Comprehensive Cancer Control
Collaborating to Conquer Cancer

COMPREHENSIVE CANCER CONTROL PLAN

TIP SHEET

ADDRESSING RISK FACTORS FOR CANCER SURVIVORS

The Comprehensive Cancer Control National Partnership (CCCNP) 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 CCCNP 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.

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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.[1]
- **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.[2]

[1] 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**.

[2] 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

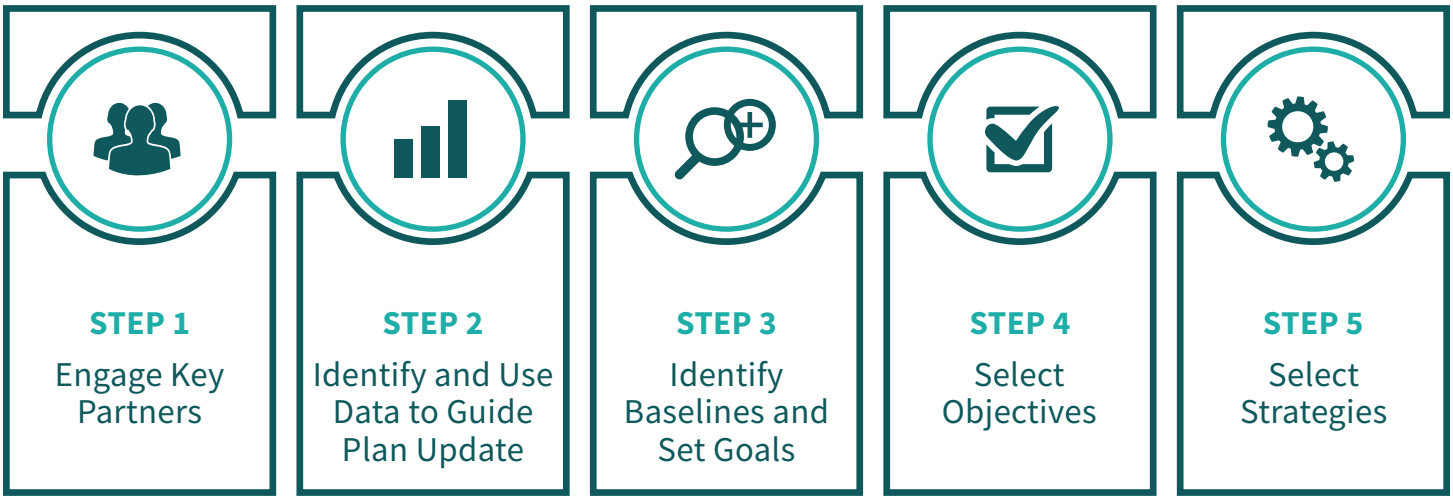
- ☐ **Ensure that your workgroup is familiar with your current cancer plan.**
- ☐ **Create a systematic process for the workgroup to follow; a process that is intentional about addressing issues of health equity throughout.**
- ☐ **Use data to focus on the populations with the highest cancer burdens.**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

Addressing Risk Factors for Cancer Survivors

Why Addressing Risk Factors for Cancer Survivors is an Important Part of Your CCC Plan

- The number of cancer survivors living in the US continues to increase in part due to early detection and improved cancer treatment. An estimated 16.9 million people with a history of cancer were alive on January 1, 2019 and this number will likely increase to 22.1 million by January 2030.[3]
- Factors like a person's income, education, race, ethnicity, sexual orientation, gender identity, disability status, or where they live, work, and play can affect the choices a person makes, but more importantly, can affect a person's opportunity to be as healthy as possible.
- Cancer survivors who minimize their exposure to cancer risk factors can help reduce the risk of cancer recurrence or progression and the incidence of additional cancers. This Tip Sheet is focused on the following risk factors for cancer survivors:
  - Alcohol consumption
  - Tobacco use
  - Poor nutrition
  - Physical inactivity
  - Obesity/overweight
- CCC coalitions have the ability and opportunity to leverage and adapt existing health behavior or lifestyle intervention programs to address cancer survivor needs.

The number of cancer survivors is increasing, and cancer survivors are living longer. Addressing cancer risk factors can improve quality of life for cancer survivors.

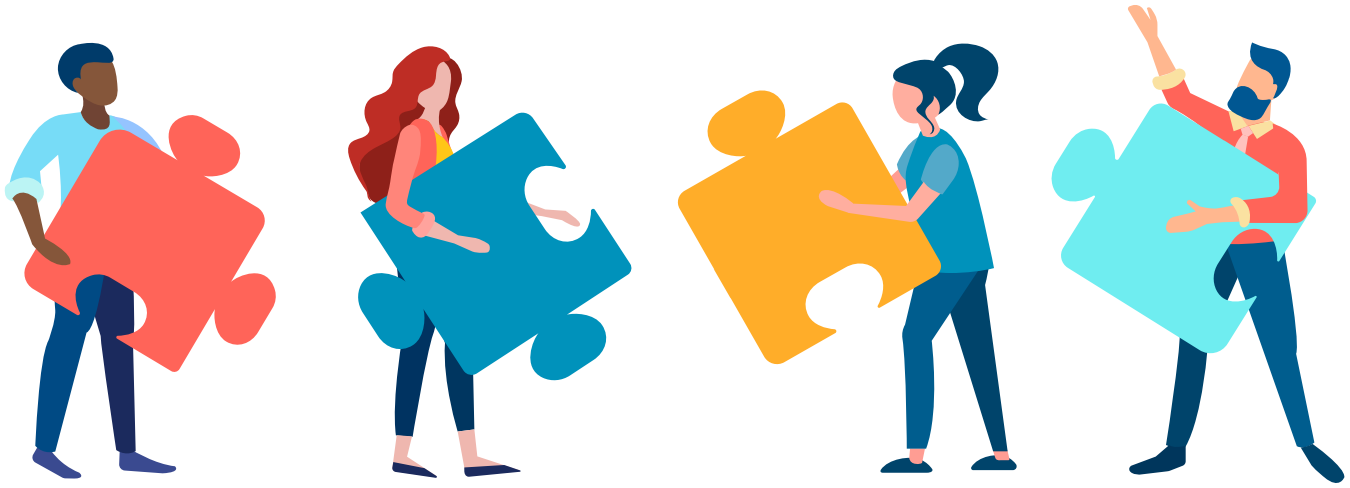


[3] American Cancer Society. Cancer Treatment & Survivorship Facts & Figures 2019-2021. Atlanta: American Cancer Society; 2019.

STEP 1
Engage Key Partners

Engage experts and organizations that focus on cancer risk factor reduction and those who focus on issues and concerns of cancer survivors. Include representatives from your populations of focus. Work with partners to leverage existing resources and adapt them for cancer survivor needs. Key Partners can be engaged in a variety of processes, such as looking at data; identifying objectives and strategies; setting priorities for the upcoming five years; and/or reviewing drafts. Some partners to engage include:

- Academic researchers studying cancer survivorship and reducing cancer health disparities in survivors
- **American Cancer Society**
- Behavioral health programs and partners, including tobacco and alcohol use programs supported by the **Substance Abuse and Mental Health Services Administration (SAMHSA)**
- Cancer centers, specifically outreach and education staff and survivorship clinics/ programs
- **Cancer Support Community**
- Cancer survivor support programs
- Cancer survivors, especially those in your populations of focus
- Trusted community leaders with experience addressing health inequities in your community (e.g., people of color, people with disabilities, LGBTQ populations)
- Dieticians
- **LIVESTRONG**
- Local fitness centers and instructors
- Nutrition, physical activity, and obesity **programs** and coalitions
- Patient navigators
- Primary care providers
- **Tobacco control programs** and coalitions, including **state quitlines**
- Worksite wellness programs and employers
- **YMCA**



STEP 2
Identify and Use Data to Guide Plan Update

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

- Identifying groups at higher risk of cancer, such as those with high rates of tobacco use, alcohol use, and obesity. It is helpful to examine this risk factor data by sex, race/ethnicity, health insurance status, geographic area, sexual orientation, and gender identity.
- Further identifying risk factor data in cancer survivors. If your Behavioral Risk Factor Surveillance System (BRFSS) does not include the optional Cancer Survivorship Module (you can **look here** to see if Survivorship Questions have been included in your BRFSS in recent years), ask your BRFSS colleagues if they are able to perform a query to inform your planning. For those who answered "yes" to the BRFSS Core question "Has a doctor, nurse, or other health professional EVER told you that you had cancer?", review the rates of obesity, overweight, smoking, sedentary lifestyle, etc.
- Identifying progress in addressing cancer risk factors and trends over time to identify specific areas for focus.
- Identifying availability and type of providers, services, and support programs that can help address cancer risk factors in different geographic areas and within population groups, including cancer survivors. This type of information will help inform the selection of 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).

It is best to use data from your own state, tribe, or territory, but national data can help you set goals by allowing you to compare your data with other locations and the nation as a whole.

Local data sources:

- **BRFSS** includes data on risk factors and cancer survivorship (check to see if survivorship has been included in the BRFSS survey).
- **County Health Rankings** from the Robert Wood Johnson Foundation include county- and state-level data on several cancer risk factors.
- Central cancer registry: **National Program of Cancer Registries (NPCR)** and **Surveillance, Epidemiology, and End Results (SEER)**
- 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.
- Programmatic data from cancer centers and/or other health systems regarding risk factors within cancer survivors; these partners may be willing to share de-identified data about risk factors such as overweight, obesity, or tobacco use among survivor populations within their catchment areas.

National data sources:

- **BRFSS**
- **Chronic Disease Indicators**
- **ACS Cancer Facts & Figures**
- **US Cancer Statistics**
- **State Cancer Profiles**
- **Cancer Trends Progress Report – Life after Cancer**
- Cancer Support Community's **Cancer Experience Registry**

When working on risk factors for cancer survivors, **don't let lack of data hinder decision-making or progress**; use the best data available and, if appropriate, include strategies in your plan focused on collecting data or information to help make decisions about what to focus on in the future.

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 to help measure your progress in addressing cancer risk factors – rates of alcohol consumption, tobacco use, poor nutrition, physical inactivity, and obesity/overweight – based on your data, partner input, and local and national objectives.
- Identify priority areas or issues to address based on data in specific populations or geographic areas.
- For cancer risk factors, it is very important to consult other chronic disease risk factor plans to help align baselines and goals. Consult **Healthy People 2030**, your health department's chronic disease plan, tobacco control plan, nutrition/physical activity/obesity plans, and **BRFSS data** to see what baselines and goals are already being used by your partners. Talk to subject matter experts regarding how you might modify these goals for your cancer survivor population. Remember to cite your data sources.

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.

To address cancer risk factors, some CCC coalitions may create a general population objective (e.g., overall reduction in adult alcohol consumption) and then create a strategy that is specific to cancer survivors, especially if data specific to cancer survivors for a particular cancer risk factor are not available.

Examples of primary objectives:

- By 2025, reduce the number of adults aged 18 years and older who have ever been diagnosed with cancer and report that poor physical or mental health kept them from doing their usual activities, such as self-care, work, or recreation, on 14 or more of the past 30 days from 25% to 20% (BRFSS).
- Decrease the obesity rate among cancer survivors from 66% to 60% by 2025 (BRFSS).
- Among adults ever diagnosed with cancer, increase the number who report consuming fruits and vegetables five or more times per day from 16% to 18% by 2025 (unless contra indicated by their healthcare provider) (BRFSS).
- By 2025, decrease the percentage of adults (aged 18 years or older) who report heavy or binge drinking within the past 30 days from 24% to 20% or less (BRFSS).
  - Specific cancer survivor strategy linked to this general population objective: Promote alcohol behavioral counseling referrals and interventions for cancer patients who continue to use alcohol at any stage during and after cancer diagnosis.

Examples of complementary health equity objectives and objectives addressing social determinants affecting health:

- By 2025, increase the percentage of cancer survivors residing in rural counties who report they were referred to a quitline from 60% to 70% (BRFSS).
- Reduce the percentage of low income (less than $35,000 annual income) adults who currently smoke from 26% to 21% by 2025 (BRFSS).
- By 2025, increase the percentage of Hispanic and Black participants in LIVESTRONG at the YMCA programs from 5% to 15% in our state (YMCA program records).
- 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 healthy survivorship interventions in a trusted setting identified by our population of focus.
- By 2025, establish commitments from 10 primary care clinics and/or Federally Qualified Heath Centers in our state to modify clinic hours to offer evening appointments.

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, such as existing lifestyle intervention and survivorship programs. Also consider 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.

The following strategies are examples of evidence-based strategies found in CCC plans related to addressing risk factors in cancer survivors. Be intentional about tailoring your chosen strategies to reach both the general population AND your population of focus.

- Train health systems providers to assess, advise, and refer cancer survivors to physical activity programs and to utilize ”exercise prescriptions” to improve fatigue, anxiety, depression, physical function, and quality of life.
- Promote alcohol behavioral counseling referrals and interventions for cancer patients who continue to use alcohol at any stage during and after cancer diagnosis, with a particular focus on LGBTQ populations who have historically used at higher rates.
- Collaborate with YMCAs across the state to increase participation in the **LIVESTRONG at the YMCA** program for cancer survivors through increased provider referrals and promotion through survivor support groups.
- Provide assistance to the largest employers in the state to incorporate and promote evidence-based obesity, nutrition, and physical activity interventions into worksite wellness programs, with a specific focus on cancer survivors.
- Work with community partners and leaders to increase access to affordable, healthy foods in communities and places of work.
- Work with the state health department’s **Nutrition and Physical Activity/Obesity Prevention Program** to increase use of technology-supported multicomponent coaching and counseling interventions aimed at reducing weight/maintaining weight loss among cancer survivors.
- Advocate for funding to add survivorship analytics to the Behavioral Risk Factor Surveillance Survey.

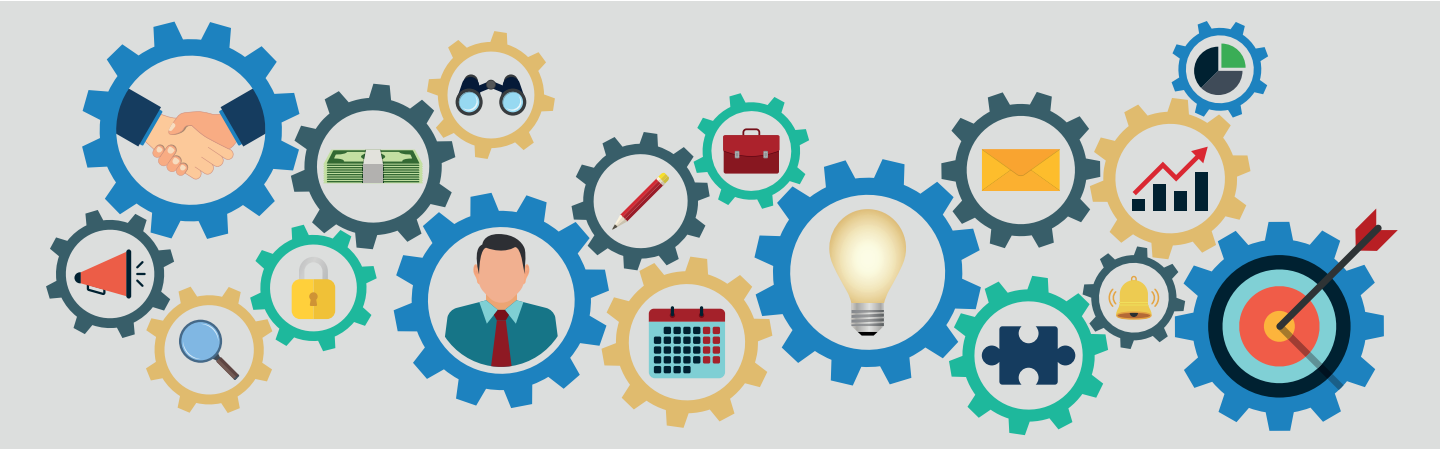
You can find evidence-based interventions from the following sources:

- **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 **Cancer Prevention and Control Research Network (CPCRN) site**, including the training “**Putting Public Health Evidence Into Practice**.”

More Resources to Address Risk Factors for Cancer Survivors

- **National Cancer Survivorship Resource Center** is a collaboration between the American Cancer Society and the George Washington University Cancer Center funded by a five-year cooperative agreement from the Centers for Disease Control and Prevention and includes resources and tools for health care providers, patients and caregivers, and policy and advocacy communities.
- **The National Cancer Survivorship Resource Center Toolkit: Implementing Clinical Practice Guidelines for Cancer Survivorship Care** provides resources to help with implementing American Cancer Society cancer survivorship care guidelines for colorectal, head and neck, and prostate cancers and the American Cancer Society/American Society of Clinical Oncology cancer survivorship care guideline for breast cancer.
- **ACS Nutrition and Physical Activity Guidelines for Cancer Survivors** discuss nutrition and physical activity recommendations during the continuum of cancer care, focusing largely on the needs of individuals who are disease free or who have stable disease following their recovery from treatment.
- The National Cancer Institute (NCI) **Office of Cancer Survivorship** offers several resources specifically for cancer survivors, including **Health and Well-Being After Cancer** resources.
- **National Comprehensive Cancer Network (NCCN) Survivorship Guidelines for Healthy Lifestyles** includes guidelines for health care providers and survivors.
- The **Advancing Patient-Centered Cancer Survivorship Care Toolkit** was developed by the GW Cancer Center to support training and technical assistance from Comprehensive Cancer Control Programs/Coalitions to health care providers/organizations in order to improve patient-centered cancer survivorship care in their state, tribe, or territory.
- CDC's **Talk to Someone Simulation** features an avatar, Linda, who gives advice related to risk reduction for cancer survivors; also included is a guide for providers about how to use the tool.
- CDC's **A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease includes strategies for tobacco-free living, healthy food and beverage, and active living.**
- 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 Comprehensive Cancer Control National Partnership offers a **compilation of resources** to address health behaviors for cancers survivors.



Worksheet: Questions to Ask and Answer

Use this worksheet to help you and your 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 addressing **cancer risk factors** (alcohol consumption, tobacco use, poor nutrition, physical inactivity, obesity/overweight) for the general population and/or cancer survivors compared to the national rates, our neighboring states, and our own rates in previous years? What are existing objectives for cancer-related risk factor programs, coalitions, or plans (e.g., tobacco or nutrition/physical activity plans) that we can adopt or adapt for cancer survivors?

   - What primary objectives do we want to set given our analysis of this data and other risk factor plan objectives?

2. What specific populations or communities are not seeing improvements in **cancer risk factor** reduction rates for the general population or cancer survivors? 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 and other cancer risk factor plan objectives?

3. How can we partner with existing chronic disease **risk factor** programs and efforts in our state?

- What strategies should we select given the answers to this question? What is the CCC coalition's "value added" effort, especially around adapting strategies for cancer survivors?

4. What other partners can we engage to help implement policy and system changes to support a reduction in **cancer risk factor** rates for cancer survivors 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 add" 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?

5. Are **cancer risk factor** reduction services easily accessible to all populations and specifically to cancer survivors? Is there a geographic area (e.g., rural counties) or subpopulations with greater barriers to accessing services?

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

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

6. What existing services, networks, or programs could we leverage to reduce **cancer risk factors** among cancer survivors?

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

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

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

- Are people most affected engaged in planning the solutions?

8. What **cancer risk factor** reduction policies or systems changes do we want to advocate for or promote for the general population and/or cancer survivors?

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

9. What gets measured is what gets done: How can we best track **cancer risk factor** outcomes for cancer survivors? How do we know we are making progress along the way?

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

10. What is the unified message that we share with policymakers regarding our recommendation for reducing **cancer risk factors** in the general population and/or cancer survivors? And how do we share with policymakers?

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

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