Tailoring Gynecologic Cancer Education for Health Care Providers

Information Collection Submitted Under
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Focus Group Testing to Effectively Plan and Tailor
Cancer Prevention and Control Communication Campaigns

Supporting Statement Part B

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B. DATA COLLECTION & STATISTICAL METHODS

Data collection will consist of a focus group methodology. In a focus group, a small group of people engage in a discussion of selected topics of interest typically directed by a moderator who guides the discussion in order to obtain the group's opinions (Edmunds, 1999; Krueger & Casey, 2000).

B1. Respondent Universe

CDC aims to conduct 2 focus groups. Each focus group will have 20 respondents.

The primary target audience is resident physicians currently enrolled in a primary care residency program at an academic medical institution. Residents will not be screened prior to participation but rather will be considered eligible by virtue of their enrollment in a residency program. The estimated number of participating residents is 36. A secondary audience is supervisors/ mentors/ directors involved with the residency program. The estimated number of participating supervisors is 4. The total number of respondents is 40. These respondents represent a convenience sample of the target audience(s) at a collaborating medical institution.

Qualitative information will be collected to provide insights about respondents' knowledge, attitudes, beliefs, and behavioral intent regarding the diagnosis and treatment of gynecologic cancers. Focus group findings will be used to inform the development and refinement of educational materials for medical residents. This activity is one of the dissemination strategies for key messages developed for CDC's *Inside Knowledge: Get the Facts about Gynecologic Cancer* campaign.

B2. Procedures for Information Collection

CDC plans to conduct 2 focus groups on-site at a collaborating medical center. Each focus group will be comprised of 20 respondents.

Respondents will be recruited via telephone by the data collection contractor, SciMetrika, LLC, using enrollment lists of the residency program of interest at the collaborating academic medical institution and the supervisors affiliated with the program. We will call eligible participants until we reach the target number of participants for each focus group.

Each respondent will sign a consent form (Appendix D) prior to participating in a focus group discussion.

The first focus group will take place prior to the introduction of any specific educational materials and will focus on elucidating existing knowledge gaps, attitudes, beliefs, behavioral intent and current practices regarding gynecologic cancers. The attached focus group guide (Appendix A) will be used to guide the discussion. The information collected

will be used by DCPC to appropriately plan for the development of the educational modules on gynecological cancer.

The second focus group will take place approximately 1-3 months after the first focus group (after the receipt of materials) and will ask about continued knowledge gaps, attitudes, beliefs, behavioral intent, current practices regarding gynecologic cancers, appeal, saliency, and likely uptake of the modules. The attached focus group guide (Appendix B) will be used to guide the discussion. Participants in Group A will not necessarily be excluded from Group B, but the two groups will be independent and recruitment for each will be separate.

B3. Methods to Maximize Response Rates

Participants will be recruited from lists of enrolled people in a residency program, our target audience, which offers an abundant supply of people in our target population. That in addition to our incentive should allow for sufficient response rates. An incentive will be offered in the form of refreshments. If that incentive fails to achieve the target number of respondents, we propose to offer a gift card to a local coffee shop.

B4.Tests of Procedures or Methods to be Undertaken

All DCPC communication campaigns are guided by the Health Communication Process (National Cancer Institute, 2002) which involves four stages: (stage 1) planning and strategy development; (stage 2) developing and pretesting concepts, messages, and materials; (stage 3) implementing the program; and (stage 4) assessing effectiveness and making refinements. The Health Communication Process is not linear, but rather is a circular model in which stages are revisited in a continuous loop of planning, development, implementation, and refinement. DCPC campaign staff carefully record all aspects of campaign development, operation, and evaluation. Innovations and improvements are incorporated into subsequent campaign cycles and periodically published in the peer-review literature (Cooper et al., 2011, Cooper et al. 2013). The use of focus group methodology to inform the development and refinement of communication campaigns has been well documented throughout the literature (Bull, et al., 2002; Edmunds, 1999; Krueger, 1994; Krueger & Casey, 2000; Cooper et al., 2011). Thus, the formative and materials-testing methods currently used by DCPC campaigns have been refined in 14 years of campaign operations.

B5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

The following individuals have been consulted on the design of this qualitative information collection:

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