Focus Group Testing to Effectively Plan and Tailor a Young Women and Breast Cancer Communication Campaign

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TABLE OF CONTENTS

B. DATA COLLECTION & STATISTICAL METHODS.....2
B1. Respondent Universe.....2
B2. Procedures for Information Collection.....5
B3. Methods to Maximize Response Rates.....5
B4. Tests of Procedures or Methods to be Undertaken.....6
B5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data.....6

List of Attachments

Attachment A. Legislative Authority – EARLY Act Reauthorization
Attachment B1. Discussion Guide for Focus Groups with Hispanic Young Women (With a Family History of Breast Cancer), English
Attachment B2. Discussion Guide for Focus Groups with Hispanic Young Women (With a Family History of Breast Cancer), Spanish
Attachment B3. Discussion Guide for Focus Groups with Hispanic Young Women (With No Family History of Breast Cancer), English
Attachment B4. Discussion Guide for Focus Groups with Hispanic Young Women (With No Family History of Breast Cancer), Spanish
Attachment B5. Materials for Testing with Hispanic Young Women, English
Attachment B6. Materials for Testing with Hispanic Young Women, Spanish
Attachment C1. Discussion Guide for Focus Groups with African American Young Women (With a Family History of Breast Cancer)
Attachment C2. Discussion Guide for Focus Groups with African American Young Women (Without Family History of Breast Cancer)
Attachment C3. Materials for Testing with African American Young Women
Attachment D1. Discussion Guide for Focus Groups with American Indian/Alaska Native Young Women (With a Family History of Breast Cancer)
Attachment D2. Discussion Guide for Focus Groups with American Indian/Alaska Native Young Women (With No Family History of Breast Cancer)
Attachment D3. Materials for Testing with American Indian/Alaska Native Young Women
Attachment E1. Screening Instrument for Hispanic Young Women (English)
Attachment E2. Screening Instrument for Hispanic Young Women (Spanish)
Attachment F. Screening Instrument for African American Young Women
Attachment G. Screening Instrument for American Indian/Alaska Native Young Women
Attachment H1. Participant Information Sheet, English
Attachment H2. Participant Information Sheet, Spanish

B. DATA COLLECTION & STATISTICAL METHODS

Study coordinators will use a focus group methodology, which is widely used in the health communication planning process, stages 1 and 2 (National Cancer Institute, 2002). Focus groups are typically facilitated by a trained moderator on selected topics to capture the collective insight of a group (typically 8-12 individuals) while preserving individual opinions and preferences (Edmunds, 1999; Krueger & Casey, 2000). With regard to breast health and breast cancer risk, young women participants can describe their experiences and preferences as open-ended responses—without the limitations of preset response categories—which results in rich data complete with nuances not often captured in quantitative data collection techniques.

Study coordinators will not employ statistical methods to analyze focus group data; rather qualifiers such as "many," "several," and "few" will be used to describe the number of participants who expressed a particular view (Carey, 1995; Morgan, 1995; National Cancer Institute, 2002; Webb & Kevern, 2001). As the focus group study progresses, the course of discussion may vary from group to group, covering certain topics in some groups and not others, and participants may not provide feedback on every topic discussed within each group (Carey, 1995; Morgan, 1995).

B1. Respondent Universe

Study participants will include women 18–44 years old that represent underserved populations, including Hispanic young women, African American young women, and American Indian/Alaska Native young women. Additional inclusion and exclusion criteria will vary depending on the campaign target audience. Questions drawn from the recruitment screening forms (Attachments E–G) will allow us to identify respondents with the relevant characteristics.

The EARLY Act (Attachment A – Legislative Authority) specifies that CDC's education campaign should target women 15–44 years old in the general public in addition to women 15–44 years old with an increased risk for developing breast and ovarian cancer. Breast cancer has been identified by CDC as the leading cause of cancer death among Hispanic women[1]. American Indian/Alaska Native women have unique risk factors for developing cancer, including family health history, culture, location, and access to health care[2]. African American women have been identified as having increased prevalence of breast cancer at younger ages[3] and as having increased mortality rates from breast cancer[4]. Therefore, focus group coordinators will seek out Hispanic women, American Indian/Alaska Native women, and African American women as study participants.

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1 CDC Breast Cancer Statistics. Accessed November 5, 2018. https://www.cdc.gov/cancer/breast/statistics/index.htm

2 CDC Cancer Health Disparities Among American Indians and Alaska Natives. Accessed November 5, 2018. https://www.cdc.gov/cancer/healthdisparities/what_cdc_is_doing/aian.htm

3 Carey K. Anders et al., "Breast Cancer before Age 40 Years," Seminars in Oncology 36, no. 3 (2009): 237-249. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2894028/

4 CDC Breast Cancer Rates by Race and Ethnicity. Accessed November 5, 2018. http://www.cdc.gov/cancer/breast/statistics/race.htm

It will be important to segment study participants within each of the above target audiences by their family history of breast and ovarian cancer. A family history of breast or ovarian cancer is an important risk factor for developing breast cancer at a young age and may influence knowledge, attitudes, beliefs, and messaging preferences. Young women with a family history of breast cancer also may have different recommended actions than other women. Similarly, study respondents will also be segmented by age. Focus group coordinators hypothesize that the changes that accompany increased age among respondents (e.g., career status, family life, focus on health and well-being) may influence knowledge and messaging preferences.

The information collection will be conducted with 22 focus groups. A breakdown of the number of participants per group is included in the table B1-A through B1-C:

Table B1-A. Hispanic Young Women Respondents

Hispanic Young Women Respondents								
	With a family history of breast or ovarian cancer				**With no family history of breast or ovarian cancer**			
	Los Angeles, CA	San Antonio, TX	Atlanta, GA	Chicago, IL	Chicago, IL	San Antonio, TX	Los Angeles, CA	Atlanta, GA
Age 18–29	1 group Spanish	1 group	-	-	1 group	1 group Spanish	1 group	1 group
Age 30–44	1 group	1 group Spanish	1 group	1 group	-	1 group	1 group Spanish	-
Total Groups	6 groups with a family history, 2 groups age 18–29, 4 groups age 30–44, 2 groups in Spanish				6 groups without a family history, 6 groups age 18–29, 2 group age 30–44, 2 groups in Spanish			
Inclusion Criteria	Include mix of • income levels • education levels (limit 1 PhD or JD per group) • marital status • child status • have/have not undergone genetic testing for BRCA gene mutation, including direct-to-consumer testing							
Exclusion Criteria	Exclude women who • are breast or ovarian cancer survivors • work in a healthcare field or live with a healthcare provider • do not use the internet at least 2 hours each week • do not own a smart phone							

Table B1-B. African American Young Women Respondents

African American Young Women Respondents						
	With a family history of breast or ovarian cancer			**With no family history of breast or ovarian cancer**		
	Los Angeles, CA	Chicago, IL	Jackson, MS	Los Angeles, CA	Chicago, IL	Jackson, MS
Age 18–29	-	1 group	-	1 group	-	1 group
Age 30–44	1 group	-	1 group	-	1 group	-
Total Groups	3 groups with a family history, 1 group ages 18–29, 2 groups ages 30–44			3 groups without a family history, 2 group ages 18–29, 1 groups ages 30–44		
Inclusion Criteria	Include mix of • income levels • education levels (limit 1 PhD or JD per group) • marital status • child status • have/have not undergone genetic testing for BRCA gene mutation, including direct-to-consumer testing					
Exclusion Criteria	Exclude women who • are breast or ovarian cancer survivors • work in a healthcare field or live with a healthcare provider • do not use the internet at least 2 hours each week • do not own a smart phone					

Table B1-C: American Indian/Alaska Native Young Women Respondents

American Indian/Alaska Native Young Women Respondents				
	With a family history of breast or ovarian cancer		**With no family history of breast or ovarian cancer**	
	Philadelphia, MS	Tulsa, OK	Philadelphia, MS	Tulsa, OK
Age 18–29	-	1 group	1 group	-
Age 30–44	1 group	-	-	1 group
Total Groups	2 groups with a family history, 1 of each age range		2 group without a family history, 1 of each age range	

Inclusion Criteria	Include mix of • income levels • education levels (limit 1 PhD or JD per group) • marital status • child status • have/have not undergone genetic testing for BRCA gene mutation, including direct-to-consumer testing
Exclusion Criteria	Exclude women who • are breast or ovarian cancer survivors • work in a healthcare field or live with a healthcare provider • do not use the internet at least 2 hours each week • do not own a smart phone

B2. Procedures for Information Collection

In order to elicit focus group responses to effectively plan and/or tailor existing DCPC communication campaigns, the following steps will occur:

1. Participants will be identified and recruited from a variety of geographic regions (e.g. Northeast, South, Midwest, and West Coast) and in both large and small cities in order to collect data from a diverse group of individuals. Participants will be recruited using proprietary databases of commercial focus group companies, and other sources. Eligibility criteria will be established for all focus group participants, and potential participants will be screened using a telephone or self-administered screening form (Attachments E–G). Prior to conducting the individual focus groups, participants will provide verbal consent to participate and will be provided a participant information sheet (Attachment H).

2. Focus group discussion, not to exceed 90 minutes, will occur under the direction of a professionally trained moderator. A focus group discussion guide will be utilized throughout the duration of the session (Attachments B1–D3). The verbal discussion that ensues will be partly directed by the moderator and partly by the comments of other participants.

As all DCPC communication campaigns utilize the Health Communication Process, similar categories of questions will be used in focus groups regardless of the specific campaign being evaluated. In stage 1, individual knowledge, attitudes, behaviors, message preferences, and media preferences will be explored.

All focus groups for this information collection will be audio-recorded, and a verbatim transcript will be compiled for each group. Focus group coordinators will analyze transcripts and code them for key patterns and themes.

B3. Methods to Maximize Response Rates

Participants will be recruited from the database of the commercial study facilities where the groups are held.

To minimize the possibility of having too few appropriate focus group participants (thereby forcing group cancellation), one additional participant will be recruited to each group than is needed. In the event that too many participants report, excess participants will receive the honorarium and will be dismissed.

B4. Tests of Procedures or Methods to be Undertaken

The *Bring Your Brave* campaign is guided by the health communication planning process, including planning and strategy development; developing and pretesting concepts, messages, and materials; implementing the program; and assessing effectiveness and making refinements (National Cancer Institute, 2002). Campaign planners and study coordinators will work together to apply this process in an iterative fashion, revisiting planning stages and activities to refine the breast health and breast cancer risk education and awareness campaign.

The formative and materials-testing methods used by *Bring Your Brave* campaign planners have been refined continuously since initial campaign inception through studies to inform campaign enhancements, as well as in collaboration with broader DCPC campaign activities. *Bring Your Brave* campaign planners monitor and record all aspects of campaign development, operation, and evaluation, so that findings and lessons learned can be periodically published in the peer-review literature (Cooper, et al., 2005; Cooper et al., 2011). 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; Jorgensen, et al., 2001; Krueger, 1994; Krueger & Casey, 2000; Wong, et al, 2004; Cooper et al., 2011).

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

The proposed protocol and discussion guide were developed and reviewed extensively by DCPC staff and Hager Sharp staff identified below. DCPC and Hager Sharp staff will participate in the analysis of the data, campaign planning and/or material refinement, as well as development of manuscripts.

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