

# Diffusion and Dissemination of Evidence-Based Dietary Strategies for the Prevention of Cancer

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## **ABSTRACT**

**Objective.** The purpose was to determine what strategies have been evaluated to disseminate cancer control interventions that promote the uptake of adult healthy diet?

**Methods.** A systematic review was conducted. Studies were identified by searching MEDLINE, PREMEDLINE, Cancer LIT, EMBASE/Excerpta Medica, PsycINFO, CINAHL, the Cochrane Database of Systematic Reviews, and reference lists and by contacting technical experts. English-language primary studies were selected if they evaluated the dissemination of healthy diet interventions in individuals, healthcare providers, or institutions. Studies of children or adolescents only were excluded.

**Results.** One hundred one articles were retrieved for full text screening. Nine reports of seven distinct studies were included. Studies were not meta-analyzed because of heterogeneity, low methodological quality, and incomplete data reporting. No beneficial dissemination strategies were found except one that looks promising, the use of peer educators in the worksite, which led to a short-term increase in fruit and vegetable intake.

**Conclusions and Implications.** Overall, the quality of the evidence is not strong and is primarily descriptive rather than evaluative. No clear conclusions can be drawn from these data. Controlled studies are needed to evaluate dissemination strategies, and to compare dissemination and diffusion strategies with different messages and different target audiences.

## **BACKGROUND**

It has been estimated that one-third of all cancer mortality in the US is related to diet.[1] Reviews of dietary studies have led groups, such as the American Institute for Cancer Research, to recommend that diet should largely be based on plant products with 400 grams of vegetables and fruits to provide more than 10 percent of energy consumed daily.[2,3] The American Cancer Society added that intake of high-fat foods and alcohol should be limited.[4] The national objectives in both the US and Canada have been set at five or more servings per day of fruits and vegetables.[5] Average intake falls considerably short of this. In the US, intake is estimated to be 3.4 total servings of fruits and vegetables per day on average, but differs by age, ethnicity, and socioeconomic status.[6]

Considerable recent research has focused on dietary change to increase fruit and vegetable consumption and to reduce fat consumption. The effectiveness of these interventions has been the subject of several systematic reviews [7]

There is some evidence that physician education in dietary counseling is an effective dietary intervention. However, there is no consistent evidence of effectiveness of other healthcare provider directed interventions. Interventions directed at individuals that were shown to have some effect in producing dietary change include: tailored interventions; multiple interventions; and provision of multiple contacts and environmental interventions. Media campaigns may result in increased knowledge and awareness of behaviors to reduce risks. [7]

As the evidence grows for the effectiveness of dietary interventions, it is expected that more attention will be given to the dissemination and diffusion of these interventions to promote dietary change. The theoretical background for research dissemination and diffusion is complex

and often contradictory. There are theoretical bases and models for dissemination and diffusion of research generally, and for behavior change of healthcare practitioners and the general public. These major fields of dissemination/diffusion and practitioner/client behavior change are inconsistently integrated into the development of interventions, and the field of cancer control is no exception. Closing the gap from knowledge generation to use in decision-making for practice or policy is conceptually and theoretically hampered by diverse terms and inconsistent definitions of terms, including diffusion, dissemination, knowledge transfer or translation or uptake or utilization, adoption, and implementation. There is a lack of distinction in the research between interventions to change behavior and strategies to disseminate that information. Furthermore, many studies have combined evaluation of both interventions and strategies within one study. Some activities (e.g., media campaigns, opinion leaders, and peer educators) can be characterized as both cancer control interventions and strategies to disseminate cancer control interventions to target audiences. This can lead to confusion about what is considered a cancer control intervention and what is considered dissemination of cancer control interventions. For the purpose of this evidence report, if an activity was used to provide educational information about the benefits of a desired cancer control behavior, it was classified as a cancer control intervention. If the activity was used to provide information about the availability or benefits of a cancer control intervention, it was classified as a strategy to disseminate a cancer control intervention.

In keeping with Lomas' views, this evidence report uses the term "dissemination" to refer to the active process of transferring cancer control interventions to target audiences and "diffusion" is used to refer to the passive spread of cancer control interventions.[8]

## METHODS

The following question was addressed by this review: *What strategies have been evaluated to disseminate cancer control interventions that promote the uptake of adult healthy diet?* Primary studies of dissemination and diffusion strategies of dietary interventions were systematically reviewed. This review does not include studies of effectiveness of direct interventions to change dietary intake; rather, it includes those studies focused on dissemination of interventions, to adults and healthcare professionals.

Primary studies were considered for inclusion if they were English language, published  $\geq 1980$  and evaluated dissemination of a cancer control intervention in one of the five topic areas. All primary studies regardless of study designs were eligible for inclusion. Reports exclusively focused on children or adolescents were excluded.

Search strategies were developed as an iterative process in consultation with the McMaster Evidence based Practice Centre (EPC) librarian. The search strategy can be located at <http://www.ahrq.gov/clinic/evrptfiles.htm#cancontrol>, report name Cancer Control Interventions, Diffusion and Dissemination, file name 27apcc.doc. Similar databases were searched for both objectives:

- MEDLINE, the U.S. National Library of Medicine (NLM) database
- PreMedline
- CancerLIT
- EMBASE the Excerpta Medica Database
- PsychINFO
- The Cumulative Index to Nursing and Allied Health Literature (CINAHL)

- Sociological Abstracts
- HealthSTAR
- Cochrane Database of Systematic Reviews (CDSR)
- Reference lists of pertinent articles and reviews; and
- The use of technical experts

All data extraction forms were developed, pilot-tested, and revised by members of the local research team. Two reviewers completed data extraction independently for all reports. Any disagreements were resolved by consensus. The research team discussed differences that could not be resolved by these reviewers. Quality assessment was undertaken using standardized quality assessment tools developed by the Effective Public Health Practice Project.

Tables were constructed to describe the most salient characteristics of the eligible studies. Meta-analysis was not undertaken because there were substantial differences across the studies, in terms of study design, intervention assessed, outcome measurements, methodological quality, and completeness of data reporting. Therefore, the report represents a systematic narrative review of the existing evidence.

## RESULTS

### Included Studies

The electronic database search identified 2,872 articles; 101 were retrieved for full text screening (Figure 9). Of these, nine reports of seven distinct studies are included: three reports about one study[9-11] and six other studies[12-17] are presented in Evidence Table 7. Ninety-two papers were excluded for lack of relevance; they did not address dissemination and diffusion strategies for dietary interventions.

Although the search inclusion criteria were broad, all of the eligible studies were conducted in the US. Six reports were published since 1998; the other four were published between 1989 and 1993.[12,13,15,16] All seven projects were funded: five by the NCI,[9,14-17] one by the NIH,[12] and one by a private foundation.[13]

One study achieved a rating of “moderate”, [14] and all others were “weak” as defined by the standardized assessment in Chapter 2. Four of the studies were randomized trials.[9,14,16-18] None of the other studies included a comparison group; three articles were descriptive,[11,13,15] one article was a cohort study[12] (Table 1).

Included studies were very diverse in the intervention that was disseminated and in strategies used for dissemination and diffusion. Only two studies compared two strategies.[16,17] Of these, one study compared the effectiveness of a training workshop to postal delivery.[17] The second study evaluated whether the use of educational facilitators (academic detailing) plus a workshop was more effective than educational facilitators (academic detailing) only.[16] Each of the other studies evaluated the effectiveness of a single dissemination strategy. One strategy assessed was “train-the-trainer” to disseminate preventive medicine education to physicians;[12] two studies evaluated media campaigns for promoting access to a phone information services;[13,15] one

study assessed the effect of peer educators for improving fruit and vegetable consumption;[9-11] and one looked at the dissemination of intervention materials to control sites following the completion of a worksite nutrition intervention.[14]

Outcomes were very diverse across studies and were not usually behavioral outcomes but rather process indicators, such as numbers of training sessions conducted,[12] numbers of physicians trained,[12] numbers of consumer telephone calls[13,15], counts of peer-education strategies according to gender and ethnicity,[11] and uptake of materials by control sites following an intervention.[14] Client-based outcomes included knowledge[12] and intake of fruits and vegetables.[9,10]

### **Dissemination Studies That Targeted Healthcare Providers**

#### **Train-the-trainer.**

One “train-the-trainer” study aimed at disseminating preventive medicine education to physicians.[12] Faculty from general internal divisions across the US were invited to apply for a month-long Stanford Faculty Development Program; 10 were chosen and trained to be Clinical Preventive Medicine facilitators. They then went to their home institutions and trained other faculty at their home site. Fidelity checks concluded that facilitators adhered closely to the curriculum they had been taught. Those medical faculty educated by the facilitators had an increase in knowledge and self-efficacy to use behavior changes to promote healthy diets. Subsequently, house staff physicians interacting with faculty who had attended the facilitator-run sessions reported an increase in the degree of preventive medicine content in teaching interactions and an increase in their ratings of self-efficacy to implement preventive medicine strategies.[12] While the train-the-trainer model shows some promise, it needs to be evaluated

with a more rigorous design; furthermore, many biases are likely to be inherent in the selection of internists who were able to leave their work situation for a month of training.

**Academic detailing (educational facilitators).**

One RCT[16] targeted dissemination to healthcare providers using academic detailing. In this trial by Dietrich et al., primary care medical practices were randomized to one of four groups: facilitator only, facilitator-plus-workshop, workshop only, or a control group. Practices in the facilitator-only group (n=24) received three to four visits from a facilitator who provided detailed instruction and assistance in selecting and implementing non-computer-based office-system interventions. Practices in the facilitator-plus-workshop group (n=26), in addition to receiving visits from an educational facilitator, had a physician from the practice attend a one-day workshop. The workshop session reviewed NCI's prevention and screening recommendations, but did not provide information on the use of office-system interventions. Practices in the workshop-only group (n=24) attended the workshop. Practices in the control group (n=24) received no information.

Cross-sectional patient surveys were conducted before randomization and again at 12-month follow-up. The study reported on two diet-related outcomes: (1) the number of patients reporting that their physician had advised them to reduce their fat intake and (2) the number of patients reporting their physician had advised them to increase their fiber consumption. At 12-month follow-up, significantly more eligible patients in the facilitator-only group reported their physician had advised them to reduce their fat intake compared with patients in the control group (0.56 vs. 0.47,  $p < 0.05$ ). There was no significant difference in the number of patients reporting advice to decrease fat intake between the facilitator-plus-workshop group and the control group at 12-month follow-up (0.51 vs. 0.47). There was no significant increase in the number of

eligible patients in the facilitator-only or facilitator-plus-workshop groups reporting advice to increase fiber consumption compared with patients in the control group at 12-month follow-up (facilitator vs. control 0.48 vs. 0.38; facilitator-plus-workshop vs. control 0.41 vs. 0.38). The overall conclusion from this RCT was that the use of educational facilitators to disseminate and implement office-system interventions could improve the provision of prevention and early detection services in community practices.

The use of educational facilitators (academic detailers) to disseminate office-system interventions appears to be a promising strategy. Further research in this area is needed.

### **Workshops.**

The RCT Tziraki et al.[17] assessed the effectiveness of two strategies for promoting the use of an NCI nutrition manual by primary care physicians and their office staff. The nutrition manual was modeled after the NCI publication “*How to help your patients stop smoking*”. Medical practices randomized to the workshop group (n=244) were invited to send one staff member to a three-hour training workshop on how to use the nutrition manual. Training was provided in four major components of the manual: (1) how to organize the office environment, (2) how to screen for patient adherence, (3) how to provide dietary advice, and (4) how to implement a patient follow-up system. Medical practices assigned to the postal-delivery group (n=256) received the nutrition manual in the mail with no further information. Medical practices in the control group (n=255) did not receive the nutrition manual.

Follow-up interviews with medical staff and observational assessments were conducted at four to six months after dissemination of the manual. Adherence scores were calculated for four areas: office organization, nutrition screening, nutrition advice or referral, and patient follow-up. There was low attendance at the workshop session; less than 50 percent of assigned practices sent

representatives (120 of 244). The authors of the trial used an “intent to treat” approach for the primary statistical analyses and included all practices in the workshop group regardless of attendance. The workshop group was significantly more adherent to the manual’s recommendations for office organization at follow-up than either the postal-delivery group (28.5 vs. 24.7 percent,  $p < 0.005$ ) or the control group (28.5 vs. 23.0 percent,  $p < 0.001$ ). Of those practices who sent a representative to the workshop, 30.6 percent were adherent to the recommendations for office organization. There was no significant difference between the postal-delivery group and the control group for office organization (24.7 vs. 23.0 percent). The workshop group was also significantly more adherent to the manual’s recommendation for nutrition screening than either the postal-delivery group (23.5 vs. 21 percent,  $p < 0.05$ ) or the control group (23.5 vs. 20.5 percent,  $p < 0.05$ ). Of those practices that sent a representative to the workshop, 25 percent were adherent to the nutrition screening recommendations. There was no significant difference between the postal-delivery group and the control group for nutrition screening (21 vs. 20.5 percent). There was no statistically significant difference between the three groups for providing nutrition advice (workshop 54.9 percent, postal delivery 53 percent, control 52.3 percent), nor for patient follow-up (workshop 14.6 percent, postal delivery 13.6 percent, control 13.6 percent). A secondary analysis showed that those practices who attended the workshop were significantly more likely than either the postal-delivery group (57 vs. 53 percent,  $p < 0.05$ ) or the control group (57 vs. 52.3 percent,  $p < 0.05$ ) to provide nutrition screening. There was no significant difference observed for patient follow-up on secondary analysis. Training workshops appear to hold some promise as a dissemination strategy; however, motivating medical professionals to attend these sessions may be a difficult barrier to overcome. Further research in this area is needed.

### **Postal delivery.**

One RCT[17] evaluated the effectiveness of postal delivery as a dissemination strategy. This trial compared the effectiveness of postal delivery with a training workshop to disseminate an NCI nutrition manual to primary care practices. Postal delivery was not found to be an effective method to disseminate the nutrition manual. Please refer to the section above on Workshops for the detailed results of this study.

### **Dissemination Studies That Targeted Worksites**

#### **Passive dissemination.**

The Working Well Trial[14,19] randomized 114 worksites of over 28,000 workers to test the effectiveness of health promotion activities that were planned and delivered with a high level of employee participation. The intervention phase lasted for two years, and then nutrition materials were disseminated to the control sites, followed by a further two-year assessment. The investigators were particularly interested to see if the control sites would utilize the materials. No information was given about the actual strategies used to get the nutrition intervention materials to the control group, nor was any report of measure of uptake given. No changes occurred in the level of nutrition activities in the control sites.

An opinion leader strategy was tested using peer educators in the worksite intervention called “5-A-Day: Healthier Eating for the Overlooked Worker”. While rated methodologically weak, it holds promise as an area for further research. It was an RCT of 5-A-Day intervention to increase fruit and vegetable consumption in an ethnically mixed population of 2,091 lower socioeconomic and trade employees.[9,10] Both the intervention group and the control worksites received an 18-month intervention program of education materials through workplace mail, cafeteria promotions, and speakers. In the intervention group, naturally occurring work “cliques” were

identified, and within those, ratings were given to each individual regarding their degree of “centrality” to communication ties and flow. Those rated highest in “centrality” became the peer educator for that clique, mimicking the “opinion leader” strategy.

Peer educators attended a 16-hour training program where they were given information about health benefits of eating fruits and vegetables, cultural trends in dietary practices, peer educator’s roles and responsibilities, and five persuasive communication strategies (foot-in-the-door, fear appeal, benefits, peer pressure, and questioning) and ways to initiate informal conversations about fruits and vegetables. They were instructed to engage in nutrition education of the co-workers for about two hours per week, on work time. They also distributed 5-A-Day materials produced specifically for this population: a nine-booklet resource guide, four issues of a newsletter, enabling gifts such as a recipe book, and vegetable seeds. The peer educator intervention lasted nine months, with consumption measured at the end of the intervention and six-month follow-up.

The result was an increase in fruit and vegetable consumption of 0.77 total servings per day more in the intervention group compared with the controls (measured by recall,  $p < 0.001$ ) and an increase of 0.46 total daily servings (measured by food frequency,  $p < 0.002$ ).<sup>[9]</sup> The effect was maintained at six-month follow-up for intake recall (increase of 0.41 daily servings,  $p = 0.034$ ) but not for food frequency<sup>[9]</sup>. In analysis of the frequency and duration of peer-education contact with co-workers, greater contact with the peer educators was related to larger immediate increases in fruit and vegetable intake, particularly vegetable intake, but was not related to total intake at six-month follow-up.<sup>[10]</sup> A qualitative design, used to study the educational strategies used by the peer educators in the intervention group,<sup>[11]</sup> found that these studies differed by gender and ethnicity.<sup>[11]</sup> Hispanic educators were more likely to use individual, rather than

group, change strategies than non-Hispanic educators; men more frequently used strategies such as “mock competition”, “giving materials” and “encouragement”, while female peer educators more often used “creating context”, and “keeping 5-A-Day visible”.[11]

Few worksite dissemination strategies have been evaluated. In one, the dissemination strategy was not evaluated.[14] The other study using an opinion leader strategy had at least a short-term impact on consumption.

### **Dissemination Studies That Targeted Individuals**

#### **Media strategies.**

Two studies evaluated multiple media channels (print, television, and radio) to assess the impact of the media campaigns on telephone calls to an information telephone line.[13,15] “Project Lean” (Low-Fat Eating for America Now) was a three-year initiative, begun in 1989, to reduce dietary fat consumption. The media campaign led to hotline access of 300,000 consumer calls in 18 months (25,000 to 28,000 calls/month), but the calls declined as publicity declined, and the line was terminated due to expense, estimated to be US \$300,000 per year.[13] While these outcomes were not assessed in a direct comparison, some important lessons were learned in this study:[13] that well-placed advertising may be the most appropriate and effective communications strategy for a national nutrition social marketing campaign as it can, more easily than PSAs, be tailored to the particular audience; can communicate information more directly and can reduce the need for an information hotline or follow-up materials. Furthermore, building a network of state and local programs and partnerships with the food service industry allowed the campaign to reach a broader audience.[13]

A second primary study was identified which was an analysis of calls to the CIS hotline. Callers were asked, “How did you first find out about the CIS?” Records of a subsample of people

(214,472) who inquired about smoking, nutrition, Pap smears, and breast self-evaluation were reviewed. Television was the most frequently reported source of learning about the information line, regardless of age, gender, or ethnic group (except callers of Asian or Pacific heritage, who reported publications as the more common source of information about the hotline).[15]

The media dissemination strategies, particularly television messages, can make people aware of information lines and prompt them to call. However, from these two studies, it appears that the lines are expensive to advertise and maintain.

## **DISCUSSION AND IMPLICATIONS**

There has been increased recognition of the need for processes to transfer new knowledge into routine practice. Traditional methods of knowledge transfer such as journals and conferences have not proven effective in changing behavior.[20] Emphasis has been placed on the importance of research examining the dissemination of evidence-based knowledge and its uptake by the targeted recipients. Target audiences include providers, policymakers and the general public.

There are several limitations of this review. It does not include the effectiveness of the dietary interventions themselves, but of the dissemination interventions to get others to know about the interventions. The results and conclusions are based on information available in published English-language reports. Contact with authors could have compensated for any reporting difficulties that resulted in a lower quality rating of the studies. Meta-analysis was deemed inappropriate due to the diversity in the target groups, interventions and outcome measures.

There are few studies of dissemination of dietary interventions for cancer prevention. Overall, the quality of the evidence is not strong and is primarily descriptive rather than evaluative. Either process measures (numbers of calls, numbers of physicians educated, or number of education sessions held) are reported or outcomes are often non-validated self-report measures. Controlled studies need to be done for any dissemination strategies, and dissemination and diffusion strategies with different messages and different target audiences need to be compared. More studies of healthcare providers with strategies such as opinion leaders or academic detailing should be done. The idea of a peer educator who is identified more as an opinion leader warrants further exploration. Cost-effectiveness needs to be established for any interventions.

Most of the focus of research on healthy diet and cancer has been on evaluating interventions to promote behavior change. There is a lack of information on how to disseminate these findings to

the community. Questions to address in future research include: What is the effectiveness of reminder strategies for health professionals to give interventions in-patient encounters? What innovative technologies can be brought to the dissemination strategies? Once media strategies have alerted the public to services, can effective interventions then be disseminated to individuals in such a way that they will utilize them to change dietary habits? Or is there an effective combination or sequencing of strategies that will result in dietary change? What policy level strategies are effective in at promoting dissemination of healthy diet interventions? What maintenance strategies can be incorporated to maintain the uptake and utilization of the evidence?

### **Competing interests**

There is no conflict of interest for any of the authors listed on this manuscript.

### **Author's Contributions**

D. Ciliska:	review of the literature, conceptualization, writing and editing
P. Robinson:	review of the literature and comments on the draft
T. Armour:	review of the literature and comments on the draft
P. Ellis:	review of the literature and comments on the draft
M. Browsers:	review of the literature and comments on the draft
M. Gauld:	review of the literature and comments on the draft
F. Baldassarre:	review of the literature and comments on the draft
P. Raina:	review of the literature and comments on the draft

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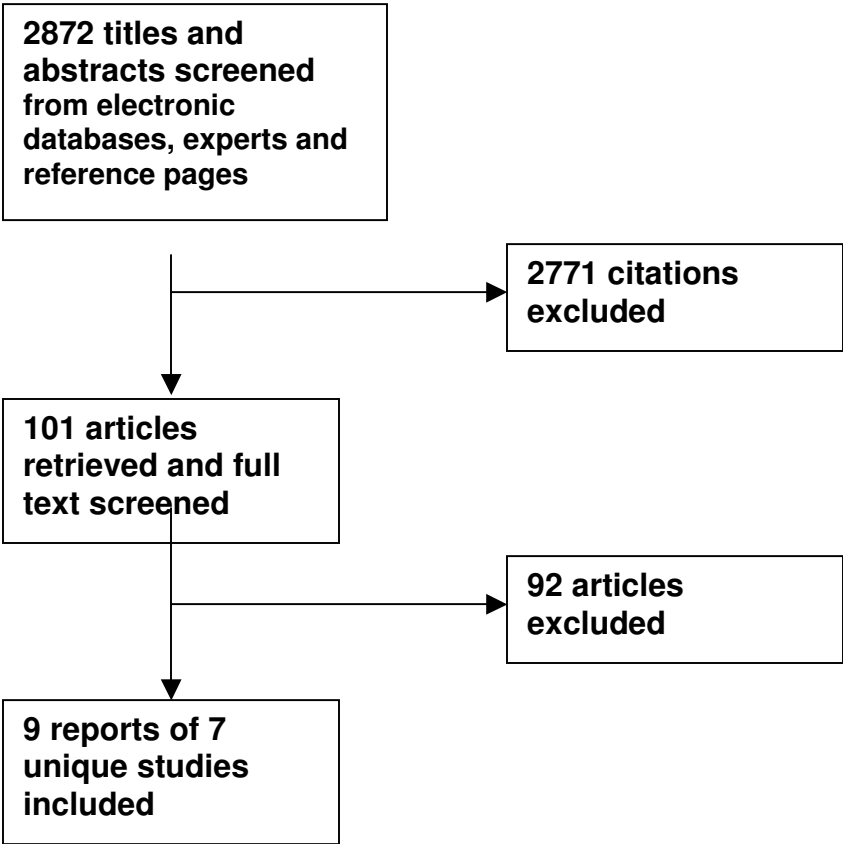
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Figure 1. Adult Healthy Diet: Search yield for studies evaluating dissemination strategies



**Table 1: Strategy for dissemination of cancer control interventions in adult healthy diet**

Author (Year) Country Study purpose	Study design Target group Quality Assessment	Dissemination strategy evaluated	Intervention(s)	Findings
<p>Albright, CL[12] (1992) United States</p> <p>Purpose: To test a dissemination model for providing clinical preventive medicine (CPM) training to internal medicine faculty across the US.</p>	<p>Study Design: Cohort, one group, pre/post</p> <p>n = 10 internists were trained as “trainers”</p> <p>91 faculty members attended home-site seminars led by trainers</p> <p>Target Group: General Internal Medicine faculty in the US</p> <p>Quality Assessment: Weak</p>	<p>Train-the-Trainer (Month-long training, off-site)</p>	<p>CPM curriculum encompassed: smoking cessation, clinical nutrition, weight control exercise, hyperlipidemia, and national screening guidelines.</p> <ul style="list-style-type: none"> <li>- curriculum provided content on clinical teaching and medical decision-making</li> <li>- clinical nutrition section included interventions that promoted adult healthy diets</li> </ul>	<ul style="list-style-type: none"> <li>- Fidelity ratings obtained from videotapes of the home-site seminars given by the trainers indicated that the trainers adhered closely to the CPM</li> <li>- Trainers teaching home-site internal medicine faculty: knowledge of smoking cessation, cholesterol and screening-specific information of faculty members significantly increased post-seminar in the last 2 of the 3 years studied (p&lt;0.02 and p&lt;0.001)</li> <li>- faculty’s ratings of their self-efficacy to implement the CPM practices for clinical nutrition demonstrated significant post-test increases for all 3 years (p&lt;0.0001)</li> <li>- faculty use of specific behavior-change interventions to promote healthy diet increased (diaries, self-help materials, and social support) (p&lt;0.05)</li> <li>- 85% of the faculty in 1986, 96% in 1987, and 84% in 1988 reported teaching the CPM strategies to their house staff</li> <li>- House staff reported significant increases in the degree to which the faculty addressed CPM in their teaching interactions (1987: p&lt;0.0001 and 1988: p&lt;0.04)</li> <li>- House staff ratings of their self-efficacy to implement specific preventive medicine strategies increased in both years (1987: p&lt;0.0001 and 1988: p&lt;0.002)</li> </ul>

**Table 1: Strategy for dissemination of cancer control interventions in adult healthy diet**

Author (Year) Country Study purpose	Study design Target group Quality Assessment	Dissemination strategy evaluated	Intervention(s)	Findings
<p>Anderson, DM[15] (1989) United States</p> <p>Purpose: To examine inquiries received by the CIS, a telephone hot-line, to determine: 1) effects of different media in stimulating calls to the CIS, and 2) demographic characteristics of callers in 4 cancer prevention and early detection subjects: smoking, nutrition, Pap smear screening and breast self-examination</p>	<p>Study Design: Descriptive study Retrospective analysis of 5 years of inquiries to one national and 26 local CIS offices in 4 subject areas. - standardized call record form was completed for each call. - Demographic information was only collected during the last 2 years of the study for first-time, non-health professional callers and was limited by federal stipulations to 20% of callers in 5 CIS offices</p> <p>n = 57,374 nutrition-related calls over the five years studied</p> <p>Target Group: Smokers in the US, Mexico and other countries</p> <p>Quality Assessment: Weak</p>	<p>Multiple media sources (television, radio, and newspapers)</p>	<p>CIS – a telephone based information and education program of the National Cancer Institute.</p>	<ul style="list-style-type: none"> <li>- source of callers' learning about the CIS hot-line were: television (33.9%), radio (28.2%), publications (included newspapers, magazine, pamphlets and posters) (26.9%), health care providers (4.3%), significant others (4.6%); and telephone assistance (2.2%)</li> <li>- television was the most common information source reported by callers for both sexes (72.2% male callers and 60.7% of female callers)</li> <li>- There was an inverse relationship between frequency of television cited as an information source and callers age and education. In the 19-year old or less age group 81.7% of callers cited television compared to 39.6% of callers in the 60-year or older age group</li> <li>- Television was the predominant source for 4 of the 5 ethnic groups– Caucasians, African-Americans, Hispanics, and Native Americans. For callers of Asian or Pacific Island heritage, the most frequently cited source was publications (46.7%), followed by television (32.1%).</li> </ul>

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<p>Buller, DB[9] (1999) United States</p> <p>Purpose: To test a peer-education strategy to promote the 5-a-Day message.</p> <p>Related Papers: Buller, DB[10] (2000) (reported below) Larkey, LK[11] (1999) (reported below)</p>	<p>Study Design: RCT</p> <p>Experimental group: n = 505 employees (in 46 cliques) assigned to receive 5-a-Day peer-education plus the general 5-a-Day program</p> <p>Control group: n = 492 employees (in 46 cliques) assigned to receive the general 5-a-Day program (cafeteria promotions and workplace mail) only</p> <p>Target Group: Anglo and Hispanic worksite population in the US (lower socioeconomic labor and trade employees)</p> <p>Quality Assessment: Weak</p>	<p>Peer-educators (n=42) (Chosen for 'centrality', rated highest by peers in communication ties and flow)</p> <ul style="list-style-type: none"> <li>- attended a 16-hour training program: training in persuasive communication techniques</li> <li>- expectation was that they would spend 2 hours/week discussing fruit and vegetable intake with coworkers</li> </ul>	<p>5-a-Day message plus accompanying 5-a-Day printed materials</p>	<p>Immediate changes post-intervention in awareness, attitudes, and dietary behavior:</p> <ul style="list-style-type: none"> <li>- Employees receiving peer- education increased their awareness of the 5-a-Day program (p&lt;0.001)</li> <li>- knowledge of the 5-a-Day concept, attitudes toward fruit and vegetable intake (p=0.024 - &lt;0.001)</li> <li>- number of daily servings of fruits and vegetables consumed (Increase of 0.77 on 24-hour intake recall p&lt;0.001 and 0.46 on food frequency questionnaire items p=0.002)</li> </ul> <p>Persistence of changes in awareness, attitudes, and dietary behavior (6-month followup):</p> <ul style="list-style-type: none"> <li>- general persistence of the statistically significant increases in the peer-education group, but of reduced magnitude for knowledge of the 5-a-Day program and diet-related attitudes</li> <li>- statistically significant increases total number of daily servings persisted when measured by 24-hour intake recall (0.41, p=0.034), but not by food frequency questionnaire</li> </ul>

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Buller, DB[10] (2000) United States  Related Papers: Buller, DB[9] (1999) (reported above)  Larkey, LK[11] (1999) (reported below)	Same study as above	Same study as above	Same study as above	Findings pertain only to the peer-education (experimental group) <ul style="list-style-type: none"><li>- 57% of employees reported printed materials stimulated discussion of fruits and vegetables with co-workers during program, 31% still discussing 6 months later, 69% discussed printed material with a family member during intervention</li><li>- greater contact with peer-educators was related to larger immediate increases in total consumption of fruits and vegetables (<math>p=0.003</math>) as measured by food frequency items</li><li>- when food types were examined separately, peer-educator contact was positively related to immediate increased vegetable intake (<math>p=0.002</math>), but not to fruit or juice intake</li><li>- the more employees reported reading the printed material, the smaller the observed immediate increase in fruit consumption (<math>p=0.002</math>)</li><li>- there was no significant association between peer contact and changes in total intake of these foods at the 6-month followup</li></ul>

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<p>Dietrich, AJ [16] (1992) United States</p> <p>Purpose: To test the impact of physician education and facilitator assisted office-system interventions on cancer early detection and preventive services</p>	<p>Study Design: RCT</p> <ul style="list-style-type: none"> <li>- 98 of the 102 practices that agreed to participate completed the study.</li> <li>- unit of randomization was the practice as represented by one physician.</li> </ul> <p>Four groups:</p> <p><u>Facilitator only:</u> n = 24 practices</p> <p><u>Workshop + Facilitator:</u> n = 26 practices</p> <p><u>Workshop only:</u> n = 24 practices</p> <p><u>Control:</u> n = 24 practices;</p> <p>Target Group: Office-based GPs and general internists in New Hampshire and Vermont.</p> <p>Quality Assessment: Weak</p>	<p>(1) Facilitators: Visited each practice 3-4 times over 3 months x approximately 120 minutes each.</p> <ul style="list-style-type: none"> <li>- Performed an initial audit of each practice to assess the status of preventive care and assisted practices in the design and implementation of office system interventions. Practices only implemented those interventions that meet their perceived needs</li> </ul> <p>(2) Facilitator + workshop Same as (1) plus physician from each practice attended a 1-day workshop led by an expert who reviewed NC's prevention and screening recommendations and taught specific skills. Also provided a written syllabus</p> <p><u>Note:</u> The workshop only and the control groups did not receive information on the use of office-systems interventions for cancer prevention or early detection</p>	<p>Multiple office-system interventions including preventive care flow sheets, chart stickers, health education posters and brochures, and patient health diaries (none of the interventions were computer-based)</p>	<p>response rate for the cross-sectional survey was 91% (n = 2436 patients) pre-experiment and 93% (n = 2595) at 12-month follow-up.</p> <ul style="list-style-type: none"> <li>- more eligible patients in the Facilitator Only group reported their physician had advised them to reduce fat intake compared to patients in the control group at 12-month follow-up (proportion 0.56 vs. 0.47, p&lt;0.05, baseline results were used as covariates).</li> <li>- no significant increase in the number of eligible patients in the facilitator + workshop group reporting their physician had advised them to reduce fat intake compared with patients in the control group at 12-month follow-up (proportion 0.51 vs. 0.47)</li> <li>- no significant increase in the number of eligible patients in the facilitator only or facilitator + workshop groups reporting their physician had advised them to increase fibre consumption compared to patients in the control group at 12-month follow-up (Proportion 0.48 (facilitator only) vs. 0.38 (control); Proportion 0.41 (facilitator + workshop) vs. 0.38 (control))</li> </ul> <p>Report's overall conclusion: Community practices assisted by a facilitator in the development and implementation of an office system can substantially improve provision of cancer early detection and preventive services</p>

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<p>Larkey, LK[11] (1999) United States</p> <p>Purpose: To assess which persuasive strategies are used by peer-health educators, which strategies are used more in one-on-one vs. group contexts, and which strategies are most likely to be used by males and by females</p> <p>Related Papers: (1) Buller, DB[10] (2000) (Same project, see additional findings above) (2) Buller, DB[9] (1999) (Same project, see additional findings above)</p>	<p>Study Design: Qualitative, descriptive study of peer-educator within original randomized trial</p> <p>Target Group: Anglo and Hispanic worksite population in the US</p> <p>Quality Assessment: Weak</p>	<p>Peer-educators (n = 42) (Chosen for 'centrality', rated highest by peers in communication ties and flow)</p>	<p>5-a-Day message (to increase fruit and vegetable intake) plus accompanying 5-a-Day printed materials</p>	<p>Peer-health educators were more likely to use "role modeling" (p=0.0004) and "creating context" (p&lt;0.0001) as collective (group) change strategies, while "encouragement" (p=0.0009) and "responding to employee needs" (p=0.0001) were more likely to be used as individual change strategies</p> <p>Strategies used differed by gender. "Mock competition," "giving materials," and "encouragement" were used by men significantly more than "creating context" and "keeping 5-a-Day visible". Women used "creating context" and "keeping 5-a-Day visible" significantly more than "mock competition", "giving materials" and "encouragement" (p&lt;0.0001 for all contrasts)</p> <p>Hispanic peer health educators were more likely to use individual change strategies than their non-Hispanic counterparts (p=0.0128)</p>

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<p>Patterson, RE[14] (1998) United States</p> <p>Purpose: To test whether the Working Well Trial nutrition intervention activities were maintained after the research program or were adopted by control sites.</p> <p>Related Papers: Sorensen, G[19] (1998) Dissemination of worksite smoking cessation interventions from the Working Well Trial to control cited at the end of the trial.</p>	<p>Study Design: RCT n = 54 control sites</p> <p>Target Group: Worksite management</p> <p>Quality Assessment: Moderate</p>	<p>Intervention materials were given to control sites (method not specified) at the conclusion of the Working Well Trial</p>	<p>Nutrition interventions from the Working Well Trial</p>	<p>Only the findings pertaining to the control sites at the conclusion of the Working Well Trial are reported in this table.</p> <ul style="list-style-type: none"> <li>- there was a significant increase in nutrition activity score (composite of nutrition classes or weight loss programs; self-help nutrition manuals and guides; videotapes, posters or brochures related to nutrition) from baseline to the end of the Working Well trial (2-year interval between start and completion of the trial) (p=0.0012)</li> <li>- there was no significant increase on nutrition activity score in the control sites, between the end of the Working Well trial (point of dissemination of the nutrition interventions to control sites) and at the follow-up survey conducted 2 years</li> <li>- at follow-up, there was no significant difference between nutrition activity scores in the intervention compared with the control worksites</li> </ul>

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Samuels, SE[13] (1993) United States  Purpose: To report on the first 3 years of the Project LEAN campaign, a national social marketing intervention, designed to promote dietary change.	Study Design: One group, post- intervention, process evaluation  Target Group: General adult population  Quality Assessment: Weak	Media awareness campaign (television and print media)	Telephone hot-line which provided advice and offered an information booklet to callers	<ul style="list-style-type: none"><li>- as a result of the ads and campaign publicity, the hot-line received nearly 300,000 consumer calls</li><li>- during the first 12 months of the campaign, calls peaked at 25,000 to 28,000 a month</li><li>- as publicity declined, so did calls to the hot-line</li><li>- Hot-line terminated at end of 18 months due to expense (over \$300,000 per year)</li></ul>

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<p>Tziraki, C (2000)[17] United States</p> <p>Purpose: To determine the effectiveness of two strategies for promoting the use of an NCI nutrition manual by primary care physicians and their office staff</p>	<p>Study Design: RCT</p> <ul style="list-style-type: none"> <li>- 810 practices were randomized; 55 practices had a change in status and became ineligible after randomization</li> </ul> <p><u>Workshop group</u>: n = 244 practices received the manual and were invited to a training workshop</p> <p><u>Postal delivery group</u>: n = 256 practices were mailed the manual</p> <p><u>Control group</u>: n = 255 practices; did not receive the manual</p> <p>Target Group: Free-standing primary care practices in Pennsylvania and New Jersey</p> <p>Quality Assessment: Weak</p>	<p>(1) Workshop (One staff member from each practice was invited to attend a 3-hour training session. Training was provided in the 4 major components of the manual; how to organize the office environment; how to screen patient adherence; how to provide dietary advice; and how to implement a patient follow-up system)</p> <p>(2) Postal delivery of the manual only (no training)</p>	<p>NCI sponsor Nutrition Manual for cancer prevention (contains multiple interventions)</p> <ul style="list-style-type: none"> <li>- Modeled after the NCI publication: "How to help your patients stop smoking."</li> <li>- The manual addressed brief counseling techniques, office system organization, material resources, staff training, and patient educational materials</li> </ul>	<p>Follow-up interviews and observational assessments were conducted at 4 - 6 months post-dissemination with a physician and staff member from each practice. Adherence scores were calculated for 4 areas: office organization, nutrition screening, nutrition advice or referral, and patient follow-up</p> <ul style="list-style-type: none"> <li>- &lt; 50% of practices assigned to the workshop group sent representatives to the training workshop (120 of 244)</li> <li>- workshop group was significantly more adherent to the manual's recommendations for office organization at follow-up than the Postal-Delivery group (28.5% vs. 24.7%, p&lt;0.005) and Control group (28.5% vs. 23.0%, p&lt;0.001); these analyses included all practices in the Workshop group regardless of attendance at the training session.</li> <li>- Of those practices who attended the workshop, 30.6% were adherent to the recommendations for office organization</li> <li>- Workshop group was significantly more adherent to the manual's recommendations for nutrition screening at follow-up than the Postal Delivery group (23.5% vs. 21%, p&lt;0.05) and Control group (23.5% vs. 20.5%, p&lt;0.05).</li> <li>- Of those practices attending the workshop, 25% were adherent to the recommendations for nutrition screening</li> <li>- no significant difference between the Postal delivery and control groups for office organization (24.7% vs. 23.0%) or nutrition screening (21% vs. 20.5%)</li> <li>- no statistically significant difference between the 3 groups for nutrition advice (Workshop 54.9%; Post 53%; Control 52.3%) nor for patient follow-up (Workshop 14.6%; Postal Delivery 13.6%; Control 13.6%).</li> <li>- the attending workshop practices were significantly more likely than either Postal Delivery (57% vs. 53%, p&lt;0.05) or Control groups (57% vs. 52.3%, p&lt;0.05) to provide nutrition screening</li> </ul>