

# COMPREHENSIVE CANCER CONTROL PLAN



## COLORECTAL CANCER

The Comprehensive Cancer Control National Partnership (CCNP) is a 20+ year collaboration of diverse national organizations working together to build and strengthen Comprehensive Cancer Control (CCC) efforts across the nation. This Tip Sheet is part of a series offered through the CCNP to assist Comprehensive Cancer Control (CCC) programs charged with developing, implementing, and evaluating cancer control plans tailored to their state/tribe/territory/jurisdiction. CCC Plans focus coalition efforts on evidence-based interventions (EBIs) that impact cancer prevention and control across the cancer continuum.



### How to Use This Tip Sheet

Tip Sheets are designed to help CCC program staff, coalition staff, and volunteers update CCC plans. Each tip sheet focuses on a specific topic (e.g., colorectal cancer screening, tobacco control, risk factors for cancer survivors). Follow the steps throughout the Tip Sheet to help guide your process in updating your cancer plan for that specific topic area. Some ideas:

- Incorporate the Tip Sheet into your plan update process – share it with your coalition workgroups and use it to help guide your decisions.
- Identify a lead person to ensure that the Tip Sheet is used by the workgroup or team assigned to update the plan section that addresses each Tip Sheet topic.
- Use the Tip Sheet to check that the topic is appropriately addressed in your plan and that the elements outlined on the next page are covered (objective, data, strategies).
- Use the **worksheet** at the end of this document with your partners to ask and answer critical questions related to the topic as you update your plan.

## Definitions

- **SMART Objective** – is an objective in the cancer plan that is Specific, Measurable, Achievable, Relevant, and Time-bound.
- **Evidence-Based Strategy** – is a specific activity that is designed to achieve the objective and is based on evidence that the strategy is expected to work in your situation, i.e., it has been evaluated and shown to work.
- **Crude vs. Age-adjusted Rates** – Crude rates are influenced by the age distribution of the state’s population. Even if two states have the same age-adjusted rates, the state with the relatively older population will generally have higher crude rates because incidence or death rates for most cancers increase with age. Age-adjusting the rates ensures that differences in incidence or deaths from one year to another, or between one geographic area and another, are not due to differences in the age distribution of the populations being compared. Find out more [here](#).
- **Populations of Focus** – are those groups experiencing the greatest cancer disparities in your region. Disparities might include higher cancer incidence or mortality; greater challenges accessing cancer screening, treatment, and/or survivorship care services; or populations experiencing bias in society and the health care system.
- **Health Equity** – occurs when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.
- **Health Disparity** – is a type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systemically experienced greater social or economic obstacles to health. These obstacles stem from discrimination or exclusion that is historically linked to characteristics such as race or ethnicity, socioeconomic status, disability, sexual orientation, and many other factors.<sup>1</sup>
- **Social Determinants of Health (SDoH)** – are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.<sup>2</sup>

<sup>1</sup>U.S. Department of Health and Human Services. The Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 2010 January 6]. Available from: [http://www.healthypeople.gov/sites/default/files/PhaseI\\_0.pdf](http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf).

<sup>2</sup>Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 12/04/2020, from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>.



## Tips for Updating Your CCC Plan

- **Use your current cancer plan as a starting point:** Think of this process as updating the current plan instead of starting a new plan from scratch.
- **Be systematic:** Assign workgroups to review and update certain sections of the plan. Create a process that is common across all workgroups tasked with updating the plan, which should include a standard set of criteria for the inclusion of plan goals, objectives, and strategies.
- **Focus workgroups on assessing and updating the “guts” of the plan:** the goals, objectives, and strategies.
- **Identify someone to take the lead** on writing the introduction, connecting text, and putting the document together for publication.
- **Use data to determine the focus of the plan:** Which cancers are most prevalent in the population? What subpopulations experience the most disparities?
- **View through a health equity lens:** Be intentional and proactive in keeping health equity issues at the forefront in every step of the cancer plan process – when engaging partners, collecting data, and setting goals. Include representatives from your population of focus in the writing of your cancer plan.

Use these resources to explore more cancer control planning tips and examples:

- **Nine Habits of Successful CCC Coalitions**
- **CCC Implementation Building Blocks** (see page 7 of the Appendices for more tips on updating your plan)

Additional resources you can use:

- Search other CCC plans to get ideas – **CDC's CCC Plan Map and Search Tool**
- **CDC Cancer Plan Self-Assessment Tool**
- **GW State Cancer Plans Priority Alignment Resource Guide and Tool**
- **A Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease**

### Checklist for Updating Your CCC Plan

- Ensure that your workgroup is familiar with your current cancer plan.
- Create a systematic process for the workgroup to follow; a process that is **intentional** about addressing issues of health equity throughout.
- Use data to focus on the populations with the highest cancer burdens.
- Focus workgroups on assessing and updating goals, objectives, and strategies.
- Identify someone to write the introduction and assemble the final document.

# COMPREHENSIVE CANCER CONTROL PLAN UPDATE TIP SHEET

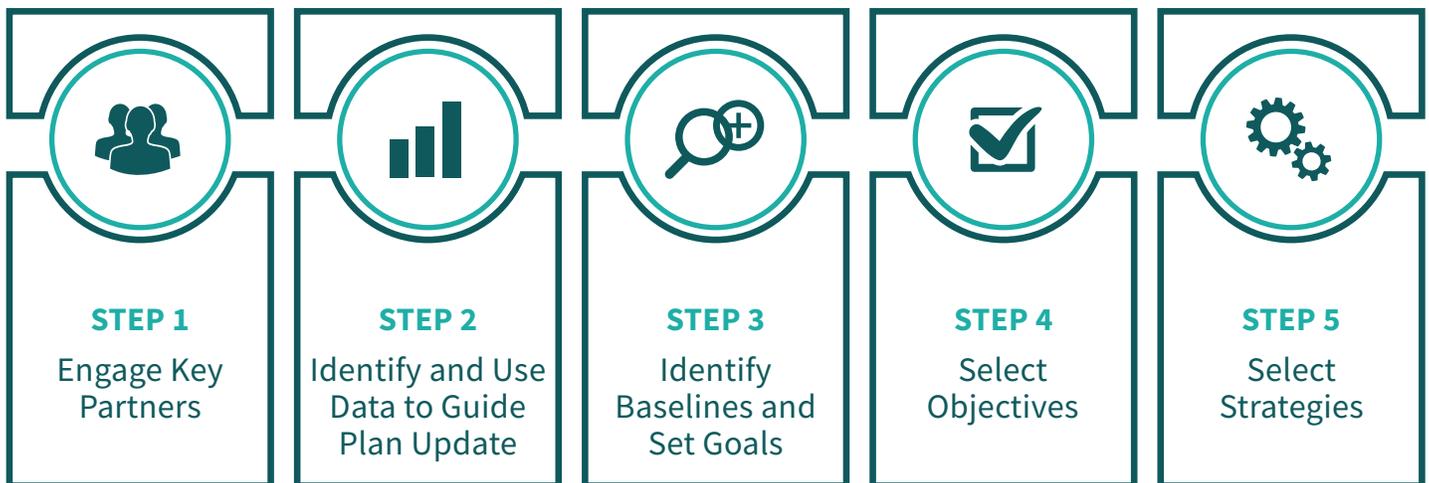
## Colorectal Cancer Screening

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### Why Colorectal Cancer is an Important Part of Your CCC Plan

- As of 2020, colorectal cancer (CRC) is the second-leading cause of cancer death in the US when men and women are combined, yet it can often be detected early or prevented through screening.
- Screening can prevent colorectal cancer through the detection and removal of precancerous growths as well as detect cancer at an early stage, when treatment is usually less extensive and more successful.
- About 1 in 3 adults ages 50 and older – around 38 million people – are still not getting screened as recommended.
- Groups who are less likely to be screened include men, Hispanic persons, American Indian persons, Alaska Native persons, people who are 50 to 64 years old, those who don't live in a city, and those with lower education and income levels.
- CCC coalitions have led the way in increasing CRC screening by engaging partners to increase screening to **80% in Every Community**.

Testing saves lives, but only if people get screened.





## STEP 1 Engage Key Partners

Engage CRC screening experts, organizations, and agencies who have access to the data you need, and partners who will be critical to implementing your CRC-related strategies. Be sure to include representatives from your populations of focus.



### CCC Programs and Coalitions

- Coalition workgroup or advisory group members focused on CRC screening



### Insurers

- State health insurance commissioner's office
- Medical coders or billers (they are a link between patients, providers, and insurers)



### Cancer Centers

- Cancer centers and academic partners with an interest in CRC-related research



### Registries

- **National Program of Cancer Registries (NPCR)**
- **Surveillance, Epidemiology, and End Results (SEER)**



### Organizations

- **American Cancer Society**
- **American Cancer Society Cancer Action Network<sup>SM</sup>**
- Community Health Centers



### Community Representatives

- Community members from your populations of focus
- Organizations who represent communities experiencing disparities in CRC
- Trusted community leaders with experience addressing health inequities in your community (e.g., people of color, people with disabilities, LGBTQ populations)



### Clinicians

- Colorectal cancer screening program staff and providers
- GI specialists or GI groups
- Provider champions
- Primary care provider representative from a primary care association
- **American College of Surgeons (ACOS) Commission on Cancer (CoC) State Chair**
- **ACOS CoC Cancer Liaison Physicians** and the health systems they work in



## STEP 2

# Identify and Use Data to Guide Plan Update

Data is essential to your cancer plan in several ways, including:

- Identifying populations that have higher incidence and mortality rates of CRC and lower screening rates. It is helpful to examine this at minimum by sex, race/ethnicity, health insurance status, geographic area, sexual orientation, and gender identity.
- Identifying your CRC screening rate, progress, and trends over time to identify specific areas for focus .
- Identifying availability and type of providers, cancer services, and ancillary support (e.g., survivor programs, etc.) in different geographic areas and population groups to inform your objectives and strategies in this topic area.
- Comparing local data with national data to highlight key areas of need or lagging progress.
- Laying a foundation to measure progress over the life of the plan (e.g., baselines and goals).



## Resources

- The **American Cancer Society *Cancer Facts and Figures* report** provides the most current information about cancer, including projections of the number of cancer cases and deaths expected in each state and in the nation in the current year.
- The **American Cancer Society Colorectal Cancer Screening Guidelines** provide recommendations for people at average, increased, and high risk for colorectal cancer.
- The **Centers for Disease Control and Prevention’s Achieving Health Equity by Addressing the Social Determinants of Health** website provides strategies to address the conditions in which we are born, live, learn, work, play, worship, and age.
- The **Behavioral Risk Factor Surveillance System (BRFSS)** is the nation’s premier system of health-related telephone surveys that collect state data about US residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services.
- The **County Health Rankings** dataset provides data on county-level social and economic factors that may be associated with lower use of preventive health care.
- The **Health Information National Trends Survey (HINTS)** tracks the use of cancer-related information by the American public and provides opportunities to understand and improve health communications.
- The **National Program of Cancer Registries (NPCR)** collects data on cancer occurrence (including the type, extent, and location of the cancer), the type of initial treatment, and outcomes.
- The **National Cancer Institute (NCI) Cancer Trends Progress Report** summarizes advances against cancer in relation to Healthy People targets set by the Department of Health and Human Services.
- The **PLACES Project** provides data (e.g., unhealthy behaviors, health outcomes, and prevention practices) for all counties, places, census tracts, and ZIP Code Tabulation Areas (ZCTAs) across the US.
- The **Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease** provides lessons learned from evidence- and practice-based strategies. The innovative ideas highlight how to maximize the effects of policy, systems, and environmental improvement strategies – all with the goal of reducing health disparities and advancing health equity.
- The **Surveillance, Epidemiology, and End Results (SEER)** program provides information on cancer statistics to help reduce the cancer burden among the US population.
- Journal article: Understanding and addressing social determinants to advance cancer health equity in the United States: A blueprint for practice, research, and policy. Alcaraz et al. 2020. *CA A Cancer J Clin*, 70: 31-46. <https://doi.org/10.3322/caac.21586>
- The **US Cancer Statistics** are the official government statistics on cancer and provide information on newly diagnosed cancer cases and cancer deaths for the whole US population.
- The **US State Cancer Profiles** characterize state cancer burdens in a standardized manner to motivate action, integrate surveillance into cancer control planning, and expose health disparities.



### STEP 3

## Identify Baselines and Set Goals

The questions in the worksheet at the end of this document can guide you through the data gathering, decision making, and priority setting processes. Think about the following as you work through the questions:

- Set goals for increases in CRC screening based on your data, stakeholder input, and local/national targets.
- Identify any priority areas based on data in specific populations.
- Consult **Healthy People 2030** goals, your health department's chronic disease plan, and **BRFSS data** to see what baselines and goals are already being used by your partners. Remember to cite your data sources.
- See CDC-reported state and territory screening rates to better understand current screening rates.



### STEP 4

## Select Objectives

It is helpful to show how your cancer plan goals contribute to national goals. Create a primary objective that mirrors national priorities, such as those in Healthy People 2030, and identify one or two other complementary health equity objectives that support specific needs within your communities, including a special focus on subpopulations that experience health disparities.

Examples of primary objectives:

- By 2025, increase the proportion of adults aged 50 to 75 years who are up to date on recommended colorectal cancer screening from 71% to 80% (BRFSS).
- Increase risk-appropriate screening for breast, cervical, and colorectal cancers, with a separate baseline and goal for each cancer. For example, by 2025, increase CRC screening among men and women from 60% to 80% (BRFSS).
- By 2025, reduce mortality from colorectal cancer from 14.6 deaths per 100,000 to 13.1 deaths per 100,000 (state cancer registry).

Example of complementary health equity objectives, and **objectives that address social determinants affecting health**:

- By 2025, increase CRC screening among rural communities from 45% to 60% (BRFSS).
- By 2025, increase the number of collaborative projects implemented with partners from different sectors (e.g., education, housing, health care, community development, or transportation) to expand proven interventions that address social determinants of health.
- By 2025, establish commitments from three organizations to offer annual CRC screening in a trusted setting identified by our population of focus.
- By 2025, establish commitments from 10 primary care clinics and/or Federally Qualified Health Centers in our state to modify clinic hours to offer evening screening options.



## STEP 5 Select Strategies

When choosing strategies that can help address needs you have identified, think about what existing networks, programs, and services you can leverage, enhance, or expand; whether the strategy is realistic and feasible, given the political will around this issue and available resources; and the impact the strategy will have on achieving the objective you have set.

For CRC screening, ensure that your strategies are supportive of nationally recognized CRC screening guidelines, such as the US Preventive Services Task Force recommendations.

The following strategies are examples of evidence-based strategies found in CCC plans. Tailor your chosen strategies to reach both the general population AND your population of focus.

### Strategies to Increase Community Demand

- Use community health workers or lay patient navigators, especially in underserved communities, for group education; 1:1 education; client reminders for screening; and small media.
- Develop a statewide education campaign that includes 1:1 and small media patient education that can be tailored by partners.

### Strategies to Increase Community Access

- Use community health workers or lay patient navigators, especially in underserved communities, to assist with reducing structural barriers by assisting with appointment scheduling, providing transportation and language translation, or providing child care.
- Reduce barriers to access to screening by offering non-clinical settings for screening (communities, worksites) and by modifying clinic hours to offer evening screening options.

### More CRC Resources

- [National Colorectal Cancer Roundtable](#)
- [CDC's National Colorectal Cancer Control Program](#)

### Strategies for Health System Changes

- Client reminders to get their CRC screening
- Provider reminder and recall
- Provider assessment and feedback
- Reduce structural barriers to screening by supporting patient navigation programs and/or simplifying patient access to screening by offering “one-stop shopping” such as FLU-FIT clinics.

Often times, using a combination of these strategies is more effective than implementing a single strategy. For health systems changes, establishing a relationship and shared outcomes with the system is important to consider upfront. It's also helpful to have a clinical champion who can energize clinic staff and keep everyone focused on improving CRC screening rates. Periodically monitoring clinic-level CRC screening rates is an important activity when implementing health system interventions, so approaches can be adjusted as needed. Electronic health record (EHR) data may need to go through a validation process to ensure screening estimates are accurate, given that most EHRs are not optimized to produce screening estimates. Clinics may need to work with their IT or health informatics staff member to examine potential issues with data entry, documentation of completed colonoscopies/FIT/FOBT tests, inclusion/exclusion criteria for numerators and denominators, and other issues.

Where to find EBIs: [The Community Guide](#), [NCI's Evidence-Based Cancer Control Programs](#), [Cochrane Reviews](#).

For information and tools on adapting strategies to fit your location, start with the [CPCRN site](#), including the training workshop, “Putting Public Health Evidence Into Practice.”

# Worksheet: Questions to Ask and Answer

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Use this worksheet to help you and your CRC coalition partners to identify gaps, opportunities, and challenges that should be reflected in your cancer plan objectives and strategies. Record your answers and use the information to help inform your selection of objectives and strategies for your updated plan.

1. Overall, how are we doing in CRC screening compared to the national rates, our neighboring states, and our own rates in previous years?

- What primary objectives do we want to set given our analysis of this data?

2. In what specific populations or communities are the screening rates lagging? Do we know why? If we don't know why, how do we find out?

- How can we engage populations experiencing disparities (or populations of focus) to identify solutions?

- What secondary objectives do we want to set given our analysis of this data?

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3. What partners can we engage to help implement policy and system changes to support CRC screening uptake over time? Do we have existing connections with them? How can we engage these partners? Why will they want to be involved? What is the value proposition for them?

- Are the populations of focus engaged in planning and implementing these changes?

- What strategies should we select given the answers to the these questions?

4. Are CRC screening and/or diagnostic services easily accessible to all populations? Is there a geographic area or subpopulation with less convenient access or greater barriers to accessing services?

- Are people most affected engaged in planning the solutions?

- What strategies should we select given the answers to the these questions?

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5. What conditions in our environment (in which we are born, live, learn, work, play, worship, and age) are affecting our communities' health?

- Are people most affected engaged in planning the solutions?

- What objectives and strategies should we include to address these “upstream” social determinants of health?

6. What existing services, networks, or programs could we leverage to increase CRC screening rates?

- What strategies should we select given the answers to the these questions?

7. What CRC policies do we want to advocate for or promote?

- What strategies should we select given the answers to the these questions?

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8. What gets measured is what gets done: How can we best track CRC screening outcomes? How do we know we are making progress along the way?

- What strategies should we select related to the answers to these questions?

9. What and how do we communicate to policy makers, regarding our unified recommendation for increasing rates?

- Are there strategies we should select related to the answers to these questions?

10. How will the strategies we selected elevate health outcomes for those who have historically experienced health outcome disparities (or populations of focus)?