

New Jersey Comprehensive Cancer Control:

2012 Status Report to the Governor and Legislature

*From the Task Force on Cancer Prevention,
Early Detection and Treatment in New Jersey*

**Prepared under the auspices of the Task Force Evaluation
Committee**

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Task Force Members

Arnold M. Baskies, MD, FACS (Chair)	David Lederman, DMD
Ansar Batool	Nancy E. Librera, MA, BSN
Teri P. Cox, MBA	George G. Rhoads, MD, MPH
Marco Gottardis, PhD	Arnold H. Rosenheck, DMD
Nancy Healey	Firoozeh Vali, PhD
Linda Johnson	James Robert Wong, MD

Office of Cancer Control and Prevention Staff and Evaluation Committee Members

Nuris Rodriguez, LCSW	Former Executive Director, OCCP
Margaret L. Knight, RN, MEd	Former Executive Director, OCCP
Sharon L. Smith, MPH	Research Scientist, OCCP
Susan M. Sanna, RN, BSN	Public Health Representative, OCCP
Marcia M. Sass, Sc.D.	Assistant Professor, Rutgers -School of Public Health, (Chair)
Joanne Abed, BA, Ph.D.	Senior Health Research Scientist, Battelle Centers for Public Health Research and Evaluation
Candido Africa, MD,	NJDOH, NJCEED Program
Wanda Allen, MSA, BS	City of Trenton Health Department
Cynthia Ayres, Ph.D, RN	Assistant Professor, Rutgers, The State University of New Jersey
Rebecca Baron, BA	Research Associate, Rutgers -School of Public Health
Arnold Baskies, MD, Task Force and Melanoma Workgroup Chair	Virtua Health and Medical Director for the American Cancer Society, Eastern Division

Linda Fleisher, MPH, Ph.D.	Principal Investigator, Atlantic Region Cancer Information Service (CIS)
Mark Fulcomer, Ph.D.	Adjunct Associate Professor, Department of Epidemiology, Rutgers -School of Public Health
Steve Godin, Ph.D, MPH, CHES	PHI Certificate, MPH Program Director, Department of Health Studies, East Stroudsburg University
Evelyn Gonzalez, MA	Director, Atlantic Region, Cancer Information Service
Nancy Librera, MA, BSN	The Valley Hospital
Elizabeth Moody, MA, LCADC	MAPP Coordinator, NJDOH, Office of Public Health Infrastructure
Jean Mouch, MD	Camden County Coalition Coordinator, Community Planning and Advocacy Council (CPAC)
Kenneth O'Dowd, Ph.D.	NJDOH, BRFSS Coordinator
Concetta Polonsky, MPH, CHES	Program Manager, New Jersey Prevention Network
Lisa Roche, Ph.D., MPH	NJDOH, Cancer Epidemiology Services
Margaret Rojewski, RN, BC, MPH	Coordinator, NJCEED Program, NJDOH, Chronic Disease Prevention and Control Services
Marge Scanny	Manager, Cancer Community Outreach, Shore Memorial Hospital
Michelle Tropper, MPH	Vice President Strategic Initiatives, American Cancer Society
Patricia Virga, Ph.D.	Monmouth County Coalition Coordinator, Vice President of Consulting Services, New Solutions, Inc.
Plyshette Wiggins, MPH	American Cancer Society

For more information about this Report, please contact:

Marcia M. Sass, Sc.D.
sassmm@sph.rutgers.edu

Please note that as of July 1, 2013, seven of the UMDNJ schools were merged with Rutgers, The State University of New Jersey.

EXECUTIVE SUMMARY

Overview: New Jersey's comprehensive cancer control program grew from a charge in 2000 by former Governor Whitman, who established the Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey (Task Force) and the Office of Cancer Control and Prevention (OCCP). Under the auspices of the New Jersey Department of Health (NJDOH), OCCP has coordinated all statewide cancer control efforts, which include the Task Force, its Workgroups, Standing Committees, and the 21 County Cancer Coalitions (Coalitions).

The present report is the fourth biennial Status Report to the Governor, the Commissioner of Health and the Legislature. It includes progress and accomplishments from January 2009 through August 2012 and the optional skin and prostate cancer projects also funded by the Centers for Disease Control and Prevention (CDC) from July 2007 through June 30, 2012. The Evaluation Plan includes a logic model that addresses context, implementation, and outcome evaluation in the development and implementation of the updated evaluation plans, and status reports assessing progress by the Task Force. Reflected in the new 2008-2012 Evaluation Plan is its alignment with the new Evaluation Chapter's primary goal of assessing the implementation and effectiveness of its strategies; determining its impact on the knowledge and behavior of the citizens of New Jersey; and measuring the resultant changes in health outcomes as is incorporated in the content of this Status Report.

The Task Force told New Jersey's story of cancer incidence and mortality as a spur to reducing the burden of the disease among its citizens. Supported through state appropriations, the Task Force conducted the first-ever statewide capacity and needs assessment in each of New Jersey's 21 counties, both to benchmark the status of the cancer burden in each county and to develop an extensive inventory of the state's cancer-related activities and resources. In order to keep data sources current, the State and county profiles continue to be updated electronically on an annual basis for use by the Workgroups, Standing Committees, and Coalitions.

The evidence-based chapters of the Second Plan have been grounded in data provided by the New Jersey State Cancer Registry (NJSCR), Behavioral Risk Factor Surveillance System (BRFSS), and trends gleaned from peer-reviewed publications with legislative initiatives, clinical trials, and the application of current technologic research and resource data integrated as recurrent themes throughout each chapter. The Second Plan's evidence-based goals, objectives and strategies have addressed the continuum of cancer control from awareness and education to quality of life issues with survivorship and diversity issues being prominent. Implementation of the Second Plan began with the approval by the Governor's Office on December 11, 2007. Given New Jersey's inclusion in the CDC's National Comprehensive Cancer Control Program since 2004 through a series of Cooperative Agreement awards to the OCCP, much of the content in this report is based on the recommendations and requirements of the CDC. With the change in guidance toward treatment of cancer-related issues as being on a continuum with other chronic diseases, this status report of progress also represents the culmination of the 2008-2012 Plan and its emphasis on eight specific cancers and the transition to treating cancer-related issues as a set of chronic disease issues.

Cancer Incidence and Mortality: Comparative New Jersey and US incidence rates for 2004-2008 for all races combined showed that they were higher both for males, 595.1 for New Jersey compared to 553.0 for the US, and females, at 453.8 for New Jersey compared to 416.5 for the US. These disparities persisted across the race categories with blacks having higher rates while API had the lowest rates. Among blacks, rates have declined steadily from 2005-2009 while a similar trend also occurred among whites following a peak in 2006 (NJDHSS, 2012a). From 2005-2008, incidence rates among New Jersey women were fairly stable. When compared with whites, for this period, the rates among black women were lower (NJDHSS, 2012a). When compared to other states, the New Jersey combined incidence rate for 2004-2008 was 509.7 compared with the US rate of 471.8, ranking seventh for both males and females (CDC, 2012).

In 2009, the latest data reported to the NJSCR indicated that 47,173 cases of invasive cancer were diagnosed among New Jersey residents. Over the five years from 2005-2009, the age-adjusted rates per 100,000 using the 2000 US Population standard have gradually decreased. The five-year period 2005-2009, for males there were 121,305 cases at a rate of 592.2. For females, for the combined 2005-2009 time period there were 117,990 new cases at a rate of 453.6. Cancer remains the second leading cause of death in New Jersey (NJDHSS, 2012). The five-year mortality for males for 2004-2008, was 41,760 deaths at a rate of 218.5 (NJDHSS, 2012). The average annual decline was about 2% annually and about 7.1% between 2004 and 2008. The five-year rate for females for 2004-2008 was 160.6 per 100,000 with 43,767 deaths. The 2004-2008 combined gender and races/ethnicities was 85,527 deaths at the rate of 182.6

Context Evaluation: In order to measure how the New Jersey cancer control program is functioning within its environment, the OCCP again has conducted its web-based stakeholder assessments in 2010 and 2012. These assessments have included the Task Force, Workgroup, Standing Committee members as well as all of the coalition members. Four new items relating to knowledge of evidence-based interventions; and policy, systems, and environmental changes; and the likelihood that members would use these were asked. They also were asked about related training interests and other chronic diseases with which they were working. Results are detailed in the Context Evaluation section of the report.

Implementation Evaluation: The accomplishments of the Task Force, Workgroups, Standing Committees, and Coalitions are highlighted in this section including efforts that have resulted due to stakeholders who have sought and obtained financial resources as well as provided in kind resources to make the efforts happen.

Choose Your Cover and the Optional Skin and Prostate Cancer Projects: Described in a separate “Implementation” section in this Status Report, Choose Your Cover (CYC), a skin cancer screening and health education initiative and the Skin Cancer Reduction – Early Education Network (SCREEN) Sun Safety Program have experienced a number of years of success. Both are aimed at reducing the incidence of skin cancer in New Jersey. Adopted as an initiative by the Task Force Prostate Workgroup, New Jersey has implemented an enhanced version of The Barbershop Initiative™, a national program created by The Prostate Net (TPN). The program improves communication about prostate cancer to men in New Jersey with a focus on medically underserved minorities through the recruitment of barbers to serve as lay health

educators and to participate with New Jersey Cancer Education and Early Detection (NJCEED) program lead agencies to get the men in for prostate cancer screening and treatment as needed.

Outcome Evaluation: Except for an increase in melanoma in both males and females and a slight increase in lung cancer in women, all other cancers in the Plan have decreased. With additional prevention, education, and screening efforts, other reductions in the burden of cancer will take many years to occur. In terms of behaviors, New Jersey has made progress toward the US Healthy People 2010 benchmarks for the six required population-based measures. New Jersey has not only achieved but exceeded the benchmark for the percentage of women over the age of 40 who have received a mammogram in the past two years. New Jersey is closer to achieving the US Healthy People 2010 targets than the US as a whole for all primary prevention measures. Please note that US Healthy People 2010 targets were used as US Healthy People 2020 targets had not been set at the time.

Recommendations and Conclusions Managed and guided by the OCCP, over time, the momentum from the energy and enthusiasm generated by individuals and organizations passionate about reducing the burden of cancer in New Jersey has resulted in many accomplishments that have been achieved to date, many through growing partnerships and collaborations in addressing the burden of cancer in New Jersey. With the structural changes that are accompanying the shift to addressing comprehensive cancer prevention and control within the context of chronic disease, it will be even more important to ensure that the leadership, vision, needed training, evaluation, and support are there to prevent back-sliding and to encourage forward movement with cancer prevention and control efforts. It should be noted that the leadership demonstrated by the Governor's appointed Chair of the Task Force has resulted in the success for the citizens of New Jersey. Cancer Control and Prevention has been recognized for its implementation nationally by the CDC; and New Jersey, for its local implementation. The Chronic Disease structure could only benefit by the cancer control model and its leadership in moving New Jersey forward.

I. INTRODUCTION

A. Background and Purpose of the Report

New Jersey's Comprehensive Cancer Control Program grew from a charge in 2000 by former Governor Whitman, who established the Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey (Task Force) and the Office of Cancer Control and Prevention (OCCP). Under the auspices of the New Jersey Department of Health¹, the OCCP staff have coordinated all statewide cancer control efforts, which include the Task Force, its Workgroups, Standing Committees, and the 21 County Cancer Coalitions (Coalitions)—a volunteer cadre of over 2,000 individuals and organizations. The Task Force has been institutionalized through the enactment of Public Law 2005, chapter 280 that mandates support for the Task Force, its Workgroups, Standing Committees, and Coalitions which is provided by the OCCP. New Jersey's comprehensive cancer control efforts have been supported annually with a state appropriation of \$1.5M, \$1.2M of which previously supported evaluation and communications efforts and through June 2012 has been used for the dedicated personnel in each of its counties. The Centers for Disease Control (CDC) also provides federal Comprehensive Cancer Control (CCC) funding to accomplish related activities. Continuing the requirements of the earlier Executive Order, this law states, "the Task Force shall report to the Governor, the Commissioner of Health and Senior Services, and the Legislature on its findings, recommendations and activities at least biennially." The Task Force has delegated the responsibility for developing the Status Reports to the Evaluation Committee.

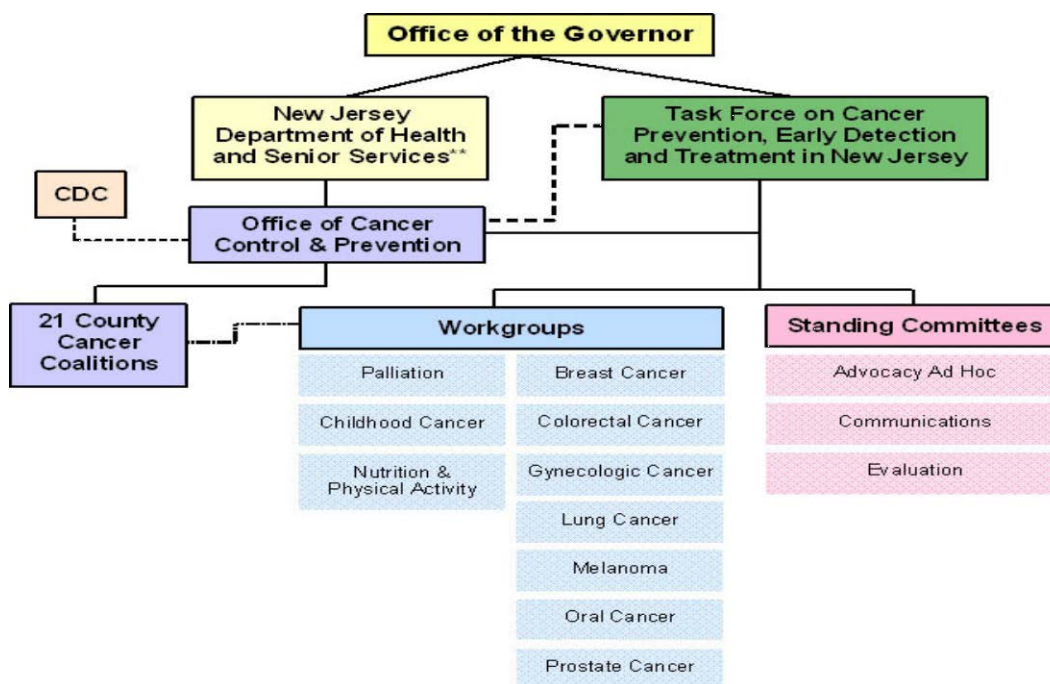
The present report is the fourth status report following those submitted in December 2004, 2006, and 2008. It briefly addresses cancer incidence and mortality and highlights progress and accomplishments from January 2009 through August 2012, the optional skin and prostate cancer projects funded by the CDC between July 2007 and June 30, 2012, and Choose Your Cover, a Melanoma Workgroup and Coalition initiative involving skin cancer screening and sun protection behavior education. The Evaluation Plan includes: a logic model that addresses context evaluation (e.g., stakeholder assessments, collaborations among Workgroups, Coalitions, and partnerships with key stakeholders); implementation evaluation (monitoring the achievement of all aspects of the workplan delineated in the Implementation Chapter of the 2008-2012 Plan, and other emerging-related issues); and outcome evaluation (e.g., monitoring changes in related behaviors and in cancer incidence and mortality). These three aspects of evaluation are incorporated in the development and implementation of updated evaluation plans, and status reports assessing progress by the Task Force. Reflected in the 2008-2012 Evaluation Plan has been its alignment with the Evaluation Chapter's primary goal of assessing the implementation and effectiveness of its strategies; determining its impact on the knowledge and behavior of the citizens of New Jersey; and measuring the resultant changes in health outcomes and also is incorporated in the content of this Status Report. Given New Jersey's inclusion in the CDC's National Comprehensive Cancer Control Program since 2004 through a series of Cooperative Agreement awards to the OCCP, much of the content in this report is based on the recommendations and requirements of the CDC. With the change in guidance toward treatment of cancer-related issues as being on a continuum with other chronic diseases, this status report

¹ The department name, New Jersey Department of Health and Senior Services (NJDHSS), was re-titled back to New Jersey Department of Health (NJDOH) on July 1, 2012. Because there are formal publications prior to the re-titling, both names are used in this report.

also represents the culmination of the 2008-2012 Plan and its emphasis on eight specific cancers and the transition to treating cancer-related issues as a set of chronic disease issues.

The development of New Jersey's Second Plan used the expertise of diverse partners, both internal and external, who had demonstrated their commitment to the reduction of the burden of cancer as demonstrated by their continued active involvement. The Internal Monitoring Program (IMP) developed by the Battelle Centers for Public Health Research and Evaluation (Battelle) in conjunction with the University of Medicine and Dentistry of New Jersey (UMDNJ) was used to incorporate experiences from implementation of the First Plan through reports generated for each workgroup. Strategies that were ongoing and demonstrated successful implementation were kept; conversely, strategies that had been identified as being unsuccessful or encountering barriers were revised to be more effective or excluded from the Second Plan altogether.

The eight cancers addressed in the Plan are breast, colorectal, gynecologic (cervical and ovarian), lung, melanoma, oral, prostate, and childhood. The department name, New Jersey Department of Health and Senior Services (NJDHSS), was re-titled back to New Jersey Department of Health (NJDOH) on July 1, 2012. The original organizational structure that has supported implementation of comprehensive cancer control activities in New Jersey is depicted below.



**Includes activities of Cancer Epidemiology Services, the NJ Commission on Cancer Research, the NJ Cancer Education & Early Detection Program, and the Center for Health Statistics.

The Task Force, Workgroups, and Standing Committees completed development of the second edition of the Plan in 2007. The evidence-based chapters were grounded in data provided by the New Jersey State Cancer Registry (NJSCR), Behavioral Risk Factor Surveillance System (BRFSS), The American Cancer Society (ACS), Healthy New Jersey 2010, and trends gleaned from peer-reviewed publications with legislative initiatives, clinical trials, and the application of

current technologic research and resource data integrated as recurrent themes throughout each chapter.

The Second Plan's evidence-based goals, objectives and strategies addressed the continuum of cancer control from awareness and education to quality of life issues. Planned and executed by the OCCP, and employing the CDC's national example of best practices from Maine, a seamless implementation of the Second Plan began with the approval by the Governor's office on December 11, 2007. It should be noted that as a result of including Research/Surveillance in each chapter, a limited number of hard copies of the 2008-2012 Plan were published. OCCP has relied on its enhanced website, www.njcancer.gov, to constantly reflect the ongoing and constant growth in the research. This has been accomplished through the insertion of hyperlinks in the electronic version of the Plan posted on OCCP's website that take the user to the primary data sources, e.g., BRFSS, NJSCR, and Cancer Control Planet, thus ensuring the most current information. This enhancement has also been available on the CD version of the Plan.

Plan implementation has continued with unwavering support from the coordinated efforts of the New Jersey Department of Health (NJDOH), Division of Family Health Services (FHS) and the programs—the OCCP, the New Jersey Cancer Education and Early Detection (NJCEED) program, the New Jersey State Cancer Registry (NJSCR), the New Jersey Commission on Cancer Research (NJCCR), the New Jersey Comprehensive Tobacco Control Program (NJCTCP), and the NJDOH's Office of Public Health Infrastructure. OCCP has continued to facilitate consensus-building and coordination among a diverse mix of partners and activities which has been demonstrated by the transition of each standing committee, workgroup and coalition to the Second Plan. An enhanced emphasis on communication with the establishment of the Task Force Communications Standing Committee has resulted in a Communications Plan aimed at improving the dialogue among collaborators. Incorporated in the 2008-2012 Evaluation Plan, the Evaluation Committee has been providing guidance to the Communications Standing Committee to assess its progress. First conducted in 2006, with the ever-growing number of stakeholders, expanded stakeholder assessments were conducted in July-August 2008, June 2010, and August 2012. Comparative findings are reported in the section on Context Evaluation.

B. Cancer Incidence, Mortality, and Progress towards Prevention and Early Detection

In 2009², the latest data reported to the NJSCR indicated that 47,173 cases of invasive cancer were diagnosed among New Jersey residents. More recently, the American Cancer Society (ACS) has released a very preliminary estimate that in 2012 there would be 50,650 new cancer cases for all sites in New Jersey (ACS, 2012). Over the five years from 2005-2009, the age-adjusted rates per 100,000 using the 2000 US Population standard³ have gradually decreased from 2006-2009 as noted with the following total cases and rates in parenthesis: 46,790 (508.9) in 2005; 48,295 (520.7) in 2006; 48,780 (519.2) in 2007; 48,257 (506.3) in 2008 and the current preliminary rate for 2009 of 487.2. Among those diagnosed for this five-year period, men represented 50.7%; whites made up 84.3%; blacks were 10.8%; Asian and Pacific Islanders (API) accounted for 3.0%; and those of Hispanic origin made up 7.4% (NJDHSS, 2012a). After

² NJDOH Cancer Epidemiology Service (CES) considers the most recent year of data as preliminary until the next year of data is released, e.g. 2009 data will be considered preliminary until 2010 data are released.

³ All rates cited are per 100,000 and age-adjusted to the 2000 US standard million population.

a 2.3% rise from 2005 to 2006, these changes have declined from 2006 to 2009 at an average of 2.2% annually with the combined downward change in the rates from 2006 to 2009 at 6.4%. For the five year period from 2005-2009, the total cases for all sites, including both genders and all ethnicities/races, was 239,295 at the rate of 508.3.

When the cases and incidence rates are evaluated by gender, the age-adjusted rates for males (all races combined) were: 593.8 for 2005; 613.3 for 2006; 614.4 for 2007; 583.7 for 2008; and a preliminary value of 556.8 for 2009. The five-year period 2005-2009, for males there were 121,305 cases at a rate of 592.2, while for the 2000-2004 time period there were 120,903 cases at a rate of 631.6. The age-adjusted rates for females (all races combined) were as follows: 454.5 for 2005; 459.2 for 2006; 456.3 for 2007; 455.2 for 2008; and 442.9 for the preliminary 2009 data. For females, for the combined 2005-2009 time period were 117,990 new cases at a rate of 453.6, while for 2000-2004, there were 114,937 new cases at a rate of 458.4. While the overall reductions were favorable, the changes for the two time periods were lower for females (at 1%) than for males (at 6.2%).

For the 2004-2008 time period, the New Jersey overall male rates for all sites and races combined were higher as compared to the US but the rates among blacks, API, and Hispanics were lower in New Jersey. For selected major cancer types in men, prostate, colorectal, and melanoma were higher in New Jersey than the US general population while the opposite was true for lung cancer. Selected major cancer sites in New Jersey among men showed that compared to other races, blacks had higher rates for prostate, lung, and colorectal cancers but were lower for melanoma and thyroid cancers.

Among women, for 2004-2008, the New Jersey rate for all races and all sites combined was also higher as compared with the rest of the US except for API. White women had higher rates than other women in New Jersey for all sites combined and for selected major sites involving the breast (invasive), lungs, endometrial (Corpus Uteri), thyroid, and melanoma. Blacks had a higher rate of colorectal cancer compared with other races but the lowest incidence for melanoma.

For 2005-2009, the National Association of Central Cancer Registries (NAACCR, 2012) data for New Jersey showed an overall incidence rate of 509.02. For whites it was 517.03 and among blacks of all ages and both sexes it was 484.61. For males it was 593.03; and for females it was 454.09.

When compared to other states (see United States Cancer Statistics data from the CDC and NIH), the New Jersey combined incidence rate for 2004-2008 was 509.7 compared with the US rate of 471.8, ranking seventh and a result that was similar for each sex (CDC, 2012).

Cancer remains the second leading cause of death in New Jersey (NJDHSS, 2012). However, based on data from the CDC for 2000-2008, the age-adjusted death rates per 100,000 population in New Jersey (with the number of deaths in parentheses) have been declining as follows: 187.4 in 2004 (17,215 deaths); 184.1 (17,036) in 2005; 180.0 (16,830) in 2006; 179.4 (16,949) in 2007; and a preliminary value of 174.6 (16,740) in 2008. From 2004 to 2008, rates declined an average 2% annually and about 6.8% between 2004 and 2008. For males, the death rates declined from a rate of 224.5 in 2005 to a preliminary rate of 208.6 in 2008. The five-year mortality for males for

2004-2008, was 41,760 deaths at a rate of 218.5 (NJDHSS, 2012). The average annual decline was about 2% annually and about 7.1% between 2004 and 2008.

There were also notable declines in deaths from cancer among women. The between year average change from 2004-2008 was 1.4% while the overall percent change for this five-year period was about 5.5% from 165.0 in 2004 to 156.1 using the preliminary data for 2008. The five-year rate for females for 2004-2008 was 160.6 per 100,000 with 43,767 deaths (NJDHSS, 2012a; NJDHSS, 2012b). The 2004-2008 combined gender and races/ethnicities was 85,527 deaths at the rate of 182.6 while for 1999-2003 were 90,197 at the rate of 202.6 (NJDHSS, 2012b) that is also evidence of overall improvement.

The comparative death rates for men for New Jersey with the US population for all sites and all races/ethnicities combined was slightly lower at 218.5 (New Jersey population) as compared to 223.0 (US population) for the period 2004-2008 as was also true of all of the individual race categories and two selected major cancer sites (lung and prostate). The combined death rate from colorectal cancer was higher in New Jersey at 22.6 as compared to 20.7 for the US. For both New Jersey and the US, black men had the highest death rates for lung, prostate, and colorectal cancers when compared to all of the other races. The lowest death rates were among the API in New Jersey (NJDHSS, 2012a).

For New Jersey women, the comparative mortality New Jersey and US rates for 2004-2008 indicated that cancers for all races and all sites combined were higher than the US as also was true for those affecting breast and colorectal cancers for all races combined. Cancer of the lung was lower among New Jersey women as compared to that of the US. Black women in both New Jersey and the US had higher deaths rates for all sites and those of the breast and colorectal. Cancer of the lung was highest among New Jersey white women. API had the lowest of the categories. When compared with the previous five-year period from 1999-2003, the combined rates as well as those specific to black and white women along with those for lung, breast, and colorectal sites declined in 2004-2008 in both New Jersey and the US (comparative rates were only done for blacks and whites for the 1999-2003 period).

The ACS has estimated that for 2012, deaths from cancer in New Jersey will be 16,650 (ACS, 2012, p.6). In terms of overall cancer death rates, New Jersey ranked 28th with a rate of 182.6 compared to 181.3 for the US, while New Jersey ranked 29th for males and 18th for females, respectively (CDC, 2012).

The historical trends for cancer incidence in New Jersey from 1979 to 2009 show a gradual reduction since the early 1990s following a steady rise before then. The trends for deaths, however, show a steadier drop since the early 1990s as reflected in figures below. In a National Institute of Health Surveillance, Epidemiology and End Results (SEER) report of five-year relative cancer survival rates for selected cancer sites, by race and sex in the United States from nine population-based cancer registries for selected years from 1975 to 2007, the rates have steadily increased for all ages and races. However, the survival rate among blacks remains lower than that for whites based on follow-up through 2008. (Complete report <http://www.cdc.gov/nchs/data/hus/hus11.pdf> and <http://www.cdc.gov/nchs/hus/contents2011.htm#048>).

Tables 1 and 2 demonstrate New Jersey’s progress toward the US Healthy People 2010 benchmarks for the six required population-based measures. Sigmoidoscopy or colonoscopy and PSA were added as early detection measures. New Jersey has not only achieved but exceeded the benchmark for the percentage of women over the age of 40 who have received a mammogram in the past two years and the percentage of adults aged 50+ who have ever had a sigmoidoscopy or colonoscopy in the last two years. For the other prevention measures, New Jersey has achieved the target for Adolescent Smoking Prevalence and is closer to achieving the other Healthy People 2010 targets than the US as a whole. Please note that Healthy People 2010 targets were used as Healthy People 2020 targets had not been set at the time.

TABLE 1: Primary Prevention

Quality Measure	NJ				US			HP 2010 Target
	2008	2009	2010	2011	2009	2010	2011	
Adult Smoking Prevalence *	14.8	15.8	14.4	16.8	17.9	17.3	21.1	12%
Adolescent Smoking Prevalence (Percentage of high school students who Smoked cigarettes on a least 1 day (during the 30 days before the survey)**		17			19.5		18.1	16%
Adult Obesity Prevalence *	23.9	23.9	24.8	26.7	27.2	27.6	27.8	15%

*BRFSS

**YRBS. 2009 and 2011 (http://www.cdc.gov/healthyyouth/yrbs/pdf/us_tobacco_trend_yrbs.pdf , <http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf> and http://www.cdc.gov/healthyyouth/yrbs/pdf/us_tobacco_combo.pdf)

TABLE 2: Early Detection

Quality Measure	2008		2010		HP2010 Target
	NJ	US	NJ	US	
Women aged 40+ who have had a mammogram within the past two years	76	76	77.3	75.2	70%
Women aged 18+ who have had a pap test within the past three years	79.9	82.8	84.1	81	90%
Colorectal Cancer Screening: Adults aged 50+ who have had a blood stool test within the past two years	20.7	20.9	17.4	16.7	50%
Colorectal Cancer Screening: Adults aged 50+ who have ever had a sigmoidoscopy or colonoscopy	58.7	61.8	65.6	64.2	50%
Prostate cancer screening: Men aged 40+ who have had a PSA test within the past two years	54.3	54.8	58.2	53.2	---

II. PROGRESS BASED ON THE EVALUATION PLAN: CONTEXT EVALUATION

Context evaluation describes how the program functions within its environment. It can help identify strengths and weaknesses of the program and the effect of unanticipated and/or external influences on the program. Context evaluation within the Plan has included three aspects: (1) stakeholder assessments, (2) collaborations among Workgroups, Standing Committees, and Coalitions, and (3) partnerships with key stakeholders. Because the latter two aspects are discussed in the section on “Implementation Evaluation,” this section over time has focused on the findings of biennial stakeholders' assessments conducted in the current year that is then compared with prior years. As with the first assessment conducted in 2006, all subsequent surveys have focused on seven key areas: membership; climate; communication; leadership; implementation; process; and benefits of participation. Within each of these topics, more specific issues were listed and members were asked to comment on their level of satisfaction for each issue. In addition, members were able to add unlimited comments on each topic. The ratings were based on five-point Likert items ranging from “Very Dissatisfied” to “Very Satisfied.” The satisfaction ratings have been restricted to those who selected response categories “Somewhat Satisfied” or “Very Satisfied” while those with “Don’t Know” and “Not Applicable” have been omitted from the analyses. The responses while not identical from year to year have not been significantly different to comment on here. The number of responses and percents for 2010 tended to be higher on most issues than for 2008 or 2012. This is not surprising as 2010 was the midpoint of the second Plan with a great deal of continuity among members and staff. Below is a composite table highlighting the Percent Range of Satisfied Responses to the Sub-Items within the Seven Key Topic Areas for 2006-2012.

Topic	Number of Specific Issues within this Topic	Satisfied Responses 2006*	Satisfied Responses* 2008	Satisfied Responses* 2010	Satisfied Responses* 2012
Overall Membership	6	73% to 86%	75% to 85%	80%-87%	78%-85%
Overall Climate	3	84% to 95%	86% to 90%	87%-89%	86%-89%
Overall Communication	4	82% to 92%	78% to 84%	82%-89%	74%-84%
Overall Leadership	3	77% to 84%	75% to 82%	79%-82%	66%-76%
Overall Plan Implementation					
Non-financial	6	66% to 78%	67% to 74%	69%-81%	59%-77%
Financial	1	35%	55%	52%	38%
Overall process	6	65% to 88%	70% to 85%	78%-88%	74%-84%
Response Rates by Year		43.0%	34.1%	29.4%	28.2%

Respondents in 2012 were given the opportunity to provide comments spanning concerns to suggestions about the ongoing changes including the national and now state transitions from having cancers as a sole focus of strategies to addressing cancers within the context of other chronic diseases, and specific to New Jersey, the transition from County Cancer Coalitions (CCC) to Regional Chronic Diseases Coalitions. This section of the report will focus on these findings.

Exclusive to the 2012 survey, respondents were asked four questions about future direction that rated their self-assessed knowledge and likelihood of use of evidence-based interventions and policy, systems and environmental change interventions. Of the 227 respondents, 157 (69.2%) rated their knowledge of evidence-based interventions as high and very high while 57 (25%) were neutral; and 177 (77%) indicated as high and very high that they are likely to use evidence-based interventions with about 38 (17%) as neutral. Knowledge of policy, systems and environmental change interventions were rated by 104 (46%) respondents as high and very high while 94 (41.4%) were neutral; and 139 (61%) said they were at the levels of high and very high for the likelihood of using policy, systems and environmental change interventions with 70 (31%) being neutral.

In terms of the training topics, there were 222 responses. Of these (in order), 130 selected evidence-based interventions; 142 selected policy, systems, and environmental change; 122 selected evaluation; 119 selected using surveillance data; and two selected other. Perhaps even more relevant was the interest in receiving training on multiple topics: one individual selected all five topics, 46 were interested in four; 49 were interested in three; 53 were interested in two; and 73 were interested in one only. This information should be beneficial for developing related trainings.

With respect to involvement with other chronic diseases, there were 117 respondents (51.5%) that indicated being currently involved in chronic disease efforts other than cancer. Most of those that responded 'yes' were involved with diabetes, 77 (66%); Heart Disease and Stroke, 75 (64%); Obesity, 75 (64%); and Tobacco Use, 73 (62%), as indicated in Figure 1 that follows.

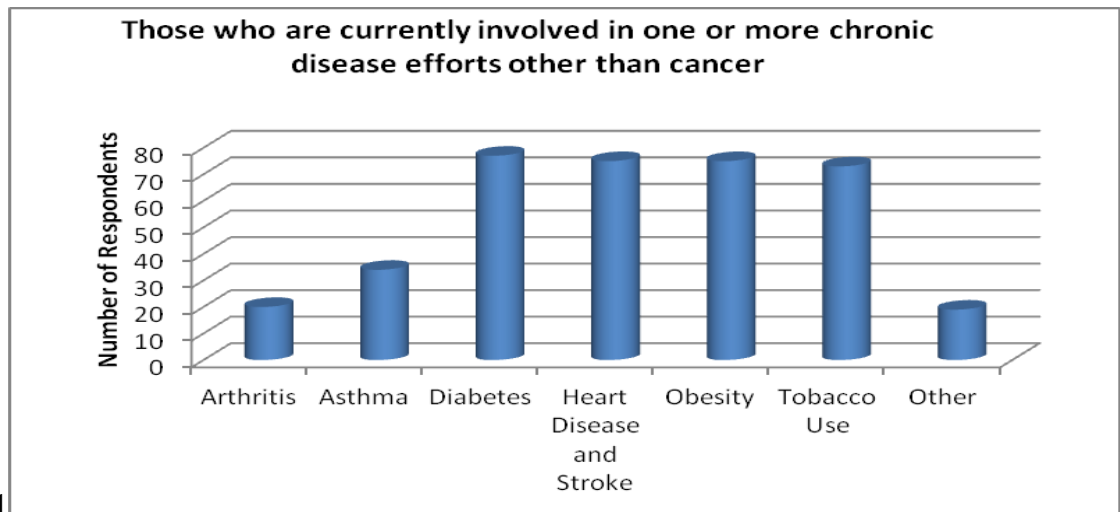


Figure 1

Summary: The 2010 assessment when compared to the 2008 assessment was generally 'positive' owing to the appreciable increase in the respondents to nearly all of the questions. With the exception of satisfaction about financial resources that dropped in rating, all other foci areas improved from 2006 to 2010. The 2012 ratings declined in all of the overall satisfaction areas. In addition to financial concerns, many of the declines in satisfaction levels as also stated in comments were driven by uncertainties related to resource allocations/funding, membership, and leadership.

The response rate, while declining over the years, has remained relatively stable. A noteworthy favorable trend appears to be the increasing duration of involvement (at least among respondents) as seen with the percent among those with less than a year of CCC members that declined from 11% in 2008 to 4% in 2012. This means that about 95% of the respondents in 2012 were members of one or more CCC for a year or more, up from 89% in 2008 and 93% in 2010. This trend, however, is not matched by the level of involvements because those who said that they were not very involved with the CCC activities increased by about 28%. Even though most of the members were moderately to very involved with the CCC activities, it is important to stress the ongoing emphasis on the role of more active members by instituting measures to retain and motivate as well as recruit them. The 20% drop among respondents who were members of any of the state-level workgroups and/or standing committees of the Task Force on Cancer Prevention, Early Detection and Treatment in 2012 is also a concern that needs to be addressed with the recent transitions of the Task Force to two Standing Committees, four Domain Driven Work Groups as well as the 10 Regional Chronic Disease Coalitions in order to bring in diverse members and sustain existing ones. The lower response rate in 2012 and the decline in satisfaction levels when 2008 and 2012 are compared may be a reflection in the changes. Many of the comments were also centered on collaboration, partnerships that might be lost due to the changes that are incompatible with member interests, and acknowledging program successes as well as many of the individual coalitions and individuals that have performed exemplary roles. While the satisfaction levels regarding what have been the benefits of participating also have decreased, the declines were modest from 2008 to 2010 at up to 4% providing room to formulate means to increase motivation and targeted programs. These also are reflected in the levels of collaboration. The assessment from the 2012 survey about knowledge

level and likelihood of implementing evidence-based interventions and policy, systems and environmental change interventions and interest in training are good guides to areas for training, evaluation, as well tracking the transitions for the Task Force, Workgroups, and Coalitions if adequate resources are available.

III. PROGRESS BASED ON THE EVALUATION PLAN: IMPLEMENTATION EVALUATION

A. Coalition Activities

As New Jersey continued to implement the Second Plan, the evidence-based recommendations contained within it continued to be employed at the local level. The County Cancer Coalition (CCC) Coordinators (Coordinators) have used the Plan's data and recommendations as well as the county-based Fact Sheets to prioritize and plan their Coalition's activities. Utilizing the data and recommendations has ensured that Coalition activities have aligned with the goals of the Plan. The Coordinators have been mandated to identify specific goals, objectives and strategies recommended in the Plan as they develop these activities in their respective counties. For most of the time period, the OCCP and the Coalitions partnered with the National Cancer Institute's Cancer Information Services (until it was phased out in 2010) to collaborate on activities that were evidence-based.

1. Coalition Self-Monitoring Activities

Coalition Stakeholder Assessments, the Coalition Membership Gap Analysis Tool, the Coalition Self-Needs Assessment Tool and Grant Progress Reports have been required to be performed by each Coalition. Annual Audits have been performed by the federally-funded OCCP staff member as a measure of quality control. In the final year of the 2008-2012 Plan, the Coalitions implemented the recommendations included in the 2011 Annual Audits.

Coalitions were required to perform an annual Coalition Self-Needs Assessment. This survey tool was utilized to assess the Coalitions by strengths, weaknesses, successes and need for improvement on a consistent basis, and could be qualitative, quantitative, or a combination of both. The Coalitions were required to submit a Grant Progress Report to the OCCP that included the Coalition's objectives, the activities being performed to meet each objective and the level of completion on each activity. These assessment tools have been critical in guiding ongoing recruitment of new stakeholders and ensuring that cancer control efforts continued to be implemented effectively at the county level.

Since a vital part of comprehensive cancer control is the coordination and collaboration of a diverse group of stakeholders, it has been important for the Coalitions to evaluate organizational involvement. An annual Coalition Stakeholder Assessment Matrix has been used to evaluate the types of organizations currently involved, the populations served, and the focus of member organizations. It has been found to be a very effective tool in assisting with coalition building. The Coalitions also have performed an annual County Cancer Coalition Membership Gap Analysis. This tool has helped to identify the desired organizations that are or are not currently

present on the Coalition membership at a local level, and has included categories ranging from cancer organizations to media services.

The OCCP utilized a Coalition Event Planning and Reporting Form to measure the Coalitions' effectiveness in prioritizing and planning their projects and events. These reports required the Coalitions to demonstrate which goals, objectives and strategies of the Plan have been met by the event and have been monitored by OCCP staff for evaluation purposes. The reports have been entered in the Internal Monitoring Program (IMP) and have also been utilized in providing quarterly quantitative data on coalition activities to the Evaluation Committee and the Task Force.

2. Evidence-Based Evaluation Related Training Initiatives

The Evaluation Committee through needs assessments conducted with the Coalition and NJCEED coordinators determined that the majority had beginning to intermediate program evaluation knowledge and skills. To assist the coordinators to further develop their skills, an Evaluation Training sub-committee was established. Program evaluation training via webinar was developed in collaboration with the Cancer Information Service Partnership Program. Two webinars were held over the time period. The webinars were recorded and now are available for those who were unable to attend as well as those who wish to review the content. In addition, individualized one-on-one trainings of the Coalitions were undertaken to support their efforts to identify evidence-based initiatives that have enabled them to evaluate both short and longer term outcomes of their efforts.

3. Major Coalition Cancer-Related Activities Per Report Period

As part of their health service grant deliverables, all Coalitions were required to complete at least one cancer-related project per grant period. Project Requirements:

- a.) Project must utilize current data findings to target one or more of the top four priority cancers in the respective county (breast, lung, colorectal, prostate).
- b.) Project must address and cite specific goals, objectives and strategies of the 2008-2012 New Jersey Comprehensive Cancer Control Plan.
- c.) Project must include public education and outreach on cancer awareness, education, prevention, early detection and screening.
- d.) Project must include a formal evaluation component as recommended by the Evaluation Committee.

Several activities continued to take place in all of the counties including new and ongoing projects during each quarter. To best obtain this information, in June 2012, a final questionnaire with six questions was sent to all 20 County Cancer Coalition Coordinators to capture activities each believed were their respective Coalition's most successful achievements from 2008 to present time. The online questionnaire was developed using Kwiksurvey.com and the web link to it was sent via email to the coordinators. Several follow up calls and emails were made to ensure completion. Because of the full report's length, excerpts highlighting the County Cancer Coalitions activities have been included here. The full report will be available on the Office of Cancer Control and Prevention's website: www.njcancer.gov.

Survey Results

The survey examined the program areas identified by the NJDOH, Division of Family Health Services (FHS), Office of Cancer Control and Prevention (OCCP) and a few others that the Evaluation Committee determined were strong suits of the coalitions. These program areas were: breast, cervical, prostate, colorectal, lung, oral, ovarian and skin cancer as well as healthy lifestyles, survivorship, palliative care and other as specified by the coordinator. Selected results of the survey are reported below.

To the question, “What would you say are the top 3 to 5 County Cancer Coalition (CCC) program areas over the 2008 – 2012 New Jersey Comprehensive Cancer Plan for which your CCC wants to be remembered?” All 20 Coordinators responded. In Figure 1 below, most CCC (73.7%) responded that breast cancer was one of the program areas for which they wanted to be remembered. The second leading areas selected were healthy lifestyles and skin cancer at (63.2% each). The two least selected were cervical and ovarian cancers.

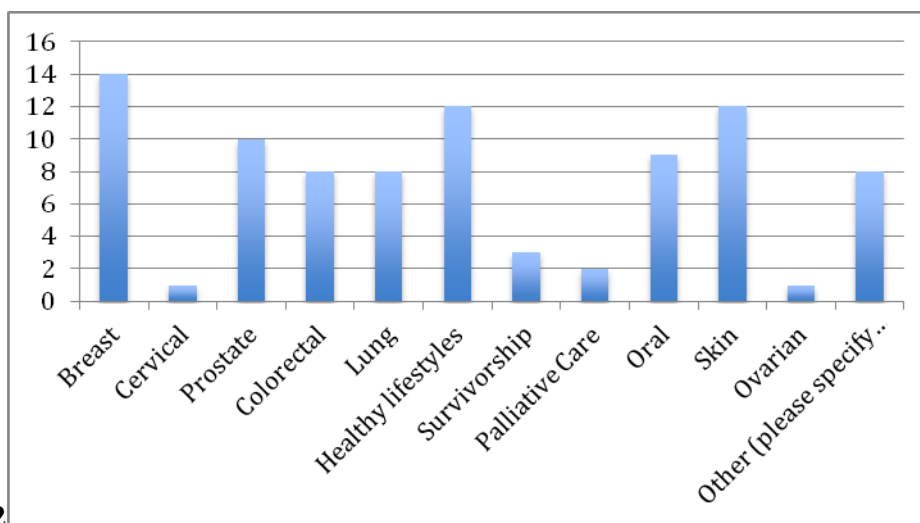


Figure 2

CCC Coordinators also were asked to describe program areas that each had selected as his/her CCC's MOST successful (Choice 1), SECOND MOST successful (Choice 2), and THIRD MOST successful achievement (Choice 3). The achievements by CCC have been included below.

Atlantic

Choice 1: Healthy Lifestyle initiatives have been a focus of Atlantic County Healthy Living Coalition (ACHLC). Two programs have specifically been successful in this regard. The driving message has been to prevent cancer through eating right, exercising, not smoking and getting routine cancer screenings. One project has been a joint venture with Rutgers Cooperative Extension in which two different assemblies are available. The programs are called A Road to Good Health and Sustainable Me! They are both IRB approved and focus on middle school students. The programs are meant to rotate for variety purposes in the schools. This program has had anywhere from 5 to 10 partners that teach five minute lessons in an assembly form. Additional activities and surveys have been completed in class before

and after the event to measure and facilitate learning. Since inception in the past four years approximately 4,300 students have passed through the program in Atlantic County.

The second program has been an annual healthy lifestyle festival held in an Atlantic County Park in August of each year. It has been planned by the ACHLC and the Atlantic County Division of Public Health with the help of 5 to 10 partners who bring lesson plans to the events. This program is family-focused and gets families moving, experiencing new foods and learning about a healthy lifestyle in a fun way. Each year it has been a little different. Examples include Olympic events done with veggies, races to guess the fruit, and food tasting. Approximately 440 participants have participated over the last four years. Both programs have been fully evaluated with follow up results included in those evaluations. These two programs have been the most successful because of the consistent follow-up data stating that people have made behavior changes since participating in the event. After the Growing Healthy Festival in August 2011, 80% of the participants said their families increased their physical activity more than one time per week with 33% increasing it more than three times per week; 86% said their families increased their fruit and vegetable intake one or more vegetables per day, and 26% increased their intake by 3 or more fruit and vegetables per day.

Choice 2: The ACHLC has had a Palliative Care Committee since the inception of committees on the coalition. This committee surveyed nurses, doctors, allied health workers and the community on palliative care in order to better understand their knowledge base. Finding that the knowledge base was low, the committee set out to teach the public and professionals about palliative care by developing, adjusting, and tailoring presentations for a variety of audiences and locations. These audiences have included nurses, doctors, students and the community among others. Locations have included senior centers, hospitals, community centers, colleges and clubs. Over the past five years the Palliative Care Committee has reached over 900 people through over 25 events. The workshops and programs have been evaluated throughout this time and have yielded on average a 20%-60% increase in knowledge for most workshops.

Choice 3: The Professional Education Committee, as well as other committees has focused on professionals in the Atlantic County area. Since the inception of the coalition there have been workshops for professionals. The intent has been to update professionals on a variety of cancer topics close to home. Over time these events have progressed into system change initiatives in which the coalition members have encouraged practitioners to examine the way they practice and to integrate important aspects such as routine cancer screening and palliative care services. These programs have been developed by committee members with continuing education credits available for nurses, social workers, physicians and/or dentists. Topics have included colorectal cancer; ovarian cancer; cervical cancer and HPV; tobacco dependence, prevention and treatment; lung and smoking cessation; prostate cancer; palliative care; end of life issues; the latest and greatest in oncology care; and multi-disciplinary approaches to cancer care. All of these programs have been fully evaluated and have been received well by the professionals. Pre-/post-tests have yielded on average a 20%-30% increase in knowledge and follow up has begun with some of the newer programs. The ACHLC has become a place for professionals to look for quality continuing education.

Bergen

Choice 1: The Coalition was very involved in providing Sun Safety activities in relation to Skin Cancer. Utilizing a Sun Safety game board and DVD titled "Dark Side of the Sun," the Coordinator conducted many presentations for children/young adults and adults at summer recreation programs, municipal pools, church groups, and other community venues such as health fairs, etc. In addition, the coalition focused on the health risks of tanning beds that led to cable TV news interviews on the topic. The Coalition also partnered with the Paramus Health Department to conduct the "Choose Your Cover" initiative at the municipal pool in Paramus. Overall a total of 962 people were educated about the importance of sun safety behaviors.

Choice 2: The Coalition focused on Lung cancer initiatives and presented many tobacco control presentations for middle school students, adults and senior adults in schools, public libraries and health fairs. In addition, the Coordinator conducted two in-service trainings for treatment providers and Registered Environmental Health Specialists; conducted cessation presentations for clients at a male halfway house; and provided counseling on tobacco cessation and technical assistance on tobacco issues. A total of 1028 individuals were educated on tobacco control issues. The coalition was also involved in the Radon Awareness/Test Kit distribution at government and community sites.

Choice 3: The Coalition cooperated with the New Jersey Oral Cancer Project to schedule and conduct oral cancer screening programs in venues such as a community college, Federally Qualified Health Center, Women, Infants and Children Program (WIC), senior citizens health fair, and a retail establishment. In addition, the Coalition was able to schedule speakers on oral cancer at Bergen County Dental Health Association meetings. The Coordinator conducted multiple presentations for the Bergen County Dental Hygienist Association. Overall, 140 individuals were screened at four combined events. At one screening site, the Coordinator was also interviewed by two Cable TV News stations on the importance of oral cancer screening. The reach of these stations includes Northern New Jersey and New York City (NY1 News) and parts of Northern New Jersey (WMBC News Newton).

Burlington/Camden

Choice 1: The Burlington-Camden County Cancer Coalition (BCCCC) collaboration with Cooper and Virtua NJCEED programs and working with the Clark Family, a nonprofit that focuses on screening women for breast cancer, has enabled this Coalition to impact the community by educating, screening and bringing about healthy changes.

Choice 2: Working with the Barbershop Initiative has provided many opportunities to conduct workshops and train barbers who have impacted their clients. Other community, professional, and religious organizations have been impacted by bringing awareness related to Prostate cancer. In addition, the Coalition has received reports of men getting prostate exams because of these efforts.

Choice 3: Collaborating with Rutgers Supplemental Nutrition Assistance Program (SNAP) and Cooperative, along with collaborations with Coalition members who have a background

with healthy lifestyles have helped make an impact on smoking cessation, cancer screenings, and nutritional changes that include exercise and helped to change negative behaviors.

Cape May

Choice 1: Chronic Disease Self-Management had one of the highest numbers of attendees in New Jersey and one of the highest number of peer leaders trained.

Choice 2: “Choose Your Cover” skin cancer screening and education was well accepted.

Choice 3: Breast cancer screening goals were met or surpassed.

Cumberland

Choice 1: As a result of the Cumberland County Cancer Capacity and Needs Assessment, it was evident that there was a breast cancer survival disparity between African American (AA) women and other races. AA women had lower survival rates. This Coalition focused considerable resources and effort to increase early detection of breast cancer for AA women and thus help improve survival from it. To address this problem, Cumberland CCC members did the following actions: (1) increased outreach for NJCEED to mostly AA women; (2) partnered with a fledgling AA breast cancer support group and added their leaders to the CCC roster; and (3) educated Cumberland County residents and health care providers about the late stage cancers being detected by mammograms in AA women. These efforts paid off and over a six to seven year period, the Coalition has seen an increased utilization of screening mammograms in AA women with resultant fewer late stage breast cancers.

Choice 2: South Jersey Healthcare (SJH), grantee for the OCCP grant, formed a Cancer Survivorship Committee to focus on the needs of cancer patients after the active treatment period was ended. The Committee partnered with the Cancer Institute of New Jersey (CINJ) and Fox Chase Cancer Center in a research study looking at the transition of cancer patients back to primary care. Cumberland CCC piloted a Survivorship Program that has continued with a meaningful session that each cancer patient completing radiation therapy now has with an advanced practice nurse. The Coalition has supported all activities, including National Cancer Survivor Day celebrations, which were educational and fun.

Choice 3: In September 2011, the Cumberland CCC held an Ovarian Cancer month-long event called "Paint the Town Teal". Educational materials about ovarian cancer were purchased using coalition funds and the City of Vineland was virtually covered in teal ribbons. As SJH welcomed a new gynecologic (GYN) oncologist to its medical staff, coalition members wanted to educate women in the county regarding the care they could receive for ovarian cancer in Cumberland County and the importance of annual GYN check-ups.

Essex

Choice 1: The Essex County Cancer Coalition (ECCC) has collaborated with the New Jersey Dental School to greatly expand its existing annual oral cancer screening day by combining it with a countywide cancer-related health fair. It changed from being an event attended mainly by UMDNJ employees to one attended by the larger community, especially from some high-

risk populations during which screening for several cancers were done. The evaluations of this event have indicated that many people are now attending the fair intending to visit the dozen-plus cancer-related exhibitors. The service providers at the fairs have included a broad range of public, private and not-for-profit organizations, many of whom also provide screening services. On average about 200 adults have attended and received free oral cancer screening, with several each year undergoing oral brush biopsies.

Choice 2: Given the nationwide effort to integrate cancer control issues into the broader base of chronic disease prevention, the ECCC undertook in collaboration with the NJCEED lead agency on the UMDNJ Newark campus, a series of steps in that regard. For example, the ECCC has worked to implement and expand the evaluation of the Stanford Take Control of Your Health, Chronic Disease Self Management Program. Although the ECCC had only just begun doing this in June of 2011, over 170 participants from 15 sites in Essex County had already been enrolled. In this program, low-income, minority participants with chronic conditions have primarily been recruited. They have learned such skills as how to eat healthfully, exercise safely, manage medications more effectively and communicate better with health providers. Coalition members have taught and provided a large number of tools to enrollees with taking control of their health. In the first phase of the program a full 90% of participants completed the program that involves six 2.5 hour workshop sessions. This work has expanded community-based relationships and solidified pre-existing ones, achieving synergy at a time of increasingly limited resources.

Choice 3: For fiscal years 2008-2011, ECCC collaborated on the New Jersey Prostate Cancer Initiative, and hosted it in the northern half of New Jersey. Findings of the Essex County Capacity and Needs Assessment had demonstrated that it was necessary to pay greater attention to prostate cancer especially in Essex County. The ECCC collaborated with NJCEED lead agencies in an effort to educate barbers across the northern counties of the state. The intent was for the barbers, once trained, to serve as lay health educators to educate their customers about prostate cancer and to refer customers to their providers or to the CEED programs for screening as appropriate. One of the highlights of this effort was the initiation of prostate cancer screening events within barbershops with the support of concerned barbers. The ECCC successfully reached out to dozens of barbershops.

Gloucester

Choice 1: Prostate cancer screening and awareness provided because of the Gloucester CCC (GCCC) partnership with NJCEED for the annual free prostate cancer event.

Choice 2: Lung cancer employee wellness events with the lung age machine have resulted in employees going into smoking cessation programs.

Choice 3: Again partnering with NJCEED, the GCCC did outreach into the minority community to increase the community's awareness and use of available breast cancer screenings. The GCCC also had a focus on colorectal screening and outreach was accomplished in conjunction with food banks. Though the GCCC was well received, it was difficult to follow-up on any progress.

Hudson

Choice 1: Being a visible presence and a strong voice for cancer awareness, prevention and control, the Hudson County Cancer Coalition (HCCC) did over 40 community events per year from 2008 to 2012. Thousands of event attendees were educated about the signs and risk of cancer and the importance of: 1) adopting a healthy lifestyle to help prevent cancer; 2) seeking cancer screening services when age and risk appropriate; and 3) promptly following-up any suspicious conditions found at any time. The HCCC also informed thousands of event attendees of the locations where free breast, cervical, colorectal and prostate cancer screenings were available through the NJCEED Program. The HCCC worked closely with Hoboken Family Planning (HFP), the NJCEED Grantee in this endeavor. This collaboration also produced three additional grants from Susan G. Komen for the Cure, the United Way, and Hudson County that have provided nearly \$55,000 of additional grant funds this year to screen uninsured people for cancer

Choice 2: The HCCC selected breast cancer awareness as its main cancer-related project for the Grant year at least three times, prostate and colorectal cancer awareness as its main cancer-related projects at least twice. For the last two years, the main cancer related projects were breast and prostate cancer awareness. Once this decision was made, the HCCC tailored the outreach and education program described in item one above to emphasize the site specific cancer(s) chosen.

Choice 3: The CCC conducted a free oral cancer screening program in Hudson County every spring for six years from 2007 through 2012 in partnership with other northern New Jersey CCCs, the Oral Cancer Consortium, Dr. Hillel Ephros and St. Joseph's Regional Medical Center. Approximately 1,000 people were screened for oral cancer and much awareness of this disease that kills more people in Hudson County than cervical cancer and melanoma combined was raised.

Hunterdon

Choice 1: Skin cancer prevention and education was Hunterdon CCC's most successful program area for a few reasons. First, it was not a topic heavily covered by schools in health class and it has received a lot of publicity in the past few years. This helped create demand for instruction in schools by parents, teachers, and school nurses. Second, Hunterdon CCC had strong local county-level partnerships for networking to promote the programs. Third, the CCC was able to maximize connections to garner support for school and non-school based interventions.

Choice 2: Tobacco cessation is one of Hunterdon CCC's most successful program areas because it was able to not only educate the public about the dangers of tobacco use and second hand smoke exposure, but because health professionals were engaged. The health system in the county is small, but in just the past year, the HCCC, in conjunction with a network of health professionals, has had several successes.

Choice 3: Healthy Lifestyle promotion was successful because Hunterdon CCC was able to educate the community in a variety of venues, and in trying to arrange programs all over the

county, it attracted new members into the Coalition. At a general "healthy lifestyle" program the CCC was also able to garner interest in other more cancer-specific programs.

Mercer

Choice 1: Mercer County Cancer Coalition's (MCCC) most successful achievement has been its involvement in increasing awareness of and access to palliative care throughout Mercer County. MCCC has been able to do this through its strong Palliative Care/CAM workgroup that included many Capital Health members. MCCC was able to provide the ELNEC Core Training (End of Life/Palliative Care Education) to professionals two years in a row and will be able to continue to provide this education through the support of Capital Health that aided in providing this year's webinar to professionals throughout the state. Other programs that were done through the Palliative Care/CAM Workgroup included collaboration with the Elixir Fund in bringing a CAM program (Bridges to Wellness) to patients and staff. This program will also continue through the support of Capital Health.

Choice 2: The second most successful achievement has been the collaboration with New Jersey Partnership for Healthy Kids. The goal of this group was to help to reduce childhood obesity in the North Ward of Trenton. The two workgroups in which MCCC was involved were the School Wellness Workgroup and Access to Healthy Foods Workgroup. In the School Wellness Workgroup, the following were achieved: (1) an increase in consumption of fresh fruits/vegetables by revitalizing the cafeteria, bringing in a salad bar, snack cart, and increasing breakfast consumption; (2) a community wellness council was established with parental involvement; (3) school policy was improved to ensure that the school was adhering to the School Wellness Policy and the Healthier Alliance Gold Standard Guidelines; and (4) physical activity was increased by building a playground with exercise equipment that would be available to the school and the surrounding community. In the Access to Healthy Foods Workgroup, two major efforts were undertaken: (1) outreach to corner stores and bodegas to create a buying coop of fresh produce at lower prices; and (2) giving technical assistance to corner store and bodega owners.

Choice 3: MCCC third most successful program was the outreach that was done for colorectal cancer. Many community programs on colorectal cancer were conducted throughout the Coalition's years. In addition, a large professional program was conducted in collaboration with healthcare providers at Capital Health in June 2012. A large community program on Colorectal and GI Cancers was planned for the Fall of 2012.

Middlesex

Choice 1: Healthy Lifestyles: because of the effective collaboration among Coalition members, awareness campaigns were varied and catered to the communities targeted. Multiple programs were held throughout the time period and were well received.

Choice 2: Skin: the participation of the Coalition members in the "Choose your Cover" initiative has been very successful and far reaching. The consistency of the message at the varied sites has raised awareness and given educational guidance for behavior change.

Choice 3: Breast: Collaboration with Coalition members has expanded community awareness for NJCEED program services and outreach messages thereby assuring a greater understanding in the community.

Monmouth

Choice 1: “Choose Your Cover” was widely supported by all five medical centers, health departments, physicians and volunteers. Monmouth CCC screened on average 800 people each year at six Monmouth County beaches. Public acceptance was high.

Choice 2: Oral cancer screening was made available throughout the county supported by local dentists, oral surgeons and a pathology lab, senior centers, addiction centers, hospital dental clinics, etc. This program has been repeated annually for five consecutive years.

Choice 3: In 2012, Monmouth CCC formed a partnership to facilitate the adoption of municipal smoke-free outdoor air ordinances. Coalition members were successful in educating the Asbury Park City Council to establish an ordinance targeting the beaches and parks. A smoke-free outdoor air ordinance was passed in Asbury Park on June 5, 2012.

Morris

Choice 1: The Morris CCC originated the multi-county program of oral cancer prevention that included screening, public education, professional education and free medical care to people screened by the program who had been detected with an oral cancer related "suspicious condition."

Choice 2: Morris CCC designed and managed the field operations for a Department of Defense-funded and UMDNJ-investigated research program that collected information on men's attitudes and understanding of prostate cancer high risk factors, screening and disease management alternatives.

Choice 3: Collaboration with the Morris County Parks Commission in ACHIEVE program activities worked to stimulate consumption of fresh foods and participation in exercise regimens to reduce obesity.

Ocean

Choice 1: In 2008, “Choose Your Cover” was implemented at beachfront sites and was supported by the Mike Geltrude Foundation. The initial goal was to conduct 300 skin cancer examinations and educate 1,500 people about melanoma/skin cancer, all on a low-cost budget. Volunteer health professionals exceeded their goal and conducted 541 free skin cancer examinations. Of those screened, 47 were referred for biopsies, including 8 people with the possibility of having the more dangerous melanoma. Volunteers distributed sunscreen and educational brochures while teaching sunbathers about this important health concern and how to have fun outdoors while protecting their skin. UV radiation hazards, sun safe practices, the importance of regular skin self-examinations and the early detection of melanoma/skin cancer were discussed during the examinations. UV index signs were displayed at each site and free local radio interviews about melanoma/skin cancer prevention and early detection were broadcast to 120,000 listeners.

Ocean County's model expanded to all of New Jersey's CCCs resulting in over 5,200 people being screened at 54 sites statewide. Over 20% of participants were referred for follow-up including 67 for deadly melanoma.

CDC recognized "Choose Your Cover" as a success story for prevention and early detection in 2008, 2009, and 2010.

Choice 2: Early detection of breast cancer is important to survivorship. A countywide "Pretty in Pink" campaign was initiated in 2007 and continues yearly. The Ocean County Cancer Coalition (OCCC) partnered with area health departments, hospitals and WOBM 92.7 FM Shawn and Sue's Breakfast Club to increase awareness about the need for women to have regularly scheduled mammograms. For the last five years in October, radio broadcasts are made on Friday morning from 5:00 a.m. to 10 a.m. about the importance of breast health. National and local health professionals were interviewed as were breast cancer survivors.

In conjunction, the Ocean County Pretty in Pink Day is held whereby a Freeholders' proclamation is issued and area businesses and schools are encouraged to wear pink. All Toms River High Schools participated as did other school systems, businesses and individuals throughout the county. Based upon the submitted pictures that were gathered in 2008, thousands wore pink to support breast cancer awareness.

The OCCC also oversaw the dissemination of additional programming by providing "mini-grants" to its partner organizations. Through the mini-grants evidence-based programs such as the "Friend-to-Friend" program, which educates older women about breast cancer and successfully encourages women to get a mammogram, additional mammograms have been provided countywide.

Choice 3: OCCC partners recognize that although area breast cancer survivors receive excellent care to meet their medical needs, there is a need to support their "body, mind and spiritual" needs. OCCC provides support to breast and all cancer survivors and co-survivors with funds from the Shawn and Sue Breakfast Club's "Pretty in Pink Fund" and donations from Soroptimist International of the Toms River Area. As the cancer journey begins each person who is diagnosed is provided a comfort bag to help keep their records during their treatment. Knowing that family members and caregivers are a key component to cancer survivorship, the OCCC annually provides a free dinner program for cancer survivors and their caregivers – Surviving the Cancer Challenge- where nearly 100 people gather together to support the journey to wellness. The programs include introduction to complementary therapies such as laughter yoga and Zen meditation to help relieve stress and reduce side effects.

Passaic

Choice 1: The Passaic County Cancer Coalition (PCCC) Breast Cancer programs were always the most successful because of the positive feedback received from the county residents. Each Fiscal Year the coalition received continued requests for returning to locations, e.g., New Lucy's Pharmacy, St. Mary's Hospital, St. Joseph Regional Medical

facilities, county schools, community centers, city health departments and various community based organizations in order to provide education, awareness, and referrals to screening services.

Choice 2: Prostate Cancer programs were also successful due to the need of Passaic County residents. The PCCC and the county NJCEED's Rainbows of Hope program always partnered on various on-site screenings, educational seminars, and most currently the June 30th 2012 BIG BREAK event, a musical about prostate cancer. Some locations where these events took place were New Lucy's Pharmacy, City of Passaic Health Division Clinic, Prospect Park Promise Community Center, Paterson St. Joseph's Getty Avenue Facility, Clifton Health Department, Passaic County Elks, and Holy Trinity Church.

Choice 3: Every fiscal year the PCCC participated in the "Choose Your Cover" statewide Campaign. The coalition partnered with the Wayne Health Department to provide yearly skin cancer screenings and education. The coalition also partnered with the Passaic County Health Department for outreach events at the Wayne Willowbrook Mall, county fair, WIC Program summer safety seminar, and school outreach, etc.

Salem

Choice 1: For Salem's County Cancer Coalition Healthy Lifestyles initiative, a partnership with the Chronic Disease Unit was established and reached the community through screening as well as education on healthy eating and exercise.

Choice 2: The next most successful venture was a collaboration with the Breast Cancer Initiative. The CCC was able to host a few mass screenings at the local hospital and ongoing screenings at the FQHC facility and a local clinic.

Choice 3: During this year the CCC was able to expand and reach out to the barbershops to include men in the process of screening through NJCEED as well as educate the barbers and initiate Chronic Disease screenings within the barbershop itself.

Somerset

Choice 1: Working with Somerset County Freeholders, hospital administrators, partners and the quit center, Somerset County Cancer Coalition was able to create and adopt smoke-free county grounds and smoke free hospital grounds. Other efforts included lung cancer awareness, education, and cessation efforts over the years in various settings therefore increasing the number of people who quit smoking in Somerset County.

Choice 2: The Coalition embarked on education, awareness, and screening for skin cancer at the inception of the grant reaching and referring thousands of individuals who were screened. The Coalition has hosted events, on an ongoing basis, at large and small venues including corporations and parks.

Choice 3: Somerset County Cancer Coalition worked in tandem with the NJCEED program to increase the number of women screened for breast cancer and referrals for treatment as well as with various other partners e.g., the hospital, community groups, corporations, etc.

The Coalition has held a breast cancer awareness signature event every October with a proclamation to highlight the importance of awareness and early detection.

Sussex

Choice 1: A county Breast Health Task Force was created. As a result, advertisement campaigns for mammography were developed and locations for mammography for the uninsured and underinsured were published. The “Tie a Ribbon” campaign was extended to all the county's municipalities and breast cancer programs were highly attended. Breast awareness necklaces were distributed to all attendees and continue to be shared from attendees to others in the community.

Choice 2: Lung cancer and the dangers of second hand smoke were presented at the county college on a monthly basis as well as education to Girl Scout Daisy troops where story time and singing were done. Monthly education at the home for unwed mothers and at the Newton Hospital prenatal clinics and hospital and school fairs were held. The Sussex County Cancer Coalition collaborated with Global Advisors on Smoke-free Policy (GASP) and Tobacco Free for New Jersey to send dangers of second-hand smoke educational materials to all municipal leaders to facilitate the adoption of Smoke-free Parks and Recreation Area Ordinances.

Choice 3: Sun Safe education programs were held at fairs and at the high school. Seven schools and one pool have successfully participated in the SCREEN program and anticipate participation each year. Through “Choose Your Cover,” at risk participants have been identified and referred for follow-up and possible treatment.

It must be noted there were major efforts in two additional areas, oral cancer screening and colorectal cancer education. Oral cancer screenings have been held in this county at multiple locations with follow-up for the uninsured provided. Screenings were extended to the Latino population and increased to the senior population-most at risk and education on oral cancer at the county fair with screening provided. Colorectal cancer education was held for the community and health care professionals and was well received.

Union

Choice 1: “Being a visible presence and a strong voice for cancer awareness, prevention and control in Union County” through mass media campaigns were the Union County Cancer Coalition’s (UCCC) most significant achievements. These campaigns included: 1) developing cancer awareness Public Service Announcements (PSAs) for television broadcasting; 2) broadcasting the PSAs on local access television channels and closed circuit television systems in municipal buildings; and, 3) making these PSAs available on the UCCC Website and YouTube. The UCCC developed three PSAs for television broadcasting, breast cancer awareness in 2008, prostate cancer awareness in 2009 and lung cancer/smoking cessation awareness in 2011. Remarkably the UCCC did this at no cost as Coalition members wrote the scripts, recruited the speakers, arranged for the taping, and did the editing. After production, the PSAs were broadcast on the county’s two local access channels for about 50 hours each for a four to six month period during 2008, 2009 and 2011. To give one example

of the impact these PSAs had, in 2008, a representative of Comcast saw the breast cancer PSA and invited the UCCC's Coordinator to be interviewed on its Newsmakers program.

Choice 2: The UCCC's Lung Cancer/ Smoking Cessation PSA was developed and broadcast to effectively communicate four very important public health messages: 1) Lung cancer is the leading cause of cancer death; 2) Smoking causes most lung cancers; 3) If you smoke, quit!; and 4) If you don't smoke, don't start! The county's two local access channels showed the UCCC Lung Cancer PSAs ~ 1,500 times per month from late October 2010 through the end of March 2011, providing approximately 50 hours of total air time on these channels. In addition, the PSA is also being shown periodically on closed circuit TV systems in the county building and in some municipal buildings.

Choice 3: The UCCC has participated in the annual Union County Free Oral Cancer Screening Event. The 2012 event marked the sixth consecutive year that the UCCC has participated in partnership with the Dr. Hillel Ephros, an Oral and Maxillofacial Surgeon at St. Joseph's Regional Center, the Oral Cancer Consortium, and other northern New Jersey CCCs. In the six events, a combined total of nearly 350 people were screened for oral cancer, free of charge.

Warren

Choice 1: The Warren County Cancer Coalition (WCCC) has provided hundreds of educational programs with breast health information over the years reaching thousands of Warren County residents. Breast cancer is the most commonly requested topic for the community and the WCCC has a number of educational modules and literature on this topic. For several years the WCCC has provided a "Ladies Night Out" event that focused on breast cancer. This popular event reached hundreds of women.

Choice 2: Skin cancer, particularly melanoma, is another common area of interest in Warren County. The WCCC has targeted the school systems to speak on several cancer topics and always emphasize skin cancer prevention for students. WCCC has participated in the Warren Hospital Annual Skin Cancer Screening to provide literature and education to participants.

Choice 3: Lung cancer is another area of focus of the WCCC. This topic also is covered in the school presentations offered. There is a variety of presentations provided throughout the community and lung cancer is included in those programs.

Note, it was very difficult to rank the areas individually because most of the educational programs and outreach target all of these areas at once. For example, the most popular community presentation has been the "Top 5 Cancers in Warren County" that includes information on breast, colorectal, lung, melanoma, and prostate cancers equally. Over the five-year time period, the WCCC has provided 273 cancer outreach programs to over 10,500 Warren County residents.

Following their narrative responses to their top three-ranked accomplishments, the Coalitions were asked to identify which of the following six items contributed to their successful programs: (a) When Coalition members are given the opportunity to choose the topics on which they work,

they tend to be more invested; (b) Input and commitment from Coalition members; (c) Resources (i.e., staff, supplies, and facilities); (d) Funding; (e) Support from administrators; and/or (f) Other, specify. Most cited was input and commitment from Coalition members followed by resources not specifically related to funding and when Coalition members are given the opportunity to choose the topics on which they work. Through the comments it was clear that the Coalitions worked to build their constituencies and work toward results on projects. Once Coalitions began to see successes, they committed to achieving others: “success begets success.”

B. Task Force, Workgroup, and Standing Committee Highlights

The Task Force is charged with the development, implementation, and evaluation of the New Jersey Comprehensive Cancer Control Plan with modification as needed. To support the success of these efforts, each of the Workgroups and Standing Committees has a workplan that in general has been reviewed quarterly throughout the year. Based on a number of volunteer efforts of the Task Force, Workgroups and Standing Committees, the following activities have occurred from January 1, 2009 to June 30, 2012.

1. Task Force

2009

- Second Plan: Oversight and work in an advisory capacity was continued to support implementation of the 2008-2012 Plan at the state and local level. Task Force members continued to attend quarterly Task Force meetings and to Chair or participate in Workgroups, Standing Committees and County Cancer Coalitions.
- At the 2009 CDC Resources Workshop, the Task Force was asked to participate through education and activation of their respective grassroots networks. Task Force Advocacy Ad Hoc Committee members continued to support increased funding for the New Jersey Comprehensive Tobacco Control Program (NJCTCP), smoke-free Atlantic City casino legislation, and new NJDOH tanning facilities regulations.

2010

- Task Force members were provided with county based information and charged to advocate on behalf of cancer-related programs. In addition, the Task Force Advocacy Ad Hoc Committee members continued to advocate for funding of the Comprehensive Cancer Control Program.
- A team comprised of Task Force members, OCCP staff, Workgroup Chairs and a CCC Coordinator attended the Comprehensive Cancer Control Leadership Institute hosted by the Comprehensive Cancer Control National Partnership on June 8-10, 2010 in Los Angeles, California. The focus of the Institute was on identifying and sharing best practices. New Jersey presented on the Choose Your Cover initiative.
- Arnold Baskies, MD, Task Force Chair and Co-Chair of the Melanoma Workgroup, assumed the role of President, American Cancer Society, Eastern Division.

2011

- Task Force Advocacy Ad Hoc Committee members continued to advocate for funding of the Comprehensive Cancer Control Program. They also reviewed the Advocacy Ad Hoc

Committee's Advocacy Recommendations for Cancer Control in New Jersey, provided feedback and suggested incorporating recommendations into the next Cancer Plan and writing a letter to the Governor on advocacy issues.

- The Task Force supported Teen Indoor Tanning Ban Legislation (A2933/S2119).

1/1/12 to 6/30/12

- Given the shift at the national level toward addressing cancer as well as other chronic diseases, feedback and direction for restructuring of state-level Workgroups and Standing Committees was provided. The final restructuring occurred in the fall of 2012.
- Several Task Force and Workgroup/Committee members participated in focus groups related to the development of the Chronic Disease State Plan. Their continued participation in the planning of the State Plan has been requested.

2. Standing Committee Activities

Advocacy Ad Hoc

- On an ongoing basis, the Advocacy Ad Hoc Committee has championed efforts to sustain appropriations for OCCP, New Jersey Comprehensive Tobacco Control Program (NJCTCP), New Jersey Commission on Cancer Research (NJCCR) and NJCEED. It has worked tirelessly on supporting Smoke-Free New Jersey issues including the smoke-free Atlantic City casino legislation and the Indoor Teen Tanning Ban. Through the ACS, access to health care issues has been undertaken not just for cancer-related needs but for all health needs, e.g., a call to action was issued in support of the New Jersey Health Benefit Exchange Act.
- Tracking of legislation on all Plan cancers and related issues also is done on an ongoing basis. The Committee Chairs routinely updated talking points and provided guidance to Task Force, Workgroup, Committee members, and Coalitions to help them stay on target with messages.
- The Committee developed Advocacy Recommendations for Cancer Control in New Jersey with input from all the other Workgroups and Committees and has used means such as letters, editorials, petitions, legislative visits, and budget hearings to get its points across.

Communications

- The Communications Committee continued to implement the Communications Plan to promote comprehensive cancer control and raise awareness of its benefits among public health and medical leaders, advocates and the cancer control community.
- Primary accomplishments include the creation of a media portal on the OCCP website, the development of the tag line, "Working together to reduce the burden of cancer in New Jersey," key messages, a revised OCCP logo, a media statement explaining the relationship of the County Cancer Coalitions to the OCCP and a revised OCCP Fact Sheet.
- The e-newsletter, IMPACT, continued to be published through summer 2011.
- In 2012, the Committee began revising the Communications Plan to reflect the new CDC grant cycle and the restructuring of the Task Force Workgroups and Coalitions. The

Committee plans to collaborate with the Communications Committee for the Chronic Disease State Plan. It also is planning to look for ways to expand the use of social media.

Evaluation

- Efforts have included reviewing and updating annually the Evaluation Plan that monitors the short-term, intermediate, and longer-term outcomes of implementation of the Task Force’s overall workplan. The Committee is responsible for the biennial Status Reports such as this one. In addition, an Evaluation Training Subcommittee has been developed to train the County Cancer Coalition Coordinators on program evaluation. A webinar, “Elements of Effective Program Evaluation,” was conducted on November 6, 2008 by the Chair of the Evaluation Committee, Marcia Sass, Sc.D., and is available at: www.njcancer.gov.
- Though efforts to schedule other webinars were made, the next successful webinar entitled, “Using Evidence to Create Effective Cancer Prevention, Education and Screening Programs” that was hosted and presented by the Cancer Information Service in collaboration with the Evaluation Committee was held on June 11, 2009. Evaluation of the webinar revealed that those who participated in the session had an increase in knowledge as well as in confidence to address evaluations of their activities. In addition to this webinar, with the support of carry-forward funding, one-on-one evaluation assessments were conducted with each of the County Cancer Coalitions. Training was done based on the assessed need(s) of each Coalition. For those with large events scheduled, evaluations to address these activities were developed, implemented, and evaluated as needed to support the coalitions.
- To improve capturing data requested as part of the CDC Performance Measures to be submitted by Comprehensive Cancer Control Programs, the Evaluation Committee worked with OCCP staff to revise the County Cancer Coalition Event Reporting Form to an Event Planning and Reporting Form. This has been in use since January 2010.
- In the late spring of 2010, 2011, and 2012, carry-forward funds were made available to support development of the segments of the status report as well as individual one-on-one evaluation activities with nearly all the County Cancer Coalitions.

3. Workgroups

Breast

- In 2009, an inflammatory breast cancer (IBC) education and awareness event was hosted by Panera in Hamilton, New Jersey in memory of a former Workgroup member. The program was attended by 100 people and proceeds from the event were donated to the Erase IBC Foundation.
- A CME article entitled “Breast Imaging” was written by Workgroup member, Melinda J. Staiger, MD, and published in Volume 9, Issue 1 (2010) of *Perspectives*, the Journal of the New Jersey Academy of Family Physicians.
- A Speakers Bureau was created to provide community educational programs.
- In October 2011, NJCEED and the County Cancer Coalitions held breast cancer awareness events at local Walgreens.

Childhood

- On June 9, 2009 the conference, “Childhood Cancer: Negotiating the Present...Planning the Future” was presented at the National Conference Center in East Windsor, New Jersey for physicians, nurses, social workers, and families of survivors. Of the 78 enrolled, 68 attended. The conference had two tracks:
 - *A Lion in the House* was for those children who have been diagnosed with cancer. This track highlighted the impacts of cancer in children and what it is like for themselves and their families as the children transition back into society after being diagnosed and treated, possibly experiencing late health effects, etc.
 - *SuperSibs!* was for siblings of children who have been diagnosed with cancer and highlighted the impacts of cancer on siblings and how they can support their siblings with cancer.
 - Each track utilized educational video modules from the award-winning documentary, *A Lion in the House*. Except for some transmission issues, comments pertaining to accomplishment of objectives, value to attendees’ practices, and value of content related to survival impacts on siblings were all rated positively.
- “Resources to Help Childhood, Adolescent, and Young Adult Cancer Survivors” was published in April 2009. Hard copies were distributed at the June 9, 2009 conference and posted on the OCCP website:
http://www.nj.gov/health/ccp/documents/childhood_resource_guide.pdf

Colorectal

Increasing colorectal cancer screening rates has been a major focus of the colorectal cancer workgroup. Projects related to increasing screening rates have been:

- Implementation of the ACS’s Colorectal Cancer Screening Toolkit. As of July 1, 2012, each Regional Chronic Disease Coalition is required to introduce the toolkit to five primary care physicians with the goal of recruiting at least two to implement the toolkit.
- Capital Health System received a colorectal cancer screening grant from the ACS and Bristol- Meyers Squibb that was initiated on 10/1/08 and ended 12/31/10. The goal was to offer colonoscopies to 300 uninsured individuals. A total of 484 patients were screened; 360 received colonoscopies with the following outcomes: 309 polyps, 88 adenomas and 4 cancers. As of March 2012, the screening grant was re-started and colonoscopies were provided to family health center patients.
- Body and Soul was implemented in Trenton by the co-chair of the Colorectal Cancer Workgroup. In 2012, the National Black Leadership Initiative on Cancer was awarded a Body and Soul grant for Trenton, East Orange and Jersey City.
- Healthcare Quality Strategies, Inc. implemented a project with primary care physicians with electronic medical record capacity to increase colorectal cancer screening rates among Medicare beneficiaries. The project was funded by Centers for Medicare and Medicaid Services (CMS). At least 65 physicians participated in the project.
- UMDNJ participated in a CMS patient navigation demonstration project to increase screening rates among Medicare beneficiaries.
- NJCEED, OCCP and the Supplemental Nutrition Assistance Program (SNAP) collaborated on a Colorectal Cancer Awareness Campaign with the New Jersey Food Banks.

- ACS funded colorectal cancer screening projects with Federally Qualified Health Centers:
 - Newark Community Health Center – Goal: To increase colorectal cancer screening using a patient navigator system.
 - Visiting Nurse Association of Central Jersey – Goal: To increase pap smears, mammograms, FOBT's and colonoscopies by working with providers to update health maintenance records and keep people on schedule (moving to a certified EMR system).

Gynecologic (Cervical and Ovarian)

Cervical

- A training manual and DVD entitled, “Cervical Cancer & HPV: What are Your Concerns?” was created and printed in March 2009. Targeted audiences for distribution have included school nurses, County Cancer Coalitions, and NJCEED lead agencies. From 2009 to 2012, several school nurse workshops were held throughout the state where the HPV DVDs and training manuals were distributed. Approximately 400 training manuals have been distributed thus far.
- A HPV / Cervical Cancer Workshop for Health Professionals was held on January 22, 2010 at Middlesex Fire Academy in Sayreville, New Jersey.
- The “HPV & Cervical Cancer Resource Guide” was developed to provide information and resources about HPV and cervical cancer to healthcare providers, patients and the community. The guide is posted on the OCCP website at:
http://www.nj.gov/health/ccp/hpv_cervical_cancer_res_guide.shtml.

Ovarian

- Assisted with the planning of a continuing medical education program for Spring 2009 at The Mansion in Voorhees, New Jersey in collaboration with Cooper Healthcare System. The target audience included primary care physicians and specialists in obstetrics and gynecology as well as fellows, residents, advanced practice nurses and other physicians with an educational need or interest. Topics included Evaluation and Management of Adnexal Masses, Hereditary Aspects of Ovarian and Breast Cancers, Surgical Management, Chemotherapy, Current Research and Psychological Perspectives in the Management of Ovarian Cancer Patients. There were 76 participants.
- The 1st Annual New Jersey Statewide Ovarian Cancer Symposium, “One Force to Make a Difference,” was held on June 12, 2010 at Educational Testing Service in Princeton with 65 in attendance. The purpose of this symposium was to raise awareness of ovarian cancer and promote fundraising efforts for ovarian cancer research. The event was free to ovarian cancer fund raising organizations and foundations, ovarian cancer survivors, advocates, members of the medical community, and members of the County Cancer Coalitions. A second similar conference was held on June 18, 2011 with 80 in attendance.

Lung

- A webinar series for healthcare providers on lung cancer prevention, early detection and treatment was held in November 2010. The Prevention webinar was held on November 1 with 71 attendees; the Early Detection webinar was held on November 8 with 62 attendees; and the Treatment webinar was held on November 15 with 60 attendees.

CMEs were provided. The majority of those who responded to the evaluation replied either “very good” or “excellent” that the webinars met their expectations, the objectives were fulfilled, and the content would assist them in their work.

- On an ongoing basis, the Lung Cancer Workgroup has been working to track and campaign for tobacco control resources and to promote smoking cessation activities. It has been promoting smoking as a socioeconomic issue and has worked with the Federally Qualified Health Center’s to provide smoking cessation services to patients they serve. The Workgroup also has supported smoke-free hospital campuses for employees and patients. As of February 2012, 89% of the hospitals have joined the smoke-free campus effort.
- The ACS and Lung Cancer Workgroup members have aimed to encourage the creation of smoke-free outdoor air municipal ordinances from 19% to at least 40% of New Jersey municipalities.
- The Workgroup has also kept the Task Force abreast of recent research, e.g., on spiral CT scans.

Melanoma

- “Choose Your Cover” initially was a joint project of the Ocean County Cancer Coalition and Melanoma Workgroup. It was launched on August 2 and 3, 2008 at three beaches in Ocean County. Crowds of beach goers were offered free skin cancer screening and education. Results included 541 free skin cancer screenings; 47 (9%) referrals including presumptive diagnosis for: 7 (3%) basal cell carcinomas; 5 (1%) squamous cell carcinomas; and 8 (2%) suspected melanomas. It is now a NJ statewide initiative to provide skin cancer screening and education at the beach and other outdoor venues. Given the progress made with the implementation of this initiative, its evolution and outcomes are featured in section IV. Implementation Evaluation.
- The CDC Skin Cancer Project SCREEN (Skin Cancer Reduction – Early Education Network), a social marketing sun safety campaign, was first funded by CDC in 2007 and continued through June 2012 with Hunterdon and Ocean County Cancer Coalitions serving as the lead agencies. Progress and outcomes of this initiative are described in section IV. Implementation Evaluation.
- The Train the Trainer program for skin protection and cancer prevention was extended to school nurses in Bergen County on October 10, 2008 to school nurses in Essex County on October 15, 2008. Seven school districts have been involved in the skin cancer program. Programs also occurred on October 26, 2009 in Hudson County and November 4, 2009 in Passaic County with similar trainings throughout 2012.
- Tanning Facility Regulations: The Melanoma Workgroup supported the NJDOH’s new regulations for tanning facilities which require the following: 1) registration of tanning facilities and a \$300 annual registration fee, 2) minors less than 14 years of age cannot use a sunlamp product in a tanning facility, 3) minors 14-18 years of age need parental consent to use a sunlamp product, 4) age and identity verification, 5) signs describing the age restrictions, 6) annual inspections, 7) certified, trained operators, and 8) cleanliness standards. As of September 2009, tanning facility registration has been ongoing. Inspections were begun in spring 2010; current inspections are limited to new venues.
- Teen Indoor Tanning Ban: In conjunction with the Advocacy Ad Hoc Committee, efforts have continued to ban the use of indoor tanning by minors under 18. Though the bill was

passed in the Assembly in the spring of 2012, Sen. Vitale amended the bill for the Senate (S1172) to include a ban for individuals 15 and under and to impose restrictions for those 16 and 17 years of age. The bill was sent back to committee and the ACS has continued to push the Senate to adopt a bill banning indoor tanning by minors under 18.

Nutrition and Physical Activity

- Updates were made to the Nutrition and Physical Activity section of the OCCP's cancer resource website: <http://web.doh.state.nj.us/apps2/cancerfacilities/cfsearch.aspx>.
- In 2010, the Workgroup began developing a set of talking points based on World Cancer Research Fund – American Institute of Cancer Research and ACS guidelines but with the intent to present as one, clear and consistent message. The content addressed nutrition, physical activity, negative impacts of obesity, and their relationship to cancer.
 - In 2011, the presentation was piloted in Somerset County at three community sites and an evaluation was developed to accompany it. The presentation received good feedback from attendees and plans in 2012 included further editing of the presentation as needed based on feedback from the evaluations.

Oral

- The Multi-County Oral Cancer Screening Project (a collaboration of Bergen, Morris, Passaic, Hudson and Union CCCs) and free screenings by other County Cancer Coalitions and Workgroup member organizations in Burlington, Essex, Hunterdon, Middlesex, Monmouth, and Sussex Counties continued from 2009 through 2012. In 2009, a total of 956 people were screened; in 2010, 1065 people were screened; in 2011, three Federally Qualified Health Centers also participated in the free screening events and a total of 903 people were screened; and in 2012 approximately 348 people were screened.
- In 2010, efforts by the Workgroup resulted in the passage of the Joint Resolution naming April as “Oral and Oropharyngeal Cancer Awareness Month.”
- The Oral and Oropharyngeal Workgroup has continued to stress the importance both of screenings for oral cancers and the training of dental health providers to be able to provide thorough screenings for oral cancer. In 2012, 170 were trained at several sessions at sessions around New Jersey. Efforts have been underway to acquire Continuing Dental Education credits for those participating in oral cancer screening events.
- Over the last few years, oral cancer screenings also have been provided at the New Jersey Statehouse Annex. On June 28, 2012, 90 people were screened and two were referred for further evaluation.

Palliation

- The Palliation Workgroup continued to monitor legislation for prescription pain medication. As of December 2009, Senate bill S2550 was signed by the Governor. This bill provides an extension of pain prescription refill from 30 days to 90 days. SJR-82, a joint resolution naming Pain Awareness Month was pending.
- The Monmouth County Cancer Coalition held presentations on palliative care in January 2010 at the Lions Club with 50 attendees, and as of May 2010, they had held two more presentations at senior centers. As of May 2010, the Atlantic County Cancer Coalition was also conducting programs on palliative care.

- Two palliative care webinars were delivered in partnership with Capital Health. The target audience was physicians, nurses, social workers, County Cancer Coalitions and NJCEED lead agencies. The first webinar on Pain Management was held on June 21, 2012 with 72 attendees and 3 people viewing the recording. The second webinar on Symptom Management was held on June 28, 2012 with 55 attendees and 6 people viewing the recording. Continuing Education Units were provided.

Prostate

- The Workgroup Chair has been highly involved in Women Against Prostate Cancer (WAPC), a national organization that advocates for prostate cancer education, public awareness, screenings, legislation, and treatment options. A local chapter in New Jersey was in the process of being developed.
- Workgroup members advocated for the Prostate/Colorectal bill which was to provide treatment dollars for prostate and colorectal cancers after screening.
- Workgroup members were funded for CDC's Prostate Cancer Project, Barbershop. This initiative is highlighted in section IV. Implementation Evaluation.

Keeping the Public Informed

1. The Website

- **Identifying Gaps:** The OCCP has continued to partner with key stakeholders to identify gaps in cancer control-related programs. This has been done primarily by collaborating with stakeholders such as the County Cancer Coalitions and other state agencies to update and maintain current information on cancer control related programs. For example, the OCCP has partnered with the NJDOH, Office of Information Technology Services (OITS), NJCEED, the Coalition Coordinators, and the NJDOH, Office of Primary Care to update the enhanced OCCP geocoded website with the most current information on hospitals, hospices, mammography centers, Federally Qualified Health Centers, NJCEED lead agencies, the County Cancer Coalitions, and nutrition and physical activity programs.
- **Geocoded Website:** Another method of promoting comprehensive cancer control in New Jersey has been by disseminating cancer resources through the geocoded, OCCP website. The following elements have been included on maps as well as in a searchable database: facility name, address, telephone/fax numbers and website address set up as a hyperlink. These maps (provided through Google) and the searchable database have allowed visitors to easily locate healthcare services by county, obtain driving directions and access information on those services by clicking on a hyperlink to that facility's website. In partnership with OITS, the OCCP has continued to update the geocoded website on an ongoing basis. The website can be accessed by logging onto www.njcancer.gov and clicking on the map of New Jersey. An additional method of promoting cancer resources and activities via the web has been by providing the Coalition Coordinators access to the Health Department's online calendar of events.
- **Website Linkages and Webinar Training with Partner Organizations:** To further promote the benefits of comprehensive cancer control and to disseminate cancer resource information to the public, the OCCP continues to partner with community organizations and systems that target at risk populations to develop linkages to the Plan and the OCCP website. In December 2008, the OCCP requested that partner organizations create a link

from their website to the OCCP website. Several organizations have created links and many organizations indicated that they already link to the OCCP website. In addition, library systems such as the New Jersey State Library and the UMDNJ University Libraries and the County Cancer Coalitions have links to OCCP's website, providing additional public access to the interactive resource guide and other cancer-related information provided through the site.

2. IMPACT: A Quarterly Newsletter

A quarterly newsletter, IMPACT, was first published in October 2005. It focused on the activities of the state-level Workgroups and the County Cancer Coalitions and was distributed electronically to all Task Force, Workgroup, Standing Committees, and Coalition members, as well as other stakeholder groups, such as the medical directors of the Centers for Primary Health Care, American College of Surgeons Cancer Liaison Physicians, and the Oncology Registrars Association of New Jersey (including all Certified Tumor Registrars in the state). Given a reduction in staff to support this activity, New Jersey was granted a redirection of funds through the CDC procurement process through June 2011 and engaged a consultant who was responsible for publications of IMPACT through June 2011.

IV. IMPLEMENTATION EVALUATION: Choose Your Cover and the Optional Skin and Prostate Cancer Projects

Choose Your Cover, the skin cancer screening and health education initiative and two optional CDC-funded projects, one to address skin and the other to address prostate cancer are described in this section. The rationale for each of these projects is addressed under each topic area below.

A. Skin Cancer Project Activities

Background

New Jersey's cutaneous melanoma incidence rates have reflected the national trend of increasing incidence. Data from the New Jersey State Cancer Registry reveal that the incidence rate of melanoma in New Jersey men and women (all races combined) has increased from 1979 to 2005. The American Cancer Society has estimated that in 2012, 2,340 new melanoma cases will be diagnosed in New Jersey. Addressing skin cancer prevention, early detection, and treatment have been major aims of the Melanoma Workgroup of the Task Force. Two initiatives, Choose Your Cover (skin-cancer screening salons), a positive approach to address skin cancer screening, early detection, and education and the Skin Cancer Reduction – Early Education Network (SCREEN) Sun Safety Program funded by the CDC beginning July 1, 2007 have been implemented through the Melanoma Workgroup and the County Cancer Coalitions.

Choose Your Cover (CYC)

This initiative emerged from the Task Force and at the time Melanoma Workgroup Chair's question to the Ocean County Cancer Coalition Coordinator as to whether it might be feasible to conduct skin cancer screening salons at the beach. And as was described in Melanoma Workgroup activities and the Ocean CCC efforts, the 2008 CYC experiences at the beaches were quite positive.

In 2009, this program saw an increase in participating counties from one (Ocean) to four (Ocean, Monmouth, Atlantic, and Cape May). The events held on July 25, 2009 again screened crowds of New Jersey beach-goers for skin cancer. The screening sites increased from 3 to 11 and the screenings increased by 154%. The results included: 1,376 free skin cancer screenings; 508 (22%) referrals including presumptive diagnosis for: 61 (4%) basal cell carcinomas; 31 (2%) squamous cell carcinomas; 54 (4%) suspected melanomas. There was collaboration between hospital systems, healthcare providers and media. Prior to the July events, efforts were made to develop a standardized instrument with pre-/and post-screening education questions and the form was piloted at one of the sites. The pilot based on three items and 173 pre-post screening forms was successful. The pre-test items included, “Do you use sunscreen, seek shade, and wear protective clothing?” Post test items included, “Now that you have participated in “Choose Your Cover” sun safety education and skin cancer, how likely are you to use sunscreen, seek shade, and wear protective clothing?”

In 2010, with the encouragement of the Melanoma Workgroup, CYC became a statewide initiative to be held at beaches, parks, pools, ballparks, and other open-air venues. A three-part skin cancer screening, pre-/ and post-screening education form was developed based on that of the National Academy of Dermatology criteria. The new form additionally had a field for participant consent for approval to use his/her de-identified information for the purposes of research. Institutional Review Board (IRB) approval was obtained as long as CITI (Collaborative Institutional Training Initiative)-trained individuals were on site to clarify the consent process for participants. Since 2010, the same forms and processes have been used. As can be seen in the CYC table below, for the complete time period, there were a total of 70 sites; 2010 had the greatest number of screening sites (22) followed by 18 in 2011 and 16 in 2012. A total of 6,604 were screened and of these, 3,721 were identified as “normal.”

Year	# Sites	Average Screenings per Site	# Screened	# Normal
2008	3	180	541	494
2009	11	125	1376	839
2010	22	87	1921	610
2011	18	78	1395	952
2012	16	86	1371	826
TOTAL:	70	94	6,604	3,721

Notes:

In years 2010 through 2012 not every site reported total referrals and presumptive diagnosis; therefore referrals and diagnosis may be underreported.

In 2011 screenings were held in June and volume at most beach sites declined.

In 2012 Ortley Beach had rain, volume down to 111; could not get screener for Brick Beach III; presumptive diagnosis data for one Atlantic City and one Cape May site not reported

Sources: 2008 Ocean County Registration and Report Forms; 2010 Choose Your Cover Melanoma/Skin Cancer Screening and Report Forms

For the subset of individuals ≥ 18 for whom consent was obtained to use their de-identified

data for the purposes of research there are N=1,452 individuals for combined years 2010 and 2011. (See TABLE 5. “Choose Your Cover” Melanoma/Skin Cancer Screening Program: Frequency Related Information for Some Key Items.) Of these, 250 (17.0%) had biopsy recommended alone or in combination with referral, an annual exam, no action, or a combination of biopsy, referral, and an annual exam. For an additional 686 (43.80%) participants, an annual exam was recommended either alone or in combination with referral or no other action.

Recommendations:	N	%	Biopsy Recommended	
			N	%
0 - None Indicated	221	15.22		0.00
1 - Biopsy recommended	109	7.51	109	0.08
2 - Referred	95	6.54		0.00
3 - No action necessary	250	17.22		0.00
4 - Recommend annual exam	496	34.16		0.00
Both 1 and 2	62	4.27	62	0.04
Both 1 and 4	46	3.17	46	0.03
Both 2 and 3	1	0.07	0	0.00
Both 2 and 4	55	3.79		0.00
Both 3 and 4	85	5.85		0.00
Three checked - 1, 2, and 4	<u>32</u>	<u>2.20</u>	32	0.02
Totals:	1452	100.00	250	0.17

On their forms (see TABLE 6: CYC Responses to Whether Individual and/or Family Members Had Had Skin Cancer or Whether the Individual Had Had a Change in a Mole by Number and Percent), 599 (41.25%) indicated that they either have had skin cancer; have had skin cancer and a family member who has had skin cancer; have had skin cancer and a mole that had changed; or have had skin cancer, a family member has had skin cancer, and a mole that had changed.

Blank/No Response	853	58.75	853	58.75
1 - I have had skin cancer	82	5.65	935	64.39
2 - I have a family member who has had skin cancer	298	20.52	1233	84.92
3 - I have a mole that has changed recently in size, color, or shape	122	8.40	1355	93.32
Both 1 and 2	35	2.41	1390	95.73
Both 1 and 3	6	0.41	1396	96.14
Both 2 and 3	49	3.37	1445	99.52
All three - 1, 2, and 3	<u>7</u>	<u>0.48</u>	1452	100.00
Totals:	1452	100.00		

In terms of presumptive diagnoses (see TABLE 7: CYC Recorded Presumptive Diagnoses by Number and Percent), there were 64 (4.41%) basal cell, 42 (2.89%) squamous cell, and 10 (0.69%) melanoma cancers. While 676 (46.6%) were identified with only one presumptive skin diagnosis, 71 (4.9%) were identified with three or more diagnoses.

Presumptive Diagnoses	N	%	Total # of Presumptive Diagnoses		
			Per Person	N	%
#1 Seborrheic keratosis	235	16.18	0 = None	502	34.57
#2 Actinic keratosis	166	11.43	1	676	46.56
#3 Dysplastic nevus	110	7.58	2	203	13.98
#4 Congenital nevus	49	3.37	3	58	3.99
#5 Basal-cell carcinoma	64	4.41	4	10	0.69
#6 Squamous-cell carcinoma	42	2.89	5	<u>3</u>	<u>0.21</u>
#7 Melanoma	10	0.69	Totals:	1452	100.00
#8 Mole/Nevis	415	28.58			
#9 Other	220	15.15			

Quite important to the CYC initiative has been the health education component that has accompanied the screening. To assess its benefit, there were five Likert items with choices ranging from 1 (Not at all Likely/Never) to 5 (Definitely/Always) included on the form that were asked pre-screening and post-screening before the participant exited. These included: (1) How likely do you think that you will develop skin cancer from exposure to the sun in the future? And (2) When in the sun how likely will you: (a) Use sunscreen? (b) Seek shade? (c) Wear a hat? (d) Wear clothing that covers the shoulders? All pre-/post-items were highly statistically significant ranging from a negative 4.9757 (less afraid of getting skin cancer after the screening) to a positive 19.9644 for use of skin protection. (See TABLE 8: Choose Your Cover Assessment of Pre-Post Changes that follows.)

TABLE 8: 2010-2011 Choose Your Cover Assessment of Pre-Post Changes

Pre-Post Item Pair	<u>Sample Sizes</u>			<u>Means</u>		<u>Standard Deviation</u>		<u>Pre By Post Correlations</u>	<u>Post-Pre Means Differences</u>	<u>T- Statistics</u>
	<u>Pre</u>	<u>Both</u>	<u>Post</u>	<u>Both Pre&Post</u>		<u>Both Pre&Post</u>				
How Likely Will You Develop Skin Cancer	1358	1176	1247	3.0153	2.8206	1.3253	1.2793	0.4705	-0.1947	-4.9757**
How Often Do You Use Sunscreen	1403	1360	1407	3.9544	4.3088	1.0848	0.9087	0.7242	0.3544	17.2267**
How Often Do You Seek Shade	1368	1325	1400	3.5645	3.8755	1.0406	0.9734	0.7420	0.3110	15.5797**
How Often Do You Wear a Hat	1371	1320	1391	3.0939	3.5947	1.3796	1.2534	0.7648	0.5008	19.9644**
How Often Do You Wear Clothing To Cover Shoulders	1363	1307	1386	3.2104	3.6656	1.1003	1.0677	0.6889	0.4552	19.2197**

** Difference in means is significant at p < .01

Skin Cancer Reduction – Early Education Network (SCREEN) Sun Safety Program

First funded in July 2007 by CDC, this program was successfully conducted through June 30, 2012. The project aims were to reduce the incidence of skin cancer in New Jersey by: 1) improving sun safety knowledge of children, parents, caregivers, and recreation/school staff; 2) improving sun safety behaviors (i.e., the use/proper use of sunscreen); and 3) increasing sun safety policy implementation and environmental changes (i.e., increases in available shaded areas). The program was implemented in the seven New Jersey counties that had the highest melanoma incidence rates based on 1999-2003 data. These have included: Cape May, Hunterdon, Warren, Morris, Monmouth, Sussex, and Ocean.

Implementation

The first 12 months of the grant cycle established a foundation for the SCREEN Sun Safety Program. It included: 1) the recruitment and training of key stakeholders within the seven targeted counties; 2) the development of three 20-minute lessons to be used in health education curriculums for elementary school children; 3) the development and purchase of sun safety social marketing materials (i.e., UV index signs; UV wrist bracelets; bumper stickers; sun safety tattoos; lifeguard buttons/pins; and sun safe fact of the day); 4) the development of daily tasks for SCREEN sites [i.e., UV sign set-up; daily sun safe fact quiz for children with sun safe prizes; site staff hourly prompts (typically 11am; 12noon; and 1pm) for children/parents to engage in sun safety behaviors such as reapplication of sun screen, and/or seeking shade]; and 5) the finalization of an IRB approved evaluation tool that assesses program efficacy (i.e., process evaluation; sun safety knowledge and behaviors). In addition, approximately 5,500 in-kind sunscreen samples were received from Johnson & Johnson and Schering-Plough that were distributed to SCREEN site patrons during program implementation.

The trainings which were conducted for the SCREEN sites covered: 1) SCREEN Sun Safety Program Curriculum; 2) methods and materials to improve sun safety health literacy in children, parents and recreation/school staff; 3) methods and materials to develop social marketing strategies to promote sun safety in children; 4) methods and materials to gain entry into the public schools and establish sun safety policies; and 5) initiating sun safety advocacy efforts and developing partnerships with local business to create sun-safe environments. Using this “train the trainer” model, personnel from all seven counties were then qualified to implement the SCREEN program within community settings in their specific counties.

Implementation has progressed fairly smoothly over the years. Refinements to the program, largely over the first four years included: 1) Site visits to monitor program adherence; 2) Refinement of an on-site training kit with a step by step guide of how to implement the program including- a) guidance on quantity of materials to distribute on a daily basis; and b) use of a daily schedule including UV announcement times and what activities to complete along with laminated (waterproof) “daily sun safe facts” and “daily sun safe slogan sheets”; 3) Increased variety and amount of social marketing materials per site including UV wrist bracelets, buttons, SPF15 lip balm, bumper stickers, UV cards, additional signage and water-based tattoos; 4) UV inserts were designed allowing site staff to display individual UV numbers as opposed to displaying sets of numbers (i.e., UV level 8, 9, 10); 5) Elimination of

problems (i.e., broken answering machines) associated with communicating the UV index daily to the sites; and 6) Reduction in the supply of bucket hats for program sites due to feedback received in 2008. Based on feedback from lifeguards and site supervisors, the bucket hats provided to site staff were used sporadically. Many of the lifeguards/camp counselors wished to use a variety of their own hats rather than the same hat over the course of the summer. It was decided that supplying bucket hats from the program budget was an inefficient use of grant funds and so these funds were redirected to purchase additional social marketing materials that were used to reward children/patrons for knowing the sun safe fact of the day. The increased incentives to participate in the program have been seen as a huge success given that more children have been involved as more incentives have been offered by the SCREEN program. Overall, evaluation feedback for the last three years (2010-2012) has indicated high satisfaction with the program, both in the elementary schools, and the community sites.

Due to the grant closing on June 30, 2012, the primary focus of the final year of the grant was to implement SCREEN in as many school sites as could be identified, along with an evaluation effort to assess program efficacy. While implementation of SCREEN did occur in some of the community sites through the summer months of 2012 (ending Labor Day weekend 2012), the monitoring and evaluation of these sites was discontinued at the end of June 2012. The SCREEN program was implemented at 15 sites in the northern region [Morris (7), and Sussex Counties (8)], and at 4 sites within the southern region [Cape May (1), Monmouth (2), and Ocean Counties (1)] in NJ for a total of 19 SCREEN sites that were receiving the sun safety program at the end of the grant cycle (June 30, 2012). The decrease in the number of sites was largely due to the five year funding cycle coming to an end just when community sites (i.e., community pools, lakes, beaches) were opening. Of the 19 sites, 15 were elementary schools. It also should be noted that despite the lower number of sites that participated, the number of children receiving SCREEN within elementary schools was well over 1,000. For the northern region, program supplies were exhausted by mid-June 2012.

Progress on Goals and Measurable Objectives

- 1) Increase sun safety knowledge: As an example of the program's outcomes, the table below based on SCREEN activities in ten schools summarizes the pre-post findings at these 10 elementary school sites. Within these 10 schools, approximately 24 health education teachers were trained in providing the three 20 minute lessons on sun safety. It should be noted that the pre-/post-test change in sun safety knowledge was highly significant at the $p < .001$ level for each county and was $p < .0001$ when the data for all of the participating elementary schools was combined. Overall, for the 1,007 children who participated in the pre/post testing, a 22% improvement was obtained. The only county that did not witness a 25% improvement in sun safety knowledge scores was Sussex.

TABLE 9: Pre-/Post-Test Assessment of Sun Safety Knowledge of 3rd, 4th, and 5th Grade Children				
Elementary Schools by County	N	Pre-Test (% correct)	Post-Test (% correct)	T-Test Results
Morris County				
Lakeview School	68	43%	73%	
Mount Arlington School	133	53%	74%	
Total for County	201	48%	73%	T= 14.6; p < .001
Ocean County				
Silver Bay School	104	47%	76%	T=11.9; p < .001
Total for County	104	47%	76%	T=11.9; p < .001
Sussex County				
Florence Burd School	117	42%	57%	
Franklin School	64	40%	N/A	
Green Hills School	35	26%	48%	
Hamburg School	60	42%	44%	
Lafayette School	49	41%	55%	
Merriam Avenue School	300	45%	60%	
Stanhope School	77	46%	73%	
Total for County	702	40%	57%	T=10.1; p < .001
All NJ School-Based Programs	1,007	43%	65%	T= 18.9; p < .0001

- 2) Improve sun safety behaviors (i.e., the use/proper use of sunscreen).

While the original intent was to assess these behaviors through the summer, because the funding ended on June 30, 2012 and the program was continued at various community locations, no additional data collection or analyses were conducted. Therefore, this information is not available. From prior years, parents and their children were more likely to use sunscreen earlier in the season but were less likely to later on resulting in the need for additional messaging and reinforcement of the hazards of sun exposure.

- 3) Increase sun safety policy implementation and environmental changes (i.e., increases in available shaded areas).

Of the community sites that have implemented SCREEN in the northern counties, since 2008 until the present, every site that has maintained the program over the years has gone from having no formal sun safety policies to adopting specific policies that have been tailored at each site. Presently, all sites now have some form of sun safety policies for their patrons. The common denominator for these policies include: daily announcements of the UV index along with announcement of appropriate sun safety behaviors (i.e.,

recommended sunscreen use; recommended use of hats, sunglasses with UV filters, and covering up; and seeking shade when the UV index is greater than 8).

- 4) Increase the available square-footage of shaded areas available to patrons/children at pools, parks, beaches, and/or elementary schools where students engage in outdoor recreation.

While the original purpose was to improve the amount of shade available at the given community sites annually from pre-program (May/June) to post-program (August), what has been learned is that construction of shade structures, or increasing the amount of shade available has been something done in the 'off-season' (typically late spring). A number of the sites had planned to construct additional shade structures. However, funding for county level recreation departments has been significantly reduced. Furthermore, due to the poor economy, efforts to obtain funding/donations from local business and industry were unsuccessful.

Overall, what can be said about the SCREEN Program include the following:

- 1) The SCREEN program was well received by a number of sites. During the five year period, a total of 47 sites participated in SCREEN, with many participating numerous years.
- 2) The social marketing materials were well received by participants and site staff. Continued work will be done to create additional marketing materials to increase the variety of materials made available to reward children participating in the program.
- 3) A significant amount of fourth year project resources went into site monitoring and this effort did improve program adherence within the numerous community locations where SCREEN was being provided.
- 4) Numerous professional presentations were conducted at professional conferences over the five year grant cycle.
- 5) The SCREEN program is presently being used in many communities in the following states besides New Jersey: New York; Iowa; Pennsylvania; Colorado; and California.

B. Prostate Activities in New Jersey: "Barbershop"

Background

In New Jersey, comparing prostate cancer incidence data for the time period 2001-2005 for white and black males 171.50 and 269.5 per 100,000 adjusted to the 2000 US Standard Million population respectively, the ratio for black males (largely an uninsured or under-insured population) was 157.14 % greater. The Barbershop Initiative™ is a national program created by The Prostate Net (TPN), a national patient education and advocacy organization founded by Virgil H. Simons. Funded by the CDC, implementation of an enhanced version of The Prostate Net's Barbershop Initiative™ model in New Jersey began in September 2007 and continued with additional funding through June 30, 2012.

Implementation

The intent of the program has been to access medically underserved minority men in New Jersey through barbershops to increase their awareness and knowledge about prostate cancer and its detection. Barbers who over time have served as respected emissaries in their communities were to be trained to serve as lay health educators to then train their patrons. This five-year venture was to be done through New Jersey Cancer Education and Early Detection (NJCEED) lead agencies in conjunction with the County Cancer Coalitions and two designated outreach coordinators (one based at the Atlantic County Healthy Living Coalition (ACHLC) for the 11 southern counties and the other based at the Essex County Cancer Coalition (ECCC) for the 10 northern counties in the state.

Methods: Because the ECCC decided not to continue with the initiative beyond the fourth year and useable data for the northern region was not available, data on barbershops/haircutters in the southern region was obtained from the ACHLC outreach coordinator and used as a starting point to gather information from participating shop owners. A brief 5-10 minute survey with eight items was developed to address aspects of the initiative such as materials distribution, types of educational sessions that might have been held, training the shop owners themselves might have done, among others. The Excel spreadsheet contained 119 shops of which five had either closed or were unavailable for contact for other reasons. An introductory letter was developed and mailed to 114 shops that remained on the list. Telephone interviews were then undertaken by two trained black male health professionals.

Findings: Of the 114 shops that covered 12 counties, there were many issues with the phone numbers (i.e., those out-of-service, those that would just ring with no answer, others that would go directly to voice mail, others that were not barbershops, etc.). Of shops that answered, there were 34 owners who stated that they had never heard of the initiative, another 12 who were uncertain whether they had heard about it, 15 who were not interested in it, among other issues. There were six shop owners who had not participated previously who were very interested in participating in the future as were the 20 who stated that they had participated and who were interviewed. All 20 spoke positively about the program and its value to their patrons as well as themselves. Of the shop owners interviewed, 18 (94.7%) had sought screening and/or other healthcare as a result of participating in the initiative. More shop owners in Atlantic and Burlington counties, 10 out of the 26 or 23.08%, expressed their willingness to participate in the future. Shop owners in Cumberland, Mercer, and Union counties were equally likely to be interested (3 or 11.54% each). These counties were followed by two shop owners each in Camden, Gloucester, and Monmouth and one in Somerset.

Conclusion: Clearly, some but not all barbers/haircutters see this type of initiative as a valuable program. With improved database tracking and some minor modifications that would reduce driving and improve scheduling and reliability of visits to the shops by the health educators/outreach workers, this program could be very successful if continued in the future.

V. PROGRESS BASED ON THE EVALUATION PLAN: OUTCOME EVALUATION

Except for an increase in melanoma in both males and females and a slight increase in lung cancer in women, all other cancers in the Plan have decreased. As can be seen below, the declines in incidence and mortality have been quite dramatic. With additional prevention, education, and screening efforts, other reductions in the burden of cancer will take many years to occur. For this reason, intermediate outcome measures are used to mark efforts. In terms of behaviors as observed in the BRFSS data, New Jersey has not only achieved but exceeded the benchmark for the percentage of women over the age of 40 who have received a mammogram in the past two years and the percentage of adults aged 50+ who have ever had a sigmoidoscopy or colonoscopy in the last two years. For the other prevention measures, New Jersey is closer to achieving the Healthy People 2010 targets than the US as a whole.

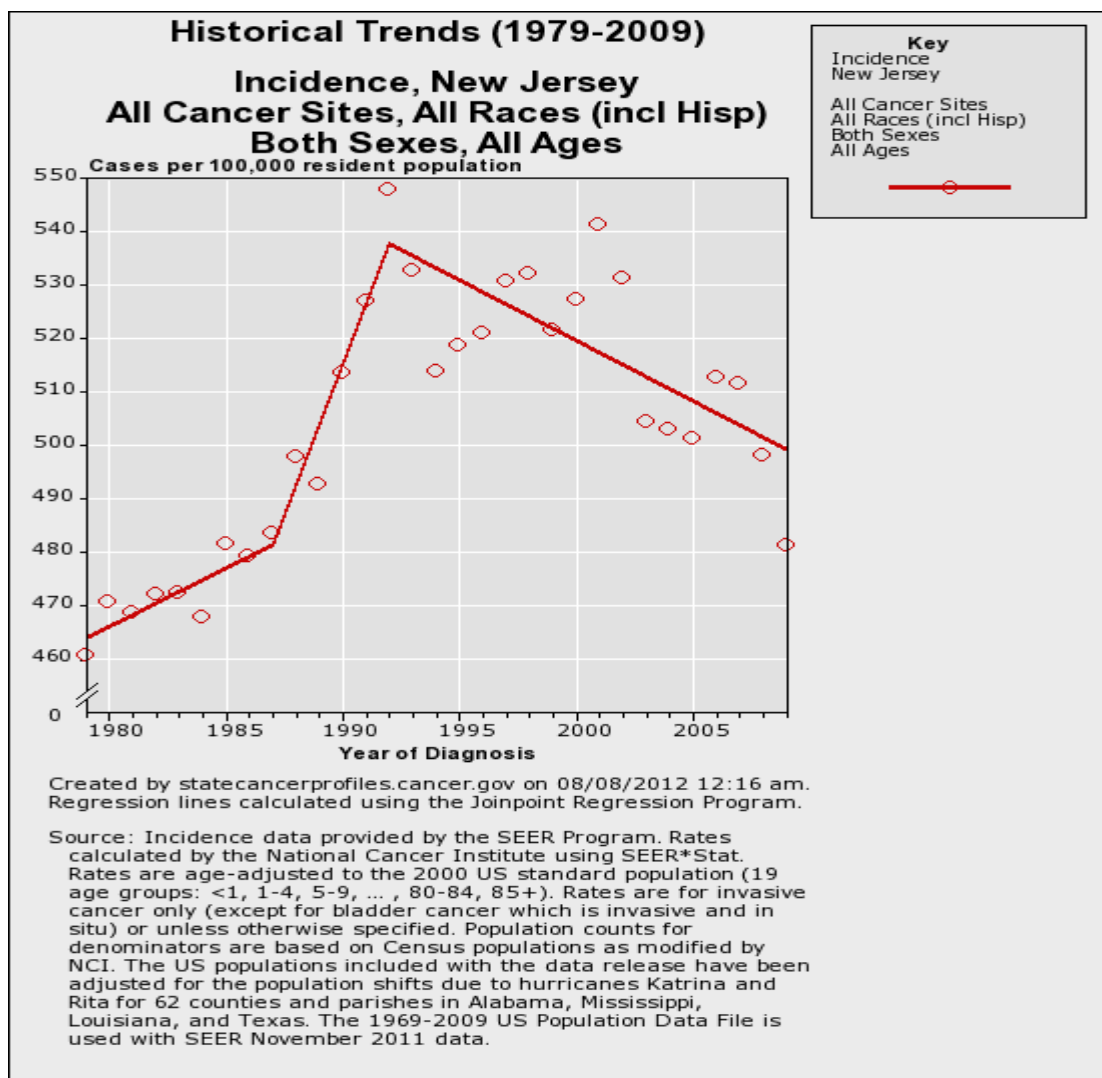


Figure 3. National Cancer Institute. (n.d.). State Cancer Profile. Historical Trend. Incidence and mortality rates. <http://statecancerprofile.cancer.gov/historicaltrend/jointpoint.withimage.php?0&4434&999&7599&001&001&00&0&0&0&1&0&1&1#graph>

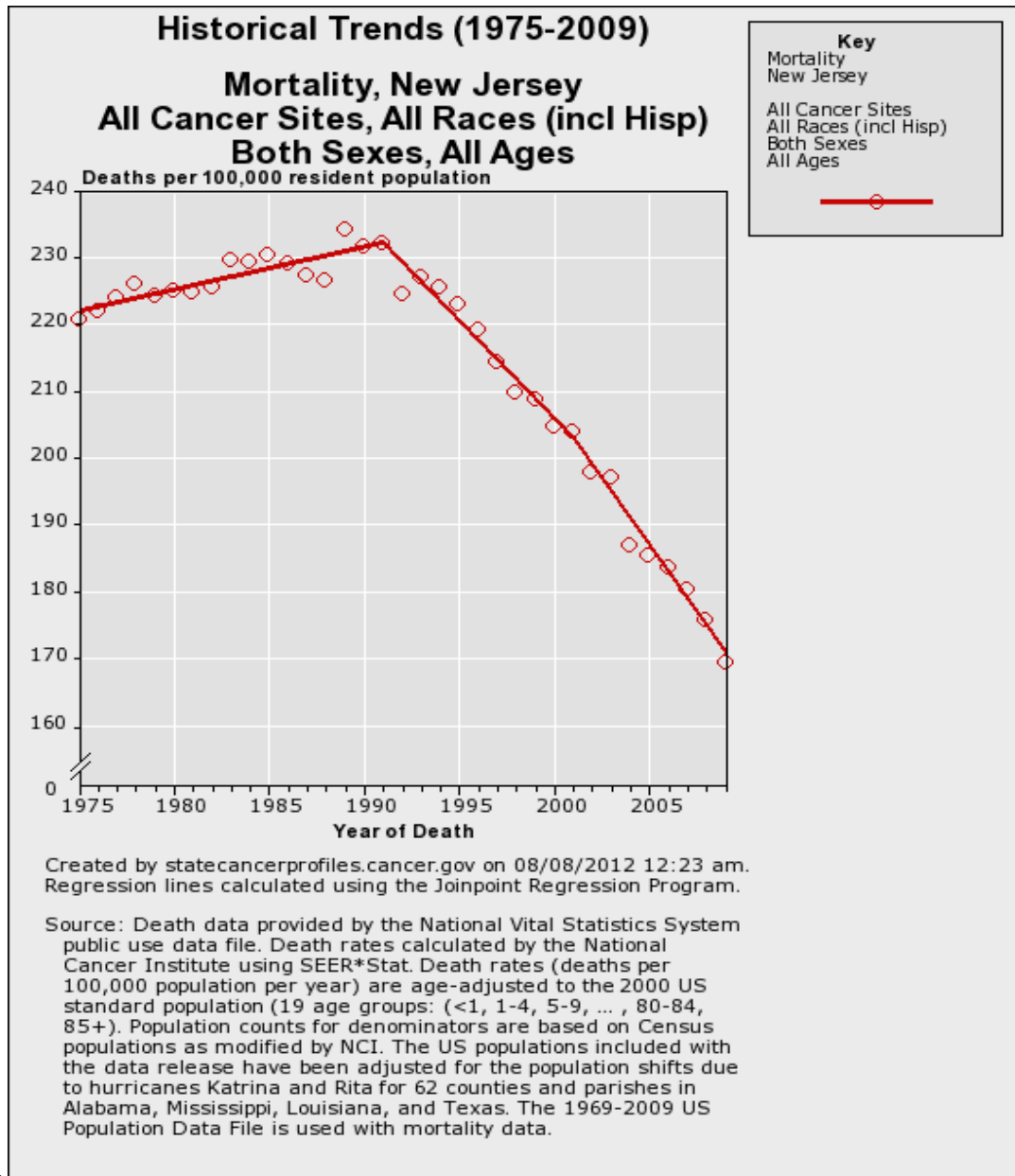


Figure 4.

National Cancer Institute. State Cancer Profile. Historical trend. Incidence rate.

<http://statecancerprofiles.cancer.gov/historicaltrend/joinpoint.withimage.php?0&4434&999&7599&001&001&00&0&0&0&2&0&1&1#graph>

Accomplishing the intermediate outcomes, many of which were described in the two implementation evaluation sections has taken a great deal of steerage: vision, leadership, persistence, and adherence to the Plan to ensure that things that have been undertaken have been carried through to their completion. As mentioned in the Implementation Evaluation section, to enhance the Coalitions' program evaluation skills to enable them to better demonstrate outcomes of their efforts, webinars on the subject were implemented and one-on-one training of the Coalitions was made available. Similarly, nearly all efforts of the Task Force, Workgroups, and Standing Committees have been evaluated and the findings have been fed back into subsequent initiatives.

VI. RECOMMENDATIONS AND CONCLUSIONS

Managed and guided by the OCCP, over time, the momentum from the energy and enthusiasm generated by individuals and organizations passionate about reducing the burden of cancer in New Jersey has resulted in many accomplishments that have been achieved to date, many through growing partnerships and collaborations in addressing the burden of cancer in New Jersey. With the structural changes that are accompanying the shift to addressing comprehensive cancer prevention and control within the context of chronic disease prevention, it will be even more important to ensure that chronic disease program coordination, awareness, education and prevention efforts are there to encourage forward movement with cancer and chronic disease control efforts. Key factors to address in preventing cancer and chronic disease are tobacco control, reducing obesity and increasing opportunities for physical activity.

To that end, moving forward in 2013, the Coalitions will implement best practice, evidence-based toolkits as core interventions. OCCP plans to collaborate with the Office of Tobacco Control to implement their Smoke-Free Policy Toolkit to increase the number of smoke-free outdoor recreation ordinances in New Jersey municipalities. In addition, OCCP will collaborate with the American Cancer Society to implement their Colorectal Cancer Screening Toolkit for Physician Practices to increase the number of colorectal cancer screening recommendations among primary care practice patients. OCCP will also collaborate with *ShapingNJ* to implement a Complete Streets Toolkit to advance wellness and create healthier environments for all users throughout New Jersey by advancing comprehensive policy development and implementation efforts which focus on nutrition and physical activity in communities in an effort to prevent or lower chronic disease burden.

It should be noted that the leadership demonstrated by the Governor's appointed Chair of the Task Force has resulted in the success for the citizens of New Jersey. Cancer Control and Prevention has been recognized for its implementation nationally by the CDC; and New Jersey, for its local implementation. The Chronic Disease structure could only benefit by the cancer control model and its leadership in moving New Jersey forward.

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