Colorectal Cancer Mortality Disparities Learning Community

State Cancer Planning

The American Cancer Society has provided training & technical assistance to grantees of the **Centers for Disease Control and Prevention's National Comprehensive Cancer Control Program** for over 25 years.

We acknowledge and thank CDC for its support of ACS staff, and in the development and dissemination of this learning session, under cooperative agreement NU58DP007540 awarded to the American Cancer Society. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

American Cancer Society®

September 4, 2025

Learning Objectives

1. Increase integration of interventions mitigating colorectal cancer (CRC) mortality disparities into the state comprehensive cancer coalition planning processes
2. Provide a real world example of a state cancer coalition that has integrated CRC mortality into their cancer plan
3. Increase knowledge of tools to use to integrate CRC mortality into state cancer plans and coalition work

…..and NETWORK with colleagues from around the country!

Our Roadmap

The ACS CCC team is hosting this CRC Mortality Learning Community to increase NCCCP recipients' and cancer coalitions' capacity to integrate interventions mitigating CRC mortality disparities into the state planning process.

1. **CRC Mortality 101**
   May 1, 2025
2. **Timely Follow-Up Colonoscopy and CRC Mortality**
   June 5, 2025
3. **CRC Survivorship**
   July 10
4. **CRC Mortality in Your Communities**
   August 7, 2025
5. **CRC Mortality and State Cancer Plans**
   September 4, 2025

Focus on gaining foundational knowledge on the latest in CRC mortality disparities

Focus on applying what we've learned to our work

Session 1: CRC Mortality 101

Speaker: Tyler Kratzer, MPH, Associate Scientist II, Cancer Surveillance - Data Science, American Cancer Society

Key Takeaways and Objectives

1. Increase participants' knowledge and understanding of the latest data and statistics for CRC mortality including disparities and potential mitigating factors
2. CRC incidence and mortality have been going down due to knowledge of **risk factors**, **screening**, and **better treatment options**, but disparities still exist:
    - There is an increasing incidence in those born after 1950 and a gap in screening uptake in those under 55
    - Shift to advanced CRC stage at diagnosis – 60% of cases compared to 52% in 2005
    - Disparities are quite stark for certain groups:
        - Through screening (access and by type of test)
        - Like Native Americans, Hispanic, and Asians

Session 2: Timely Follow-Up Colonoscopy and CRC Mortality

Speaker: Chyke Doubeni, MD, MPH, Professor of Family Medicine, Klotz Chair in Cancer Research, Associate Director of the Comprehensive Cancer Center, The Ohio State University Wexner Medical Center

Key Takeaways and Objectives

1. Increase participants' knowledge and understanding of research and mitigating factors related to CRC mortality outcomes and timely colonoscopy follow up to initial non-colonoscopy tests, including barriers to follow-up and risk with delays or lack of follow-up
2. Completing a CRC screening test is essential, but insufficient by itself and a negative test should be repeated at regular recommended intervals
3. There are evidence-based interventions to increase follow-up to a positive or abnormal fecal test at the patient, provider, and system level

Session 3: CRC Mortality and Survivorship

Speaker: Danielle Burgess, VP of Disease Awareness, Fight CRC, Marianne Pearson, MSW, LCSW, VP of Cancer Care, Colorectal Cancer Alliance

Key Takeaways and Objectives

1. Increase participants' knowledge of cancer survivorship specifically related to colorectal cancer (CRC), including resources and evidence-based interventions addressing CRC survivorship
2. Increase participants' knowledge of ways to engage cancer survivors in their work, support services and advocacy
3. As CRC incidence in younger people continues to climb, and if we successfully curb CRC mortality rates, we will have more CRC survivors with specific needs
4. There are multiple organizations with resources, advocacy, and policy engagement options for CRC survivors

Session 4: CRC Mortality Data in Your Community

Speaker: Char Raunio, Associate Director, State Partnerships American Cancer Society,

Washington and Oregon, American Cancer Society

Key Takeaways and Objectives

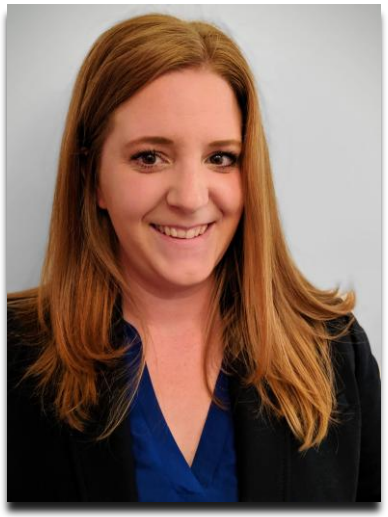
1. Increase knowledge of and practice using tools coalitions can use to assess the burden to apply and adapt evidence-based interventions
2. It's essential to understand your community landscape to begin successful work to affect CRC mortality as a coalition
3. Engaging partners to reach the population you seek is going to help make your work more impactful
4. There are multiple tools that you can use to assess data related to CRC mortality, including down to the county or zip code level, but we explored the CRC Data Dashboard specifically

Watch the Recordings Today!

Disclosures

Our speakers today has no conflicts of interest to disclose related to this presentation

Guest Speakers



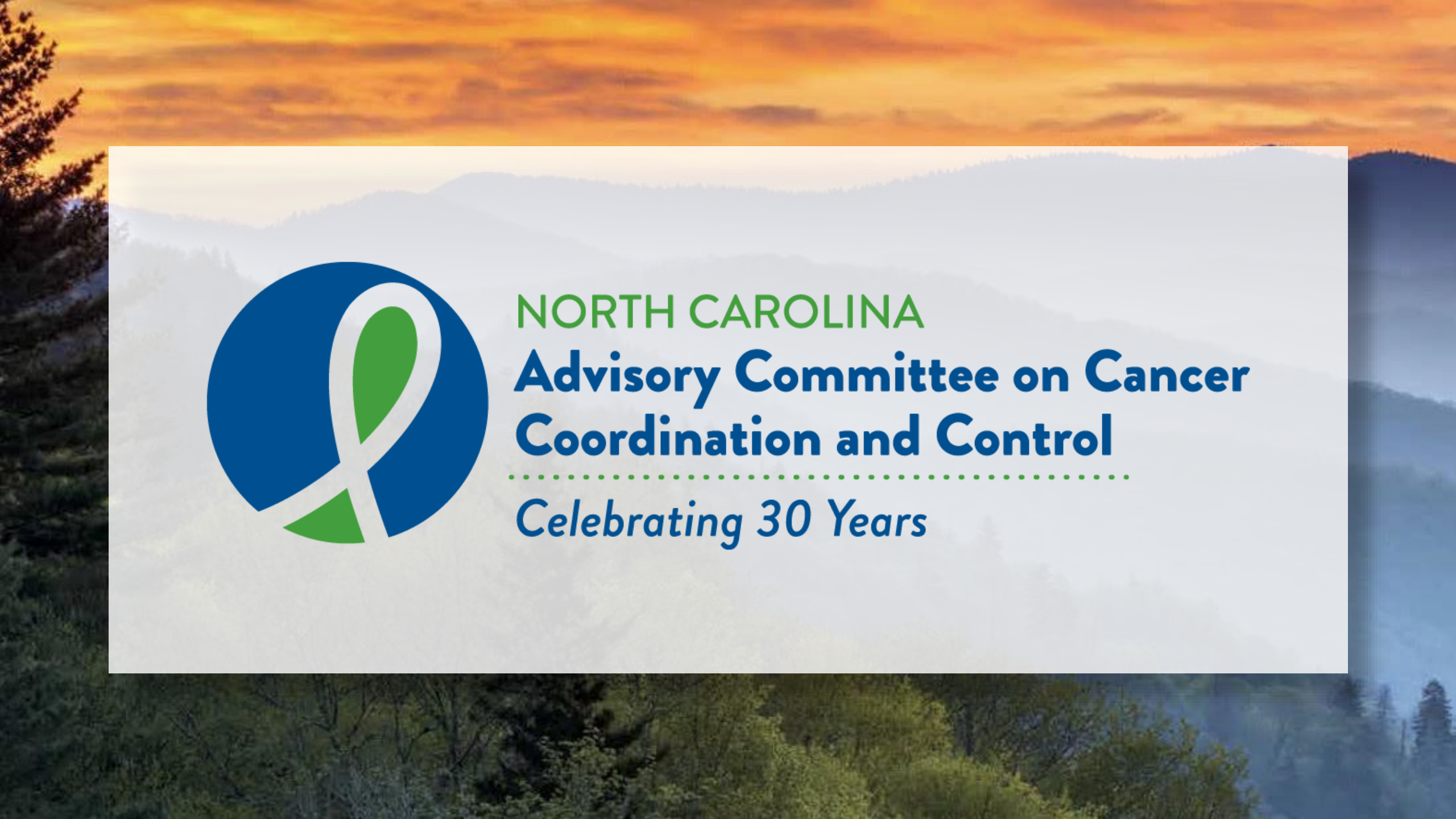
Sarah Arthur, MBA
Comprehensive Cancer Control Program Director, Advisory Committee for Cancer Coordination and Control Executive Director, Division of Public Health

Larissa M. Williams, MPH
Comprehensive Cancer Control Program Coordinator
Division of Public Health

Comprehensive Cancer Control

Collaborating to Conquer Cancer

NORTH CAROLINA

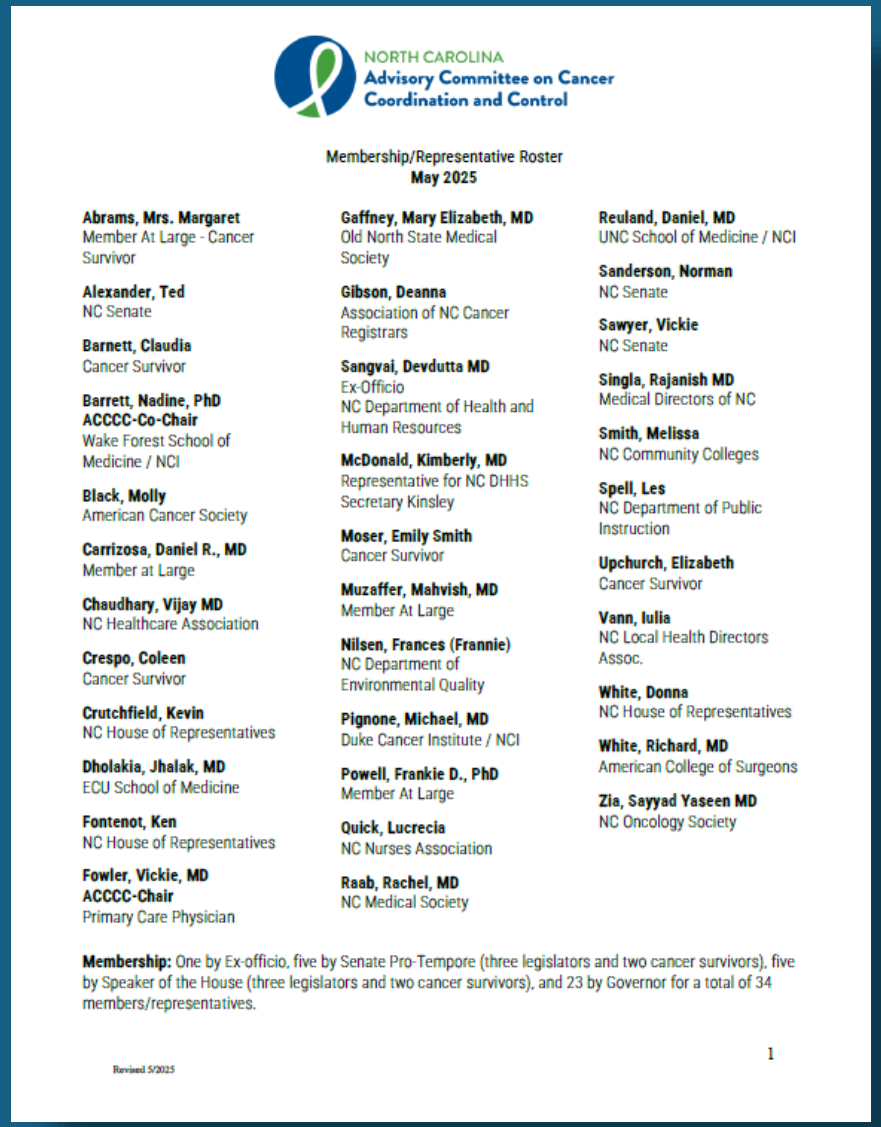


NORTH CAROLINA

Advisory Committee on Cancer Coordination and Control

Celebrating 30 Years

34 designated members representing survivors, legislators, physicians, health care professionals and cancer advocates



NORTH CAROLINA
Advisory Committee on Cancer Coordination and Control

Membership/Representative Roster
May 2025

Abrams, Mrs. Margaret
Member At Large - Cancer Survivor

Alexander, Ted
NC Senate

Barnett, Claudia
Cancer Survivor

Barrett, Nadine, PhD
ACCCC-Co-Chair
Wake Forest School of Medicine / NCI

Black, Molly
American Cancer Society

Carrizosa, Daniel R., MD
Member at Large

Chaudhary, Vijay MD
NC Healthcare Association

Crespo, Coleen
Cancer Survivor

Crutchfield, Kevin
NC House of Representatives

Dholakia, Jhalak, MD
ECU School of Medicine

Fontenot, Ken
NC House of Representatives

Fowler, Vickie, MD
ACCCC-Chair
Primary Care Physician

Gaffney, Mary Elizabeth, MD
Old North State Medical Society

Gibson, Deanna
Association of NC Cancer Registrars

Sangvai, Devdutta MD
Ex-Officio
NC Department of Health and Human Resources

McDonald, Kimberly, MD
Representative for NC DHHS Secretary Kinsley

Moser, Emily Smith
Cancer Survivor

Muzaffer, Mahvish, MD
Member At Large

Nilsen, Frances (Frannie)
NC Department of Environmental Quality

Pignone, Michael, MD
Duke Cancer Institute / NCI

Powell, Frankie D., PhD
Member At Large

Quick, Lucrecia
NC Nurses Association

Raab, Rachel, MD
NC Medical Society

Reuland, Daniel, MD
UNC School of Medicine / NCI

Sanderson, Norman
NC Senate

Sawyer, Vickie
NC Senate

Singla, Rajanish MD
Medical Directors of NC

Smith, Melissa
NC Community Colleges

Spell, Les
NC Department of Public Instruction

Upchurch, Elizabeth
Cancer Survivor

Vann, Iulia
NC Local Health Directors Assoc.

White, Donna
NC House of Representatives

White, Richard, MD
American College of Surgeons

Zia, Sayyad Yaseen MD
NC Oncology Society

Membership: One by Ex-officio, five by Senate Pro-Tempore (three legislators and two cancer survivors), five by Speaker of the House (three legislators and two cancer survivors), and 23 by Governor for a total of 34 members/representatives.


NORTH CAROLINA
Comprehensive Cancer Control
ACTION PLAN
2020-2025

		2024										2025										
		Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov
Planning Phase	Pre-Planning Meetings – Comp Cancer Staff, ACCCC Chairs and Subcommittee Chairs																					
	Develop/refine plan development process/modify timeline																					
	Establish an internal plan and development committee (PDC)																					
	Set basic emphasis/framework																					
	Work with PDH to draft a plan outline																					
	Take plan outline to ACCCC Subcommittees for strategic thoughts																					
Writing Phase	Expand plan outline, incorporate ACCCC Subcommittee suggestions into a rough draft of the cancer plan																					
	Share with reviewers – set deadline for final review																					
	Include feedback and refine working draft cancer plan																					
Review Phase	Share working draft cancer from ACCCC leadership																					
	Get feedback on working draft from ACCCC Leadership																					
	Continue to incorporate recommendations/refine working draft cancer plan																					
	Meet with graphics on timeline, required signatures																					
	Final plan sent for approvals																					
Distribution Phase	Final plan sent to graphics (PA2 process)																					
	Development distribution / communication plan																					
	Final plan sent to printing																					
	Plan printing & delivered																					
	Release Plan																					

North Carolina Colorectal Cancer Objective

Reduce North Carolina colorectal cancer incidence and mortality rates.

NC COLORECTAL CANCER STRATEGIC ACTIONS	EVIDENCE-BASED INTERVENTIONS[3]
• Promote awareness of screening methods and recommendations for adults who meet specific age criteria. • Conduct targeted outreach using evidence-based strategies to decrease disparities in colorectal cancer mortality. These efforts should focus on population groups who experience high mortality rates from colorectal cancer. • Support Federally Qualified Health Centers with low colorectal cancer screening rates to increase screening and referrals. • Educate policymakers about the need for increased funding for programs, coalitions and action groups to support additional screening opportunities in communities.	• Sponsor group education to increase community demand for cancer screening services. • Reduce barriers to increase community access to cancer screening services. • Develop and disseminate public education programs that empower survivors to make informed decisions. • Use interpreter services or bilingual providers to promote health equity. • Educate the public that cancer is a chronic disease that people can and do survive. • Use recommendations from The Guide to Community Preventive Services (The Community Guide) https://www.thecommunityguide.org/.

Note: The North Carolina Colorectal Cancer Roundtable (NC CRCRT) is a good example of an organization that uses these strategies to support colorectal cancer reduction efforts in North Carolina by enhancing statewide access to screening, quality treatment and supportive services and maximizing quality of life for cancer patients, survivors and their families. The NC CRCRT serves as a statewide advisory board and works with government officials, policymakers, public and private organizations and the public.

2020-2025 NC Colorectal Cancer Measures

NC COLORECTAL CANCER MEASURES	NC BASELINE	NC 2025 TARGET
Colorectal cancer incidence rate[23]	35.2/100,000	29.6/100,000
Colorectal cancer mortality rate[21]	12.6/100,000	11.0/100,000

[27]The **target rate** was determined by calculating the percent change from year-to-year from 2008 forward, to the latest available incidence data (2017) and mortality data (2018). An annual average percent change was calculated from those percentages (for the years 2008-2017) for incidence and (2008-2018) for mortality. The targets were set for 2025 based on the projected rates from 2018 through 2025.

Cancer in North Carolina:
DATA AND RESOURCE GUIDE

MAY 2024

Colorectal Cancer

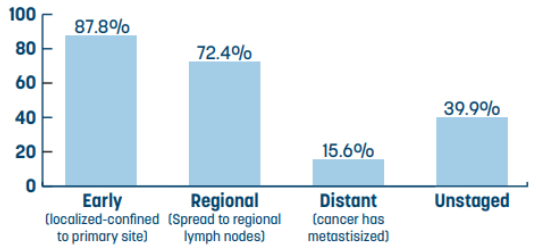
RISK FACTORS

Age	Colorectal polyps	Overweight or obese	Smoking tobacco	Family history	Chronic inflammatory colon conditions

Colorectal cancer was the fourth leading cause of cancer deaths in North Carolina in 2022 (12.7 per 100,000).[1] Colorectal cancer develops in the colon and/or the rectum. While the colorectal cancer risk increases with age, lifestyle choices like maintaining a healthy weight, eating whole grains and fiber rich foods, reducing red meat consumption, and limiting alcohol can significantly reduce the overall risk of colorectal cancer. Sexual and gender minority (SGM) populations face a disproportionate burden of colorectal cancer with both a higher incidence of colorectal cancer and later-stage diagnosis. Transgender people are less likely to get screened for colorectal cancer and have a higher rate of late-stage diagnosis.[2] (See Appendix B for information on colorectal cancer interventions and evidence-based strategies and Appendix D for colorectal cancer screening recommendations.)

Results from the 2022 Behavioral Risk Factor Surveillance Survey (BRFSS) show that 29.6% of North Carolina adults aged 45 and older report "never having had a colonoscopy screening for colorectal cancer," yet a colonoscopy can find polyps which can be removed before they become cancerous.[3] Early detection is directly correlated with survival of colorectal cancer. This correlation emphasizes the importance of colorectal cancer screenings. Recommended screening tests include stool-based tests and/or direct visualization tests (colonoscopy, CT colonography, and flexible sigmoidoscopy).[4] The type of test is based on risk and benefit for the individual. Early screening makes colorectal cancer mostly preventable. Between 2017-2021, the colorectal cancer cumulative observed survival rate, the percentage of patients who would be expected to be alive five years after being diagnosed with colorectal cancer, was 49.8%.[5]

NC COLORECTAL CANCER 5-YEAR SURVIVAL RATE BY STAGE OF DIAGNOSIS



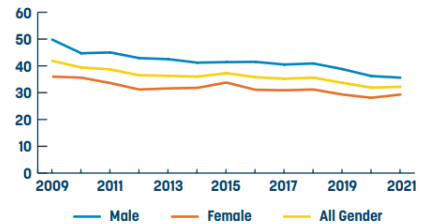
North Carolina Colorectal Cancer Data

Increase in colorectal cancer screening and changes in lifestyle behaviors are reflected in the decline of North Carolina colorectal cancer incidence and mortality rates in the past 10 years as illustrated in the incidence and mortality charts. Colorectal cancer incidence and mortality rates have been falling in older age groups in recent years, but they have been rising among younger people.[7,1] This trend prompted a change in the national screening guidelines. The guidelines changed the recommended age to start regular colorectal cancer screening from age 50 to 45 for people at average risk of colorectal cancer.

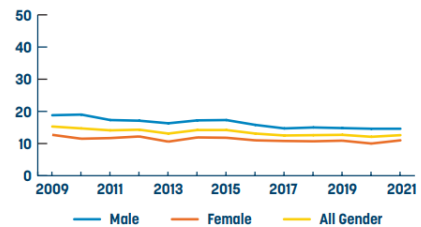
Despite higher incidence in men than in women, trends over time are very similar by sex. The colorectal cancer incidence rate dropped from 42.0 per 100,000 population during the 2007-2011 period to a rate of 35.3 per 100,000 in the 2017-2021 period.[6,7] In 2020, the national colorectal cancer incidence rate stood at 33.0 per 100,000.[8]

From 2008-2012 and 2018-2022, the colorectal cancer mortality rate dropped from 14.8 per 100,000 population to 12.7 per 100,000.[9,1] In 2020, the national colorectal cancer mortality rate stood at 13.0 per 100,000 population.[8]

HISTORICAL NC COLORECTAL CANCER INCIDENCE RATES

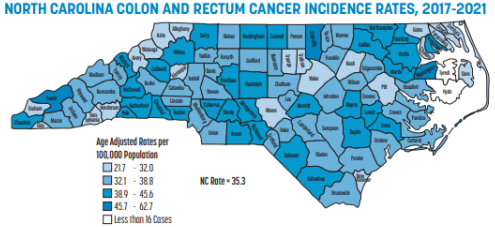


HISTORICAL NC COLORECTAL CANCER MORTALITY RATES



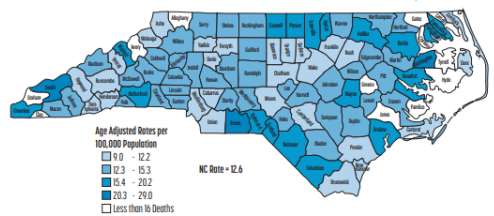
North Carolina colorectal cancer incidence and mortality rates vary by county. The North Carolina State Center for Health Statistics maps show the differences in these rates. The cancer mortality map shows elevated mortality rates in the northeastern part of the state. Researchers from the University of North Carolina, Lineberger Comprehensive Cancer Center reported finding a cluster of 10 counties with higher rates of colorectal cancer mortality in 2019. In those 10 counties, an average of 55 people died in each county from colorectal cancer per 100,000 people, with mortality rates as high as 75 per 100,000 people. By comparison, the overall colorectal mortality rate per county for North Carolina at that time was 45 deaths per 100,000 people. The researchers reported that socioeconomic deprivation, which included lack of employment and income along with many other risk factors, contributed to the cluster.[10]

NORTH CAROLINA COLON AND RECTUM CANCER INCIDENCE RATES, 2017-2021



Source: State Center for Health Statistics, March 2024.

NORTH CAROLINA COLON AND RECTUM CANCER MORTALITY RATES, 2017-2021

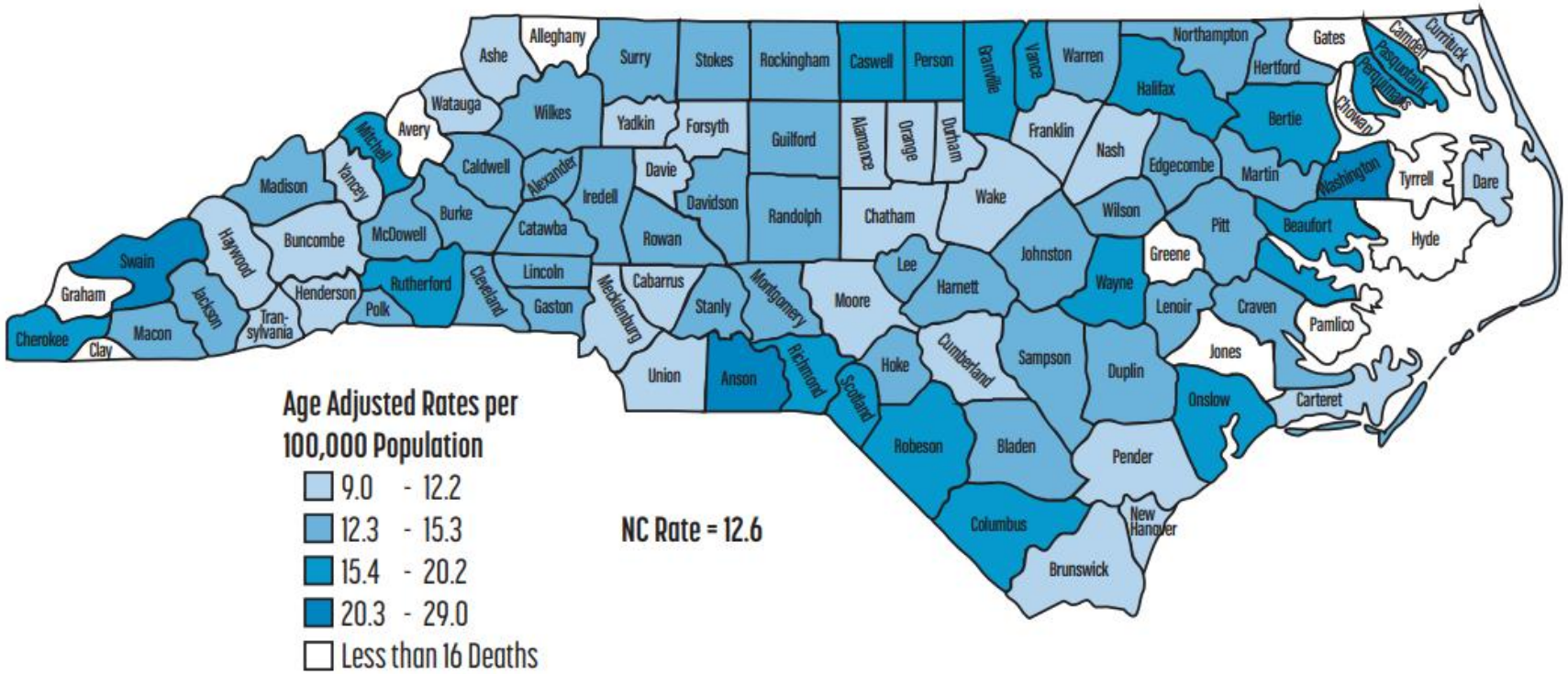


Source: State Center for Health Statistics, March 2024.

County	Incidence Rate[7] (2017-2021)	Mortality Rate[1] (2018-2022)	Distant Stage Diagnosis %[11] (2016-2020)	Current Smoker % (2020)[13]
Columbus	39.4	17.2	22%	23%
Craven	37.5	13.2	27%	19%
Cumberland	32.9	12.0	23%	20%
Currituck	21.8	10.3	26%	17%
Dare	24.5	11.3	36%	15%
Davidson	42.0	13.8	24%	20%
Davie	37.8	10.5	21%	19%
Duplin	41.7	15.4	22%	21%
Durham	31.4	11.6	23%	15%
Edgecombe	34.8	14.3	22%	23%
Forsyth	34.4	11.7	22%	17%
Franklin	34.9	9.8	22%	19%
Gaston	41.7	13.1	23%	20%
Gates	27.8	**	12%	21%
Graham	28.0	**	18%	23%
Granville	50.1	19.5	24%	20%
Greene	35.1	14.1	19%	23%
Guilford	34.1	12.2	23%	17%
Halifax	41.0	15.8	27%	25%
Harnett	40.1	15.3	20%	19%
Haywood	37.3	13.4	19%	19%
Henderson	30.9	12.5	19%	17%
Hertford	45.4	15.2	20%	23%
Hoke	35.0	12.3	22%	20%
Hyde	**	**	23%	23%
Iredell	35.1	12.2	20%	17%

County	Incidence Rate[7] (2017-2021)	Mortality Rate[1] (2018-2022)	Distant Stage Diagnosis %[11] (2016-2020)	Current Smoker % (2020)[13]
Jackson	35.1	11.5	23%	20%
Johnston	36.1	11.2	22%	18%
Jones	40.0	**	11%	23%
Lee	36.0	14.8	16%	19%
Lenoir	41.2	14.7	23%	23%
Lincoln	36.3	12.2	22%	18%
Macon	34.6	16.7	26%	20%
Madison	36.7	12.9	24%	19%
Martin	41.8	13.7	13%	23%
McDowell	45.6	17.0	21%	21%
Mecklenburg	34.0	11.3	23%	14%
Mitchell	44.8	15.1	17%	20%
Montgomery	37.0	14.8	23%	21%
Moore	29.4	12.0	25%	16%
Nash	29.1	9.6	24%	20%
New Hanover	29.2	10.6	20%	16%
Northampton	41.4	12.6	21%	23%
Onslow	38.6	16.0	21%	20%
Orange	29.9	10.2	23%	13%
Pamlico	38.4	**	16%	20%
Pasquotank	30.8	15.2	26%	19%
Pender	33.0	11.0	22%	19%
Perquimans	36.8	19.1	26%	20%
Person	38.7	15.8	30%	20%
Pitt	29.8	12.2	21%	18%
Polk	37.3	15.0	28%	17%

North Carolina Colon and Rectum Cancer Mortality Rates, 2017-2021

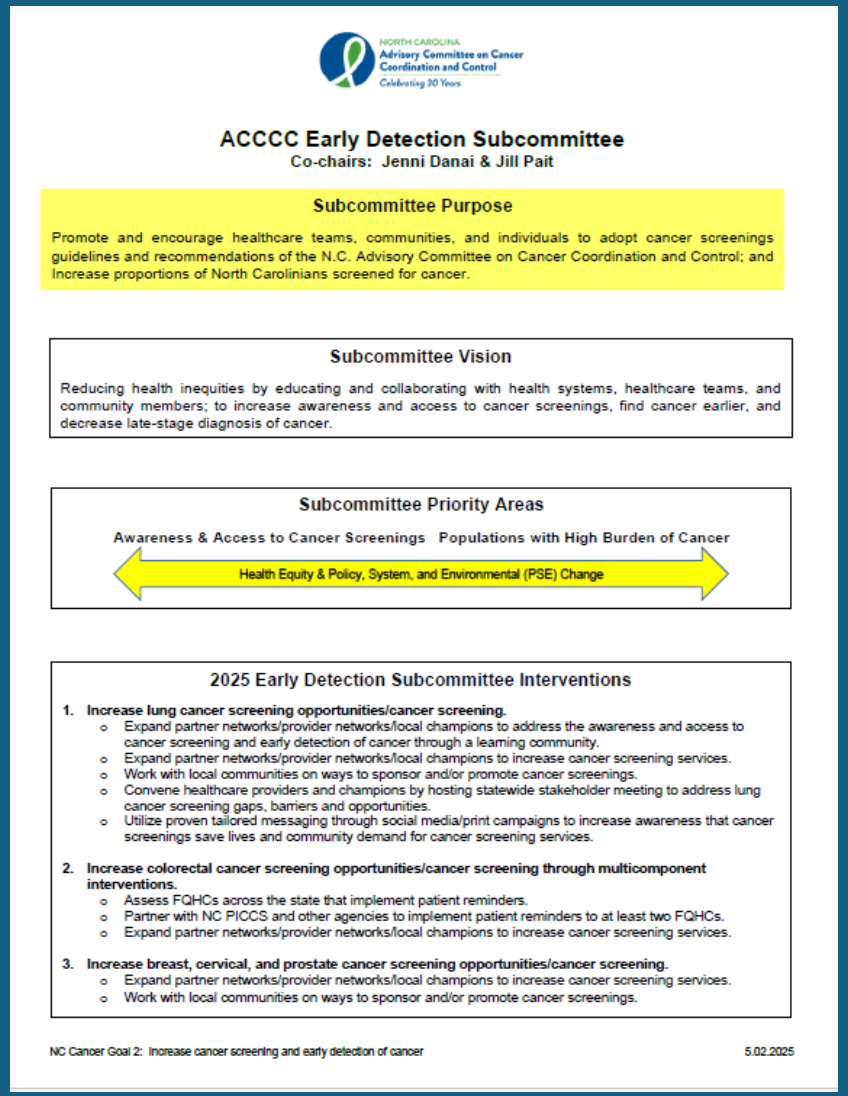


Source: State Center for Health Statistics, March 2024.

NC Cancer Goal 2: Increase cancer screening and early detection of cancer.

Objective: Increase colorectal cancer screening opportunities/cancer screening through multicomponent interventions.

a. "Get Screened Campaign"
b. Patient reminders at FQHCs



NORTH CAROLINA Advisory Committee on Cancer Coordination and Control Celebrating 30 Years

ACCCC Early Detection Subcommittee
Co-chairs: Jenni Danai & Jill Pait

Subcommittee Purpose

Promote and encourage healthcare teams, communities, and individuals to adopt cancer screenings guidelines and recommendations of the N.C. Advisory Committee on Cancer Coordination and Control; and Increase proportions of North Carolinians screened for cancer.

Subcommittee Vision

Reducing health inequities by educating and collaborating with health systems, healthcare teams, and community members; to increase awareness and access to cancer screenings, find cancer earlier, and decrease late-stage diagnosis of cancer.

Subcommittee Priority Areas

Awareness & Access to Cancer Screenings Populations with High Burden of Cancer

Health Equity & Policy, System, and Environmental (PSE) Change

2025 Early Detection Subcommittee Interventions

1. **Increase lung cancer screening opportunities/cancer screening.**
   - Expand partner networks/provider networks/local champions to address the awareness and access to cancer screening and early detection of cancer through a learning community.
   - Expand partner networks/provider networks/local champions to increase cancer screening services.
   - Work with local communities on ways to sponsor and/or promote cancer screenings.
   - Convene healthcare providers and champions by hosting statewide stakeholder meeting to address lung cancer screening gaps, barriers and opportunities.
   - Utilize proven tailored messaging through social media/print campaigns to increase awareness that cancer screenings save lives and community demand for cancer screening services.
2. **Increase colorectal cancer screening opportunities/cancer screening through multicomponent interventions.**
   - Assess FQHCs across the state that implement patient reminders.
   - Partner with NC PICCS and other agencies to implement patient reminders to at least two FQHCs.
   - Expand partner networks/provider networks/local champions to increase cancer screening services.
3. **Increase breast, cervical, and prostate cancer screening opportunities/cancer screening.**
   - Expand partner networks/provider networks/local champions to increase cancer screening services.
   - Work with local communities on ways to sponsor and/or promote cancer screenings.

NC Cancer Goal 2: Increase cancer screening and early detection of cancer 5.02.2025

Small Group Breakouts

15 Minutes

Pick one of your states to start walking through these questions with help from the CRC Data Dashboard (or the expert in your group!):

- Overall, how does your state's CRC screening and mortality rate compare to the national rates? Your neighboring states? **Are there areas that jump out in the state with high mortality or low screening rates?**
- In what specific populations or communities are the CRC screening rates lagging or CRC mortality higher? **Think about specific populations and age groups.** Do we know why? If we don't know why, how do we find out?
- Are CRC screening and/or diagnostic services easily accessible to all populations? **Think about the connections to get to a follow-up colonoscopy.** Is there a geographic area or subpopulation with less convenient access or greater barriers to accessing services?
- What partners can we engage to help implement policy and system changes to support CRC screening uptake over time? **Think about health systems/clinics in certain areas or the populations they serve.** Do you have existing connections with them? How can you engage these partners?

American Cancer Society

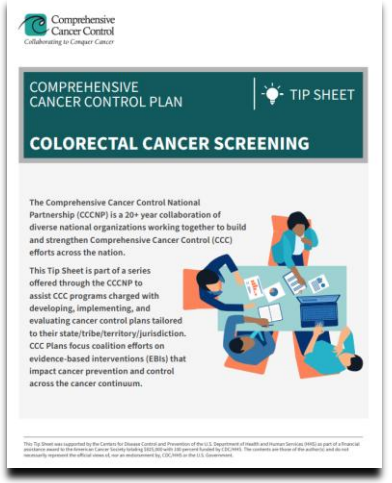
Call To Action

Use the ACS4CCC Tip Sheets as you update your cancer plans

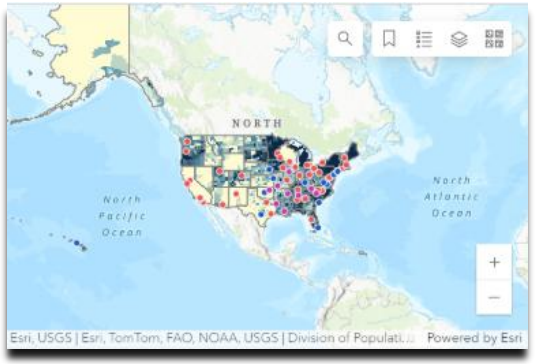
- CRC Screening (and Mortality)
- Health Equity (with an eye to CRC Mortality)

CRC State Cancer Planning Resources

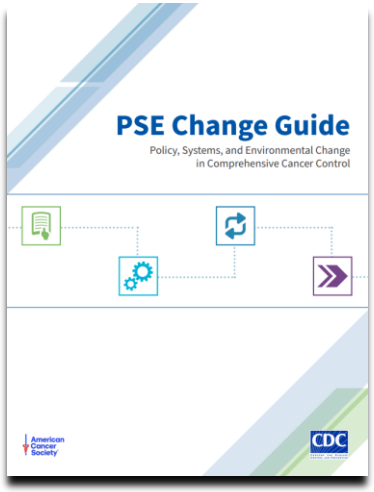
[TIP SHEET: Comprehensive Cancer Control Plan: Colorectal Cancer Screening]



[Colorectal Cancer Data Dashboard]



[PSE Change Guide]



ACS CRC Mortality Learning Community Roadmap

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   May 1, 2025
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Focus on gaining foundational knowledge on the latest in CRC mortality disparities

Focus on applying what we've learned to our work

Recordings and Slides Available for all 5 CRC LC Sessions!

https://acs4ccc.org/acs-ccc-resources/program-and-coalition-health/

ACS Webinar for Cancer Coalition Series

2025 Webinar Topics:

1. CCC Coalitions & the Evolving Landscape of Cancer Survivorship
2. Fueling the Mission: ACS Resources to Power Your Coalition's Work
3. What You Need to Know About Prostate Cancer Screening
4. Cancer and Climate Change
5. Advocacy vs Lobbying: What's the Difference?

Watch the Recordings Today!

Check out resources from ACS CCC!

acs4ccc.org

Your one-stop shop for coalition resources across ACS

Monthly E-Newsletter

ACS Coalition University

Brief, on-demand trainings for CCC coalition staff & leadership on topics such as.....

Thank you from your ACS CCC Team!

Sarah Shafir
Principal Investigator

Donoria Evans
Director, Data & Evaluation

Disa Patel
Senior Data and Evaluation Manager

Liddy Hora
Program Manager

Aubree Thelen
Program Manager

acs4ccc.org