1993.*

Laurie Robinson, Director  
Women's Health Unit  
Massachusetts Department of  
Public Health

Women's Health, Fourth Floor  
250 Washington Street  
Boston, MA 02108-4619  
(617) 624-5070  
Fax (617) 624-5075

**Michigan**

*CDC funding for a comprehensive program began in 1991.*

Carol Callaghan, MPH  
Program Director  
Chief, Cancer Section, CHP/CDP  
Michigan Department of  
Community Health

Community Public Health Agency  
3423 North Martin Luther King, Jr. Blvd.  
Lansing, MI 48909  
(517) 335-8379  
Fax (517) 335-9397

**Minnesota**

*CDC funding for a comprehensive program began in 1991.*

Jonathan S. Slater, PhD  
Program Director  
Chief  
Cancer Control Section

Minnesota Department of Health  
717 Delaware Street, Southeast  
Minneapolis, MN 55440-9441  
(612) 623-5591

Main Office (612) 623-5500  
Fax (612) 623-5520

Shelly D. Madigan  
Program Coordinator  
Assistant Chief  
(612) 623-5543  
Fax (612) 623-5520

**Mississippi**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1996.*

Hazel Gaines  
Director  
Women's Health  
Mississippi State Department of Health

2423 North State Street  
Jackson, MS 39215-1700  
(601) 960-7856  
Fax (601) 354-6104

Alan Penman  
Program Coordinator  
(601) 960-7725  
Fax (601) 354-6061

**Missouri**

*CDC funding for a comprehensive program began in 1992.*

Marianne Ronan, MPA  
Program Director  
Chief  
Bureau of Cancer Control  
Division of Chronic Disease Prevention  
and Health Promotion  
Missouri Department of Health  
101 Park Deville Drive, Suite A  
Columbia, MO 65203  
(573) 876-3233  
Fax (573) 446-8777

**Montana**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1996.*

Richard Paulsen  
Program Director  
Cancer Control Program  
Montana Department of Public Health  
and Human Services  
Cogswell Building  
1400 Broadway  
Helena, MT 59620  
(406) 444-3624  
Fax (406) 444-1861

**Nebraska**

*CDC funding for a comprehensive program began in 1992.*

Kathy Ward  
Program Director  
Director  
Chronic Disease Division  
Nebraska Department of Health  
301 Centennial Mall South, Third Floor  
Lincoln, NE 68509-5007  
(402) 471-3914  
Fax (402) 471-6446  
Debra Tomlinson-Hoffman  
Program Coordinator  
(402) 471-0370  
Fax (402) 471-6446

**Nevada**

*CDC funding for a capacity-building program began in 1994. Funding for a comprehensive program began in 1996.*

Pamela S. Graham, BS, RN  
Nevada Department of Human Resources  
Breast and Cervical Cancer Control and  
Prevention Program  
Capitol Complex  
410 East John Street, No. 3  
Carson City, NV 89710  
(702) 687-1818  
Fax (702) 687-1688

**New Hampshire**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1996.*

Margaret Murphy  
Program Director/Program Coordinator  
Office of Chronic Disease and Health Data  
New Hampshire Division of  
Public Health Services  
6 Hazen Drive  
Concord, NH 03301-6527  
(603) 271-4886  
Fax (603) 271-3745

**New Jersey**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1995.*

Doreleena Sammons-Posey  
Program Coordinator  
New Jersey State Department of Health  
and Senior Services  
Division of Family Health Services  
50 East State Street, Sixth Floor  
Capital Plaza, CN 364  
Trenton, NJ 08625-0364  
(609) 292-8540 or 984-1302  
Fax (609) 292-3580

**New Mexico**

*CDC funding for a comprehensive program began in 1991.*

Lydia Pendley  
Project Director  
Breast and Cervical Cancer Project  
New Mexico Department of Health  
2329 Wisconsin Street, NE, Suite A  
Albuquerque, NM 87110  
(505) 827-2380  
Fax (505) 841-8333  
  
Anita Salas  
Program Manager  
(505) 841-8330, Ext. 20  
Fax (505) 841-8333

**New York**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1993.*

Susan True  
Acting Director  
Bureau of Chronic Disease Services  
New York State Department of Health  
Empire State Plaza  
Corning Tower, Room 584  
Albany, NY 12237-0678  
(518) 474-1222  
Fax (518) 473-2853

**North Carolina**

*CDC funding for a comprehensive program began in 1992.*

Joseph L. Holliday, MD, MPH  
Program Director  
Breast and Cervical Cancer  
Control Program  
Division of Health Promotion  
PO Box 29605  
Raleigh, NC 27626-0605  
(919) 715-0125  
Fax (919) 733-0488

**North Dakota**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1996.*

Sandra D. Adams, Program Director  
Division of Health Promotion and  
Education  
North Dakota Department of Health  
and Consolidated Laboratories  
600 East Boulevard Avenue  
Bismarck, ND 58505-0200  
(701) 328-2367  
Fax (701) 328-1412  
  
Mary Dasovick  
Program Coordinator  
Cancer Prevention and Control Program  
(701) 328-2333  
Fax (701) 328-1412

**Northern Mariana Islands**

*CDC funding for a comprehensive program began in 1996.*

Dr. Isamu J. Abraham  
Secretary of Health  
Commonwealth Health Center  
Department of Public Health Service  
PO Box 409 CK  
Saipan, MP 96950  
011 (670) 234-8950  
Fax 011 (670) 234-8930

**Ohio**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1993.*

Frank S. Bright, MS, Program Director  
Chief  
Bureau of Health Promotion  
and Risk Reduction  
Ohio Department of Health  
246 North High Street  
Columbus, OH 43266  
(614) 466-2144  
Fax (614) 644-7740  
  
Lois Hall, MS, Program Coordinator  
(614) 752-2464  
Fax (614) 644-7740

**Oklahoma**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1994.*

Adeline Yerkes, RN, MPH  
Program Director  
Chief  
Chronic Disease Service  
Oklahoma State Department of Health  
1000 N.E. Tenth Street  
Oklahoma City, OK 73117-1299  
(405) 271-4072  
Fax (405) 271-5149

**Oregon**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1994.*

Jane Moore, PhD, RD  
Program Director  
Health Promotion and Chronic Disease  
Prevention  
Oregon Health Division  
800 N.E. Oregon Street, No. 730  
Portland, OR 97232  
(503) 731-4273  
Fax (503) 731-408

**Palau, Republic of**

*CDC funding for a comprehensive program began in 1996.*

Yorah Demei  
Ministry of Health  
Republic of Palau  
PO Box 6027  
Koror, PW 96940  
011 (680) 488-2552  
Fax 011 (680) 488-1211

**Pennsylvania**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1993.*

Peter Archey  
Program Director  
Pennsylvania Department of Health  
Cancer Control Program  
Health and Welfare Building  
Commonwealth and Forster Street  
Room 1011  
Harrisburg, PA 17120  
(717) 783-1457  
Fax (717) 772-0608

**Puerto Rico**

*CDC funding for a capacity-building program began in 1994.*

Mariwilda Padilla Diaz  
Program Administrator  
Cancer Prevention and Detection Program  
Commonwealth of Puerto Rico  
Department of Health  
PO Box 9342  
San Juan, PR 00908  
Rubén L. Mercado  
Program Director  
(787) 274-7860  
Fax (787) 274-7863

**Rhode Island**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1994.*

Carol Browning, MS, RN  
Program Director  
Rhode Island Women's Cancer Program  
Rhode Island Department of Health  
Cannon Building, Room 409  
Three Capitol Hill  
Providence, RI 02828  
(401) 277-3442  
Fax (401) 277-4415

**South Carolina**

*CDC funding for a comprehensive program began in 1991.*

Brenda C. Nickerson, RN, MSN  
Director  
Division of Cancer Prevention and Control  
South Carolina Department of Health and Environmental Control  
Center for Health Promotion  
Mills Jarrett Building  
PO Box 101106  
Columbia, SC 29201  
(803) 737-3934  
Fax (803) 253-4001

**South Dakota**

*CDC funding for a capacity-building program began in 1994. Funding for a comprehensive program began in 1996.*

Norma Schmidt, MA  
Program Director  
Breast and Cervical Cancer Program  
Division of Health, Medical, and Laboratory Services  
445 East Capitol Avenue  
Pierre, SD 57501-3185  
(605) 773-5728  
Fax (605) 773-5509

**Tennessee**

*CDC funding for a capacity-building program began in 1994. Funding for a comprehensive program began in 1996.*

Tammylee LeBouef, RN  
Program Director  
Breast and Cervical Cancer Prevention and Control  
Community Health Services Section  
Tennessee Department of Health  
426 Fifth Avenue, North, Sixth Floor  
Nashville, TN 37247-5210  
(615) 532-8480  
Fax (615) 532-8478

**Texas**

*CDC funding for a comprehensive program began in 1991.*

Margaret C. Mendez, MPA  
Director  
Breast and Cervical Cancer Control Program  
Texas Department of Health  
Bureau of Chronic Disease Prevention and Control  
1100 West 49th Street  
General Building, Room G407  
Austin, TX 78756-3199  
(512) 458-7644  
Fax (512) 458-7650

**Utah**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1994.*

Kathryn Rowley, Program Director  
Utah Cancer Control Program  
Utah Department of Health  
PO Box 142868  
Salt Lake City, UT 84114-2868  
(801) 538-6712  
Fax (801) 538-9495  
(800)-717-1811  
Catherine Hoelscher  
Program Coordinator  
(801) 538-7049  
Fax (801) 538-9495

**Vermont**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1995.*

Jean Ewing, MS, Program Director  
Cancer Control Chief  
Vermont Department of Health  
Health Surveillance  
Third Floor  
108 Cherry Street  
PO Box 70-05402  
Burlington, VT 05401  
(802) 863-7331  
Fax (802) 865-7701

**Virginia**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1996.*

Becky Hartt, MA  
Program Director  
Breast and Cervical Cancer  
Early Detection Program  
Division of Women's and Infant's Health  
Virginia Department of Health  
PO Box 2448, Suite 106  
Richmond, VA 23218  
(804) 786-7569  
Fax (804) 371-6032

**Virgin Islands**

*CDC funding for a capacity-building program began in 1994. Funding for a comprehensive program began in 1996.*

Darlene Carty Petty  
Program Manager  
48 Sugar Estate  
Roy L. Schneider Hospital  
Office of the Commissioner  
Virgin Islands Department of Health  
St. Thomas, VI 00802  
(809) 744-9000, Ext. 4643  
Fax (809) 777-4001

**Washington**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1993.*

Veronica Foster  
Program Manager  
Breast and Cervical Cancer  
Early Detection Program  
Washington State Department of Health  
PO Box 47835  
Olympia, WA 98504-7835  
(360) 586-0995  
Fax (360) 664-2619

**West Virginia**

*CDC funding for a comprehensive program began in 1991.*

Nancye Bazzle, MPH  
Program Director  
Office of Maternal and Child Health  
Breast and Cervical Cancer  
Screening Program  
West Virginia Department of Health  
and Human Resources  
1411 Virginia Street, East  
Charleston, WV 25301-3013  
(304) 558-5388  
Fax (304) 558-2183

**Wisconsin**

*CDC funding for a capacity-building program began in 1992. Funding for a comprehensive program began in 1993.*

Gale D. Johnson  
Program Manager  
Bureau of Public Health  
Wisconsin Department of Health and  
Social Services  
1414 East Washington Avenue, Room 96  
Madison, WI 53703-3044  
(608) 261-6872  
Fax (608) 266-8925

**Wyoming**

*CDC funding for a capacity-building program began in 1993. Funding for a comprehensive program began in 1996.*

Judith Kluever  
Program Manager  
Breast and Cervical Cancer Program  
Division of Preventive Medicine  
Wyoming Department of Health  
Hathaway Building Room 482  
Cheyenne, WY 82002  
(307) 777-6006  
Fax (307) 777-5402



## American Indian/Alaska Native Organizations

**CDC** launched a major initiative in 1994 to directly fund American Indian/Alaska Native organizations to establish comprehensive screening programs to improve our capacity to reach American Indian/Alaska Native women.

### **Arctic Slope Native Association Limited**

*CDC funding for a comprehensive program began in 1994.*

Leeanne Mercier, ANP  
Program Manager  
Arctic Slope Native Association Limited  
North Slope Borough  
PO Box 69  
Barrow, AL 99723  
(907) 852-0270  
Fax (907) 852-2855

### **Cherokee Nation of Oklahoma**

*CDC funding for a comprehensive program began in 1994.*

Brenda Stone, DO  
Program Director  
Cherokee Nation  
PO Box 948  
Tahlequah, OK 74465  
(918) 456-0671, Ext. 2735  
Fax (918) 458-6174

### **Cheyenne River Sioux Tribe**

*CDC funding for a comprehensive program began in 1994.*

Arliss Keckler  
Program Director  
Cheyenne River Sioux Tribe  
PO Box 590  
Eagle Butte, SD 57625  
(605) 964-6190  
Fax (605) 964-1062

### **Eastern Band of Cherokee Indians**

*CDC funding for a comprehensive program began in 1994.*

Susie Haynes, GONP  
Cherokee Women's Wellness Center  
PO Box 736  
Cherokee (Swain), NC 28719  
(704) 497-5537  
Fax (704) 497-5747

### **The Hopi Tribe**

*CDC funding for a comprehensive program began in 1996.*

Beatrice Norton  
Program Director  
Office of Health Services  
The Hopi Tribe  
PO Box 123  
Kykotsmovi, AZ 86039  
(520) 734-2441  
Fax (520) 734-2435

### **Maniilaq Association**

*CDC funding for a comprehensive program began in 1994.*

Toni Lane  
Program Director  
Woman's Health Program  
Maniilaq Medical Center  
PO Box 43  
Kotzebue, AL 99752  
(907) 442-7237  
Fax (907) 442-7310

**Native American Community Health Center, Inc.**  
*CDC funding for a comprehensive program began in 1996.*  
Sheila Walsh  
Program Director  
Native American Community Health Center, Inc.  
3008 North Third Street, Suite 100  
Phoenix, AZ 85012  
(602) 266-9166, Ext. 268  
Fax (602) 263-7870

**Native American Rehabilitation Association of the Northwest, Inc.**  
*CDC funding for a comprehensive program began in 1996.*  
Jacqueline Mercer  
Program Director  
Native American Rehabilitation Association of the Northwest, Inc.  
Indian Health Clinic  
2901 E. Burnside  
Portland, OR 97214  
(503) 230-9875  
Fax (503) 230-9877

**Navajo Nation**  
*CDC funding for a comprehensive program began in 1996.*  
Carmelita Davis  
Project Coordinator  
Navajo Division of Health  
PO Box 1390  
Window Rock, AZ 86515  
(520) 871-6258  
Fax (520) 871-6255

**Pleasant Point Passamaquoddy**  
*CDC funding for a comprehensive program began in 1994.*  
Clayton Cleaves  
Program Director  
Passamaquoddy Tribe Pleasant Point Reservation Health Center  
PO Box 351  
Perry, ME 04667  
(207) 853-0644  
Fax (207) 853-2347

**Poarch Band of Creek Indians**  
*CDC funding for a comprehensive program began in 1994.*  
Steven Pettitt, Rph  
Clinical/Program Director  
Poarch Band of Creek Indians  
8511 Jack Springs Road  
Atmore, AL 36502  
(334)368-8630  
Fax (334) 368-3757

**Southcentral Foundation**  
*CDC funding for a comprehensive program began in 1994.*  
Barbara Stillwater PhD  
Program Director  
Southcentral Foundation  
670 West Fireweed Lane  
Anchorage, AK 99503  
(907) 265-4900  
Fax (907) 265-5925

**South Puget Intertribal Planning Agency**  
*CDC funding for a comprehensive program began in 1994.*  
Diana Moser, BSN, RNC  
Program Director  
South Puget Intertribal Planning Agency  
2750 Old Olympic Highway, Southeast  
Shelton, WA 98584  
(360) 426-3990  
Fax (360) 427-8003

## National Organizations

**CDC** awards funds to 12 national organizations to educate their constituents about breast and cervical cancers, to increase access to breast and cervical cancer screening among priority populations, and to develop strategies for reaching priority populations in collaboration with state health agencies.

### **American Association of Retired Persons (AARP)**

*AARP builds coalitions with many types of organizations to increase the number of women 50 and older who get annual mammograms and to educate older women about available options to pay for screening, including use of the Medicare mammography benefit.*

Anne Wright  
Program Specialist  
American Association of Retired Persons  
601 E. Street, NW  
Washington, DC 20049  
(202) 434-2203  
Fax (202) 434-6474

### **American Federation of Teachers Education Foundation (AFT)**

*The AFT Breast and Cervical Cancer project has developed several strategies including publishing information that describes the objectives of the project, cervical cancer and its detection, breast cancer and its detection and various information kits for members who request specific disease or treatment facts. The organization is cooperating with state health agencies in all sites to include them in the education and work site screening development.*

Barbara Van Blake  
Director  
Human Rights and Community Relations Department  
American Federation of Teachers  
Education Foundation

555 New Jersey Avenue, NW  
Washington, DC 20001-2079  
(202) 879-4400  
Fax (202) 393-8648

Constance T. Cordovilla  
Project Coordinator  
American Federation of Teachers  
Education Foundation  
555 New Jersey Avenue, NW  
Washington, DC 20001  
(202) 879-4490  
Fax (202) 879-4597

### **American Indian Health Care Association, Inc.**

*Educational materials are being developed that are sensitive to the cultural norms of Native American women regarding the early detection of breast and cervical cancer.*

*Ttracking systems are being developed to track Native American women with breast and/or cervical cancer. The software should provide all 36 urban Indian clinics with patient management reports as well as reports which indicate the incidence and prevalence of breast and cervical cancer.*

Paul Abel  
American Indian Health Care Association  
7050 West 120th Avenue, Suite 206A  
Broomfield, CO 80020  
(303) 460-7420  
Fax (303) 460-7426

**Mayo Foundation, Inc**

*Provides training and ongoing support to mid-level providers to conduct clinical breast exams and Pap tests in the seven-state area served by the Aberdeen and Bemidji Indian Health Service Areas. Participants are learning to use culturally sensitive and culturally specific methods to recruit American Indian women patients.*

Thomas E. Kottke, MD  
Principal Investigator  
Mayo Clinic  
200 First Street SW  
Rochester, MN 55905  
(507) 284-4898  
Fax (507) 284-0161  
Mary Alice Trapp  
Project Coordinator  
Damon 62  
Mayo Clinic  
200 First Street Southwest  
Rochester, MN 55905  
(507) 284-1075  
Fax (507) 284-0161

**National Caucus and Center on Black Aged, Inc. (NCBA)**

*NCBA is collaborating with national organizations with the capacity to interface locally with medically underserved older women, especially women of color, to increase their awareness, involvement, and participation in breast and cervical cancer prevention, screening, and treatment programs as well as to develop culturally relevant community-based intervention strategies.*

Linda Jackson  
National Caucus and Center on  
Black Aged, Inc.  
1424 K Street, NW, Suite 500  
Washington, DC 20005  
(202) 637-8400  
Fax (202) 347-0895

Samuel J. Simmons  
President/CEO  
Principal Investigator  
National Caucus and Center on  
Black Aged, Inc.  
1424 K Street, NW, Suite 500  
Washington, DC 20005  
(202) 637-8400  
Fax (202) 347-0895

**National Center for Farmworker Health**

*The NCFH seeks to reduce cost and create access to breast and cervical cancer screening by recruiting, training, and supervising farmworker women and Traveling Lay Health Advisors (TLHAs). The TLHAs provide basic education on women's health, referral to breast and cervical cancer screening sites, tracking and follow-up services, and translation of services for farmworkers.*

E. Roberta Ryder, Executive Director  
Rosamaria Murillo, Project Coordinator  
National Center for Farmworker Health  
1515 Capitol of Texas Highway, South  
Suite 220  
Austin, TX 78746  
(512) 328-7682  
Fax (512) 328-8559

**National Coalition of Hispanic Health and Human Service Organizations (COSSMHO)**

*COSSMHO has established the Salud Para Todas Task Force on the prevention of breast and cervical cancers among Hispanic women. The Task Force's objective is to improve access and delivery of comprehensive breast and cervical cancer screening services by linking with state and local health departments, Hispanic community-based organizations, and comprehensive cancer centers.*

Rocio Gonzalez-Early  
National Coalition of Hispanic Health and

Human Service Organizations  
1501 16th Street, NW  
Washington, DC 20036-1401  
(202) 387-5000  
Fax (202) 797-4353  
Adolph Falcon  
Vice President of Policy  
National Coalition of Hispanic Health and  
Human Service Organizations  
1501 16th Street, NW  
Washington, DC 20036-1401  
(202) 797-4341  
Fax (202) 797-4353

**National Education Association**

*NEA generates training materials on work-site breast and cervical cancer early detection and control programs in local schools, develops model policies for local school districts and collective control services, and establishes networks throughout the country that will increase breast and cervical cancer screening messages among its members.*  
Rena Large, MPH, CHES  
Project Coordinator  
Health Information Network  
National Education Association

**National Hispanic Council on Aging (NHC<sub>o</sub>A)**

*Implements a peer-based outreach program and "health circles" initiative to improve the delivery of comprehensive breast and cervical cancer early detection and control programs for midlife and older Latina women, ages 55-75.*  
Lydia P. Buki, PhD  
NHC<sub>o</sub>A  
2713 Ontario Road, NW  
Washington, DC 20009  
(202) 265-1288  
Fax (202) 745-2522

**Susan G. Komen Breast Cancer Foundation**

*The Komen Foundation has initiated a coordinated approach to breast health education and breast and cervical screening for Hispanic women in the Fort Worth, Texas, community. Educational and outreach efforts as well as clinical exams are being coordinated with existing health department, hospital, and American Cancer Society programs.*

Linda Frame  
Project Director  
Susan G. Komen Breast Cancer  
Foundation  
5005 LBJ, Suite 370, LB74  
Dallas, TX 75244  
(972) 385-5038  
Fax (972) 385-5040

**World Education**

*The project introduces an early detection breast and cervical cancer curriculum into Adult Basic Education (ABE) and English for Speakers of Other Languages (ESOL) classrooms across the United States.*  
John Comings, President  
Sabrina Kurtz, Project Coordinator  
World Education  
210 Lincoln Street  
Boston, MA 02111  
(617) 482-9485  
Fax (617) 482-0617

**YWCA of the U.S.A.**

*The ENCORE<sup>plus</sup> program provides women with a spectrum of support services related to breast and cervical health including community outreach and education, referral to clinical screening services, and follow-up through diagnostic and treatment services.*

*The YWCA of the U.S.A. also partners with Avon Products, Inc., through Avon's Breast Cancer Awareness Crusade.*

Myrna Candreia, Program Director  
ENCORE<sup>plus</sup>

Office of Women's Health Initiatives

YWCA of the U.S.A.

624 Ninth Street, NW

Washington, DC 20001

(202) 628-3636

Fax (202) 783-7123

Marydale DeBor

DeBor and Associates

c/o CAI

505 Eighth Avenue

20th Floor

New York, New York 10018

(212) 594-7741

Fax (212) 629-3321

To obtain more information or additional copies of this document,  
please contact the  
Centers for Disease Control and Prevention  
National Center for Chronic Disease Prevention and Health Promotion  
Mail Stop K-64  
4770 Buford Highway, NE, Atlanta, GA 30341-3724  
(770) 488-4751  
E-mail: [cancerinfo@cdc.gov](mailto:cancerinfo@cdc.gov)  
Internet address: <http://www.cdc.gov/nccdphp/dcpc>

