J Canc Educ (2014) 29:188–193
DOI 10.1007/s13187-013-0568-8

Sustainability in a State Comprehensive Cancer Control Coalition: Lessons Learned

Renee A. Desmond · Kathryn Chapman · Gavin Graf · Bret Stanfield · John W. Waterbor

Published online: 17 October 2013

Abstract The Alabama Comprehensive Cancer Control Coalition (ACCCC) has developed an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality, and to improving the quality of life for cancer survivors, their families, and their caregivers. The ACCCC is currently in a maintenance phase and a formal plan for sustainability of the coalition was needed to keep the members engaged and productive. A training session in coalition sustainability conducted in 2013 identified the following elements as essential to success: (1) increased marketing of the coalition by simplifying its mission; (2) improved networking including flexibility in coalition meeting location and attendance; (3) increased membership satisfaction through transformational leadership; (4) revision of the working structure of committees and improved accountability; and (5) enhancement of partner satisfaction with coalition activities designed to recruit and retain new partners. A self-administered membership satisfaction survey was given to assess coalition mission, meeting logistics, organization, capacity building, and coalition goals. Results indicated that the subcategories of communication, mission, and meeting logistics were rated satisfied to very satisfied on a five-point scale. Although the ACCCC had clearly written goals, improvement could be made in leadership participation and new member orientation could be improved. Most members rated their parent organization as highly involved with the ACCCC and many offered suggestions on capacity building. Results of the sustainability training have clarified the ACCCC's plans to ensure coalition viability and improve strategies to inform stakeholders of the benefits of participation in the coalition.

Keywords Cancer coalition · Alabama · Program evaluation · Survey

Introduction

A previous report of Alabama Comprehensive Cancer Coalition (ACCCC) activities focused on the development of the Alabama state cancer plan [1]. Upon completion of that phase of work, the leadership recognized that in order to ensure sustainability of the coalition and resources over time, the ACCCC membership must grow and reach out to new partners and keep current members engaged. The leadership recognized the need for professional education in coalition sustainability. Sustainability, as defined by Butterfoss, refers to the coalitions' ability or capacity to support and maintain its activities over time [2]. It is recognized that three social entities influence community capacity: individuals, organizations, and networks of associations. Ultimately, it is organizations that actually implement recommended strategies [3]. Analyses of research collaborations have shown that cancer research efforts are generally well-coordinated with national policy efforts to influence the integration of research knowledge across organizations [4]. The measurement of a coalition's relational structure and how this affects sustainable capacity for health promotion is an area that is understudied [5].

As the ACCCC is now in a maintenance phase, a formal plan for sustainability of the coalition was needed. Specifically, the leadership was interested in what would motivate members

R. A. Desmond (✉)
Department of Medicine, Division of Preventive Medicine, University of Alabama at Birmingham, 1720 2nd Avenue South MT 637, Birmingham, AL 35294-4410, USA
e-mail: desmond@uab.edu

K. Chapman · G. Graf · B. Stanfield
Comprehensive Cancer Control Prevention Program, Alabama Department of Public Health, Montgomery, AL, USA

J. W. Waterbor
Department of Epidemiology, University of Alabama at Birmingham, 1720 2nd Avenue South MT 637, Birmingham, AL 35294-4410, USA

to work on behalf of the coalition and how to diversify and strengthen the coalition. A formal training session in coalition sustainability conducted in 2013 identified the following elements as essential to success: (1) increased marketing of the coalition by simplifying its mission; (2) improved networking including flexibility in coalition meeting location and attendance; (3) increased membership satisfaction through transformational leadership; (4) revision of the working structure of committees and improved accountability; and (5) enhancement of partner satisfaction with coalition activities designed to recruit and retain new partners. The purpose of this report is to describe the baseline metrics of these elements and the strategies proposed or enacted to effect positive change in these areas.

Materials and Methods

In late 2012, the Evaluation Director for the ACCCC met with the Comprehensive Cancer Control Program (CCCP) staff leadership and proposed that an expert in coalition building in community health be invited to conduct a training session for the ACCCC membership. With funding available from the CCCP, an expert was invited to conduct a training session about coalition sustainability and capacity building at the quarterly meeting in January 2013. Two key objectives of the sustainability training were: (1) to help participants identify key sustainability objectives, and (2) to strengthen the coalition infrastructure and resource development. The educational training included a mixture of engaging lecture presentations as well as self-assessments by coalition members on topics such as transformational leadership, coalition membership gap analysis, and member recruitment [2]. Following the training session, in March of 2013, the coalition's Executive Committee met to discuss a topical list of items that were generated from members. Several themes emerged and possible strategies were proposed to address changes in each thematic area (Table 1).

It was also acknowledged that in recent years, the ACCCC had not convened the standing committees defined by the coalition bylaws meeting and instead relied on more of an ad hoc structure. An electronic poll of ACCCC members was conducted by Alabama Department of Public Health (ADPH) staff to discern which standing committee designations would be preferred by coalition members. Respondents selected from four choices and included additional comments if desired.

Finally, a self-administered survey was given to ACCCC membership to assess coalition satisfaction. The results of the same survey conducted in 2010 survey have been previously described [1]. A follow-up wave of this same survey was administered at the quarterly April 2013 meeting. The 2013 instrument was approved by the UAB Institutional Review Board and took 10–15 min to complete. A total of 28 members in 2010 and 20 participants in 2013 provided anonymous responses. On average, the respondents surveyed had been coalition members for 5 years (range 1–15 years). The content areas in the survey included communication, mission, personal satisfaction, coalition leadership, organizational involvement, and capacity building. The responses to each item were chosen from Likert scales with 1=very dissatisfied to 5=very satisfied, 1=strongly disagree to 5=strongly agree, or for some items 1=not at all to 5=quite a lot. For each survey item, the descriptive statistics of mean, median, and range as well as frequency data were reported. For simplicity in analyses, the responses of 4 (satisfied) and 5 (very satisfied) were combined and compared with the sum of 3 (neutral), 2 (dissatisfied), and 1(very dissatisfied). The responses were compared to the 2010 data to assess qualitative trends using a chi-square test of proportions to assess trends. A copy of the survey is available from the corresponding author upon request (RD).

Table 1 Lesson learned from the professional education session on coalition sustainability

Theme	Strategy
Visibility	Develop a vision statement.
	Develop a mission statement.
	Market the Coalition using a simple message.
	Identify an individual to be the coalition's spokesperson.
Membership	E-mail brief minutes of each meeting to all Coalition members or post on website.
	Broaden membership by adding physicians and other providers.
	Contact all past members who are now inactive.
	Recruit organizations, rather than people, as new members.
Leadership	Consider renaming the Executive Committee the Steering Committee.
	Better define the role of our standing committees.
	Determine whether the addition of regional coalitions would benefit our mission.
	Better delineate the organizational structure of the coalition.
Lead Agency	Hire a part-time paid staff member to assist in meeting coalition goals.
	Consider moving the coalition base out of the Health Department.
	Consider holding an annual retreat of the Executive Committee.
	Evaluate all coalition activities in detail.
Logistics	Rotate meeting locations throughout the state, provide travel reimbursement, and lunch.
	Continue to provide Ustream® to connect to those who cannot attend meetings.

Results

Overall, the coalition measures indicated a strong internal consistency (Table 2). The survey contained five multi-item scaled measures with Cronbach's alpha values ranging from 0.78 for "organizational involvement" to 0.90 for "capacity building." Internal consistency was also high for the 2010 survey with the exception of communication, measured on a three-item scale. The results in several key areas are described below as well as any strategies or actions to address each issue.

Communication, Visibility, and Mission

In 2010, 57.1 % of members surveyed were satisfied or very satisfied with communication among members of the coalition. This proportion increased to 80.0 % in 2013 ($p=0.13$). Satisfaction about the extent to which coalition members are listened to and heard within the group was essentially unchanged at 75.0 % in 2013 compared to 77.8 % in 2010. Satisfaction with information provided to members on available resources was 79.3 % in 2010 and 85.0 % in 2013.

Satisfaction that the coalition's mission was clearly stated was 67.8 % in 2010, increasing to 90.0 % in 2013 ($p=0.09$) with 85.0 % agreeing that the coalition reviewed its mission, goals, and objectives periodically in that same period. In addition, a greater proportion of respondents (80 % in 2013, up from 63.0 % in 2010, $p=0.33$) expressed satisfaction with the process used to establish the coalition mission in 2013.

Overall in 2013, 95.0 % agreed that the coalition had clearly written goals and objectives which was significantly higher than 66.7 % in 2010 ($p=0.03$) and 95.0 % agreed that the coalition engaged in planning for the future compared to 88.9 % in 2010.

Action Notwithstanding the continuous need for improvement, the ACCCC fared well on these elements.

Table 2 Mean scores for coalition member survey stratified by year

Characteristic	*N*	Mean	SD	No. of items	Alpha
2013					
Communication[a]	20	4.20	0.90	3	0.876
Meeting logistics[b]	20	4.30	0.48	14	0.881
Satisfaction and leadership[b]	20	4.29	0.60	9	0.876
Organizational involvement[c]	20	4.58	0.49	5	0.785
Capacity building[c]	20	4.24	0.72	9	0.904
2010					
Communication[a]	27	4.00	0.58	3	0.338
Meeting logistics[b]	27	4.10	0.56	14	0.872
Satisfaction and leadership[b]	27	4.01	0.72	9	0.902
Organizational involvement[c]	27	4.28	1.04	5	0.924
Capacity building[c]	27	3.72	1.07	9	0.857

[a] 1-5 scale where 1=very dissatisfied and 5=very satisfied.

[b] 1-5 scale where 1=strongly disagree and 5=strongly agree.

[c] 1-5 scale where 1=not at all and 5=quite a lot.

Membership

A membership survey database listing company affiliation revealed that the number of members was 231 in 2013 consisting of 32 % government entities, 36 % university and like other educational institutions, 12 % nonprofit organizations, and 19 % private companies. Mapping by county of member address showed a concentration of members in urban areas with 27 % ($n=70$) members residing in Jefferson County where Birmingham is located, and 29 % ($n=69$) members residing in Montgomery County where the state capitol as well as the central offices of the Alabama Department of Public Health are located. This baseline information was used to identify underrepresented geographic areas of the state and to develop outreach initiatives for members in strategic geographic areas.

Included in the membership satisfaction survey was an open-ended query "How can we attract new members to the organization?" Suggestions included increasing visibility of the coalition and offering continuing education credits for attendance at quarterly meetings. Other ideas included marketing on television, at fundraisers, and at church events; publicizing coalition activities through e-mail lists to members of various associations and agencies; seminar presentations at health-oriented coalitions; web-based broadcasts of meetings; rotation of meeting locations; and recruiting national speakers. Only 45.0 % of respondents thought that the coalition provided adequate orientation for new members, a decrease from 63.0 % in 2010 ($p=0.25$).

Action In order to increase diversity for the ACCCC and attract members from diverse geographic areas, key organizations will be recruited to be involve including hospice organizations, elected officials and local legislators, media outlets, community members, and more clinical healthcare providers. Enhanced orientation procedures for new members were implemented.

Leadership/Organizational Structure/Decision Making

In 2013, most members (90.0 %) understood the Coalitions' plan compared to 2010 (66.7 %) ($p=0.09$). The proportion who were satisfied with the Coalition's cancer control plan also increased significantly from 59.3 to 95.0 % during the same time period ($p=0.006$). Similarly, the proportion who felt that they were making a contribution to the plan increased

from 59.2 to 95.0 % ($p=0.006$). In 2013, the majority (90.0 %) of respondents indicated that they enjoyed attending coalition meetings, and that they felt confident in expressing their opinions (95.0 %). Most agreed that the coalition had strong and competent leadership (85.2 % in 2010 and 85.0 % in 2013). In 2013, 85.0 % agreed that there are opportunities for coalition members to take leadership roles, but only 50.0 % agreed that members are willing to take on leadership roles compared to 55.6 % in 2010. About three-fourths (78.9 %) agreed that there was a clear process for leadership selection in 2013 compared to 85.2 % in 2010. Written comments indicated that new leaders should be selected through general election of members following nomination.

The ACCCC bylaws revision of 2005 designated the standing committees as follows: prevention, early detection, survivorship, environmental, medical and occupational exposure, surveillance, and research. Over the years, the coalition leadership had not convened in this fashion but had convened committees according to cancer sites (e.g., prostate) and specific exposure (e.g., tobacco). An anonymous online poll conducted by the CCCP staff following the January 2013 meeting found that 37.1 % of respondents preferred a committee structure based on traditional areas of cancer control. Only 14.3 % preferred a structure that was based on specific cancer sites or risk factors, 40 % preferred a mixture of the two structures (40.0 %), and 8.6 % were undecided. Some specific comments that supported these opinions are detailed in Table 3. There was only moderate satisfaction with the standing committee reports in 2013 (63.1 %) and in 2010 (53.8 %).

Table 3 Summary of survey participant comments regarding choice of ACCCC committee structure

Committee structure	Participant response
Specific cancer or risk factor	"I am interested in all areas but specialize in breast."
	"It is easier to keep focused on the task at hand when you simplify your subject matter, i.e. one cancer type."
Traditional areas of cancer control	"I believe that the committees based on areas of cancer control encompass all the cancers."
	"It would allow more people to contribute that may not actually deal directly with cancer but want to help educate others."
	"Many cancers have common risk factors."
	"In the long run this is more cost effective as the expertise of a particular method of control can be adapted to a different cancer."
	"These seem to be more in line with the ACCCC's goals."
A mixture of two	"Some people are interested in a particular type of cancer while others are interested in the overall cancer picture."
	"By meeting with people interested in other cancers, we might be able to find new opportunities and ways to work together."
Other	"A task oriented committee structure would be more effective for the assignment and completion of work."

Action This category was considered to be the primary category in which obstacles to sustainability resided. Coalition leadership invited input from members to negotiate new committee designations. A proposed revision of the committees retained the "Prevention," "Early Detection," and "Surveillance" committees; changed the name of "Survivorship" to "Survivorship and Palliative Care;" and added two important committees, "Access to Care" and "Communications." The committees of "Environmental, Medical, and Occupational Exposure" and "Research" were deleted because of lack of available expertise and the consensus that all standing committees should be open to cooperation on research activities. The membership voted to amend the bylaws to reflect these changes. Committee reports are now required to make the new designations more accountable. In addition, promotion of member involvement in leadership roles is being explored.

Meeting Logistics and Participation

The majority of surveyed participants were satisfied with meeting scheduling during 2010 and 2013 (80.7 and 95.0 %, respectively, $p=0.21$). Members agreed that routine matters were handled quickly during both time periods (84.6 and 90.0 %, $p=0.68$). There was satisfaction about advance meeting agendas and holding timely meetings (88.9 and 95.0 %, $p=0.63$), and satisfaction that meetings ran smoothly without interruptions (85.2 and 100.0 %, $p=1.0$). For both surveys, a slightly lower proportion indicated satisfaction that everyone was participating in discussions (70.4 and 75.0 %, $p=1.0$) and decision making (74.1 and 80.0 %, $p=0.53$). Although 100 % agreed that the atmosphere was friendly, cooperative, and pleasant, interest was not rated highly (55.6 and 60.0 %, respectively). A greater proportion of members agreed that they were well-informed about what was going on in 2013 compared to 2010 (80.0 and 59.3 %, $p=0.21$). Most members agreed that they feel comfortable speaking out (92.6 and 95.0 %, $p=1.0$) and agree that members typically follow the agenda (85.2 and 90.0 %, $p=1.0$). Overall, 90.0 % of coalition members surveyed agreed that the coalition environment was supportive.

Action A need was recognized to make meetings more accessible to members and other interested guests. The location of the quarterly meetings has changed periodically to accommodate members from various regions of the state. While for many years the central location of Montgomery was chosen as the meeting site, during 2012, the four quarterly meetings were held in other parts of the state: Tuskegee (East), Montgomery

(Mid-South), Birmingham (Central), and Huntsville (North). The October 2012 Coalition meeting held in Huntsville (Public Health Area 2) recruited three new members. In 2013, meetings were scheduled in Birmingham and Montgomery. Also, a live broadcast of all of the Coalition meetings was introduced in late 2012 and online capability was added in 2013. This Ustream® link is e-mailed to members prior to live broadcast and members may also login with an assigned password to view previous quarterly meeting broadcasts.

Partnership Involvement and Capacity Building

All coalition members surveyed in 2013 agreed that their parent organizations supported the work of the coalition and benefited from their involvement. All members also agreed that their organization was aware of the mission of the coalition, acknowledged their contribution to the coalition, and stated that they used the coalition as a resource for cancer information.

Overall, the members rated their parent organizations as highly involved with the ACCCC although many members suggested that improvements could be made to strengthen these working relationships. Member organizations currently acknowledged the ACCCC through: (1) participating in coalition programs and projects; (2) value of the coalition to members; (3) briefings at Monday morning staff meetings; (4) support on their website; (4) use of the ACCCC to modify goals and expectations of the member's staff organizations; and (5) reporting key proceedings on evaluation reports.

Capacity building is an area that has improved in the coalition since 2010 but members suggested additional strategies. The proportion building their own knowledge in cancer prevention and control increased significantly from 66.7 % in 2010 to 85.0 % in 2013 ($p=0.05$), and skills in cancer prevention and control increased from 62.9 % in 2010 to 85.5 % in 2013. Building the member's home organization's capacity in cancer prevention and control increased from 59.2 % in 2010 to 80.0 % in 2013 ($p=0.33$). In 2013, the majority of members agreed that they were learning from other organizations (80.0 %), learned how organizations can work together (90.0 %), shared resource material with other agencies and organizations (80.0 %), and helped their organization move toward its goals (75.0 %). Slightly fewer thought that the coalition helped them do their work (68.4 %) in 2013. The proportion who agreed that their ACCCC membership helped other organizations was 84.5 % in 2013 and 66.4 % in 2010. Members offered several comments related to organizational involvement. Several indicated that their organization acknowledged their coalition participation and encouraged their attendance. Some organizations included the coalition link on their website and encouraged member feedback to their home agency.

Action The membership was highly satisfied with the items related to the partnership and capacity building so specific improvements were not identified.

Lead Agency

The issue of headquarters for the ACCCC activities was commented on by members and briefly discussed by the leadership. Currently, the ADPH functions as the lead agency for the ACCCC taking on the basic communications and administrative responsibilities. Even though there is potential for the lead agency to constrain the activities of the coalition as described by Butterfoss [2], it was decided that the benefits to continuing the current relationship outweighed any limitations. It was acknowledged that the ADPH personnel do an outstanding job in promoting and contributing to the coalition while recognizing the separate mission of the two entities.

Action Although there was some discussion of moving the ACCCC headquarters to a nongovernmental agency, it was realized that the dedication of the CCCP staff and infrastructure could not be easily duplicated by a private partner in the new future. No changes were made.

Discussion

Our findings identified several key factors that are associated with member satisfaction that aligned with coalition sustainability. To sustain activities, the lead agency must be supportive and provide assistance with logistical activities such as scheduling meetings and conference calls, and providing new member orientation. The lead agency should also assist in providing resources consistent with the coalition's mission [6]. Having a recognized spokesperson or "champion" in a leadership role is also an important element in sustainability [6].

Evaluation of the partnership through surveys was an effective way to assess the satisfaction of members with key elements of the coalition. The coalition was able to utilize member input to realign the standing committees in order to further goals of the coalition for cancer control in Alabama. The newly defined standing committees reflect the spectrum of control efforts in the State from prevention to early detection, diagnosis, access to treatment, survivorship, palliative care, and hospice. Crosscutting themes of health disparities and health equity and the need for continued research are reflected in all the committees.

It is recognized that the ACCCC should expand its organizational capacity to recruit members that represent diverse organizations. In order to increase diversity, key organizations that the ACCCC would like to involve include hospice organizations, elected officials, local legislators, media outlets,

community members (including those from ethnic communities and religious organizations), and more diverse clinical healthcare providers. The members who participate in the coalition can help define problems and offer solutions which may be reflected in changes in programs in their members' organizations as they assume leadership roles [3]. The ACCCC must maintain diversity in stakeholders in order to be able to identify strategies to assist disparate populations. A recent study reported that diversity of coalition membership was associated with dollars leveraged and community capacity outcomes [7].

Challenges of coalition sustainability include limited time of coalition members to participate, and limited resources for developing incentives to engage and keep coalition members interested in coalition activities. It is important to identify factors that are associated with a member's integration of coalition goals and activities into their own organizations. One key factor identified has been participatory decision making [3]. It is critical for coalition members to participate in a variety of roles to provide them an opportunity to apply new skills [8]. Additional efforts should be directed toward new member orientation when guest members are successfully recruited.

Leadership training and staffing is also a key to success of the coalition and influences social capital, a measure of community capacity [8]. The ACCCC leadership has added inter-meeting conference calls and other meetings between the regularly scheduled ACCCC quarterly meetings to discuss relevant coalition issues such as meeting scheduling and agenda items thereby reducing time spent on administrative issues at regular coalition meetings. Although the theory on community coalitions is still developing, it has been demonstrated that a sense of community is associated with decision making and coalition cohesion which depends on leadership and staff [8].

A limitation of the evaluation of some of the coalition data presented herein is that it is based on self-report. It may be helpful to develop assessments that are from an outsider perspective [8]. A qualitative evaluation such as a face-to-face meeting may add further context to the coalition member's perception of their coalition and partnerships [9]. Also, the number of respondents for the member survey reflected those in attendance at the quarterly meeting. On average, attendance at quarterly meetings was 42 (20 % of the total membership) during 2010–2013 although this number can include guests and other nonmembers. Expansion of qualitative interviews with nonactive ACCCC members may be helpful. Due to logistics in transportation previously described, video streaming and meeting location rotations are used to increase participation in quarterly meetings.

The ACCCC faces continued funding challenges due to grant restructuring and program changes. The ACCCC will continue to work in partnership with the ADPH and other institutions and organizations to improve cancer prevention, control, and care in Alabama; evaluate areas of greatest need; and help coordinate resources to meet the identified needs. Tracking the progress of implementation of cancer control objectives will occur through annual evaluation. In conclusion, moving the ACCCC forward to sustainability requires implementation of sustainability strategies and periodic evaluation of these strategies.

Acknowledgments We would like to thank Ms. Bertha Bradford of UAB's Division of Preventive Medicine for her proofreading, editing, and administrative support.

This research was supported by a grant from the Centers for Disease Control and Prevention with its recipient, Alabama Department of Public Health (DP12-1205 1U58DP003854-01).

References

1. Litton A, Waterbor JW, Chapman K, Abdullah F, Thomas S, Desmond RA (2012) An achievement of professional, public, and patient education: the design and evaluation of a comprehensive cancer control plan for Alabama Journal of Cancer Education. J Cancer Educ 27(3): 478–485
2. Butterfoss FD (2007) Coalitions and partnerships in community health. Jossey-Bass, San Francisco
3. Zakocs RC, Gukenburg S (2007) What coalition factors foster community capacity? Lessons learned from the fighting back initiative. Health Educ Behav 34:354–375
4. Provan KG, Leischow SJ, Keagy J, Nodora J (2010) Research collaboration in the discovery, development, and delivery networks of a statewide cancer coalition. Eval Program Plan 33(4):349–355
5. Wells R, Ford EW, McClure JA et al (2007) Community-based coalition's capacity for sustainable action: the role of relationships. Health Ed Behav 34:124–139
6. Aitaoto N, Tsark J, Braun KL (2009) Sustainability of the Pacific diabetes today coalitions. Prev Chronic Dis 6:1–8
7. Kegler MC, Swan DW (2012) Advancing coalition theory: the effect of coalition factors on community capacity mediated by member engagement. Health Educ Res 27:572–584
8. Brown LD, Feinberg ME, Greenberg MT (2012) Measuring coalition functioning: refining constructs through factor analysis. Health Educ Behavior 39:486–497
9. Sy AU, Hecker KA, Buenconsejo-Lurn L et al (2011) An assessment of the Pacific regional cancer coalition: outcomes and implications of a regional coalition internal and external assessment. Hawaii Med J 70(S2):47–53