American Cancer Society

American Cancer Society
Comprehensive Cancer Control Initiative

Evaluation and Performance Measurement Report

FY02 | December, 2025

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American Cancer Society Comprehensive Cancer Control Initiative

Executive Summary

The American Cancer Society's Comprehensive Cancer Control Initiative (ACS CCC) has been funded since 2001 to improve capacity of CDC's National Comprehensive Cancer Control Program (NCCCP) recipients and their coalitions through training and technical assistance (TTA). The ACS CCC TTA includes both content-driven TTA, provided through webinars and resources for information sharing, and relationship-based TTA, provided through communities of practices and learning communities that engage groups to promote the use of evidence-based interventions.[1] This report details results for FY02 (September 30, 2024 - September 29, 2025) of the DP23-0017 cooperative agreement.

FY02 At-A-Glance

1,335 Direct Lives Touched

714 attendees at **5 Webinars**

621 attendees at **2 Learning Communities** and **2 Communities of Practices**

7,036 Lives Touched Through Content

6,568 new users on acs4ccc.org

468 views of **15 webinar** and **learning community recordings**

91% Partners Engaged

60 of the 66 NCCCP recipients and cancer coalitions reached through TTA events

FY02 Results

The ACS CCC team reached **60** of the 66 recipients and cancer coalitions in FY02 through TTA events. In total, **1,335 people** participated in ACS CCC events (**686** unique attendees).

Webinars

Five (5) webinars were well attended and highly rated.

714 participants from **56** distinct NCCCP recipients and cancer coalitions

NCCCP Recipient and Cancer Coalition Outcomes:

98% of respondents satisfied

20% average knowledge growth

Cancer Planning Learning Community

Five (5) sessions were held to improve capacity to lead the cancer planning process

299 participants from **43** distinct NCCCP recipients and cancer coalitions

NCCCP Recipient and Cancer Coalition Outcomes:

89% (n=9) identified and adopted implementation strategies in their cancer plan[2]

[1]Le LT, Anthony BJ, Bronheim SM, Holland CM, Perry DF. A Technical Assistance Model for Guiding Service and Systems Change. J Behav Health Serv Res. 2016 Jul; 43(3):380-95. doi: 10.1007/s11414-014-9439-2. PMID: 25239308.

[2]Based on post-survey results

Colorectal Cancer Mortality Disparities Learning Community

Five (5) sessions were held to improve capacity to integrate strategies that reduce CRC mortality disparities into the cancer planning process.

281 participants from **38** distinct NCCCP recipients and cancer coalitions

NCCCP Recipient and Cancer Coalition Outcomes:

91% have or intend to integrate CRC strategies into their cancer plan or coalition activities[2]

Communities of Practices

Two (2) cohorts of Facilitated Leadership for Cancer Coalitions (FLCC) Communities of Practices

41 participants from **33** distinct NCCCP recipients and cancer coalitions

- **16** attendees at FLCC Cohort 4
- **17** attendees at FLCC Cohort 5
- **8** attendees at the FLCC Refresher Session.

NCCCP Recipient and Cancer Coalition Outcomes: Increased participants' skills and capacity:[3]

44% (n=9) Cohort 4

41% (n=12) Cohort 5

Resources

4 ACS Coalition University Modules

490 page views

3 Resources Modernized

3 Resources Created

Newsletters

12 newsletters sent

413 Subscribers

60% Average Open Rate

Website

ACS CCC's website, acs4ccc.org, compiles relevant ACS information from across the enterprise on a website targeting leaders of and partners within cancer control coalitions.

6,583 New Users

10,545 sessions

For more information, contact the team at acs4ccc@cancer.org or visit the ACS CCC website at acs4ccc.org.

Acknowledgement

We acknowledge the Centers for Disease Control and Prevention, for its support of the American Cancer Society staff in the development and dissemination of this evaluation report under cooperative agreement NU58DP007540 awarded to American Cancer Society. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

[2]Based on post-survey results

[3]Changes in matched participants from pre- and post-surveys

Introduction

Cancer is a major public health problem worldwide and the American Cancer Society estimates that over 2 million new cases will be diagnosed in 2025.[4] Early detection and prevention strategies can help to mitigate the burden of disease, unequal access to care, and high cost of treatment for later stage cancers. Progress requires multi-sector collaboration to advance the shared goals of improving cancer control outcomes. The American Cancer Society's Comprehensive Cancer Control Initiative (ACS CCC) has been funded since 2001 to improve the capacity of CDC's National Comprehensive Cancer Control Program (NCCCP) recipients and cancer coalitions to address cancer control issues through technical assistance and training.

This report details the ACS CCC activities and progress towards outcomes occurring in the second year of a five-year cooperative agreement with CDC (September 30, 2024 - September 29, 2025). While the primary audience of this work is NCCCP recipients, the outcomes measured in the evaluation plan relate to NCCCP recipients and cancer coalitions as cancer coalitions work closely with recipients to implement cancer plans. When available, this report specifies NCCCP recipient funded roles (such as CCC Director and CCC Program Coordinator/Manager). Program evaluation findings will be used to improve ACS CCC initiative planning and activities.

Our Team

The American Cancer Society Comprehensive Cancer Control Initiative (ACS CCC) team brings a variety of coalition, communication, and evaluation experience to its training and technical assistance efforts. Moreover, our partners within ACS and across the nation magnify our team's work through their collaborative support of programs and coalitions. In FY02, such partners included the Comprehensive Cancer Control National Partnership (CCCNP), George Washington Cancer Center (GWCC), the ACS National Roundtables, and other partners listed in Appendix 1.

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Acknowledgements

ACS CCC would like to thank the Centers for Disease Control and Prevention (CDC) National Comprehensive Cancer Control Program (NCCCP) recipients and cancer coalitions along with colleagues across ACS and partner agencies for their contributions to this initiative through data collection activities and technical assistance and training engagement. We acknowledge the Centers for Disease Control and Prevention, for its support of the American Cancer Society staff in the development and dissemination of this evaluation report under cooperative agreement NU58DP007540 awarded to American Cancer Society. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

[4] Cancer Facts & Figures 2025

Program Overview

The ACS CCC provides training and technical assistance (TTA) through CDC's DP23-0017 cooperative agreement to "strengthen the capacity of NCCCP recipients and cancer coalitions to make progress towards the priorities listed in CDC-RFA-DP22-2202" (per DP23-0017 NOFO). The team's TTA includes both content-driven TTA, provided through webinars and resources for information sharing, and relationship-based TTA, provided through communities of practices and learning communities that engage groups to promote the use of evidence-based interventions.[5] Appendix 2 contains ACS CCC's logic model.

The ACS CCC utilizes four core strategies[6] as outlined in DP23-0017 to support NCCCP recipients and strengthen coalition capacity. The team utilized the ADDIE (analysis, design, development, implementation, and evaluation) Instructional Design (ID) method as a framework in designing and developing TTA opportunities. This model is the framework recommended by the CDC for use in developing public health trainings that improve the learner's competence, capacity, and performance. To ensure consistency, quality, and effectiveness across learning opportunities, ACS TTA followed the CDC's Quality Training Standards[7] as they: 1) are informed by needs assessments; 2) include learning objectives; 3) include accurate and relevant content; 4) offer opportunities for learner engagement; 5) are designed for usability and accessibility; 6) include evaluation for program improvement; 7) offer opportunity for learner assessment, and 8) include follow-up support for the learner.

NCCCP Overview

Since 1998, the Centers for Disease Control and Prevention (CDC) has led the National Comprehensive Cancer Control Program (NCCCP) by funding recipients to develop and implement strategic cancer prevention and control plans. These plans uniquely address the burden of cancer in their respective communities, using the latest data to guide their efforts and relevant research on evidence-based interventions. Currently, the 66 recipients include the 50 states and the District of Columbia, 8 US territories and freely associated states, and 7 American Indian/Alaska Native tribes and tribal organizations.

Coalitions work with stakeholders across many sectors to implement the activities in the cancer control plan. Stakeholders can include representatives from public health programs, colleges/universities, hospitals, faith-based organizations, medical professional associations, local businesses, policy makers, legislators, or governmental agencies (local, state, national).

NCCCP recipients receive targeted guidance and technical assistance to support work towards these six core priorities:

- Primary prevention
- Cancer screening
- Survivorship
- Disseminating evidence-based strategies to partners
- Promoting access to quality health care
- Evaluating policies and programs to make sure they work

[5]Le LT, Anthony BJ, Bronheim SM, Holland CM, Perry DF. A Technical Assistance Model for Guiding Service and Systems Change. J Behav Health Serv Res. 2016 Jul;43(3):380-95. doi: 10.1007/s11414-014-9439-2. PMID: 25239308.

[6]1) Develop a TTA plan using information gathered through a variety of source; 2) Convene, support, and sustain the partnerships and partnership networks necessary to support implementation of TTA activities; 3) Use a variety of training delivery methods to deliver TTA, including the establishment of Communities of Practices to facilitate information sharing across NCCCP recipients; and 4) monitor and evaluate TTA efforts and disseminate finding

[7]Centers for Disease Control and Prevention. (2024, August 22). *Quality training standards*. Centers for Disease Control and Prevention. https://www.cdc.gov/training-development/php/qts/index.html#cdc_generic_section_2-quality-training-standards

Methods

A comprehensive program evaluation was designed to monitor program process and activities and assess the results over time to address program accountability and advance program improvement. Building on established training evaluation models, the evaluation combines a focus on utilization and Kirkpatrick's New World model[8] to establish relevant constructs and methods.

In FY02, the evaluation focused on monitoring program processes and relevant short-term outcomes related to the first two levels of the Kirkpatrick Model: Reaction (Satisfaction, Relevance), and Learning (Knowledge/Skills, Intention to apply, and Capacity.)

The evaluator employed a mixed methods approach to data collection and analysis, including the following:

- **Surveys:** Training and technical assistance participants completed surveys for each event to assess knowledge, capacity, and satisfaction. ACS performed all survey data analysis with Stata 17.0 for Likert scale and categorical items; and used Microsoft Excel or MaxQDA for content analysis when coding open-ended responses.
- **Document Review:** ACS completed a review of program documentation, including TTAAC notes, the FY02 workplan, annual performance report (APR), and monthly progress reports.

Program progress and outcomes are reported based on DP23-0017 strategies and required outcomes.

[8]Kirkpatrick, J. & Kirkpatrick, W. (2016). *Four levels of training evaluation*. East Peoria, IL; Versa Press, Inc.

Results

Performance Measures

Performance measures are useful to monitor activities and identify opportunities for improvement, as well as show high-level activities and accomplishments. CDC outlined three performance measures to inform implementation and evaluation of efforts through the DP23-0017 cooperative agreement.

Performance Measures	FY02 Target	FY02 Actual	Notes
Number, mode, and type of training and technical assistance provided for DP22-2202 recipients	16	18	Target included 4 FLCC refresher sessions, 2 FLCC cohorts, 2 learning communities, 4 webinars, and dissemination of 4 micro-learnings. Actual included 1 FLCC refresher session, 2 FLCC cohorts, 2 learning communities, 5 webinars, dissemination of 4 micro-learnings, creation of 1 Storytelling training module, and revisions to 3 resources (Nine Habits, PSE Guide, and Environmental Scans Worksheet) While 2 screening guides (colorectal cancer and lung cancer) were developed in FY02, they were not disseminated until October 2025.
Number of DP22-2202 recipient staff/coalition members participating in training per recipient	600	841	FY02 actual (841) NCCCP recipients and coalitions who attended events. When accounting for all attendees, 1,335 individuals were reached.
Number and type of strategies and evidence-based interventions adopted as a result of TTA efforts	13*	20	Out of potential 10 skills, all skills were selected at least once by FLCC participants in Cohort 4. Out of a potential of 5 strategies, all strategies were selected for the Cancer Planning Learning Communities. Out of a potential of 5 strategies, all strategies were selected for the CRC Mortality Disparities Learning Communities.

*The target was updated to 13 after the start of FY02 as the evaluation plan adjusted to capture adoption for the two learning communities.

Progress on CCC Activities

In the second year, the ACS CCC implemented activities in accordance with the approved workplan. Key activities included identifying NCCCP recipients and cancer coalition technical assistance and training needs, developing and disseminating resources (such as webinars and toolkits), and actively engaging in, supporting, and leveraging the work of national partnerships. A table of ACS CCC's activities can be found in Appendix 1.

Strategy 1: Develop a TTA plan using information gathered through a variety of sources

ACS CCC delivered training and technical assistance to support capacity-building for NCCCP recipients to effectively implement evidence-based approaches in their local communities. The team created their annual ACS TTA Work Plan using:

- FY01 Evaluation & Performance Measurement Report
- Informal literature review
- Training and Technical Assistance Advisory Committee (TTAAC)
- NCCCP leadership and program consultants' identification of high-level needs

Additionally, the Strategic Director coordinated with the fellow TTA provider, George Washington Cancer Center (GWCC), to develop a joint TTA plan that ensured aligned topics and schedules. The FY02 workplan included the dissemination and promotion of ACS's Coalition University, webinars on timely cancer control topics, two cohorts of the Facilitative Leadership for Cancer Coalitions community of practice, a Cancer Planning learning community, and a Colorectal Cancer Mortality Disparities learning community.

Strategy 2: Convene, support, and sustain the partnerships and partnership networks necessary to support implementation of TTA activities

Partnership engagement is a key component of the ACS CCC initiative. Collaboration is a core principle of comprehensive cancer control, and the ACS has a long history of working alongside community, national, and governmental organizations to advance cancer prevention and control efforts. ACS is one of 17 organizations within the Comprehensive Cancer Control National Partnership (CCCNP), a partnership which supports comprehensive cancer control (CCC) coalitions in the formation and implementation of their cancer plans at the states, tribes and tribal organizations, and territories and freely associated states. ACS CCC has played an integral role in CCCNP since its very inception in 1998, offering subject matter expertise, collaborative leadership in conducting CCC workshops and forums, and staff engagement in priority area cancer workgroups. The Strategic Director served as the Sustaining Coalitions Workgroup Co-Chair prior to leaving ACS in June 2025.

ACS CCC continued its commitment to invest in this 20+ year national partnership in staff time and in-kind ACS enterprise support. **In FY02, ACS CCC staff were active members of four CCCNP priority workgroups (Vaccine Preventable Cancers, Cancer Screening, Evaluation, Sustaining Coalitions).** This included communication support and facilitation for CCCNP events. The Strategic Director coordinated planning and facilitation of one Coalition Check-in with partners of the CCCNP Sustaining Coalitions Workgroup, reaching 71 participants. Coalition Check-ins are informal, half-hour peer-to-peer exchanges on a topic of interest to cancer coalition leaders. The ACS CCC Program Manager supported the coordination and production of a November 2024 Cancer Conversation that reached 131 participants. Cancer Conversations are one-hour, didactic learning opportunities designed for NCCCP recipients and cancer coalitions. During FY02, the CCCNP determined to have an 'ad-hoc' year and paused the priority workgroups. Since then, ACS CCC staff continued to attend and engage in the full CCCNP meetings.

Additionally, ACS CCC collaborated with GWCC to continue the Training and Technical Assistance Advisory Committee (TTAAC). The TTAAC allows attendees to provide feedback on ACS and GWCC's TTA activities and plans. This group met four times in FY02 and provided feedback on ACS TTA activities (joint TTA plan, dissemination ideas for ACS Coalition University, priority resources to modernize, and ideas for ACS learning communities), which informed future ACS TTA activities. The TTAAC was comprised of a variety of CCC Program Directors, Coordinators/Managers, and coalition leadership with a range of experience. At the end of FY02, 6 participants responded (50% response rate) to a poll with:

- **100% stating they would recommend TTAAC to colleagues in the future, and**
- **100% agreeing they were able to learn what other CCC programs and/or coalitions are doing.**

Two respondents shared ideas for improvement, such as having clear objectives for meetings or working on a specific project or resource as a group.

TTAAC Members by CCC Role

CCC Role	All Participants
CCC Program Directors	3
CCC Program Coordinator/Manager	7
CCC coalition leadership, such as a chair	2
Total	**12**

Lastly, ACS CCC is uniquely positioned to facilitate collaboration among state and national partners through our close organizational ties with the ACS National Roundtables. ACS National Roundtables are coalitions of organizations dedicated to the shared goal of "giving all people a fair and just opportunity to prevent and survive cancer."[9] ACS National Roundtables continue to be a proven model for creating sustained partnerships across diverse sectors and diverse communities. Currently, ACS provides leadership and staff support for roundtables in topic areas of direct relevance to NCCCP recipients, including breast cancer, cervical cancer, colorectal cancer, lung cancer, HPV vaccination, patient navigation, and prostate cancer. **In this second year, ACS CCC continued to collaborate with the national roundtables by hosting a webinar with the ACS National Prostate Cancer Roundtable (ACS NPCRT) and a five-session learning community with the ACS National Colorectal Cancer Roundtable (ACS NCCRT).** Prior to her departure, the Strategic Director served on the state-based initiatives workgroups of ACS National Roundtables (ACS NLCRT and ACS NCCRT). Since June, the NCCRT Program Manager has provided a bi-directional interface between state and national cancer control initiatives as she splits her time between ACS CCC and ACS NCCRT and has participated in an ACS NLCRT State-Based Initiatives Priority Team meeting.

Strategy 3: Use a variety of training delivery methods to deliver TTA, including the establishment of Communities of Practices to facilitate information sharing across NCCCP recipients

The primary focus of the ACS CCC's team's work is providing TTA to all 66 NCCCP recipients and coalitions. In FY02, 5 webinars were hosted, reaching 714 participants (554 unique participants), including 369 participants (253 unique individuals) from 56 different NCCCP recipients and cancer coalitions. These webinars were conducted by inviting CCCNP partners and other subject matter experts to present a short didactic presentation on a topic, followed by a Q&A with the audience. Partnerships are detailed in Appendix 1.

Additionally, the team conducted Facilitative Leadership for Cancer Coalitions (FLCC) communities of practices and learning communities, reaching 621 individuals. The fourth and fifth cohort of FLCC communities of practices was completed with 16 participants completing Cohort 4 and 17 participants completing Cohort 5. Including the refresher session (n=8), these events reached 33 different NCCCP recipients and cancer coalitions. Cohort 4 followed the traditional 14-week intensive workshop that has been provided to groups of NCCCP recipients with knowledge and skills in facilitating meetings and engaging stakeholders to implement their state or tribal cancer plans. Cohort 5 was an abbreviated version that covered 6 weeks. The team did not continue the FLCC Refresher Sessions in FY02 due to competing priorities and limited attendance; however, Cohort 5 attendees voiced interest to continue sessions if they became available in the future.

In FY02, the ACS CCC team hosted two learning communities: Cancer Planning and Colorectal Cancer (CRC) Mortality Disparities. Each had five sequential sessions open to all NCCCP recipients and cancer coalitions (participants were encouraged to attend all but were not required). The Cancer Planning Learning Community aimed to improve NCCCP recipients' and cancer coalitions' confidence and ability to lead the cancer planning process. The CRC Mortality Disparities Learning Community focused on strengthening their confidence and capacity to integrate strategies that reduce CRC mortality disparities into the cancer planning process.

Summary Reach of TTA

CCC Role	All Participants	All NCCCP Recipients and Coalitions Participants	Unique NCCCP Recipients and Coalition Jurisdictions
Webinars (n=5)	714	369	56
FLCC (Cohort 4, Cohort 5, and Refresher Session)	41	41	33
Cancer Planning Learning Community	299	235	43
CRC Mortality Disparities Learning Community	281	196	38

Note: This is a non-unique count of individuals. Appendix 3 summarizes unique count of individuals.

[9] https://www.cancer.org/about-us/our-partners/american-cancer-society-roundtables.html

The ACS CCC team sustained their commitment to strong communication and high-quality resources for NCCCP recipients and cancer coalitions. Throughout the year, the team distributed monthly newsletters featuring ACS CCC events, ACS National Roundtable activities, relevant and timely resources, and other spotlights. Building on FY01 deliverables, the team disseminated the four online modules through the ACS Coalition University. By the end of FY02, the team refreshed the acs4ccc.org website by modernizing existing resources with updated data and improved formatting for better readability. The team also continued to support coalition storytelling by completing a learning module that highlights two strategies for coalitions to share about their efforts. Lastly, the team developed two screening guides, one for lung cancer and one for colorectal cancer (CRC), which were not disseminated in FY02. Each guide provides information to support cancer control planning, including screening guidelines, relevant data, strategies for partner engagement, and evidence-based interventions to promote and advance screening initiatives.

Strategy 4: Monitor and evaluate TTA efforts and disseminate finding

In FY02, the evaluator completed the FY01 Evaluation and Performance Measurement Report. In addition to the polls following each webinar, the evaluator assessed the team's communication quarterly using Google Analytics and provided recommendations for sharing resources and promoting materials. To better understand the use of ACS resources, the evaluator conducted key informant interviews with the South Carolina Program Director and the ACS regional staff based in South Carolina. Through these interviews, a case study was drafted on the lasting impact of ACS resources, the support from both ACS CCC and ACS regional staff, and how other coalitions could use ACS CCC resources to strengthen onboarding, build foundational knowledge, and support coalition structures.

Process Outcomes of CCC Activities

Per CDC's DP23-0017 Notice of Funding Opportunity, ACS CCC's TTA activities are created to "strengthen the capacity of NCCCP recipients and cancer coalitions". When available, registration information included participants' self-identification of their CCC role and connection to their comprehensive cancer control coalition. The following information on outcomes is specific to responses from NCCCP recipients and cancer coalitions (NCCCP respondents or NCCCP participants) unless otherwise noted, with details on all respondents found in the appendices.

Satisfaction

Webinars and ACS Coalition University

Satisfaction was consistently high across all five webinars hosted by the ACS CCC Team. On average, 98% of NCCCP respondents indicated they would recommend future sessions to a colleague. Recommendation rates ranged from 95% satisfaction of the Fueling the Mission: ACS Resources to Power Your Coalition's Work (n=19) to 100% for Cancer and Climate Change (n=35), What You Need to Know About Prostate Cancer Screening (n=16), and Comprehensive Cancer Coalitions & The Evolving Landscape of Cancer Survivorship (n=18). A detailed breakdown of respondent counts and satisfaction rates is provided in Appendix 4.

The ACS CCC team disseminated four online learning modules developed in FY01 through the ACS Coalition University. These modules are freely accessible as they do not require a log-in and can be taken multiple times. Each module includes a voluntary embedded survey, which received an average of 8 responses (min. 3, max. 15), asking whether users would recommend the module. On average, 85% of respondents (not just NCCCP respondents) were satisfied with the modules, with "Building Healthy Teams" receiving the lowest score (71%, n=7) and "Influencing People" receiving the highest score (100%, n=3). See Appendix 5 for ACS Coalition University data.

Learning Communities and Communities of Practices

Across the two learning communities, an average of 93% of NCCCP respondents indicated they would recommend future sessions to their colleagues, reflecting a high satisfaction of the learning community model. The Cancer Planning Learning Community demonstrated more consistency, with scores ranging from 88% to 100% across its five sessions. While the CRC Mortality Disparities Learning Community had a wider range of satisfaction (73% to 100%), three of the five sessions had 100% satisfaction, indicating strong participant approval.

At the end of both learning communities, NCCCP respondents provided comments on the value of the learning community. These responses highlighted the quality of the information ACS CCC provides along with the opportunities the ACS CCC team provides for NCCCP recipients and cancer coalitions to learn from one another.

Comments shared from the Cancer Planning and CRC Mortality Disparities participants when asked, "In one sentence, how would you describe the value of the learning community?"

The FLCC Cohort 4 and Cohort 5 communities of practices both had strong ratings with all NCCCP respondents (n=21) rating the workshop as either "good" or "excellent". Like the learning communities, one respondent from Cohort 4 shared that the most valuable part of the workshop was "the opportunity to bounce ideas off of other CCC staff."

Detailed tables are provided in Appendices 6-8 for each learning community and FLCC.

Additional Needs

To assess TTA needs, the ACS CCC team consistently included one question across all webinars asking, "what assistance or resources would [participants] need to successfully apply what [they] learned on the job". The team was able to use this data after each webinar to inform them of their next steps. In FY02, the Evaluation Team expanded the options from 4 to 5 to better align the team's capacity to provide support. Across five webinars, NCCCP respondents most frequently selected the following support needs:

- 66% resources and tools to assist with implementation (e.g. factsheets or toolkits)
- 48% webinars
- 46% linkages with other CCC coalitions (e.g. learning communities)
- 46% virtual learnings (e.g. brief, 5-minute videos or on-demand learning modules)
- 42% state-specific technical assistance from national experts (e.g. office hours)

Specifically, the prostate webinar respondents selected a broader range of TTA needs, which may indicate participants are newer to this topic and participants are seeking any additional support. In contrast, the webinar that shared ACS resources had fewer selections, likely because the webinar's focus was on sharing resources rather than evidence-based interventions or other best practice strategies. Details on TTA can be found in Appendix 4.

After the two learning communities, respondents were asked what topics or presenters they would like to see in future learning communities. Eleven individuals responded to this open-ended question, with 45% (n=5) sharing a specific cancer such as lung, prostate, cervical, or HPV-related. Other ideas shared were related to partnership (27%, n=3) such as leveraging rural partnerships or partnerships with little or no funding, survivorship activities (27%, n=3), and other foundational training topics (36%, n=4) such as coalition's role in policy and advocacy, statewide data collection and common data points, building communication skills in marketing and public awareness, and translating research findings into lay languages.

Key Takeaways

- **Prioritize Peer Learning Opportunities:** Participants consistently valued the chance to learn from one another, especially through learning communities and FLCC. To support this, future TTA could emphasize these peer exchange formats.
- **Strengthen Resource Integration:** Participants often selected resources and tools to assist with implementation. Instead of simply sharing a resource related to the event, TTA events could include demonstrations or case examples showing how the resource could be applied.
- **Include Foundational and Translational Topics:** Respondents shared the desire to learn foundational skills alongside cancer-specific content, such as communication, data use, and policy engagement. Some additional suggestions included hearing from survivors and clinical perspectives. Additionally, ACS Coalition University modules had strong satisfaction and intent scores, but low number of responses. The team should consider integrating these foundational modules into live sessions to increase usage and feedback
- **Explore Opportunities to Leverage TTAAC:** All respondents indicated they would recommend the advisory committee to others and noted several ideas that could strengthen its impact. One suggestion involved developing a shared resource; however, to preserve the advisory nature of the committee rather than shifting toward a work group model, ACS and GWCC may consider creating more opportunities for TTAAC to offer input on specific resources or help shape future TTA activities. This approach would allow the committee to focus on forward-looking strategy and planning, rather than primarily reflecting on past efforts or dissemination.

Impact Outcomes of CCC Activities

Increased reach of TTA activities to NCCCP recipients and cancer coalitions

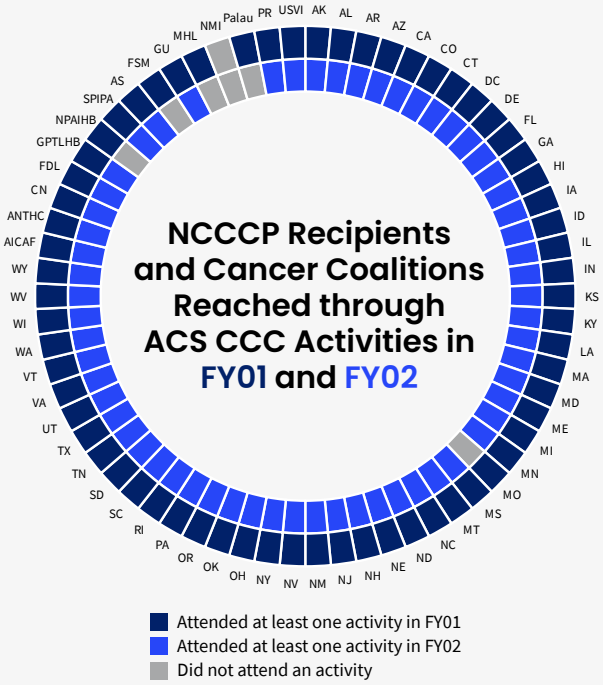
ACS CCC has a target audience of the 66 funded NCCCP recipients and cancer coalitions. **In FY02, the team successfully reached 91% of the 66 NCCCP jurisdictions (n=60).** Of the six not reached, the majority (67%, n=4) were from the US Affiliated Pacific Islands, which received targeted outreach in FY01. Webinars had the broadest reach as they engaged 56 unique NCCCP jurisdiction, aligning with the higher attendance numbers compared to the learning communities and FLCC. Appendix 3 details the individuals reached per activity and unique NCCCP recipients and cancer coalitions engaged.

The overall reach of individuals from NCCCP recipients and cancer coalitions nearly doubled from FY01 (n=433) to FY02 (n=841), a 94% increase. This corresponds with the ACS CCC team's strategy to expand engagement through additional learnings, as the two learning communities consisted of ten individual sessions. While those efforts successfully reached more people, it's important to note that future activities with closed registration may result in a lower overall reach. However, this could allow for more focused engagement and capacity-building.

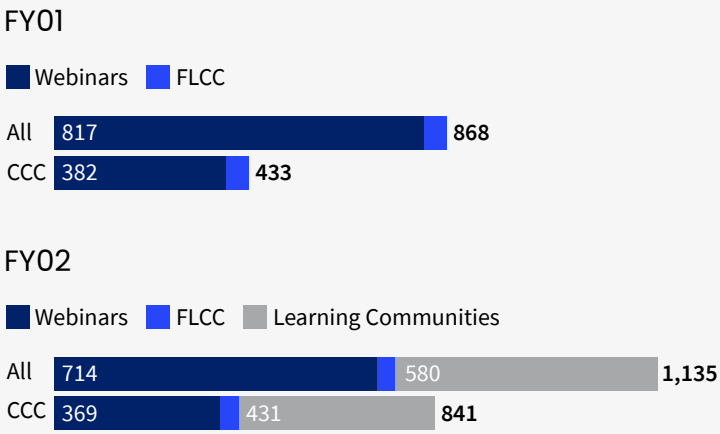
ACS CCC Reach

While less NCCCP recipients and cancer coalition jurisdictions were reached in FY02 compared to FY01, the team nearly doubled their individuals reached.

Jurisdictions Reached

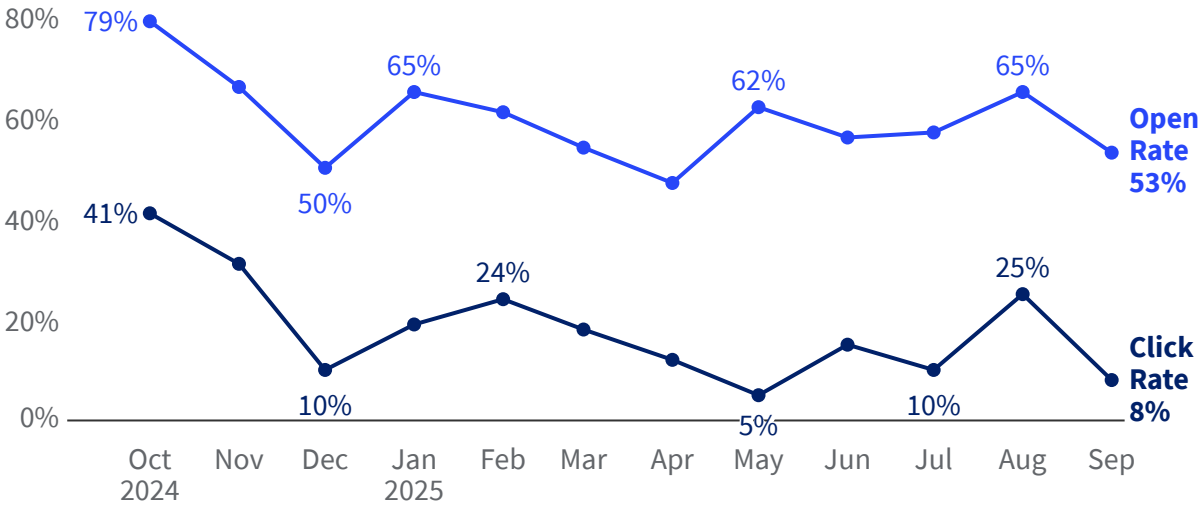


Individuals Reached



The ACS CCC newsletter was sent to 413 subscribers and averaged a 60% open rate[10] The lowest open rate was in April, which had an updated newsletter sent two days after the original. In June and December, a personal note was sent out in lieu of a newsletter from the Strategic Director, with an average 56% open rate.

FY02 Open and Click Rates



Additionally, acs4ccc.org, the team's online resource and information hub, recorded 6,583 new users and 10,545 sessions. Notably, 58% of the sessions came from direct links, underlining the continue value of the ACS CCC newsletter and TTA events in driving traffic and connecting the target audience with key resources.

[10]Open rate: The percentage of contacts who opened your email compared to how many contacts were sent the email.

The website saw 29,272 pageviews, with 67% (19,618) directed to the homepage. This represents a drop from FY01, which saw 44,727 pageviews, including 26,398 homepage views. This decline is likely influenced by changes in user behavior around cookie consent. As more users opt out of tracking cookies, analytics may undercount returning visitors and pageviews.[11]

Among the most visited pages in FY02 is the ACS Coalition University landing page, which was the fourth most visited webpage (749 pageviews). This newly launched resource contains four learning modules that saw a combined total of 490 pageviews. The Nutrition, Physical Activity, Body Weight, and Cancer Survivorship webpage saw consistent traffic throughout the year. Unlike other pages that spiked around TTA events, this steady engagement may suggest growing coalition interest in survivorship-related content. Lastly, the Program and Coalition Health webpage ranked high as well, likely due to it hosting recordings for both learning communities.

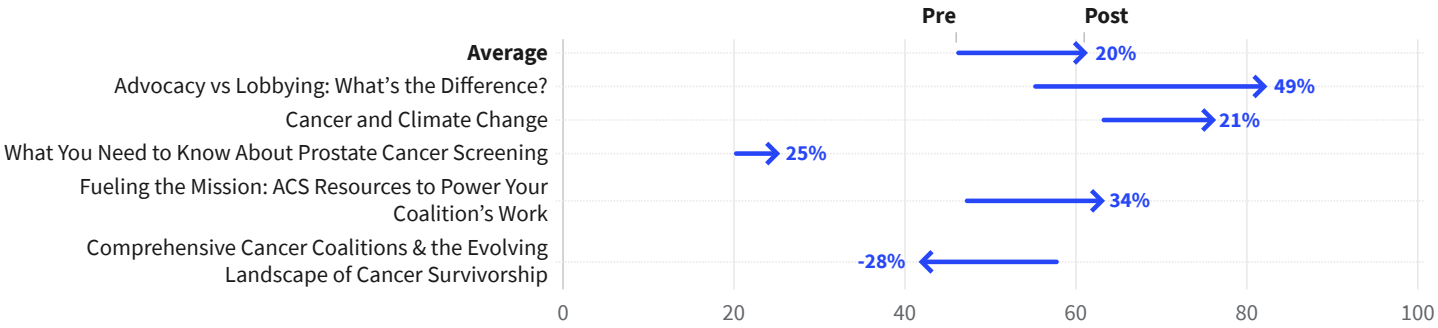
Webpage	FY02 Pageviews
Homepage	19,618
Program and Coalition Health	1,242
Webinars	907
ACS Coalition University – **New in FY02**	749
What's Happening	711
Nutrition, Physical Activity, Body Weight, and Cancer Survivorship	386
Cancer Plan Tip Sheets	370
Policy Systems and Environmental Changes	353
ACS Regional Partners	325
Cancer Control Planning	296

Increased knowledge, awareness, and attitudes regarding EBIs and resources that aid implementation

Webinars

Each of the five webinars ACS CCC conducted had pre- and post-polls that contained knowledge-based questions to objectively measure knowledge gained from participants. These questions were provided by speakers and revised by the Evaluation Team for clarity. **Overall, webinar participants' knowledge increased by an average of 27%, including a 20% increase among NCCCP respondents specifically.** NCCCP respondents and all participants exhibited similar trends overall; the figure below highlights differences among NCCCP respondents across the five webinars.

NCCCP Recipient and Coalition Attendee Webinar Knowledge Outcomes



Arrows show the direction of change in knowledge scores, starting from baseline (pre-webinar) levels and ending at post-webinar levels. Percent change is displayed numerically.

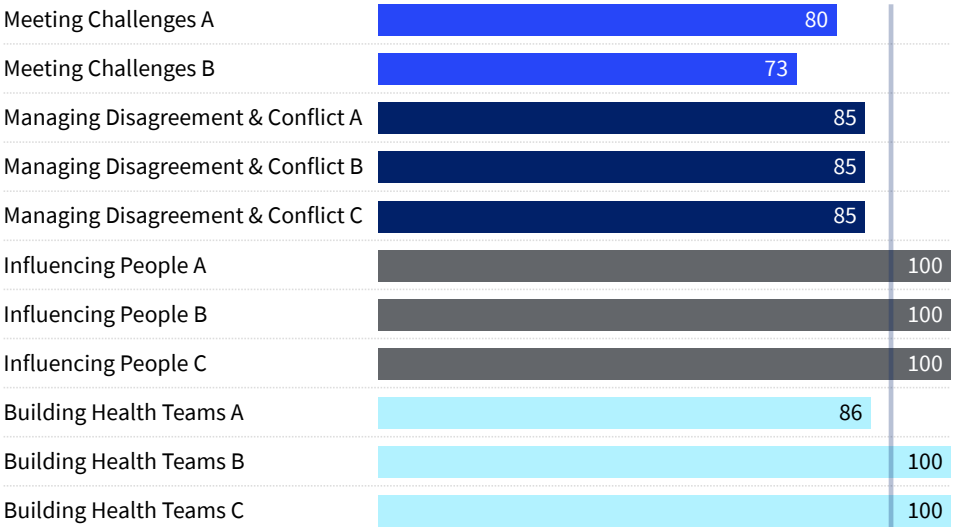
[11]Google. (n.d.). *About Consent Mode*. Google Analytics Help. Retrieved September 29, 2025, from https://support.google.com/analytics/answer/9976101?hl=en

Knowledge outcomes were similar between all participants and NCCCP participants. The greatest change was observed in the advocacy vs lobbying webinar, with NCCCP respondents having a 49% increase in knowledge. The last webinar on survivorship saw a decrease in knowledge of 28%. This drop in knowledge may suggest the evaluation questions did not measure learning, or that participants need continued support with this topic. While it is possible the webinar itself did not effectively support learning, it seems unlikely as 100% of NCCCP respondents reported that they were satisfied (n=18) and 94% shared that they are able to apply what they learned (n=18).

ACS Coalition University

Each module of ACS Coalition University has specific learning objectives (Appendix 5). The voluntary survey at the end of each module asked all respondents to answer if the objective was met through the module.[12] Across all learning modules, 90% of the learning objectives were met. The least effective module was "Meeting Challenges" as one objective was met 73% of the time and another 80% of the time. The highest rated (100%) was "Influencing People", but this module only received three responses. As this survey has been open and promoted for a year, conducting user testing may be beneficial to understand the impact of ACS Coalition University.

Percent of respondents indicating learning objective was met



Line indicates the 90% average across all learning objectives. Appendix 5 has full text of all learning objectives.

Cancer Planning Learning Community

The team facilitated a five-part Cancer Planning Learning Community, with the overall session series informed by the CCCNP Cancer Plan Tip Sheets framework. The initiative aimed to strengthen the self-efficacy of NCCCP recipients and cancer coalition staff in leading the cancer planning process. The primary audience was NCCCP recipients and coalition staff who were new to the cancer planning process. However, experienced NCCCP recipients and coalition staff seeking refresher or opportunities to connect with peers were also encouraged to participate.

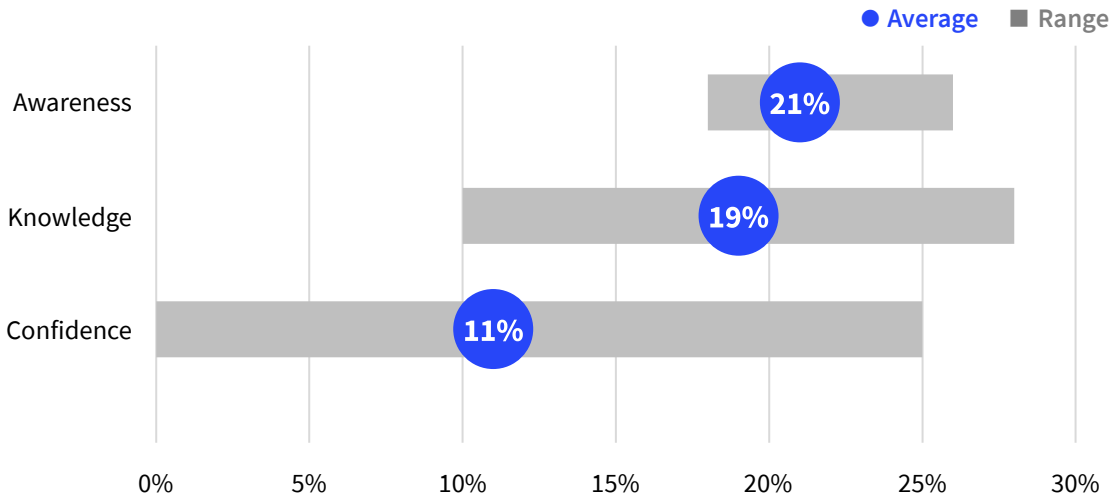
Each session, except Session 3, had pre- and post- polls to assess changes in participants' awareness, knowledge, and confidence. Session 3 did not include an awareness question due to its more didactic format and focus on knowledge and confidence. The following results identify changes for matched NCCCP respondents. The post-polls also contained intent to apply the call-to-action, which is reported in the next section: Increased adoption of strategies and evidence-based interventions to improve and sustain efforts of NCCCP recipients. All data for the Cancer Planning Learning Community can be found in Appendix 6.

[12]Question text: "As a result of this learning module, I know:"

Across all five sessions, participants from NCCCP recipients and cancer coalitions increased their awareness by 21% (min 18%, max 26%), knowledge by 19% (min 10%, max 28%), and confidence by 11% (min 0%, max 25%). Awareness levels were relatively consistent across sessions, suggesting a shared baseline understanding of the topics. Knowledge gains varied more, with the smallest increase in Session 2 (Use Data) and the largest in Session 5 (Share Progress). This may reflect that participants are more familiar with using data versus sharing progress with stakeholders. Confidence showed the greatest variability, with no change being reported in Sessions 2 (Use Data) and 3 (Adapt Strategies). For both sessions, participants began and ended at an average rating of "Somewhat confident," which was also the typical post-session rating across other sessions. Notably, Session 3 (Adapt Strategies) had the highest initial rating in confidence, suggesting participants were already comfortable with adapting EBIs. Session 4 (Facilitation Skills) also began with "Somewhat confident" ratings and saw only a modest increase (9%). Lastly, the lack of change in Session 2 (Use Data) may be due to misalignment between the session content, which was focused on engaging partners to identify and analyze data, and how participants interpreted the confidence question, which could have been read as individual data analysis skills.

1. Engage Key Partners
2. Identify & Use Data to Guide Your Cancer Plan Efforts
3. Identify & Adapt Implementation Strategies
4. Learn Facilitation Skills to Guide Group Consensus
5. Monitor & Share Progress

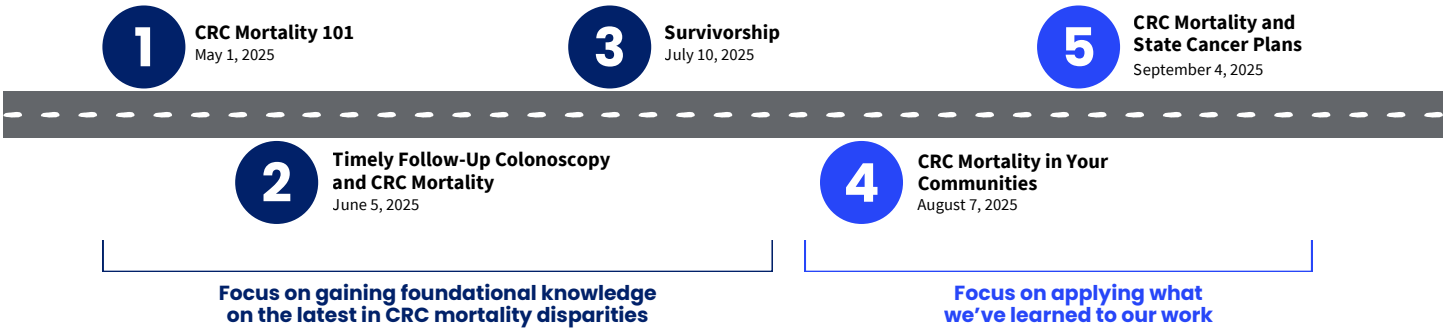
Average score across all five Cancer Planning Learning Community sessions



Colorectal Cancer Mortality Disparities Learning Community

In addition to the Cancer Planning Learning Community, the team led a five-part learning community to build the capacity of NCCCP recipients and coalitions to integrate strategies that reduce colorectal cancer mortality disparities into their comprehensive cancer plans. The primary audience was NCCCP recipients and coalition staff who are prioritizing CRC initiatives or would like an opportunity to connect.

Similar to the Cancer Planning Learning Community, each session had pre- and post- polls to assess the session's impact. However, Sessions 1-3 were more didactic and therefore had three objective knowledge-based questions to assess knowledge gained during the sessions. Sessions 4 and 5 were focused on practicing and implementing skills learned and therefore followed the Cancer Planning Learning Community method of asking awareness, knowledge, confidence questions. As with the Cancer Planning data, the next section provides results for matched NCCCP respondents with all data for the CRC Mortality Disparities Learning Community available in Appendix 7.



Overall, matched participants saw a 38% increase in their knowledge. This included an average of 58% for Session 1-3 and an average of 8% growth for Sessions 4 and 5. Session 1 saw the greatest increase with a 114% increase, from 35% to 75%. The smallest change was seen in Session 5 (5%), which could be due to the high baseline (4 out of 5) as attendees may already have experience in developing strategies and objectives that address CRC mortality disparities in their cancer plans.

On average, for Session 4 and 5, respondents awareness grew by 9% while their confidence decreased by 1%. This decline is likely due to the small sample size as Session 4's confidence question had limited NCCCP responses (n=4), and when looking at all respondents, confidence increased by 10%.

Facilitative Leadership for Cancer Coalitions Communities of Practices

ACS CCC led two Facilitative Leadership for Cancer Coalitions (FLCC) skill-building training workshops in FY02.[13] Both cohorts completed a pre- and post-workshop survey to assess knowledge gained across the training series. Appendix 8 contains results for both cohorts.

Number of Cohort Participants and Survey Respondents

Cohort	Participants	Pre	Post
Cohort 4: 14-week[1]	16	17	9
Cohort 5: 6-week[2]	17	15	12

[1]A total of 19 individuals registered with 16 participated in the full workshop. Seventeen (17) completed a pre-workshop survey, while 9 completed the post-workshop survey, with 9 participants completing both. Results from participants who dropped out were excluded from the analysis.

[2]A total of 18 individuals registered and 17 participated in the cohort. Two transferred their registration to another and their response was removed from analysis. Sixteen (16) participants completed the pre-survey; however, one of these participants attended only two sessions and was excluded from the analysis (n=15, 88% response rate). At the end, 12 (71%) participants took the post survey, and 11 (65%) participants took both the pre-survey and post-survey.

Both cohorts saw an increase in participants' skills and capacity, with Cohort 4 seeing a 44% increase and Cohort 5 a 41% increase. Most skills with higher initial rankings saw smaller increases, such as *holding one-on-one conversations to productively resolve disagreements and overcome conflict while preserving relationships* that saw a 24% increase in Cohort 4. Similar trends were seen in Cohort 5, where higher pre- scores for *active listening* and *keeping the group focused* increased by 25% and 27%, respectively. One exception observed in Cohort 4 was *identify and recruit partners that can execute the strategies*, where the score increased by 36%, even though it had a high pre-score.

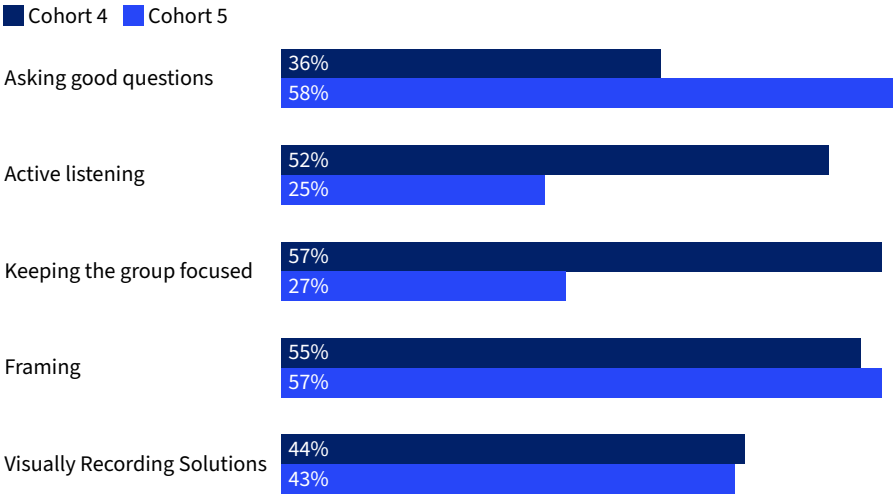
Respondents in both cohorts showed greater improvement in their ability to facilitate group dialogue[14], with Cohort 4 increasing on average by 49% and Cohort 5 increasing 43%. While both cohorts saw similar growth, they varied on where that growth happened. For example, *asking good questions* saw a 36% growth in Cohort 4 compared to Cohort 5's 58% growth. Conversely, Cohort 4 saw higher growth in *active listening* (52% vs 25%) and *keeping the group focused* (57% and 27%). These variances could be due to small sample sizes or differences in baseline levels as the post-scores averaged an Advanced (Implement independently) rating.

[13]Cohort 4 was an intensive 14-week cohort while the second, Cohort 5, was tailored to align with evolving program priorities and resource considerations and consisted of five, 2.5-hour sessions, and one, 1.5-hour coaching session.

[14]Respondents rated themselves on a 1-5 scale from fundamental awareness to expert in response to, "Please rate your capacity to do the following steps to effectively and efficiently facilitate any group dialogue."

Due to the abbreviated nature of Cohort 5, this cohort did not have the same number of skills to rank. Cohort 4 focused on ten skills and Cohort 5 three skills in addition to the five facilitation skills mentioned above. Both cohorts saw growth in the skills, with groups ending, on average, with a self-identified rank of Intermediate (Implement with support). This could be indicative that additional peer learning and practice would be beneficial to move participants towards implementing independently.

Facilitative Skill Growth between Cohort 4 and Cohort 5



Increased adoption of strategies and evidence-based interventions to improve and sustain efforts of NCCCP recipients

Multiple methods were used to assess adoption of ACS CCC activities, depending on the TTA modality.

- Webinars and ACS Coalition University included two measures as participants were asked if 1) they had capacity to apply what they learned ("I can apply what I have learned to my work", and 2) their intent to use skills ("I intend to use the skills, strategies, or evidence-based interventions I have learned in my work in the next 3-6 months").
- Learning communities (both Cancer Planning and Colorectal Cancer Mortality Disparities) used the same two measures (capacity to apply and intent to use) during each session. Additionally, follow-up surveys were sent immediately following the last session to anyone who attended at least one session. These surveys asked participants which sessions they attended or watched, and what they had implemented from those sessions. Since the sessions were held monthly for five months, participants could report on actions taken up to five months after the first session.
- FLCC communities of practices followed the same process as the learning communities but with a 3-month follow-up survey after the end of the 14-week community of practice. This allowed more time for participants to have opportunities to apply the skills they learned.

Webinars and ACS Coalition University

Across five webinars, 98% of NCCCP recipients and cancer coalitions said they can apply what they learned and 88% expressed their intention to apply what they had learned. Across all four modules of ACS Coalition University, 100% of respondents reported capacity to apply and 93% reported they intend to apply what they learned in the next 3-6 months. Additional details can be found in the supplemental tables in Appendices 4 and 5.

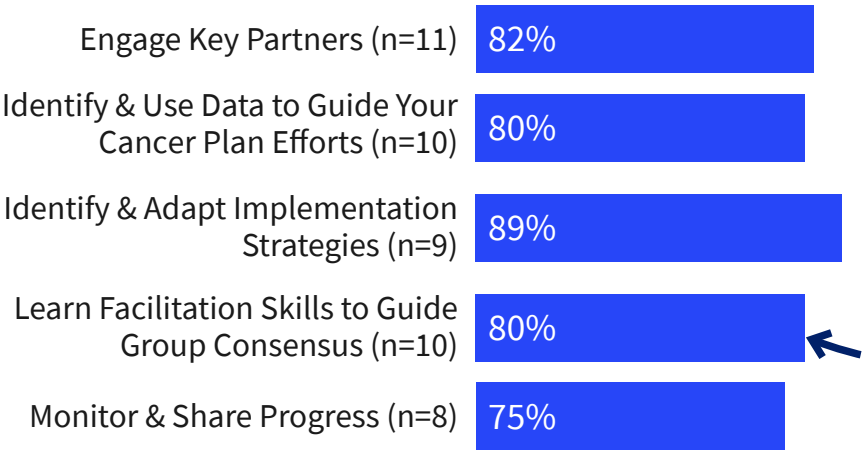
Cancer Planning Learning Community

Across the five sessions, an average of 89% of NCCCP respondents said they can apply what they learned in the session and 92% said they intended to complete the session specific call-to-action.

Session	Call to Action	Strategy Adopted
Engage Key Partners	I intend to reach out to a new or existing partner to engage them in the cancer planning process.	Engage key partners in the cancer planning process.
Identify & Use Data to Guide Your Cancer Plan Efforts	I intend to explore a new data set to identify a data gap my coalition could work towards.	Use data to guide cancer plan efforts.
Identify & Adapt Implementation Strategies	I intend to use a resource shared today to identify an EBI that fits with my program's goals and context.	Identify and adopt implementation strategies.
Learn Facilitation Skills to Guide Group Consensus	I intend to try one new thing in my meetings to help drive consensus in decisions	Facilitate group discussions to build consensus.
Monitor & Share Progress	I intend to identify one way my coalition can enhance how it monitors and shares progress on our cancer plan.	Determine methods to monitor and share progress on the cancer plan.

Of the 128 individuals who attended at least one session, 17 (13%) responded to the follow-up survey. Participants were asked to share on a scale of strongly disagree to strongly agree what actions they were able to implement based on the session they attended. **Each strategy was used by at least one participant.** No one disagreed that they were able to use strategies gained from the learning community. Sometimes participants used other information gleaned from the sessions instead of the session's main objective, so they did not mark themselves as adopting a strategy. For example, one respondent said they were unsure if they had monitored and shared progress at the end of the learning community; however, they shared that they took the idea of a cancer plan and dashboard from another recipient back to their steering committee to help in starting the cancer planning. This highlights that learning and adoption were done outside of the specific call to action.

Strategies adopted by NCCCP recipients and cancer coalitions after Cancer Planning Learning Community



I used the group discussion facilitation skills when planning for a recent coalition meeting that included new partners and some decision making. It was helpful to have some tools to engage the partners and reach a decision that all people contributed to.

The session title 'n' shares the number of respondents who attended or watched recording. The percentage is the percent of participants who indicated they adopted the strategy.

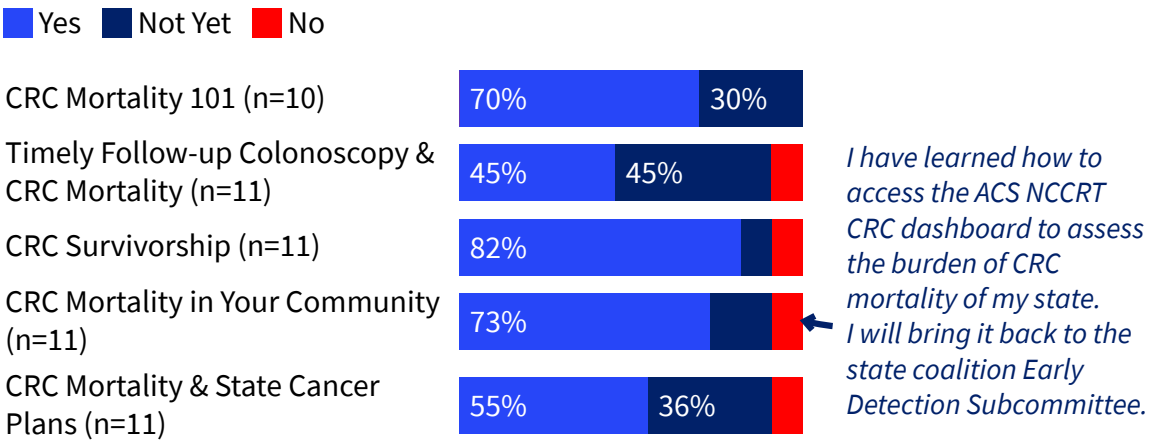
Colorectal Cancer Mortality Disparities Learning Community

NCCCP recipients and cancer coalition participants in the five-session learning community reported that, on average, 92% could apply what they learned, and 86% intended to complete the session-specific call-to-action.

Session	Call to Action	Strategy Adopted
CRC Mortality 101	Explore resources to identify populations that may have higher CRC mortality rates in my community.	Explored resources to identify populations that may have higher CRC mortality rates in my community
Timely Follow-up Colonoscopy & CRC Mortality	Include messaging in coalition material that follow-up colonoscopy after a positive or abnormal stool-based test is essential.	Included messaging in coalition material that follow-up colonoscopy after a positive or abnormal stool-based test is essential
CRC Survivorship	Find ways to direct people to support and/or use their voices in my work.	Found ways to direct people to support and/or use their voices in my work
CRC Mortality in Your Community	Use the CRC dashboard or other data tools to assess the burden of CRC mortality in my state.	Used the ACS NCCRT CRC dashboard or other data tools to assess the burden of CRC mortality of my community
CRC Mortality & State Cancer Plans	Use the ACS4CCC Tip Sheets to update my cancer plan.	Integrated CRC strategies into our cancer planning process or coalition activities.

Like the Cancer Planning Learning Community, a follow-up survey was sent to 143 individuals who attended at least one session, with 17 respondents (12% response rate), and **all five strategies were used at least once.** Participants were asked whether they completed the call to action from the sessions they attended or watched a recording of. Participants' adoption ranged from 45% (Session 2) to 82% (Session 3). While 45% of participants in Session 2 adopted the strategy, an additional 45% reported their intent to adopt the strategy in the future. Session 5 focused on bringing the whole learning community together to integrate CRC strategies into coalition activities. This session was adopted by 55% of respondents, with an additional 36% indicated they intend to adopt, an encouraging sign given this was the final session and there was limited time and opportunity for implementation. **Across all sessions, at least 91%[15] of NCCCP respondents shared they had either adopted or plan to adopt the strategy into their work.**

Strategies adopted by NCCCP recipients and cancer coalitions after CRC Mortality Disparities Learning Community



The session title 'n' shares the number of respondents who attended or watched recording. The percentage is the percent of participants who indicated they adopted the strategy (Yes) or had not yet adopted (Not Yet).

[15]Due to rounding, the percentages shown (45% adopted and 45% intend to adopt for Session 2) do not sum to exactly 91%. In total, 10 out of 11 respondents indicated they had either adopted or planned to adopt the strategy.

Facilitative Leadership for Cancer Coalitions Communities of Practices

During the end of the fourth FLCC cohort, participants were asked to select which facilitative skills they planned to use in the following three months. Participants were able to select up to ten skills to apply, with ten completing these questions. Participants ranged in selecting 1 to 10 skills, with an average of 6 skills being selected.

After three months, 10 participants responded to a follow-up survey to share what skills and resources they used. **All skills were used at least once, with participants selecting between 1 and 6 skills, and an average of 3 skills used per participant over the past three months.** The two skills most used by respondents were:

- Design effective and participatory meetings and engagements where objectives are met and "work gets done" (70%), and
- Use facilitative tools to build connection, gather and analyze information, and make decisions (60%).

These two skills were the same as last year's cohort, Cohort 3. There was some variation in other skills used across the cohorts, with the biggest differences observed in building outcome-focused, collaborative teams and holding 1:1s to support problem-solving and skill development (see Appendix 8 for more details). These variations may be due to time constraints, as one participant noted that a challenge was "having the time to fully utilize my new skills." However, even if they did not have the time to use their skills, one participant shared they "feel confident and ready to handle [challenges]" in the future.

The least selected skills, each chosen by only one participant (10%), were:

- Hold one-on-one conversations to productively resolve disagreements and overcome conflict while preserving relationships,
- Effectively help a team identify necessary changes and overcome resistance to making changes,
- Leverage a range of influence strategies to move individuals or groups to take desired actions, and
- Effectively respond to team or participant challenges (e.g., dysfunctional behavior) in a group setting.

When asked how these skills were used, participants reported using whiteboards to help share ideas and collaborate. One participant commented that they have started workgroup meetings focused solely on activities and strategies defined in their plan.

> "[FLCC] has built more effective teams and has increased engagement."
>
> **– FLCC participant sharing how they have designed meetings using skills learned from the community of practice.**

Resource Use

FLCC Participants were asked to share which resources they had used in the previous three months with 7 participants reported using the FLCC toolkit, 4 using tipsheets, and 2 using the ACS CCC newsletter.

> "Our coalition is in the process of updating our cancer plan, and I was able to use the tip sheets to prioritize goals in the state plan."
>
> **- FLCC participant on the usefulness of the tip sheets**

Key Takeaways

- **Balance Reach with Depth:** While webinars reached more jurisdictions and were consistently rated highly, learning communities offered deeper engagement through peer learning and strategy development, a format that NCCCP recipients and coalitions have consistently valued. Although follow-up survey response rates were limited, early findings suggest participants intended to apply what they learned and, in some cases, had already begun doing so. Continuing to offer both broad-reach formats and more intensive learning cohorts can balance scale and impact. Additionally, targeted outreach to the US Affiliated Pacific Islands (USAPI) in FY01 brought in additional partners by offering training at a time most convenient for those recipients and coalitions. This underscores an ongoing tension: while increasing the number of webinars and activities may reach more people overall, targeted efforts like the USAPI expand the number of partners engaged, even if fewer individuals are reached. The team should continue to balance both needs when planning future activities.
- **Use TTAAC to Understand Survivorship TTA Needs:** The drop in knowledge observed in the survivorship webinar may suggest the evaluation questions did not measure learning, or that participants need continued support with this topic. The TTAAC could be a useful avenue to understand NCCCP recipients and cancer coalitions' understanding on implementing survivorship strategies and identifying other TTA needs.
- **Identify Ways to Bolster Implementation of Learning Communities:** Although follow-up survey responses were limited, the data that was collected shows adoption of strategies among participants. For instance, 81% of the Cancer Planning Learning Community reported adopting strategies, indicating substantial uptake. Similarly, in the CRC Learning Community, 65% of respondents reported they had adopted strategies, and an additional 28% shared that they still intend to implement them. To support those still planning to adopt, additional implementation support, such as office hours, may be beneficial.

Discussion and Recommendations

During FY02, the ACS Comprehensive Cancer Control Initiative expanded its reach, reaching 94% more individuals compared to FY01. This growth was driven by the strategic expansion of learning communities and the continued delivery of high-quality webinars and communities of practices. Central to these activities are strong collaborations with national partners and ACS experts, which help ensure the work remains credible, relevant, and aligned with national cancer control strategies.

Evaluation results showed deepened engagement and strengthened capacity of NCCCP recipients and cancer coalitions. Events consistently received high satisfaction across all TTA modalities, with 98% of NCCCP respondents recommending ACS CCC webinars and 93% recommending learning communities. The FLCC communities of practices continued to build facilitation capacity as both cohorts reported over 40% growth in skills. Participants also reported strong intent to apply what they learned, with 92% of Cancer Planning Learning Community participants and 86% of CRC Mortality Disparities Learning Community participants indicating intent to adopt strategies. While follow-up survey response rates were limited, all learning community strategies were adopted at least once. NCCCP respondents shared feedback on the value of peer learning that the learning communities provided, stating that they liked being able to speak and interact with others working on these topics.

> "It is greatly beneficial to hear about what other programs are doing, what type of populations people are working with, and creative ways to provide better care."
>
> **- NCCCP Respondent sharing the value of peer learning**

Recommendations

To enhance the impact of training and technical assistance (TTA), the ACS CCC team could prioritize peer learning formats such as learning communities and the FLCC community of practice as these formats were consistently valued by participants for fostering collaboration and practical skill-building. Integrating ACS Coalition University modules into live sessions may also improve engagement and feedback, especially for foundational topics like communication, data use, and policy engagement.

Additionally, participants frequently requested implementation support and desire to learn more foundational topics, indicating a need for more hands-on examples and follow-up opportunities. The team could include more resource integration by demonstrating how tools and materials can be applied during TTA events. Also, offering office hours or refresher sessions could help bridge the gap between intent and actual adoption of strategies, especially for complex topics like survivorship.

Finally, ACS CCC should explore ways to leverage the Training and Technical Assistance Advisory Committee (TTAAC) to sustain engagement and inform future activities. The TTAAC could serve as a space for feedback and connection. ACS and GWCC may consider options such as developing a shared resource or hosting quarterly informal calls through TTAAC to help maintain momentum and connection across the network.

Limitations

The CCC role and coalition is determined using registration information, which includes participants self-selected CCC roles and their coalition names. This information is used to identify their roles, jurisdictions, and the number of NCCCP recipients and cancer coalitions reached. The April Prostate webinar did not include NCCCP recipients and cancer coalitions designation in the registration. Therefore, the evaluator did a cross-reference of previous ACS CCC data and used a pre-poll question to gather as much of the information as possible. About a third (n=48) of attendees did not have any information from the cross-reference or pre-poll. After the webinar, the ACS team ensured a registration template was created so future webinars include all necessary information.

Additionally, sample sizes were often small. While additional data points could tell a different story, it may be more beneficial to conduct focus groups or interviews to understand the program's impact.

Appendices

Appendix 1: ACS CCC Activity List

Activity	Date	Comments
Webinars		
Advocacy vs Lobbying: What's the Difference?	Dec 2024	Presenters represented ACS CAN and Susan G. Komen
Cancer and Climate Change	Jan 2025	Presenters represented NCI and ACS Discovery
What You Need to Know About Prostate Cancer Screening	Apr 2025	Presenters represented members from the ACS NPCRT: Yale Cancer Center and the University of Michigan Medical School
Fueling the Mission: ACS Resources to Power Your Coalition's Work	May 2025	Presenters represented ACS's Project ECHO and Early Detection
Comprehensive Cancer Coalitions & the Evolving Landscape of Cancer Survivorship	Jun 2025	Presenter represented ACS Survivorship & Wellness
Communities of Practices		
Cancer Planning Learning Community	Feb – Jun 2025	Presenters represented partners from CCCNP, Cancer Registries, Cancer Prevention and Control Research Network, FLCC presenters, and state comprehensive cancer control programs.
Colorectal Cancer Mortality Disparities Learning Community	May – Sep 2025	Presenters represented ACS Discovery, a member from the ACS NCCRT, CRC survivors, ACS State Partnerships, and state comprehensive cancer control programs.
FLCC Cohort 4	Sep 2024 – Mar 2025	14-week intensive workshop for NCCCP recipients to gain knowledge and skills in facilitating meetings and engaging stakeholders to implement their state or tribal cancer plans.
FLCC Cohort 5	Jun – Aug 2025	6-week abbreviated workshop for NCCCP recipients to gain knowledge and skills in facilitating meetings and engaging stakeholders to implement their state or tribal cancer plans.
FLCC Refresher Session	Jan 2025	All previous cohorts were invited to attend the optional refresher session. While this was initially planned to happen quarterly, staff transitions and limited attendance at the first session led to the ACS CCC team's decision to pause this opportunity.
Advisory Committee		
Training and Technical Assistance Advisory Committee (TTAAC)	Oct 2024– Sep 2025	Joint advisory committee with GWCC
Resources		
ACS CCC Newsletter	Oct 2024 – Sep 2025	Monthly newsletter

Activity	Date	Comments
Resource Dissemination: ACS Coalition University: Team Building, Coalition Meeting Challenges, Influencing People, and Managing Disagreement and Conflict modules	Ongoing	These micro-learning online modules were created in FY01 and disseminated throughout FY02.
Resource Creation: • American Cancer Society: A Lung Cancer Screening Guide for Cancer Coalitions • American Cancer Society: A Colorectal Cancer Screening Guide for Cancer Coalitions • Digital Storytelling for Cancer Coalitions Training Module	Sep 2025	The screening guides were developed to share information relevant to cancer control planning and include guidelines, data, opportunities to engage partners, and interventions to activate and advance screening initiatives. The Digital Storytelling Training Module teaches coalitions how to reach their audiences through stories.
Resource Modernization • Nine Habits of Successful Coalitions, 3rd Edition • PSE Change Guide: Policy, Systems, and Environmental Change in Comprehensive Cancer Control and new online interactive PSE Change Guide • Environmental Scans: A Worksheet for CCC Coalitions	Oct 2024 – Sep 2025	Resources were updated to ensure updated links, citations, and reformatted to improve the user experience.

Appendix 2: ACS CCC Logic Model

<table>
<tr><th colspan="6">ACS CCC Training Technical Assistance Program Logic Model</th></tr>
<tr><th>Inputs</th><th>Strategies/Activities</th><th>Outputs</th><th>Short-term Outcomes</th><th>Intermediate Outcomes</th><th>Long-term Outcomes</th></tr>
<tr>
<td rowspan="4">• ACS CCC Expertise
• ACS Patient Support Pillar Subject Matter Experts and Leaders
• ACS Community Impact leadership and Associate Directors, State Partnerships
• Evidence-based information, tools and resources
• CDC
• CCCNP
• Seven ACS Roundtables
• Other national partners</td>
<td>TTA Planning (A1)
• Needs Assessment (environmental scan & brief assessments)
• Create, update, & maintain TTA plan
• Partner engagement/dissemination</td>
<td>Plan to address identified needs among NCCCP recipients and cancer coalitions
• Needs assessment documentation
• TTA Plan
• Identified training needs
• Provision of effective TTA to programs</td>
<td>Increased TTA providers' understanding of current NCCCP recipient and cancer coalition needs to provide effective TTA to NCCCP recipients and cancer coalitions</td>
<td rowspan="4">Increased adoption of strategies and evidence-based interventions to improve and sustain efforts of NCCCP recipients and cancer coalitions</td>
<td rowspan="4">Increased capacity, reach, utilization, impact and sustainability of NCCCP recipients and cancer coalitions</td>
</tr>
<tr>
<td>National Partner Collaboration Coordination (A2)
• Convene NCCCP TTA Advisory Group
• Continue to actively participate in the CCCNP and ACS Roundtables (State-based Initiatives Workgroups)
• Coordinate with Partner Networks</td>
<td>Enhanced partner engagement to deliver high-quality TTA
• #/type TTA Advisory Group members*
• Resource Matrix and # activities with partner engagement
• # CCCNP*
• # ACS Roundtable meetings</td>
<td>Increased networking, partnerships, and coordination among TTA providers</td>
</tr>
<tr>
<td>TTA Implementation (A3)
• Facilitate information sharing between NCCCP recipients
• Deliver TTA using variety of delivery methods: Communities of Practices, Quarterly Webinars, Cancer Clip Video series, Coalition Conversation sessions, Website, Email, Newsletter</td>
<td>Increase in the # and type of TTA activities delivered by ACS and partner networks
• #/type TTA activities**
• # TTA Resources developed (e.g. Key Take-aways, Best Practices Summaries)
• # TTA Resources disseminated
• # participants*(**)</td>
<td rowspan="2">Increased reach of TTA activities to NCCCP recipients and cancer coalitions

Increased NCCCP recipients' and cancer coalitions' knowledge, awareness, and attitudes regarding EBIs and resources that aid implementation</td>
</tr>
<tr>
<td>Performance Monitoring, CQI, Evaluation (A4)
• Evaluate TTA activities
• Conduct comprehensive evaluation
• Disseminate findings</td>
<td>• Evaluation Advisory Workgroup
• Evaluation Plan
• # and type Evaluation Activities
• # CQI/Program Improvement Activities
• #/type of products disseminated</td>
</tr>
<tr>
<td colspan="6">*ACS Pillar Metric
**CDC Performance Measure
CDC Period of Performance Outcome
Revised 03/20/2024</td>
</tr>
</table>

Appendix 3: Individuals and NCCCP Recipients and Cancer Coalitions Reached by Event

Educational Reach								
TTA Event	**All Participants** including non NCCCP recipients and cancer coalitions	**NCCCP recipients and cancer coalitions[1]**	**Participants from NCCCP recipients and cancer coalitions[2]**	**CCC Program Directors**	**CCC Program Coordinator/ Manager**	**CCC coalition leadership, such as a chair**	**CCC coalition member**	**Other NCCCP recipient or cancer coalition**
Educational Webinars				*Roles of NCCCP recipients and cancer coalitions*				
Advocacy vs Lobbying: What's the Difference?	**164**	39	95	10	21	13	37	14
Cancer and Climate Change	**174**	40	87	14	23	9	33	8
What You Need to Know About Prostate Cancer Screening[3]	**143**	32	58	14	14	10	9	11
Fueling The Mission: ACS Resources to Power Your Coalition's Work	**108**	30	56	7	12	13	19	5
Comprehensive Cancer Coalitions & The Evolving Landscape of Cancer Survivorship	**125**	38	73	16	20	15	21	1
Total Attendees	**714**	**n/a**	**369**	**61**	**90**	**60**	**119**	**39**
Total Attendees (Unique Attendees)	**554**	**56**	**253[4]**	**35**	**58**	**43**	**104**	**33**
Cancer Planning Learning Community				*Roles of NCCCP recipients and cancer coalitions*				
Session 1: Engage Key Partners	**53**	25	43	9	10	9	7	8
Session 2: Identify & Use Data to Guide Your Cancer Plan Efforts	**59**	30	43	8	17	5	3	10
Session 3: Identify & Adapt Implementation Strategies	**70**	34	55	11	21	8	5	10
Session 4: Learn Facilitation Skills to Guide Group Consensus	**59**	33	47	9	19	5	9	5
Session 5: Monitor & Share Progress	**58**	29	47	10	11	10	5	11

Educational Reach								
TTA Event	**All Participants** including non NCCCP recipients and cancer coalitions	**NCCCP recipients and cancer coalitions[1]**	**Participants from NCCCP recipients and cancer coalitions[2]**	**CCC Program Directors**	**CCC Program Coordinator/ Manager**	**CCC coalition leadership, such as a chair**	**CCC coalition member**	**Other NCCCP recipient or cancer coalition**
Total Attendees	**299**	**n/a**	**235**	**47**	**78**	**37**	**29**	**44**
Total Attendees (Unique Attendees)	**131**	**43**	**101[4]**	**20**	**34**	**16**	**18**	**18**
CRC Mortality Disparities Learning Community				*Roles of NCCCP recipients and cancer coalitions*				
Session 1: CRC Mortality 101	**62**	25	43	6	12	6	10	9
Session 2: Timely Follow-Up Colonoscopy & CRC Mortality	**43**	22	32	4	11	6	7	4
Session 3: CRC Survivorship	**60**	27	40	5	14	4	10	7
Session 4: CRC Mortality in Your Community	**54**	23	37	3	13	6	10	5
Session 5: CRC Mortality & State Cancer Plans	**62**	28	44	4	14	7	8	11
Total Attendees	**281**	n/a	196	22	64	29	45	36
Total Attendees (Unique Attendees)	**148**	38	95[4]	13	30	15	23	17
FLCC Community of Practice				*Roles of NCCCP recipients and cancer coalitions*				
Cohort 4	**16**	16	16	3	13	0	0	0
Cohort 5	**17**	16	17	5	12	0	0	0
Refresher Session	**8**	8	8	1	7	0	0	0
Total Attendees	**41**	**n/a**	**41**	**9**	**32**	**0**	**0**	**0**
Total (Unique Attendees)	**41**	**33**	**41**	**9**	**32**	**0**	**0**	**0**
FY02 Total Education Participants	**1,335**	**N/A**	**841[4]**	**139**	**265**	**126**	**193**	**119**
FY02 Unique Participants	**686**	**60**	**336[4]**	**50**	**94**	**56**	**135**	**62**

[1]Count of NCCCP recipients or cancer coalition state, tribe, tribal organization, territory, and freely associated states reached.
[2]Participants from NCCCP recipient or cancer coalitions were determined through registration unless otherwise noted. Participants were considered a part of NCCCP recipient or cancer coalition if they said they were a part of CCC or listed a coalition under their organization. Without a list of recipients, it was not possible to delineate recipients from those involved in the coalition.
[3]Webinar registration process did not include a question about CCC coalition affiliation. To address this, the evaluator added the question to a pre-event poll and cross-referenced responses with past registration data. However, this method likely led to underreporting of NCCCP recipients and CCC coalition members, as 48 attendees could not be matched to a coalition.
[4]The total number of NCCCP recipients and cancer coalitions may not match the sum of individual roles reported, as some participants selected different roles across events, suggesting possible role changes over time.

Appendix 4: Webinar Supplemental Tables

Satisfaction

Percent of respondents said they would recommend future sessions to a colleague.		
ACS CCC Webinars	**All respondents**	**NCCCP recipients and cancer coalitions**
Advocacy vs Lobbying: What's the Difference?	99% (n=77)	98% (n=66)
Cancer and Climate Change	98% (n=63)	100% (n=35)
What You Need to Know About Prostate Cancer Screening	98% (n=46)	100% (n=16)
Fueling the Mission: ACS Resources to Power Your Coalition's Work	93% (n=28)	95% (n=19)
Comprehensive Cancer Coalitions & The Evolving Landscape of Cancer Survivorship	97% (n=30)	100% (n=18)
Average	**96%**	**98%**

Knowledge Gained

All Webinar Participants				
Webinar	**N (matched)**	**Pre**	**Post**	**Percent Change**
Advocacy vs Lobbying: What's the Difference?	66	54%	81%	50%
Cancer and Climate Change	59	59%	73%	24%
What You Need to Know About Prostate Cancer Screening	10	23%	33%	43%
Fueling the Mission: ACS Resources to Power Your Coalition's Work	21	50%	68%	36%
Comprehensive Cancer Coalitions & the Evolving Landscape of Cancer Survivorship	22	52%	42%	-19%
			Average	**27%**

CCC Coalition Participants				
Webinar	**N (matched)**	**Pre**	**Post**	**Percent Change**
Advocacy vs Lobbying: What's the Difference?	58	55%	82%	49%
Cancer and Climate Change	33	63%	76%	21%
What You Need to Know About Prostate Cancer Screening	5	20%	25%	25%
Fueling the Mission: ACS Resources to Power Your Coalition's Work	15	47%	63%	34%
Comprehensive Cancer Coalitions & the Evolving Landscape of Cancer Survivorship	15	58%	42%	-28%
			Average	**20%**

Webinar "Can Apply" and "Intent to Apply"

All Participants				
Webinar	**N**	**Capacity**	**N**	**Intent**
Advocacy vs Lobbying: What's the Difference?	73	93%	71	89%
Cancer and Climate Change	62*	95%	61*	82%
What You Need to Know About Prostate Cancer Screening	46	98%	45	93%
Fueling the Mission: ACS Resources to Power Your Coalition's Work	28	96%	26	85%
Comprehensive Cancer Coalitions & the Evolving Landscape of Cancer Survivorship	29	93%	29	90%
Average		**95%**		**88%**
NCCCP Recipients and Cancer Coalitions				
Webinar	**N**	**Capacity**	**N**	**Intent**
Advocacy vs Lobbying: What's the Difference?	62	94%	60	87%
Cancer and Climate Change	35*	100%	35*	86%
What You Need to Know About Prostate Cancer Screening	16	100%	16	88%
Fueling the Mission: ACS Resources to Power Your Coalition's Work	19	95%	18	83%
Comprehensive Cancer Coalitions & the Evolving Landscape of Cancer Survivorship	18	100%	18	94%
Average		**98%**		**88%**

*A respondent selected two choices and was dropped from the analysis.

Webinar TTA Needs

All Participants						
TTA Needs	**Advocacy vs Lobbying (n=62)**	**Climate (n=59)**	**Prostate (n=40)**	**ACS Resources (n=24)**	**Survivorship (n=29)**	**Average**
State-specific technical assistance from national experts (e.g. office hours)	52% (n=32)	37% (n=22)	55% (n=22)	13% (n=3)	31% (n=9)	38%
Linkages with other CCC coalitions (e.g. learning communities)	55% (n=34)	41% (n=24)	40% (n=16)	25% (n=6)	48% (n=14)	42%
Resources and tools to assist with implementation (e.g. factsheets or toolkits)	58% (n=36)	69% (n=41)	78% (n=31)	38% (n=9)	76% (n=22)	64%
Virtual learnings (e.g. brief, 5-minute videos or on-demand learning modules)	47% (n=29)	54% (n=32)	48% (n=19)	13% (n=3)	55% (n=16)	43%
Webinars	60% (n=37)	63% (n=37)	75% (n=30)	13% (n=3)	52% (n=15)	53%

NCCCP Recipients and Cancer Coalitions						
TTA Needs	**Advocacy vs Lobbying (n=51)**	**Climate (n=32)**	**Prostate (n=14)**	**ACS Resources (n=17)**	**Survivorship (n=18)**	**Average**
State-specific technical assistance from national experts (e.g. office hours)	57% (n=29)	47% (n=15)	50% (n=7)	12% (n=2)	44% (n=8)	42%
Linkages with other CCC coalitions (e.g. learning communities)	59% (n=30)	47% (n=15)	43% (n=6)	18% (n=3)	61% (n=11)	46%
Resources and tools to assist with implementation (e.g. factsheets or toolkits)	57% (n=29)	75% (n=24)	86% (n=14)	41% (n=7)	72% (n=13)	66%
Virtual learnings (e.g. brief, 5-minute videos or on-demand learning modules)	49% (n=25)	56% (n=18)	57% (n=8)	12% (n=2)	56% (n=10)	46%
Webinars	57% (n=29)	50% (n=16)	71% (n=10)	18% (n=3)	44% (n=8)	48%

*Respondents may have answered at multiple events. Webinar titles were shortened for formatting purposes: Advocacy vs Lobbying: *Advocacy vs Lobbying: What's the Difference?*; Climate: *Cancer and Climate Change*; Prostate: *What You Need to Know About Prostate Cancer Screening*; ACS Resources: *Fueling the Mission: ACS Resources to Power Your Coalition's Work*; Survivorship: *Comprehensive Cancer Coalitions & the Evolving Landscape of Cancer Survivorship*

Appendix 5: ACS Coalition University Data

Satisfaction

Percent of respondents said they would recommend future sessions to a colleague.	
Module	**% (n)**
Meeting Challenges	85% (n=15)
Managing Disagreement & Conflict	85% (n=7)
Influencing People*	100% (n=3)
Building Health Teams	71% (n=7)
Average	**85%**

*One respondent did not answer this question

Knowledge

As a result of this learning module, I know:		
Module	**Learning Objective**	**% (n)**
Meeting Challenges 77% average learning objectives met	A. That challenging behaviors during a meeting often indicate that something in the meeting process isn't working for participants.	80% (n=15)
	B. How to use simple interventions to address common meeting challenges.	73% (n=15)
Managing Disagreement & Conflict 85% average learning objectives met	A. Identify 1-2 conflict resolution principles to help navigate disagreements.	85% (n=7)
	B. List at least two components of the conversation model for conflict resolution discussions.	85% (n=7)
	C. Describe the importance of identifying what interests are common to both sides of a conflict.	85% (n=7)
Influencing People* 100% average learning objectives met	A. Use the "push" and "pull" framework of influencing people.	100% (n=3)
	B. Use at least three influence strategies.	100% (n=3)
	C. Identify components of an 'influencing' conversation.	100% (n=3)
Building Health Teams 95% average learning objectives met	A. Identify key factors that teams need to function in an effective way.	86% (n=7)
	B. Describe the importance of clearly defined objectives and strategies in building healthy teams.	100% (n=7)
	C. Facilitate change in my coalition.	100% (n=7)
	Average	**90%**

*One respondent did not answer this question

Capacity and Intent

Percent of respondents who said they "can apply" and "intend to apply" what they learned in the next 3-6 months.		
Module	**Capacity**	**Intent**
Meeting Challenges	100% (n=15)	100% (n=15)
Managing Disagreement & Conflict	100% (n=7)	100% (n=7)
Influencing People	100% (n=4)	100% (n=4)
Building Health Teams	100% (n=7)	71% (n=5)
Average	**100%**	**93%**

Appendix 6: Cancer Planning Learning Communities Supplemental Tables

Satisfaction

Percent of respondents said they would recommend future sessions to a colleague.		
Session	**All respondents**	**NCCCP recipients and cancer coalitions**
Session 1: Engage Key Partners	90% (n=30)	92% (n=26)
Session 2: Identify & Use Data to Guide Your Cancer Plan Efforts	100% (n=23)	100% (n=19)
Session 3: Identify & Adapt Implementation Strategies	90% (n=21)	88% (n=17)
Session 4: Learn Facilitation Skills to Guide Group Consensus	95% (n=20)	93% (n=14)
Session 5: Monitor & Share Progress	94% (n=17)	93% (n=15)
Average	**94%**	**93%**

Network

Percent of respondents said they were able to learn what other CCC programs and/or coalitions are doing.		
Session	**All respondents**	**NCCCP recipients and cancer coalitions**
Session 1: Engage Key Partners	86% (n=29)	88% (n=25)
Session 2: Identify & Use Data to Guide Your Cancer Plan Efforts	87% (n=23)	84% (n=19)
Session 3: Identify & Adapt Implementation Strategies	33% (n=21)	35% (n=17)
Session 4: Learn Facilitation Skills to Guide Group Consensus	79% (n=19)	79% (n=14)
Average	**71%**	**71%**
Note: A networking question was not included during Session 5 post-poll due to limited evaluator capacity during the finalization of survey materials.		

Awareness

Percent of respondents said they were able to learn what other CCC programs and/or coalitions are doing.				
Session	**Group**	**Pre**	**Post**	**Percent Change**
Session 1: Engage Key Partners	All (n=26)	3.2	3.8	19%
	NCCCP (n=23)	3.2	3.8	19%
Session 2: Identify & Use Data to Guide Your Cancer Plan Efforts	All (n=19)	3.3	3.9	18%
	NCCCP (n=15)	3.4	4.0	18%
Session 4: Learn Facilitation Skills to Guide Group Consensus	All (n=14)	3.5	4.5	29%
	NCCCP (n=10)	3.4	4.3	26%
Session 5: Monitor & Share Progress	All (n=14)	3.4	4.1	21%
	NCCCP (n=13)	3.4	4.1	21%
Average	**All**			**22%**
	NCCCP			**21%**
Note: Session 3 did not include awareness questions due to its didactic format. Instead, objective, knowledge-based questions were used, similar to those in ACS CCC's webinars.				

Knowledge

Awareness change for matched respondents (all respondents and NCCCP recipients & cancer coalitions)				
Session	**Group**	**Pre**	**Post**	**Percent Change**
Session 1: Engage Key Partners	All (n=26)	3.5	4.1	17%
	NCCCP (n=23)	3.6	4.1	14%
Session 2: Identify & Use Data to Guide Your Cancer Plan Efforts	All (n=19)	3.1	3.9	26%
	NCCCP (n=15)	3.1	3.9	26%
Session 3: Identify & Adapt Implementation Strategies	All (n=19)	72%	75%	4%
	NCCCP (n=15)	69%	76%	10%
Session 4: Learn Facilitation Skills to Guide Group Consensus	All (n=14)	3.2	3.8	19%
	NCCCP (n=10)	3.4	3.9	15%
Session 5: Monitor & Share Progress	All (n=14)	3.1	4.0	29%
	NCCCP (n=13)	3.2	4.1	28%
Average	**All**			**19%**
	NCCCP			**19%**

Confidence

Awareness change for matched respondents (all respondents and NCCCP recipients & cancer coalitions)				
Session	**Group**	**Pre**	**Post**	**Percent Change**
Session 1: Engage Key Partners	All (n=26)	2.7	3.3	22%
	NCCCP (n=23)	2.7	3.3	22%
Session 2: Identify & Use Data to Guide Your Cancer Plan Efforts	All (n=24)	3.0	3.1	3%
	NCCCP (n=20)	3.1	3.1	0%
Session 3: Identify & Adapt Implementation Strategies	All (n=9)	3.2	3.2	0%
	NCCCP (n=7)	3.6	3.6	0%
Session 4: Learn Facilitation Skills to Guide Group Consensus	All (n=14)	3.1	3.5	13%
	NCCCP (n=10)	3.4	3.7	9%
Session 5: Monitor & Share Progress	All (n=14)	2.7	3.3	22%
	NCCCP (n=13)	2.8	3.5	25%
Average	**All**			**12%**
	NCCCP			**11%**

Capacity

Percent of respondents said they can apply what they learned.		
Session	**All respondents**	**NCCCP recipients and cancer coalitions**
Session 1: Engage Key Partners	90% (n=29)	88% (n=25)
Session 2: Identify & Use Data to Guide Your Cancer Plan Efforts	87% (n=23)	84% (n=19)
Session 3: Identify & Adapt Implementation Strategies	90% (n=21)	88% (n=17)
Session 4: Learn Facilitation Skills to Guide Group Consensus	100% (n=20)	100% (n=14)
Session 5: Monitor & Share Progress	82% (n=17)	87% (n=15)
Average	**90%**	**89%**

Intent

Percent of respondents said they intend to complete the call to action			
Session	**Call to Action**	**All respondents**	**NCCCP recipients and cancer coalitions**
Session 1: Engage Key Partners	I intend to reach out to a new or existing partner in the next 3-6 months to engage them in the cancer planning process.	85% (n=27)	87% (n=23)
Session 2: Identify & Use Data to Guide Your Cancer Plan Efforts	I intend to explore a new data set in the next 3-6 months to identify a data gap my coalition could work towards.	82% (n=22)	83% (n=18)
Session 3: Identify & Adapt Implementation Strategies	I intend to use a resource shared today to identify an EBI that fits with my program's goals and context.	90% (n=21)	88% (n=17)
Session 4: Learn Facilitation Skills to Guide Group Consensus	I intend to try one new thing in my meetings to help drive consensus in decisions in the next 3-6 months.	100% (n=19)	100% (n=14)
Session 5: Monitor & Share Progress	I intend to identify one way my coalition can enhance how it monitors and shares progress on our cancer plan in the next 3-6 months.	94% (n=16)	100% (n=14)
	Average	**90%**	**92%**
Note: Respondents who answered they were not doing cancer planning in the next 3-6 months were removed from analysis.			

Adoption

Percent of respondents that adopted strategies			
Session	**Strategy**	**All respondents**	**NCCCP recipients and cancer coalitions**
Session 1: Engage Key Partners	Engage key partners in the cancer planning process.	77% (n=13)	82% (n=11)
Session 2: Identify & Use Data to Guide Your Cancer Plan Efforts	Use data to guide cancer plan efforts.	75% (n=12)	80% (n=10)
Session 3: Identify & Adapt Implementation Strategies	Identify and adopt implementation strategies.	82% (n=11)	89% (n=9)
Session 4: Learn Facilitation Skills to Guide Group Consensus	Facilitate group discussions to build consensus.	67% (n=12)	80% (n=10)
Session 5: Monitor & Share Progress	Determine methods to monitor and share progress on the cancer plan.	80% (n=10)	75% (n=8)
	Average	**76%**	**81%**
Note: The n correlates to the number of respondents who attended or watched the recording of the session. The percentage is the percentage of those respondents who indicated they adopted the strategy.			

Appendix 7: Colorectal Cancer Mortality Disparities Learning Communities Supplemental Tables

Satisfaction

Percent of respondents said they would recommend future sessions to a colleague.		
CRC Mortality Disparities Learning Community	**All respondents**	**NCCCP recipients and cancer coalitions**
Session 1: CRC Mortality 101	100% (n=17)	100% (n=16)
Session 2: Timely Follow-up Colonoscopy & CRC Mortality	100% (n=12)	100% (n=9)
Session 3: CRC Survivorship	94% (n=18)	93% (n=14)
Session 4: CRC Mortality in Your Community	100% (n=16)	100% (n=13)
Session 5: CRC Mortality & State Cancer Plans	77% (n=13)	73% (n=11)
Average	**94%**	**93%**

Network

Percent of respondents said they were able to learn what other CCC programs and/or coalitions are doing.		
Session	**All respondents**	**NCCCP recipients and cancer coalitions**
Session 1: CRC Mortality 101	88% (n=16)	87% (n=15)
Session 2: Timely Follow-up Colonoscopy & CRC Mortality	n/a	n/a
Session 3: CRC Survivorship	93% (n=15)	92% (n=13)
Session 4: CRC Mortality in Your Community	71% (n=17)	77% (n=13)
Session 5: CRC Mortality & State Cancer Plans	92% (n=13)	91% (n=11)
Average	**86%**	**87%**
Note: A networking question was not included during Session 2 post-poll due to limited evaluator capacity during the finalization of survey materials.		

Awareness

Awareness change for matched respondents (all respondents and NCCCP recipients & cancer coalitions)				
Session	**Group**	**Pre**	**Post**	**Percent Change**
Session 4: CRC Mortality in Your Community	All (n=17)	3.6	4.2	17%
	NCCCP (n=12)	3.8	4.1	8%
Session 5: CRC Mortality & State Cancer Plans	All (n=16)	4.1	4.4	7%
	NCCCP (n=14)	4.0	4.4	10%
Average	**All**			**12%**
	NCCCP			**9%**
Sessions 1-3 were more didactic and focused on knowledge growth. Therefore, those sessions were measured only with knowledge pre/post-polls to assess growth by percentage correct.				

Knowledge

Knowledge change for matched respondents (all respondents and NCCCP recipients & cancer coalitions)				
Session	**Group**	**Pre**	**Post**	**Percent Change**
Session 1: CRC Mortality 101	All (n=17)	33%	77%	133%
	NCCCP (n=16)	35%	75%	114%
Session 2: Timely Follow-up Colonoscopy & CRC Mortality	All (n=16)	29%	42%	45%
	NCCCP (n=12)	33%	44%	33%
Session 3: CRC Survivorship	All (n=15)	60%	78%	30%
	NCCCP (n=11)	64%	82%	28%
Session 4: CRC Mortality in Your Community	All (n=14)	3.7	4.2	14%
	NCCCP (n=10)	3.7	4.1	11%
Session 5: CRC Mortality & State Cancer Plans	All (n=13)	4.0	4.2	5%
	NCCCP (n=11)	4.0	4.2	5%
Average	**All**			**45%**
	NCCCP			**38%**

Note: The average percent change is not as relevant as each session as sessions 1-3 were measured with objective, knowledge-based questions whereas sessions 4 and 5 were measured with a self-selected Likert scale on knowledge for how to use information.

Confidence

Awareness change for matched respondents (all respondents and NCCCP recipients & cancer coalitions)				
Session	**Group**	**Pre**	**Post**	**Percent Change**
Session 4: CRC Mortality in Your Community	All (n=8)	4	4.4	10%
	NCCCP (n=4)	4.3	4	-7%
Session 5: CRC Mortality & State Cancer Plans	All (n=16)	4.2	4.4	5%
	NCCCP (n=14)	4.1	4.3	5%
Average	**All**			**7%**
	NCCCP			**-1%**

Sessions 1-3 were more didactic and focused on knowledge growth. Therefore, those sessions were measured only with knowledge pre/post-polls to assess growth by percentage correct.

Capacity

Percent of respondents said they intend to complete the call to action in the next 3-6 months.		
Session	**All respondents**	**NCCCP recipients and cancer coalitions**
Session 1: CRC Mortality 101	94% (n=17)	94% (n=16)
Session 2: Timely Follow-up Colonoscopy & CRC Mortality	100% (n=12)	100% (n=9)
Session 3: CRC Survivorship	88% (n=16)	85% (n=11)
Session 4: CRC Mortality in Your Community	94% (n=17)	100% (n=13)
Session 5: CRC Mortality & State Cancer Plans	85% (n=13)	82% (n=11)
Average	**92%**	**92%**

Intent

Percent of respondents said they intend to complete the call to action in the next 3-6 months.			
Session	**Call to Action**	**All respondents**	**NCCCP recipients and cancer coalitions**
Session 1: CRC Mortality 101	Explore resources to identify populations that may have higher CRC mortality rates in my community.	100% (n=16)	100% (n=15)
Session 2: Timely Follow-up Colonoscopy & CRC Mortality	Include messaging in coalition material that follow-up colonoscopy after a positive or abnormal stool-based test is essential.	83% (n=12)	89% (n=9)
Session 3: CRC Survivorship	Find ways to direct people to support and/or use their voices in my work.	87% (n=15)	83% (n=12)
Session 4: CRC Mortality in Your Community	Use the CRC dashboard or other data tools to assess the burden of CRC mortality in my state.	94% (n=16)	92% (n=13)
Session 5: CRC Mortality & State Cancer Plans	Use the ACS4CCC Tip Sheets to update my cancer plan.	69% (n=13)	64% (n=11)
	Average	**87%**	**86%**
Note: Session 5 is likely lower intent as states may not be updating their cancer plan in the next 3-6 months.			

Adoption

Percent of respondents that adopted strategies			
Session	**Strategy**	**All respondents**	**NCCCP recipients and cancer coalitions**
Session 1: CRC Mortality 101	Explored resources to identify populations that may have higher CRC mortality rates in my community	Yes: 64% (n=11) *Yes and Not Yet: 100%*	Yes: 70% (n=10) *Yes and Not Yet: 100%*
Session 2: Timely Follow-up Colonoscopy & CRC Mortality	Included messaging in coalition material that follow-up colonoscopy after a positive or abnormal stool-based test is essential	42% (n=12) *92%*	45% (n=11) *91%*
Session 3: CRC Survivorship	Found ways to direct people to support and/or use their voices in my work	77% (n=13) *92%*	82% (n=11) *91%*
Session 4: CRC Mortality in Your Community	Used the ACS NCCRT CRC dashboard or other data tools to assess the burden of CRC mortality of my community	67% (n=12) *92%*	73% (n=11) *91%*
Session 5: CRC Mortality & State Cancer Plans	Integrated CRC strategies into our cancer planning process or coalition activities.	50% (n=14) *86%*	55% (n=11) *91%*
	Average	**60%** ***92%***	**65%** ***93%***
Note: Session 5 is likely lower intent as states may not be updating their cancer plan in the next 3-6 months.			

Appendix 8: FLCC Cohorts Supplemental Tables

Background

Number of Cohort Participants and Survey Respondents				
Cohort	**Participants**	**Pre**	**Post**	**3-month Follow-up**
Cohort 4: 14-week[1]	16	17	9	10
Cohort 5: 6-week[2]	17	15	12	n/a

[1]A total of 19 individuals registered with 16 participated in the full workshop. Seventeen (17) completed a pre-workshop survey, while 9 completed the post-workshop survey, with 9 participants completing both. Results from participants who dropped out were excluded from the analysis.
[2]A total of 18 individuals registered and 17 participated in the cohort. Two transferred their registration to another and their response was removed from analysis. Sixteen (16) participants completed the pre-survey; however, one of these participants attended only two sessions and was excluded from the analysis (n=15, 88% response rate). At the end, 12 (71%) participants took the post survey, and 11 (65%) participants took both the pre-survey and post-survey.

Satisfaction

Workshop Rating: Overall, how would you rate the workshop?					
Cohort	**Poor**	**Fair**	**Average**	**Good**	**Excellent**
Cohort 4 (n=9)	0	0	0	1 (11%)	8 (89%)
Cohort 5 (n=12)	0	0	0	1 (8%)	11 (92%)

Skills and Capacity Change: Cohort 4

Workshop Rating: Overall, how would you rate the workshop?						
Mean Rating – Scale Fundamental Awareness (1) to Expert (5)	**All Recipients**			**Matched Recipients**		
	Pre	**Post**	**Change (%)**	**Pre**	**Post**	**Change (%)**
Design effective and participatory meetings and engagements where objectives are met and "work gets done."	2.9	4.0	1.1 (38%)	2.8	4.0	1.2 (43%)
Use facilitative tools to build connection, gather and analyze information, and make decisions.	2.4	4.1	1.7 (71%)	2.4	4.1	1.7 (71%)
Effectively respond to team or participant challenges (e.g., dysfunctional behavior) in a group setting.	2.4	3.7	1.3 (54%)	2.4	3.7	1.3 (54%)
Effectively help a team identify necessary changes and overcome resistance to making changes.	2.7	3.8	1.1 (41%)	2.9	3.8	0.9 (31%)
Leverage a range of influence strategies to move individuals or groups to take desired actions.	2.5	3.6	1.1 (44%)	2.3	3.6	1.3 (57%)
Hold one-on-one conversations to productively resolve disagreements and overcome conflict while preserving relationships.	2.9	3.8	0.9 (31%)	3.1	3.8	0.7 (24%)
Hold one-on-one conversations to help others resolve their challenges and develop skills.	3.1	3.9	0.8 (26%)	3.1	3.9	0.8 (26%)
Build effective teams where all members are outcome-focused, share the workload and collaborate effectively.	2.7	3.9	1.2 (44%)	3.1	3.9	0.8 (26%)
Identify and recruit partners that can execute the strategies.	2.8	4.2	1.4 (50%)	3.1	4.2	1.1 (36%)
Identifying impactful and scalable coalition strategies.	2.5	3.8	1.3 (52%)	2.7	3.8	1.1 (41%)
Average	**2.7**	**3.9**	**1.2 (45%)**	**2.8**	**3.9**	**1.1 (41%)**

Skills and Capacity Change: Cohort 4 (continued)

Please rate your capacity to do the following steps to effectively and efficiently facilitate any group dialogue:						
Mean Rating – Scale Fundamental Awareness (1) to Expert (5)	All Recipients			Matched Recipients		
	Pre	Post	Change (%)	Pre	Post	Change (%)
Framing	2.2	3.8	1.6 (73%)	2.4	3.8	1.3 (55%)
Asking good questions	2.6	3.8	1.2 (46%)	2.8	3.8	1.0 (36%)
Active listening	2.9	4.2	1.3 (45%)	2.8	4.2	1.4 (52%)
Keeping the group focused	2.8	4.0	1.2 (43%)	2.6	4.0	1.4 (57%)
Visually recording solutions	2.7	3.7	1.0 (37%)	2.6	3.7	1.1 (44%)
Average	**2.6**	**3.9**	**1.3 (49%)**	**2.6**	**3.9**	**1.3 (49%)**

Skills and Capacity Change: Cohort 5

I can … / As a result of the workshop, I can …						
Mean Rating – Scale Fundamental Awareness (1) to Expert (5)	All Recipients			Matched Recipients		
	Pre	Post	Change (%)	Pre	Post	Change (%)
Design effective and participatory meetings and engagements where objectives are met and "work gets done."	3.1	3.8	0.7 (23%)	2.9	3.8	0.9 (31%)
Use facilitative tools to build connection, gather and analyze information, and make decisions.*	2.8	3.8	1.0 (36%)	2.7	3.9	1.2 (44%)
Effectively respond to team or participant challenges (e.g., dysfunctional behavior) in a group setting.	2.6	3.5	0.9 (31%)	2.5	3.5	1.0 (40%)
Average	**2.8**	**3.7**	**0.9 (31%)**	**2.7**	**3.7**	**1.0 (38%)**
Please rate your capacity to do the following steps to effectively and efficiently facilitate any group dialogue:						
Mean Rating – Scale Fundamental Awareness (1) to Expert (5)	All Recipients			Matched Recipients		
	Pre	Post	Change (%)	Pre	Post	Change (%)
Framing	2.5	3.7	1.2 (48%)	2.3	3.6	1.3 (57%)
Asking good questions	2.6	3.8	1.2 (46%)	2.4	3.8	1.2 (58%)
Active listening	3.3	4.0	0.7 (21%)	3.2	4.0	0.8 (25%)
Keeping the group focused	3.1	3.8	0.7 (23%)	3.0	3.8	0.8 (27%)
Visually recording solutions*	2.8	3.7	0.9 (32%)	2.6	3.8	1.2 (46%)
Average	**2.9**	**3.8**	**0.9 (34%)**	**2.7**	**3.8**	**1.1 (43%)**
*These options were not answered by all respondents during the pre-survey (n=14 all recipients n=9 matched recipients).						

Skills Adopted: Cohort 4

Frequency of Skills Used			
	Mean	Minimum	Maximum
Number of skills used in the last three months by participant	3	1	6

Skills used by FLCC Cohort 4 Participants within three months (n=10)	
Skills	**Number Participants**
Design effective and participatory meetings and engagements where objectives are met and "work gets done."	7 (70%)
Use facilitative tools to build connection, gather and analyze information, and make decisions.	6 (60%)
Build effective teams where all members are outcome-focused, share the workload and collaborate effectively.	4 (40%)
Identify and recruit partners that can execute the strategies.	4 (40%)
Identifying impactful and scalable coalition strategies.	3 (30%)
Hold one-on-one conversations to help others resolve their challenges and develop skills.	2 (20%)
Effectively respond to team or participant challenges (e.g., dysfunctional behavior) in a group setting.	1 (10%)
Effectively help a team identify necessary changes and overcome resistance to making changes.	1 (10%)
Leverage a range of influence strategies to move individuals or groups to take desired actions.	1 (10%)
Hold one-on-one conversations to productively resolve disagreements and overcome conflict while preserving relationships.	1 (10%)

Frequency of skills used within three months		
Number Skills	**Frequency**	**Percent**
1	2	20%
2	1	10%
3	4	40%
4	2	20%
5	0	0%
6	1	10%
7	0	0%
8	0	0%
9	0	0%
10	0	0%

Number of times skill used by cohort		
Skill	**Cohort 3**	**Cohort 4**
Design productive, participatory meetings that achieve objectives	6	7
Use facilitation tools to connect, gather insights, and make decisions	7	6
Build outcome-focused, collaborative teams	1	4
Identify and recruit partners	5	4
Identify impactful and scalable coalition strategies	5	3
Hold 1:1s to overcome conflict while preserving relationships	3	2
Effectively respond to challenges in a group setting	1	1
Help teams identify and overcome resistance to change	3	1
Leverage a range of influence strategies	3	1
Hold 1:1s to support problem-solving and skill development	6	1