Preface

The *North Carolina Comprehensive Cancer Control Plan 2014-2020: A Call to Action* was developed by a large and diverse group dedicated to saving lives and improving the quality of life for North Carolinians affected by cancer. The effort to reduce the cancer burden in North Carolina will require a coordinated and collective effort of communities, public and private organizations and individuals. Representatives of the North Carolina Advisory Committee on Cancer Coordination and Control; North Carolina Cancer Partnership; North Carolina Department of Health and Human Services; Division of Public Health; Cancer Prevention and Control Branch and many others interested in reducing the cancer burden in North Carolina are listed in Appendix H.
Dear Fellow North Carolinians:

We are pleased to share the North Carolina Comprehensive Cancer Control Plan 2014-2020: A Call to Action. Cancer has been the leading cause of death in North Carolina since 2009. We are all affected by cancer, and it has an enormous economic, physical and emotional impact on North Carolinians. The purpose of this Cancer Plan is to reduce the cancer burden in our state.

This Cancer Plan is organized using the cancer continuum: prevention, early detection, care and treatment and focuses on six specific cancers: lung, colorectal, breast, prostate, cervical and melanoma. It does not have detailed cancer information, so comprehensive references are provided in the Appendices. An interdisciplinary collaboration of professionals from across the state designed this plan to provide a framework for cancer prevention and control.

We hope that public health and healthcare agencies, community organizations and individuals across North Carolina will benefit from using this Cancer Plan as they work together to address cancer prevention and control. One part of the Plan entitled: “Everyone Has A Part to Play in the Fight Against Cancer” describes specific strategies for individuals, community organizations, schools, businesses, healthcare professionals and policy makers.

We hope you find the Cancer Plan useful in your efforts to make a difference in the fight against cancer in North Carolina.

Regards,

Dr. Tom Shea, Chair
North Carolina Advisory Committee on Cancer Coordination and Control
5505 Six Forks Road Raleigh, NC 27609

M I S S I O N : To facilitate the reduction of cancer incidence and mortality for all North Carolinians, enhance statewide access to quality treatment and support services, and maximize quality of life for all North Carolina cancer survivors, patients, and their loved ones through educating and advising government officials, policy makers, public and private organizations, and the public.

N. C. DHHS is an equal opportunity employer and provider
Executive Summary

North Carolina Comprehensive Cancer Control Plan 2014-2020: A Call to Action (Cancer Plan) is a statewide blueprint for cancer prevention and control in North Carolina. The Cancer Plan was developed through a collaboration of an interdisciplinary team of individuals who devoted many hours to designing a plan that is specific to the particular needs of North Carolina. Cancer has been the leading cause of death in North Carolina since 2009. As such, it has a huge psychological, social and economic effect on individuals and the state.

The overarching purpose of the Cancer Plan is to reduce the morbidity and mortality associated with cancer in our state. There are five goals that are designed to help achieve this. They are preventing new cancers, detecting cancer at its earliest stages, treating all cancer patients with the most appropriate/effective therapy, enhancing the quality of life for every person affected by cancer and reducing cancer-related disparities in North Carolina. The six specific cancers that are the focus of this Cancer Plan are lung, colorectal, breast, prostate, melanoma and non-melanoma skin cancers and cervical cancer. In order to meet our goals, the Cancer Plan has specific objectives and strategies to address the cancer continuum and the six specific cancers. It also describes evaluation strategies to measure progress towards meeting our goals.

**Prevention:** The Cancer Plan focuses on behaviors, policies and environmental changes that can reduce North Carolinians’ cancer risk. After describing the behaviors that place people at risk for cancer, the Cancer Plan provides guidance on ways to lower these risks by adopting healthy behaviors and promoting environmental changes. Recommendations made are for both individuals and organizations/systems.

**Early Detection:** The focus of early detection is on promoting and delivering cancer screenings based on the guidelines and recommendations of the N.C. Advisory Committee on Cancer Coordination and Control. An emphasis in this area is on reaching people most at risk and those with limited access to screenings.

**Care and Treatment:** The Cancer Plan provides guidance on ways to improve access to care, enhance care coordination and assure quality treatment for all cancer patients and their families. It describes professional and public education strategies that will provide information on patient navigation systems, cancer clinical trials and appropriate services for palliation and survivorship services.

Woven throughout this Cancer Plan are ways to address disparities in cancer among populations experiencing a disproportionate burden of disease, disability and death. It is critically important that we reach underserved populations with cancer prevention, early detection and treatment messages and services.
Everyone has a part in the fight against cancer. The grid on page 28 describes ways that individuals, community organizations, healthcare professionals and policy makers can help prevent, detect and treat cancer. It also suggests ways to advocate for policy changes that reduce the risks for cancer and promote good care for those with the disease.

This Call to Action is designed to address the barriers to cancer prevention and care while outlining a plan of action. The action plan will be implemented by a diverse partnership of North Carolina cancer programs, organizations and individuals in order to assure North Carolinians timely and equitable access to healthcare throughout the cancer care continuum. We hope you find this a useful tool.
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The 2014-2020 North Carolina Comprehensive Cancer Control Plan (Cancer Plan) provides not only current cancer information for North Carolina but also provides a framework for action to reduce the effects of cancer. Cancer is a complicated disease with many different signs and symptoms. Nearly everyone knows someone who has been affected by cancer – a friend, family member, coworker or neighbor. Maybe you have had cancer or have been a caregiver for someone who has cancer.

According to the North Carolina Central Cancer Registry 2011 data, approximately 140 people in North Carolina are newly diagnosed with cancer every day. Another 50 people lose their lives daily to this disease.¹

The Cancer Plan is not intended to provide in-depth cancer information. This information can be found in the resources listed in the Appendices. Instead, it serves as a working guide to help public health and healthcare groups, community organizations, institutions, agencies and individuals across North Carolina work together to address cancer prevention and control.

The purpose of the Cancer Plan is to reduce the cancer morbidity and mortality in North Carolina. The overarching goals are to prevent future cancers, detect cancer at its earliest stages, treat all cancer patients with the most appropriate and effective therapy, enhance the quality of life for every person affected by cancer and reduce cancer-related disparities in North Carolina.

Cancer Plan Organization

The Cancer Plan is organized using the cancer continuum: prevention, early detection and care and treatment. It also emphasizes six specific cancers:

- the four most deadly cancers (lung, colorectal, breast and prostate),
- the most common cancers (melanoma and non-melanoma skin cancers) and
- the cancer that can be prevented through vaccination and early detection: cervical cancer.

The sections have information specific to North Carolina and the priority cancers discussed. The Appendices contain detailed cancer information and resources. The Cancer Plan with accompanying information and a community brochure that can be copied and used locally, are available on the N.C. Division of Public Health, Chronic Disease and Injury Section Web site located at http://publichealth.nc.gov/chronicdiseaseandinjury.

History

North Carolina’s commitment to cancer prevention and control dates back to 1945 when the leadership from the N.C. Medical Society and the American Cancer Society (ACS) worked with the North Carolina General Assembly to pass the Cancer Control Act of 1945. This legislation created the first Cancer Control Program in the nation and originally included funding to assist indigent cancer patients.

Legislation was passed in 1993 to create the N.C. Advisory Committee on Cancer Coordination and Control (Advisory Committee)
Evaluation, Surveillance and Research Subcommittee
This subcommittee conducts an assessment of partners' activities in meeting the goals and objectives related to the Cancer Plan. The subcommittee provides surveillance in the monitoring and review of the data regarding the health of North Carolinians. This subcommittee also assists with research for position statements, provides data for the Cancer Plan and assists with writing white papers.

Legislation and Education Subcommittee
This subcommittee recommends policies on cancer-related issues. The subcommittee is made up of legislators and Advisory Committee members, with the Advisory Committee Co-Chair serving as an ex-officio member.

The N.C. Cancer Prevention and Control Branch (Branch) provides staff for the Advisory Committee. (See Appendix A for Branch Information) The Branch
focuses on prevention, screening and early detection, treatment and survivorship, as well as education efforts. They emphasize the importance of evidence-based measures to ensure that effective programs and policies are implemented to make efficient use of limited resources.

N.C. Cancer Partnership

The N.C. Cancer Partnership, a larger group of interested cancer survivors, organizations, individuals and professionals assists the Advisory Committee with its work. All members of the Advisory Committee, N.C. Cancer Partnership and Branch will work toward implementation of this Cancer Plan.
Between 2008 and 2012, there were over 89,500 cancer deaths. Nearly 18,412 of those deaths occurred in 2012.
Cancer has been the leading cause of death in North Carolina since 2009.\(^1\) Between 2008 and 2012, there were over 89,500 cancer deaths. Nearly 18,412 of those deaths occurred in 2012.\(^1\) Nationally and in North Carolina, cancer is the leading cause of death among 45-64 year olds, and the second leading cause of death for people 65 and over.\(^1,2\) In 2010, the North Carolina age-adjusted death rate for cancer, 177.8 per 100,000, was higher than the 2010 national rate, 171.8 per 100,000.\(^3\) 2010 is the most recent national data.

Cancer has a huge economic effect on individuals, the state and the nation. According to the National Institutes of Health (NIH), total cancer care cost the United States an estimated $125 billion in 2010.\(^4\) During the same period, the average cost per cancer case in North Carolina was $41,401.\(^5\) This total does not account for indirect costs due to lost productivity from illness and premature death. It is estimated that in 2010 North Carolinians under the age of 75 lost an average of 8.2 years of life due to cancer.\(^6\) (See Appendix F for a series of maps showing cancer mortality and incidence rates by county)

### Priority Cancers

**Lung cancer** has been the leading cause of cancer deaths in North Carolina for over two decades. Between 2008 and 2012, over 27,000 deaths were due to lung cancer in North Carolina. Of those, nearly 5,454 lung cancer deaths occurred in 2012.\(^1\) According to the 2014 Surgeon General’s Report, 87 percent of lung cancer deaths are preventable. Survival rates (20%) for lung cancers are poor.\(^7\)

ACS reports that lung cancer death rates began declining in 1991 in men and in 2003 in women. From 2006 to 2010, rates decreased 2.9 percent per year in men and 1.4 percent per year in women. This gender difference in lung cancer deaths reflects historical differences in patterns of smoking uptake and cessation over the past 50 years.\(^8\)

**Colorectal cancer** was the second leading cause of cancer deaths in North Carolina in 2012. There were 1,533 colorectal cancer deaths in 2012 and over 7,550 deaths from 2008-2012 in North Carolina.\(^1\) According to the 2012 Behavioral Risk Factor Surveillance System (BRFSS), 70.6 percent of North Carolina adults over age 50

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**N.C. Cancer Burden and 2014-2020 Priorities**

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Cervical cancer (female only) was responsible for about 0.6 percent of all cancer deaths in North Carolina in 2012. There were 117 cervix uteri (cervical) cancer deaths in 2012 and over 560 deaths from 2008-2012 in N.C.1 Cervical cancer can be prevented by HPV vaccine and detected through Pap test screening and the HPV test. If detected, early treatment of pre-cancerous conditions can prevent cervical cancer. In 2012, 35.5 percent of girls and 8.6 percent of boys ages 13-17 in North Carolina completed three or more doses of the HPV vaccine.11

Melanoma skin cancer was responsible for 72.8 percent of all North Carolina skin cancer deaths in 2010. There were 289 melanoma cancer deaths in 2012 and over 1,479 deaths from 2008-2012 in the state. The rate of new melanoma diagnoses is rising rapidly—with an average increase of more than five percent per year from 1995 to 2011.1

Breast cancer (female only) was the third leading cause of cancer deaths among North Carolina females in 2012. There were 1,286 female breast cancer deaths in 2012 and over 6,350 deaths from 2008-2012.1 According to the 2012 BRFSS, 66.6 percent of North Carolina women reported, “ever having had a mammogram.”9 Between 2007 and 2011, 95 percent of women in North Carolina diagnosed in the earliest stage of breast cancer survived five years compared to 34 percent diagnosed in the advanced stages. Early detection saves lives.10

Prostate cancer (male only) was the fifth leading cause of cancer deaths among males in North Carolina in 2012. There were 844 prostate cancer deaths in 2012 and over 4,350 deaths from 2008-2012 in the state.1 Prostate cancer death rates have been decreasing since the early 1990s in men of all races and ethnicities, although they remain more than twice as high in African Americans as in any other racial or ethnic group.8 In 2012, 31.6 percent of men were told by a health professional of the advantages and disadvantages of a Prostate-Specific Antigen (PSA) test, a blood test used to check men for prostate cancer.9 Almost 60 percent (58.9 %) of men in the same group stated they had “ever had a PSA test.”9

The two cancers discussed below are not in the top ten causes of cancer deaths in North Carolina but are important to North Carolinians for different reasons. Cervical cancer is included because it is preventable through the use of Human Papillomaviruses Vaccine (HPV). It can also be easily detected through screening and treated in early stages. Melanoma and other skin cancers are included because they are the most common cancers.

Pancreatic cancer was the fourth cause of North Carolina cancer deaths in 2012.1 In 2012, there were 1,175 pancreatic cancer deaths. It is not included in this Cancer Plan since there currently are no established guidelines for preventing pancreatic cancer and no screening tests.

Childhood and Adolescent cancer
According to the National Cancer Institute (NCI), cancer is the leading cause of death by disease among United States children between infancy and age 14. The causes of most childhood cancers are unknown, and for the most part they cannot be prevented. The major types of childhood cancers are

Breast cancer

Pancreatic cancer

Prostate cancer

Childhood and Adolescent cancer
leukemia, lymphoma, brain and other central nervous system tumors. These account for more than half of new cases of childhood cancer. White and Hispanic children are more likely than children from any other racial or ethnic groups to develop cancer.  

Although cancer is not as common in adolescents and young adults (AYA) as in adults, there are certain cancers that affect this group. These include lymphoma, thyroid, brain and central nervous system cancers. AYA cancer patients are a special group with unique challenges. Among those are the need for school and career counseling, fertility counseling and fertility protecting services, genetic counseling and AYA-specific psychosocial support.

Unequal Burden in North Carolina

Health Disparities

NCI defines health disparities as differences in the incidence, prevalence, mortality and survival of a disease and the related adverse health conditions that exist among specific population groups including:

- racial and ethnic minorities;
- residents of rural areas including Southern Appalachia;
- lesbian, gay, bisexual and transgender people;
- older people,
- people with disabilities;
- people with low incomes and
- people who are uninsured.

Across all chronic health conditions, health disparities exist. Cancer is no different. It is critical to work effectively with communities to eliminate all disparities. This Cancer Plan addresses disparities in cancer among populations experiencing a disproportionate burden of disease, disability and death through prevention, early detection, care and treatment.

Health Equity

Health equity occurs when every person has the opportunity to attain his or her full health capability and no one is blocked from achieving this capability because of his or her social position or circumstances. The World Health Organization states, “These circumstances are shaped by the distribution of money, power and resources, which are themselves influenced by policy choices.” The goal is to achieve the highest level of health possible for all groups. Research shows health outcomes for minorities –

| North Carolina Cancer Incidence and Mortality Rates by Race and Gender per 100,000 Population Age-Adjusted to the 2000 US Census** |
|---------------|---------------|---------------|---------------|---------------|---------------|
|               | White Males   | White Females | Minority Males| Minority Females| Total         |
| Cancer Mortality Rate 2012¹⁴| 203.1          | 138.5         | 245.3         | 155.4         | 170.5         |
| Cancer Incidence Rate 2011¹⁵| 521.9          | 444.4         | 550.6         | 424.2         | 476.7         |

** Note: The N.C. State Center for Health Statistics often publishes data by race for only two groups: white and minority. The State Center recognizes and appreciates the various population groups in North Carolina and the need for more details on race. A number of factors have hampered efforts to obtain accurate data on minority populations.
African Americans, American Indians and Hispanic/Latinos – are worse than for Whites. Social and economic factors such as income, education, racism, housing, employment, food accessibility, transportation and the environment are key components in determining an individual’s health status. Therefore, it is necessary to address these underlying factors in order to improve the health status of individuals and eliminate health disparities.

**Health Equity Recommendations**

These health equity recommendations to reduce health disparities in general are adapted from the Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials.18

- **Identify/build** strategic partnerships with community organizations in a variety of settings to address social determinants of health such as employment, transportation, housing and public policy initiatives.

- **Build** community empowerment to address health disparities at the local level.

- **Encourage** alternative ways of thinking about public health practice, such as dialogues on the impact of structural racism on health.

- **Advocate, encourage and support** diversity within the workforce at all levels and positions.

- **Increase** funding for the development of initiatives for addressing health disparities and creating health equity.

**Specific Cancer Recommendations**

The following recommendations are designed to specifically reduce disparities in cancer.

- **Improve** early detection through routine screenings.

- **Implement** evidence-based community interventions designed to improve the health of minority populations.

- **Use** a variety of culturally competent media to market cancer information to diverse populations in a variety of settings.

- **Educate** about the benefits of increased access to care for underserved populations to include:
  - healthcare coverage,
  - increased funding for preventive screening programs, such as Breast and Cervical Cancer Control Programs (BCCCP) and colorectal screening programs and
  - increased access to nutrient dense foods through the elimination of food deserts.

- **Develop** research projects to study the differences in participation in, and results from, cancer prevention and care clinical trials between minority/ethnic and other population groups.

- **Increase** funding for preventive cancer screening programs.

- **Increase** access to nutrient dense foods through the elimination of food deserts.
Access to Cancer Care

Differences in survival between population groups are influenced by many different factors.

Lack of Medical Coverage

People with little or no health insurance coverage have a serious problem getting care. The North Carolina Institute of Medicine report, Healthy North Carolina 2020 states there are an estimated 1.7 million uninsured individuals under the age of 65 living in North Carolina. People with little or no health insurance are more likely to be diagnosed with cancer at later stages and, thus, have less chance of cancer survival.

Unequal Access to Cancer Prevention, Early Detection and Treatment

Many North Carolinians face additional financial and physical barriers to receiving preventive health care and health education as well as treatment for existing health problems.

Lack of transportation and insufficient resources are major barriers to health care in North Carolina’s rural communities where access to primary care physicians may be very limited.

The United States Census Bureau reports that between 2008 and 2012, 16.8 percent of North Carolinians were living in households whose income was at or below the federal poverty level. In 2012, approximately 22.7 percent of North Carolinians lived in rural areas.

Many cancer centers and doctors across North Carolina provide cancer care and treatment to rural patients close to home. However, the need for specialized care or treatment away from home is needed sometimes for rare kinds of cancer or late-stage cancers. North Carolina has several nationally recognized cancer centers that can give that specialized care. However, care at these centers often requires traveling long distances, a particular challenge for low-income people.

(See Appendix C for information on cancer hospitals)
The cancer continuum, which includes prevention, early detection, care and treatment and survivorship, is a useful framework to view plans, priorities and progress as well as identifying research and resource needs.
The Cancer Plan is designed to address the barriers to cancer prevention and care while outlining a plan of action for cancer programs, community organizations, policy makers and individual North Carolinians.

The overarching goals of the Cancer Plan are:

- **Prevent** new cancers.
- **Detect** cancer at its earliest stages.
- **Treat** all cancer patients with the most appropriate/effective therapy.
- **Enhance** the quality of life for every person affected by cancer.
- **Reduce** cancer-related disparities in North Carolina.

In order to meet these goals, the Cancer Plan has specific objectives and strategies to address the cancer continuum, the six specific cancers, cancer surveillance and plan evaluation.

The cancer continuum, which includes prevention, early detection, care and treatment and survivorship, is a useful framework to view plans, priorities and progress, as well as identifying research and resource needs.

The Action Plan will be implemented by a diverse partnership of North Carolina cancer programs, organizations and individuals in order to assure North Carolinians timely and equitable access to healthcare throughout the cancer care continuum.
Cancer Risk and Protective Factors

Risk Factors
Risk factors increase a person’s chances of developing cancers. In addition to the risk factors listed in the chart, additional factors are growing older and gender. Risk factors such as growing older, gender and family history of cancer are beyond a person’s control. However, knowledge of family history may help with early detection of cancers with a strong genetic link. Cancers known to run in families include melanoma skin cancer and cancers of the breast, ovary, prostate and colon.

Protective Factors
For cancers without a known genetic link, a person can significantly lower his or her risk by adopting protective healthy behaviors and improving the environments where he or she lives. Both risk and protective factors are discussed in the following pages.

Specific Risk Factors’ Relationship to Priority Cancers

<table>
<thead>
<tr>
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<th>Colorectal</th>
<th>Breast</th>
<th>Prostate</th>
<th>Cervical</th>
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Cancer Risk Associated with Poor Nutrition, Physical Inactivity, Overweight and Obesity

About one third of the most common cancers in the United States can be prevented by a healthy diet, physical activity and weight management according to the American Institute of Cancer Research.\textsuperscript{22}

Overweight and Obesity

The percentage of overweight and obese adults and children has increased markedly over the past few decades. In North Carolina, more than two-thirds of adults are overweight or obese.\textsuperscript{24}

Almost one third of North Carolina’s children ages 10 to 17 are overweight or obese.\textsuperscript{18} High rates of overweight and obesity in the state and nation cause decreases in life expectancy, productivity and quality of life.

A healthy weight depends on a person’s height so recommendations for a healthy weight are often expressed in terms of body mass index (BMI). BMI is a number that is calculated using both weight and height. (See Appendix D for Body Mass Index Chart)

Poor Nutrition, Physical Inactivity and/or Overweight/Obesity increases the risk for these cancers:\textsuperscript{22}

- breast
- prostate
- liver
- colorectal
- esophageal
- kidney
- stomach
- lung
- pancreas
- endometrial (uterine)
- mouth, pharyngeal
- and laryngeal

In general, the higher the number, the more body fat a person has, although there are exceptions. BMI in a range from 18.5 to 24.9 is considered healthy. Persons who have a BMI range from 25.0 to 29.9 are considered overweight. A BMI of 30 or greater indicates that the person is obese.\textsuperscript{7}

Physical Activity and Healthy Eating

Physical activity and healthy eating are risk factors for cancer independent of healthy weight. The 2008 Physical Activity Guidelines for Americans notes that physically active people have a significantly lower risk of colon cancer than inactive people do. Physically active women have a significantly lower risk of breast cancer. In addition, cancer survivors have a better quality of life if they are physically active compared to survivors who are inactive.\textsuperscript{23}

The American Institute for Cancer Research recommends meeting physical activity and healthy eating recommendations in addition to maintaining a healthy body weight.\textsuperscript{22}

All adults should avoid inactivity. Some physical activity is better than none at all.
Core Behaviors to Reduce Overweight and Obesity

Increase Physical Activity
A pattern of regular physical activity beginning in childhood or adolescence is critical for lifelong weight management. Physical activity burns calories both during and after activity. Physical activity should consist of not only aerobic activities that get the heart pumping, such as walking or bicycling, but also activity that strengthens muscles and bones and increases flexibility.

Eat More Fruit and Vegetables
Fresh fruits and vegetables are low in calories and high in vitamins, minerals, fiber and antioxidants. A diet with lots of fruits and vegetables is higher in volume and fiber while being lower in calories.

Eat Less Red and Processed Meats
High intake of processed meats such as bacon, sausage, lunchmeats and hot dogs are linked to an increase in colorectal cancer incidence and mortality. Prepare meats by baking, broiling or poaching rather than by frying or chargrilling. Cooking meats at high temperatures can cause the formation of toxins that have been shown to cause cancer in animals.

Drink Less Sugar-Sweetened Beverages
Reduce the number of sugar-sweetened beverages, including soda, sweet tea, energy drinks and sports drinks. These beverages provide calories with little or no nutritional value.

Decrease Television Viewing and Screen Time
Reduce television and screen time so there is more time for physical activity. This also reduces exposure to advertisements for foods that are high in fat and sugar.

Eat Less Energy-Dense Foods
Reduce the number of calorie-rich foods such as packaged snack foods; frosted cakes, cookies and candies; cheeseburgers; fried chicken; French fries and doughnuts. Foods that are energy-dense contain a large number of calories, mostly from fat and sugar. Decreasing the portion sizes of these foods reduces calories.

Adult Physical Activity Guidelines

• Adults should do at least 2½ hours (150 minutes) of moderate-intensity or 1¼ hours (75 minutes) of vigorous-intensity aerobic physical activity per week.

• Adults should also do muscle-strengthening activities that are moderate or high intensity and involve all major muscle groups on 2 or more days a week.

Note: U.S. Department of Health and Human Services, 2008 Physical Activity Guidelines for Americans

Encourage Breastfeeding
Promote breastfeeding to increase healthy nutrition for infants, and decrease the risk of childhood obesity. Some studies suggest that breastfeeding may slightly lower breast cancer risk in mothers.

(For additional North Carolina information see North Carolina’s Plan to Address Obesity: Healthy Weight and Healthy Communities 2013-2020 at http://www.eatsmartmovemorenc.com/ESMMPlan/ESMMPlan.html)
Cancer Risk Associated with Tobacco Use and Exposure to Secondhand Smoke

Tobacco use is the number one preventable cause of premature death and disease in North Carolina and the nation. Annual North Carolina medical costs incurred from smoking are $3.8 billion.¹

In the United States, tobacco use is responsible for:
- nearly 20 percent of all deaths,
- at least 30 percent of all cancer deaths and
- 87 percent of lung cancer deaths.⁸

Smoking

In North Carolina, more than 12,200 people die each year due to smoking. Lung cancer is the leading cause of cancer death in North Carolina and the United States for both men and women.³

Survival rates

Survival rates for lung cancer are among the lowest of all cancers despite medical developments in its diagnosis and treatment. The national five-year survival rate for lung cancer in 2003-2009 was 17 percent, a rate that has barely changed for more than 20 years.⁸ In North Carolina, the five-year observed survival rate for lung cancer is 20 percent.¹

Tobacco use increases cancer risk for:⁸

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<th>Cancer Site</th>
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<td>lung</td>
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<td>colon/rectum</td>
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<td>skin</td>
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<td>cervix</td>
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<td>acute myeloid leukemia</td>
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<td>uterus</td>
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</table>

Other tobacco products

Smokeless tobacco users have an increased risk of developing cancer of the oral cavity. There is no known safe form of tobacco use including e-cigarettes, snuff, chewing tobacco, cigars and hookahs.

Secondhand smoke

Nonsmokers die from lung cancer and heart disease and hundreds of thousands of children suffer from respiratory infections because of exposure to secondhand smoke. There is no risk-free level of exposure to secondhand smoke. Thus, for every one person who dies from smoking, 20 more suffer at least one serious tobacco-related illness.²⁶

Protection from Tobacco Exposure

Protect and promote the health of everyone by reducing tobacco use and exposure to secondhand smoke. This will reduce cancer incidence and prevalence, as well as help North Carolinians live longer, be more productive and have happier lives.

Key Strategies

Protect people from tobacco smoke

Create more smoke-free/tobacco-free spaces where people live, work, play and learn.

- Maintain a statewide smoke-free law for all North Carolina restaurants and bars.
Educate about the need for recurring state funding for a statewide media campaign to educate North Carolinians, particularly youth, about the harmful effects of tobacco use.

Enforce bans on tobacco advertising, promotion and sponsorship

- Maintain compliance with the NC Youth Access to Tobacco law so that North Carolina meets federal requirements to keep youth tobacco sales rates below 10 percent.
- Maintain activity under contract with the FDA to enforce the North Carolina’s requirements of the Family Smoking Prevention and Tobacco Control Act.

Raise the price of tobacco products through increased taxes on cigarettes and other forms of tobacco

- Educate and inform the public and decision-makers of the health and economic benefits of tobacco price increases to prevent young people from becoming addicted and to help tobacco users who want to quit.

Offer help to quit tobacco use

Encourage people who use any type of tobacco products to quit.

- Increase the number of healthcare systems that adopt clinical practice guidelines for treating tobacco use dependence, and make it a systematic part of clinical assessment, much like a vital sign.

Warn people about the dangers of tobacco use

- Promote evidence-based media campaigns and local interventions that educate about the harms and addictiveness of tobacco use, the dangers of secondhand smoke and the best practices to reduce tobacco use.
Cancer Risk Associated with Environmental Exposures

According to NCI, researchers have estimated that as many as 67 percent of cancer cases are linked to some type of environmental factor such as exposures to radiation, infectious agents and substances in the air, water and soil. Some workers may be exposed to cancer-causing chemicals and other substances in their workplaces.

Certain types of exposures are linked to specific cancers; for instance, radon exposure is linked to lung cancer.

**Radon** is a radioactive gas that cannot be seen, smelled or tasted. It is considered the primary cause of lung cancer for non-smokers. When released naturally from soil and rocks, it can accumulate and reach harmful levels when trapped in enclosed spaces such as homes, schools or other buildings. If detected, building modifications can be made to prevent the accumulation of high levels of radon. The N.C. Department of Health and Human Services Radon Program (ncradon.org) offers monitoring and mitigation guidance.

**Arsenic** is a naturally-occurring element found in natural rock formations. It is tasteless and odorless when it leaches into groundwater. Long-term exposures to high levels of arsenic have been linked with non-melanoma skin cancers, lung cancer and other types of cancer.

**Pesticides** are chemicals used to reduce or eliminate unwanted pests or weeds. Exposure to pesticides may occur through inhalation, skin contact and ingestion. Exposure to pesticides has been linked with prostate, breast, bladder, colon and other types of cancer.

**Low-level medical radiation** is commonly used for x-rays to diagnose broken bones and dental cavities. The risk of cancer from such radiation is considered very small since they are used infrequently and at very low doses.

**High-level medical radiation** is used to diagnose and treat certain types of cancer; it can increase cancer risk later in life.
Protection from Environmental Exposures

Minimize environmental exposures to radiation, chemicals and other toxic substances at home, schools, offices and the worksite.

Key Strategies

Check homes, buildings, and schools for high levels of radon
Test and monitor for elevated levels of radon. A radon reduction system may be installed to remove the radon trapped under the building and vent it to the atmosphere at a safe distance from the building.

Test well water for arsenic levels exceeding state and federal limits
Test according to North Carolina Well Water and Health schedule. If levels are elevated, seek assistance to treat water or use alternative source of safe drinking water.

Minimize or avoid use of pesticides and other chemicals

☐ Research and use alternative methods of pest control.

☐ Wear protective clothing, gloves and eye protection when working with pesticides or other chemicals. Work outside or in a well-ventilated area.

☐ Wash hands and clothes thoroughly after working with pesticides or other chemicals. Remove shoes outside the home.

☐ Wash fruits and vegetables thoroughly before eating. Select organic when possible.

Reduce exposure to diagnostic X-rays
Speak with your doctor about alternative diagnostic methods.

Cancer Risk Associated with Ultraviolet Radiation Exposure

UV radiation comes from the sun, sunlamps and tanning beds. It causes early aging of the skin and skin damage that can lead to skin cancer.

Protection from UV Exposure

Avoid exposure to ultraviolet radiation from the sun and other sources such as tanning beds.

Key Strategies

Protect the skin with sunscreen
Use a generous amount of sunscreen with a sun protection factor (SPF) of at least 30.

Avoid long periods of exposure to the sun
Especially avoid the sun between 10 a.m. and 4 p.m. when it is the strongest.

Wear protective clothing and sunglasses with UV protection
Protective clothing includes wide brimmed hats and tightly woven long sleeve shirts or clothing with sun protection embedded in it.8

Educate about the importance of a state law to protect minors from UV exposure at indoor tanning beds
Several measures have shown to decrease the use of tanning salons by adolescents:

☐ imposing an age limit or requiring parental permission,

☐ mandating salons to post the warning signs of tanning bed use and

☐ limiting advertisement.
Cancer Risk Associated with Viral Exposure

Human papillomaviruses (HPVs) infection is the main cause of cervical cancer. Tobacco use, long use of birth control pills and having given birth to three or more children are also risk factors for cervical cancer. HPV infection also may be a risk factor for other types of cancer such as oral cancers.

Protection from Viral Exposures

Since HPV is a major contributor to cervical cancer, there is a focus on the prevention and treatment of HPV. The HPV vaccine is proven effective in the prevention of many forms of HPV and can prevent cervical cancer as well as anal cancer, mouth and throat cancers, cancer of the penis in men and esophageal cancers in gay men.

Regular Pap tests can prevent cervical cancer by detecting cancer at an early stage, so successful treatment can begin early.

Key Strategies

Protect children with HPV vaccines

HPV vaccines are recommended for boys and girls starting around 11 to 12 years old until age 26, if appropriate.

Schedule regular Pap test screenings according to recommended guidelines to detect cancer early

(See Appendix B – Cancer Information Resources for cancer screening information)

Cancer Risk Associated with Alcohol Use

Drinking too much alcohol can increase the chance of developing cancers of the mouth, throat, esophagus, larynx, liver, breast, colon and rectum. Cancer risk increases with the amount of alcohol a person drinks.

Smoking alone is a known risk factor for some cancers. Smoking and drinking together intensifies the cancer-causing properties of each substance and poses an even greater risk. The risk of throat and mouth cancers is especially high because alcohol and tobacco both come in direct contact with those areas.

Protection from Alcohol Abuse

According to the American Institute of Cancer Research, studies show an association between alcohol drinking and several types of cancer. Reduce the risk by reducing or eliminating alcohol use. People who drink alcohol should limit their alcohol intake to two drinks per day for men and one drink per day for women.20

A standard alcoholic drink in the United States contains 14.0 grams (0.6 ounces) of pure alcohol.

Generally, this amount of pure alcohol is found in

- 12 ounces of beer (3 - 7 percent alcohol)
- 8 ounces of malt liquor beer (3 - 7 percent alcohol)
- 5 ounces of wine (9 - 15 percent alcohol)
- 1.5 ounces or a “shot” of 80-proof liquor (usually 35 - 40 percent alcohol), but can be higher.
Cancer Prevention and Control Action Plan

In order to decrease the cancer risk and increase cancer protective factors, the Cancer Plan has five overarching goals. They are:

- **Prevent** new cancers.
- **Detect** cancer at its earliest stages.
- **Treat** all cancer patients with the most appropriate and effective therapy.
- **Enhance** the quality of life for every person affected by cancer.
- **Reduce** cancer-related disparities in North Carolina.

The Cancer Plan focuses on four areas: prevention, early detection, care and treatment and survivorship including palliative care.
Most cancers can be prevented by taking steps to reduce risk factors such as:

- avoiding tobacco use and secondhand smoke,
- limiting exposure to environmental toxins,
- limiting alcohol use,
- limiting exposure to ultraviolet rays from the sun and tanning beds,
- eating a variety of fruits and vegetables,
- maintaining a healthy weight,
- being physically active and
- having recommended check-ups.

(See Appendix B – Scientific Information Resources)

Cancer Prevention Strategies

Education and promotion of healthy behaviors

- Provide education on evidence-based practices, policies, systems and environmental change approaches that focus on: health disparities, tobacco use prevention and control, cancer screening, physical activity and healthy eating.\(^{21,25}\)
- Develop and use strategic, effective and tailored messaging and media campaigns in combination with other strategies to support healthy behaviors and reduce risk factors.
- Continue the N.C. Department of Public Instruction Standard Course of Study for K-12 students that promotes healthy behaviors.
- Promote radon testing/mitigation in homes, schools, workplaces and other community settings.
- Promote HPV vaccination for girls and boys starting at age 11 or 12 years until age 26, if appropriate.
- Promote cancer-screening tests that may prevent future breast, colorectal, cervical and skin cancers.

Promotion of public policy

- Support the development and enforcement of state and local policies to prevent and minimize tobacco use, eliminate secondhand smoke and promote quitting.
- Support the development of state and local policies to encourage colorectal cancer screening for preventive purposes in people between the ages of 50 and 75.
- Support education and policy approaches in worksites and communities that can reduce occupational and environmental exposures to carcinogens.
  - Promote education and policy approaches that limit unprotected exposure to ultraviolet light.
  - Promote radon testing, radon resistant construction and mitigation of radon in schools, daycare centers, workplaces and homes.
- Support health education and health promotion policies, processes and interventions that increase the awareness of cancer screenings.
Screening means checking the body for cancer before a person has symptoms. Appropriate screening and early detection methods can have a significant impact on the incidence and mortality from certain cancers.

Recommended screening varies depending on the type of cancer. Regular screening tests may find breast, cervical, colorectal and skin cancers early when treatment might be most successful.

Research on effective cancer screening is an ongoing process with new methods being tested and released while approved older methods are reevaluated. Check sources for up-to-date information on recommended cancer screening.

(See Appendix B – Scientific Information Resources for information on cancer screenings)

**Early Cancer Detection Focus**

*Promote the adoption of recommended cancer screening and early detection methods and referral procedures.*

“Never give up and early detection saves lives.”

– Patricia, cervical cancer survivor since 1992

**Early Cancer Detection Strategies**

**Education and promotion of healthy behaviors**

- Encourage healthcare providers to recommend and deliver cancer screenings based on the latest screening recommendations. (See Appendix B – Scientific Information Resources for information on cancer screenings)

- Partner with public and private healthcare providers and community leaders to:
  - increase cancer awareness,
  - improve opportunities for cancer screening with emphasis on people with high risk of developing cancer and
  - improve opportunities for cancer screening with emphasis on people with limited access to screenings.

- Promote research for early detection that will lead to improved outcomes, cancer care and quality of life. (See Appendix B – Scientific Information Resources for information on clinical trials and research)
Cancer Care Continuum

The cancer care continuum begins with cancer screening or diagnosis, goes through treatment, continues throughout survivorship and includes end-of-life care.

**Survivorship** covers the physical, psychosocial and economic issues of disease, beyond the diagnosis and treatment phases. It may include issues related to:

- accessibility of healthcare and follow-up treatment,
- continued effects of treatment,
- reoccurring and/or additional cancers and
- quality of life.

**Palliative care** involves taking care of symptoms and providing relief from pain and stress of an illness.

**Patient navigation** involves helping patients, families and caregivers work through issues that arise during the cancer journey. All cancer patients, especially low-income patients, can have problems getting cancer care. Some of these problems might be:

- transportation which makes it difficult or impossible to get to treatment or other care,
- lack of health insurance,
- fear of the unknown and/or
- distrust of the medical system.

Patient navigators often work with a patient starting with diagnosis and continuing through all phases of the cancer experience. These navigators offer help to patients, families and caregivers by working with the healthcare system to ensure they receive needed care.

**Quality Care**

According to the National Institute of Medicine (IOM), patients should receive cancer care that:

- is given by qualified medical providers,
- is decided by both the patient and the medical team (called shared decision making),
- considers age, sex, race, ethnic background, customs, social background and religion,
- is given in a safe and helpful way and

“...we can live with hope because we are not alone in this journey.”

– Lidia and Ana Maria, breast cancer survivors since 2006 and 2010
• is done in a way that saves money and time.

There are other issues involved in providing cancer care. They are the need for:

• a well-trained and reliable work force in which evidence-based practice guidelines are used,

• continuous monitoring of the quality of care across the state to be sure everyone is working together and following guidelines,

• patient navigation to help patients, families and caregivers work with the healthcare system to receive needed care and

• health information technology (HIT) and electronic health records (EHRs) to keep track of referrals made, evidence-based care given and guidelines followed.

The continuum provides patients, their loved ones and/or caregivers with the knowledge, resources and tools to support them through their cancer experience.
Cancer care includes:

- taking care of symptoms and relief from pain beginning at diagnosis,
- focusing on the whole person,
- watching to see if the cancer returns (recurrence) or if an additional new cancer develops and
- supporting the patient, the patient’s family, other loved ones and caregivers throughout survivorship.

Care and treatment should be based on the age of the patient. The very young and very old need care and treatment by healthcare professionals who specialize in cancer care for their population groups. Adolescent and young adult (AYA) cancer patients are another group who require special attention.

Cancer Care Strategies

Access to Care and Care Coordination

- Work with professional associations and other groups to:
  - promote a statewide patient navigation model with increased training and networking of patient navigators,
  - increase the number of patient navigators available to help patients overcome both structural and psychosocial barriers to care across the cancer continuum,
  - promote increased access to clinical trials for cancer care that will lead to improved outcomes and quality of life, especially for medically underserved populations and
  - promote adherence to national guidelines for cancer diagnosis and treatment.

Quality Treatment

- Offer educational opportunities and support to non-Commission on Cancer (CoC) accredited cancer centers, general physicians, other healthcare workers and local agencies so they can:
  - follow national guidelines for cancer diagnosis and treatment,
  - offer evidence-based, value-based and patient-centered care and communications,
  - engage the patient in the care and treatment plan, including informed decision making,
  - use electronic health records,
  - provide age-sensitive and age-appropriate cancer treatment for pediatric, adolescent, young adult (AYA) and geriatric cancer patients,
  - utilize a team approach to patient care that uses appropriate specialist and non-specialist professionals,
  - achieve and adhere to CoC quality guidelines for accreditation and
  - provide educational opportunities for healthcare professionals that enhance or increase their knowledge and skills in:
    - comprehensive, team-based cancer care,
    - palliative care and
    - end-of-life services.
A person becomes a cancer survivor at the time of cancer diagnosis and remains one throughout his or her life. More people today are cancer survivors for longer periods because of better ways to find cancer early and improved treatment.

Cancer survivors can have many problems that begin during and after treatment. Problems include physical, emotional, psychosocial, spiritual and/or financial concerns. Survivorship care supports the patient, the patient’s family members, other loved ones, friends and other caregivers.

A healthcare professional can work with patients to write individualized survivorship care plans. The care plan can include problems one might anticipate after treatment and where to get help for those problems. The plan can help with emotional wellness, physical health and other support services.

Palliative Care

Palliative care offers patients relief from the symptoms, pain and stress of an illness. It should offer the best possible feeling of well-being for patients and their families from the time of diagnosis throughout survivorship. Pain makes life difficult, causing problems with normal daily activities. All patients and their families should be educated about the importance of communicating the patient’s pain and the need to control it.

Every treatment plan should include palliative care and focus on the patient’s needs both during and after treatment. The plan should include the patient and family and/or caregiver in deciding needs and ways to address them. Palliative care uses medicines, non-drug treatments, emotional support and spiritual care.

Persons with cancer who no longer have choices for treatment that may cure or slow the progress of the cancer may be referred to hospice care. Hospice care includes palliative and comfort care to allow for death with dignity.

“A positive mental attitude is good medicine.”

– John, a prostate cancer survivor since 2007
Professional Outreach and Education
- Increase outreach and education to general physicians, other healthcare workers and local agencies to:
  - promote surveillance for incidence of recurrence, second primary cancers and long-term/late effects of treatment;
  - monitor maintenance therapy;
  - encourage management of psychosocial complications of diagnosis and treatment;
  - assist patients with transition/return to a healthy lifestyle;
  - promote prevention strategies to minimize recurrence and second primary cancers;
  - encourage access to certified genetic counseling;
  - encourage the use of oncology rehabilitation services;
  - use a standardized comprehensive care guide/checklist that includes:
    - a tool for assessing their care and
    - information on supportive services, including survivorship, legal and financial counseling;
  - encourage the adoption of policies to increase access to pain management, improve symptom management, use proven complementary and integrative services and enhance end-of-life services;
  - promote strong policies about adequate pain management and
  - offer continuing medical education on pain management.

Public Education
- Participate in cancer health and wellness campaigns designed to increase public knowledge about:
  - cancer recurrence,
  - second primary cancer prevention,
  - continuum of cancer care,
  - treatment choices,
  - palliative care and
  - end-of-life services.
Everyone Has a Part in the Fight Against Cancer

Regardless of a person’s role in the fight against cancer – as a cancer survivor, family member or friend, community leader, policy maker, business leader or employer, school staff or student, public health or healthcare professional – his or her skills and knowledge are vital in the fight against cancer. Everyone can play a role by working with decision makers and community members to: 1) support lifestyle behavior change to reduce cancer risks; 2) expand opportunities for screening, diagnostic tests, cancer treatment and patient support services and 3) support policy and environment changes to encourage and support healthy lifestyle choices.

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Early Detection</th>
<th>Survivorship/Care</th>
<th>Policy/Systems Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Stop smoking or never start.</td>
<td>□ Get needed regular screenings.</td>
<td>□ Support individual cancer survivors and caregivers in your community.</td>
<td>□ Educate legislators/policy makers on the need for monetary and other support for cancer services for North Carolinians.</td>
</tr>
<tr>
<td>□ Avoid secondhand smoke.</td>
<td>□ Discuss your family cancer history with other family members.</td>
<td>□ Volunteer with agencies and organizations that help cancer survivors.</td>
<td>□ Educate local government and agencies about the need for healthy lifestyle programs and expanded clean air initiatives in communities, schools and places of employment and worship.</td>
</tr>
<tr>
<td>□ Eat more vegetables and fruits.</td>
<td>□ Encourage family, friends and coworkers to get regular screenings.</td>
<td>□ Make the healthy choice the easy choice by eliminating cancer risk factors in social and physical environments.</td>
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<tr>
<td>□ Maintain a healthy weight.</td>
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<tr>
<td>□ Be physically active.</td>
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<tr>
<td>□ Protect the skin and eyes from the sun/UV radiation • wear protective clothing, hats and sunglasses, • use sunscreen and • avoid tanning beds.</td>
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<tr>
<td>□ Get necessary vaccines and ensure youth get the HPV vaccination.</td>
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<tr>
<td>□ Reduce stress.</td>
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<tr>
<td>□ Educate family, friends and coworkers about things they can do to lower their chances of getting cancer.</td>
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<tr>
<td>□ Test the home for radon and take action to eliminate high levels.</td>
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### Everyone Has a Part in the Fight Against Cancer

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<tr>
<th>Individuals (continued)</th>
<th>Prevention</th>
<th>Early Detection</th>
<th>Survivorship/Care</th>
<th>Policy/Systems Change</th>
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<tbody>
<tr>
<td>Educate family/friends/ coworkers about ways to improve youth health by:</td>
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<tr>
<td>• supporting youth tobacco use prevention and cessation programs,</td>
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<tr>
<td>• advocating for improved nutritional standards in foods/ drinks served or sold in schools,</td>
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<tr>
<td>• telling those under 18 to avoid tanning beds and</td>
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<td>• supporting the use of sun protection at schools, sports events and playgrounds.</td>
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<thead>
<tr>
<th>Community Organizations</th>
<th>Prevention</th>
<th>Early Detection</th>
<th>Survivorship/Care</th>
<th>Policy/Systems Change</th>
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<tbody>
<tr>
<td>Have a no-tobacco policy inside and outside of buildings.</td>
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<tr>
<td>Start tobacco cessation programs.</td>
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<td>Encourage physical activity through walking clubs or other activities.</td>
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<td>Provide healthful food at events, meals or in vending machines.</td>
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<tr>
<td>Encourage sun-safe behaviors and sun-protected physical environments.</td>
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<tr>
<td>Educate others about the need for radon testing.</td>
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<tr>
<td>Encourage community members to get appropriate screenings.</td>
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<tr>
<td>Provide screening events.</td>
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<tr>
<td>Provide educational workshops.</td>
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<tr>
<td>Promote patient navigation and community health worker programs.</td>
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<tr>
<td>Encourage participation in clinical trials.</td>
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<tr>
<td>Volunteer to help cancer survivors, e.g., providing transportation to treatment, offering childcare during treatments, etc.</td>
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<tr>
<td>Educate legislators/policy makers about the need for funding for cancer prevention, screening, treatment and research.</td>
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<tr>
<td>Encourage local government agencies to develop healthy living programs and clean air policies.</td>
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<tr>
<td>Provide health insurance coverage and increased access to care.</td>
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### Everyone Has a Part in the Fight Against Cancer

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<tr>
<th><strong>Prevention</strong></th>
<th><strong>Early Detection</strong></th>
<th><strong>Survivorship/Care</strong></th>
<th><strong>Policy/Systems Change</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Include cancer prevention messages in health and other classes.</td>
<td>□ Educate students about the importance of age appropriate cancer screenings.</td>
<td>□ Educate administrators, staff and faculty about patients’ rights in the Americans with Disabilities Act.</td>
<td>□ Educate policy makers about the need for healthy lifestyle programs on campus.</td>
</tr>
<tr>
<td>□ Provide healthful foods and drinks in vending machines and cafeterias.</td>
<td></td>
<td>□ Educate teachers about the issues related to cancer treatment and survivorship.</td>
<td>□ Educate legislators/policy makers about the need for monetary and other support for cancer prevention, detection and treatment services.</td>
</tr>
<tr>
<td>□ Make the campus tobacco-free, including new tobacco products like e-cigarettes.</td>
<td></td>
<td>□ Educate school personnel on ways to ease a student’s return to school after cancer treatment.</td>
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<td>□ Encourage sun-safe behaviors and sun-protected physical environments.</td>
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<tr>
<td>□ Increase physical education requirements and physical activity opportunities.</td>
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<tr>
<td>□ Educate students about the HPV vaccine as a way to prevent cervical cancer and other HPV caused cancers.</td>
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<table>
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<tr>
<th><strong>Businesses</strong></th>
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</thead>
<tbody>
<tr>
<td>□ Encourage employees to adopt a healthy lifestyle including healthy meals and regular physical activity.</td>
<td>□ Provide full financial coverage for recommended cancer screenings.</td>
<td>□ Educate employees on ways to ease a coworker’s return to work after cancer treatment.</td>
<td>□ Support healthy behaviors.</td>
</tr>
<tr>
<td>□ Maintain a tobacco-free workplace inside and outside of buildings.</td>
<td>□ Allow time off to get cancer screenings.</td>
<td>□ Educate managers that there may be a need to change the worker’s schedule during treatment.</td>
<td>□ Provide health insurance coverage to all workers.</td>
</tr>
<tr>
<td>□ Provide sun-protective clothing and encourage use of sunscreen for outside workers.</td>
<td>□ Encourage promotion of QuitlineNC to tobacco users.</td>
<td>□ Educate staff and managers about patients’ rights in the Americans with Disabilities Act.</td>
<td>□ Educate legislators/policy makers to ensure strong public policy for cancer prevention, screening, treatment and research funding.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Carry short-and long-term disability insurance.</td>
<td>□ Ensure all evidence-based treatment is provided by insurance with no cost to patient.</td>
</tr>
</tbody>
</table>
## Everyone Has a Part in the Fight Against Cancer

<table>
<thead>
<tr>
<th>Business (continued)</th>
<th>Prevention</th>
<th>Early Detection</th>
<th>Survivorship/Care</th>
<th>Policy/Systems Change</th>
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</thead>
<tbody>
<tr>
<td><strong>Health Care Professionals</strong></td>
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<tr>
<td></td>
<td>☐ Encourage patients and staff to adopt a healthy lifestyle by:</td>
<td>☐ Recommend and/or provide appropriate cancer screenings.</td>
<td>☐ Provide appropriate medical care, information and referral for survivors.</td>
<td>☐ Educate legislators/policy makers to ensure the availability and support for cancer prevention, screening and treatment.</td>
</tr>
<tr>
<td></td>
<td>• avoiding tobacco use and secondhand smoke,</td>
<td>• Allow time off work to get cancer screenings elsewhere.</td>
<td>• Offer survivorship educational forums for patients and caregivers.</td>
<td>• Work for changes within the organization to support healthy behaviors.</td>
</tr>
<tr>
<td></td>
<td>• using sun protection,</td>
<td>• Provide insurance coverage for cancer screenings.</td>
<td>• Use patient navigators and community health worker programs when appropriate.</td>
<td>• Offer health insurance that covers cancer screenings.</td>
</tr>
<tr>
<td></td>
<td>• avoiding tanning beds and</td>
<td></td>
<td>• Encourage consideration of clinical trials as a treatment option.</td>
<td>• Ensure that Tobacco Treatment Clinical Practice Guidelines are integrated into clinical protocols.</td>
</tr>
<tr>
<td></td>
<td>• being physically active.</td>
<td></td>
<td>• Provide tobacco treatment or referrals to cancer survivors who smoke.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Maintain a smoke-free environment inside and outside facilities.</td>
<td>☐ Offer cancer screening.</td>
<td>☐ Sponsor or support legislation that promotes cancer prevention/control.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Offer cancer screening.</td>
<td>☐ Administer appropriate vaccines.</td>
<td>☐ Support evidence-based intervention policies and programs that lead to environmental and behavioral changes and support healthy lifestyles.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Support proven cancer prevention and control programs.</td>
<td>☐ Promote system and funding changes that will increase access to cancer screenings, medications and care.</td>
<td>☐ Support legislation that funds cancer treatment and research including palliative care.</td>
<td>☐ Consider adopting the recommendations of the N.C. Advisory Committee on Cancer Coordination and Control.</td>
</tr>
<tr>
<td></td>
<td>☐ Participate in community events that support cancer survivors.</td>
<td>☐ Provide information to cancer survivors and coworkers.</td>
<td>☐ Ensure that tobacco settlement and tobacco tax funds are used for tobacco and cancer control purposes.</td>
<td></td>
</tr>
</tbody>
</table>
Cancers Addressed in the North Carolina Comprehensive Cancer Control Plan

The cancer continuum (prevention, early detection, care, survivorship including palliative care) discussed in the previous section is the framework for addressing the cancer burden in North Carolina.

The six priority cancers (lung, colorectal, breast, prostate, cervical and skin) are discussed in the next section. Maps showing North Carolina cancer mortality and incidence rates are located in Appendix F.
Lung Cancer refers to any cancer that forms in the tissues of the bronchus or lung. Lung cancers are usually grouped into two main types, small cell and non-small cell. These differ in growth rate as well as how they are treated.

Lung cancer was the leading cause of cancer deaths in North Carolina in 2012 (29.6%). It is estimated that 8,624 people will be diagnosed with lung cancer and 6,180 people will die from lung cancer in 2014.

Risk Factors
Risk factors for lung cancer include smoking and exposure to secondhand smoke, radon and environmental hazards such as asbestos, coal dust and other substances. Nearly all lung cancer is caused by smoking. Among people who have never smoked, radon is the leading cause of lung cancer. People who smoke and are exposed to radon have an increased risk of lung cancer. A person’s risk of lung cancer may be higher if his or her parents, siblings or children have had lung cancer. This could be true because they also smoke or they live or work in the same place where they are exposed to radon and other substances that can cause lung cancer.

Prevention
Lung cancer is preventable by not smoking and by reducing exposure to secondhand smoke, radon and other environmental hazards.

Treatment
Treatment is usually most successful when the cancer is detected early. Lung cancer treatment options include surgery, chemotherapy, radiation and targeted drug therapy.

Lung Cancer Strategies

- Support state and local policies that reduce occupational and environmental exposures to lung carcinogens with an emphasis on tobacco use, secondhand smoke and radon (including homes, schools and workplaces).
- Support messaging campaigns about lung cancer risk factors which include radon exposure, tobacco use and exposure to secondhand smoke.
- Educate policy makers about the need for increased funding for programs, coalitions and action groups that address or reduce the risk factors of lung cancer.
- Encourage the building of radon-resistant new construction and testing and mitigation of radon in schools, daycare centers, workplaces and homes.
- Promote awareness of the USPSTF recommendation for low-dose computed tomography (CT Scans) to healthcare providers for adults who meet specific age and smoking history criteria.
- Support lung cancer research.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Base Line</th>
<th>2020 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung cancer mortality rate</td>
<td>49.9/100,000</td>
<td>38.5/100,000</td>
</tr>
<tr>
<td>Lung cancer incidence rate</td>
<td>68.5/100,000</td>
<td>60.7/100,000</td>
</tr>
<tr>
<td>Estimated number of homes mitigated for radon from 10/2010 to 03/2013</td>
<td>6,886</td>
<td>Increase by 25%</td>
</tr>
</tbody>
</table>
Colorectal Cancer Objectives

1. Reduce the mortality rate due to colorectal cancer.
2. Reduce the incidence rate due to colorectal cancer.
3. Increase the percentage of North Carolina adults ages 50-75 who have had a colorectal cancer screening test within the past five years.

Colorectal cancer develops in the colon and/or the rectum. Colorectal cancer was the second leading cause of cancer deaths in North Carolina in 2012 (8.3%). It is estimated that 4,746 people will be diagnosed with colorectal cancer and 1,665 people will die from colorectal cancer in 2014.

Risk Factors
Risk factors for colorectal cancer include increasing age, colorectal polyps, overweight and obesity, smoking, a family history of colorectal cancer, chronic inflammatory conditions of the colon and certain genetic conditions. Diabetes also increases the risk of developing colon cancer.

Prevention
Colorectal cancer is mostly preventable. A colonoscopy, one type of colorectal cancer screening, can find polyps which can be removed before they become cancer. Other screening tests include the two fecal blood tests – Fecal Occult Blood Test (FOBT) and Fecal Immunochemical Test (FIT) – and sigmoidoscopy. Results from the 2012 BRFSS Survey show that 70.6 percent of North Carolina adults over age 50 report, “ever having had a sigmoidoscopy or colonoscopy screening for colorectal cancer.”

While colorectal cancer risk increases with age, lifestyle choices can significantly reduce the overall risk of colorectal cancer.

According to the American Institute for Cancer Research, 50 percent of the estimated cases of colorectal cancer in the United States are preventable by diet, activity and weight management.

Treatment
Treatment is usually most successful when the cancer is detected early. Colorectal cancer treatment options include surgery, chemotherapy and radiation therapy.

(See Appendix F for a map showing colorectal cancer mortality and incidence rates by county)

Colorectal Cancer Strategies
- 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.
- Promote the use of the guidelines and recommendations of the N.C. Advisory Committee on Cancer Coordination and Control.

(See Appendix B - Scientific Information Resources)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Base Line</th>
<th>2020 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal cancer mortality rate</td>
<td>14.3/100,000</td>
<td>10.1/100,000</td>
</tr>
<tr>
<td>Colorectal cancer incidence rate</td>
<td>37.8/100,000</td>
<td>26.4/100,000</td>
</tr>
<tr>
<td>% adults who had sigmoidoscopy or colonoscopy colorectal screening</td>
<td>70.6%</td>
<td>81.4%</td>
</tr>
</tbody>
</table>
Breast Cancer is a malignant tumor that starts in the cells of the breast. While the disease occurs mostly in women, men also can get it. Breast cancer was the third leading cause of cancer deaths in North Carolina women in 2012 (7.0%).\(^1\) It is estimated that 9,712 females in North Carolina will be diagnosed with breast cancer and 1,412 females will die from breast cancer in 2014.\(^2\) Between 2007 and 2011, 95 percent of women diagnosed in the earliest stage survive at least five years compared to 34 percent diagnosed in the advanced stage.\(^9\)

**Risk Factors**
The strongest risk factor for breast cancer is being female. Other risk factors include increasing age, a family history of breast cancer, early puberty, late menopause, obesity, smoking and alcohol use.

Additionally, according to the American Institute for Cancer Research, 38 percent of the estimated cases of breast cancer in the United States are preventable by diet, physical activity and weight management.\(^15\)

**Prevention**
Mammograms are the most effective method to detect breast cancer early before it causes symptoms or can be detected by touch. According to the 2012 BRFSS Survey, 66.6 percent of North Carolina women of all ages reported, “ever having had a mammogram.”\(^9\)

**Treatment**
Treatment is usually most successful when the cancer is detected early. Breast cancer treatment may involve surgery, radiation therapy, chemotherapy and other therapies.

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Breast Cancer Objectives

1. *Reduce the mortality rate in women due to breast cancer.*
2. *Reduce the rate of stage III and IV breast cancer in women.*
3. *Increase the percentage of North Carolina women over the age of 50 who have had a mammogram according to recommended guidelines within the past two years.*

---

**Breast Cancer Strategies**

- Conduct targeted outreach using evidence-based strategies to decrease disparities in breast cancer mortality among women who experience high death rates from breast cancer.
- Partner with NCBCCCP and WISEWOMAN providers and other agencies to improve data sharing and patient tracking to assure that eligible patients get appropriate screening and treatment services for breast cancer. (See Appendix A)
- Promote the use of the guidelines and recommendations of the N.C. Advisory Committee on Cancer Coordination and Control. (See Appendix B - Scientific Information Resources)

(See Appendix F for a map showing breast cancer mortality and incidence rates by county)

---

<table>
<thead>
<tr>
<th>Measures</th>
<th>Base Line</th>
<th>2020 Target(^{28})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer mortality rate(^{14})</td>
<td>21.4/100,000</td>
<td>16.8/100,000</td>
</tr>
<tr>
<td>Stage III and IV breast cancer rate(^{15})</td>
<td>46.3/100,000</td>
<td>40.9/100,000</td>
</tr>
<tr>
<td>% women over age 50 who had mammograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>within the past two years(^9)</td>
<td>79.4%</td>
<td>TBD*</td>
</tr>
</tbody>
</table>

* Note: Recommendations have changed recently and awaiting BRFSS data changes.
Prostate cancer is the presence of abnormal cells and/or a tumor in the prostate gland, a part of the male reproductive system. Prostate cancer was the fifth leading cause of cancer deaths in North Carolina in 2012 (4.6%) and is the most frequently diagnosed cancer in men. It is estimated that 8,399 males in North Carolina will be diagnosed with prostate cancer and 1,009 males will die from prostate cancer in 2014.

Prostate cancer tends to grow slowly when compared to other cancers. Most men with prostate cancer will die of other causes rather than prostate cancer.

Risk Factors
Risk factors for prostate cancer include being male, increasing age, African American and American Indian ancestry with a family history of prostate cancer. The older a man is, the greater his risk for getting prostate cancer. About 80 percent of cases are in men over 65 years of age. Prostate cancer is more common in African American men than in men of other racial backgrounds. Moreover, African American men are more often diagnosed with prostate cancer when it is in advanced stages. They are over two times more likely to die from prostate cancer than white men. In addition, any man with a father, brother or son who has had prostate cancer is two to three times more likely to develop the disease.

Prevention
Because there is no known cause of prostate cancer, it is difficult to determine how best to prevent it. Dietary practices such as eating red meats, dairy products and fatty foods and cooking meats at high temperatures appear to increase the risk of prostate cancer. Obesity appears to increase the risk of aggressive prostate cancer. There is some evidence that occupational exposures to certain toxic chemicals increases the risk. Exercising and eating cruciferous vegetables such as broccoli, cabbage and cauliflower and foods with Lycopene. Taking certain drugs such as aspirin, cholesterol lowering and anti-inflammatory medications may decrease the risk.

Treatment
Some forms of prostate cancer are so slow growing that they may not require treatment. For those who do need treatment, it may include surgery, active surveillance (also known as watchful waiting), chemotherapy, radiation therapy and hormone therapy.

(See Appendix F for a map showing prostate cancer mortality and incidence rates by county)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Base Line</th>
<th>2020 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate cancer mortality rate</td>
<td>21.0/100,000</td>
<td>13.0/100,000</td>
</tr>
<tr>
<td>% men who have talked to health care provider about advantages and disadvantages of PSA test</td>
<td>31.6%</td>
<td>Increase by 10%</td>
</tr>
</tbody>
</table>

Prostate Cancer Strategies
- Conduct targeted outreach using evidence-based strategies to decrease disparities in prostate cancer mortality among male population groups who experience high death rates from prostate cancer.
- Conduct messaging campaigns to increase awareness of the importance of informed decision making regarding prostate cancer.
Cervical cancer is cancer in women that forms in tissues of the cervix, the mouth of the uterus. It is usually caused by human papillomavirus (HPV) infection. Cervical cancer was the 21st leading cause of cancer death in North Carolina in 2012 (0.6 %). It is estimated that 380 women will be diagnosed with cervical cancer and 123 women will die from cervical cancer in 2014.\(^1\)

### Risk Factors
The primary risk factors for cervical cancer are being a woman and having had an HPV infection. Other risk factors are smoking, using oral contraception for five or more years, having given birth to three or more children and having sex with a partner who is infected with HPV.

### Prevention
Cervical cancer is easily detected and can mostly be prevented though the use of the HPV vaccine. An important way women can prevent cervical cancer is to have regular screening tests starting at age 21. Two tests can help prevent cervical cancer. The Pap test (or Pap smear) looks for precancers, which are cell changes on the cervix that may become cervical cancer if they are not treated appropriately. The other test is the human papillomavirus (HPV) test. This test looks for the virus that can cause the cell changes.

### Treatment
Treatment is usually most successful when the cancer is detected early. Treatment options for cervical cancer include surgery, chemotherapy and/or radiation therapy.

### Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>Base Line</th>
<th>2020 Target(^2^)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical cancer mortality rate(^1^)</td>
<td>2.0/100,000</td>
<td>1.3/100,000</td>
</tr>
<tr>
<td>Cervical cancer incidence rate(^1^)</td>
<td>7.3/100,000</td>
<td>6.1/100,000</td>
</tr>
<tr>
<td>*data only available for % of population ages 13-17 vaccinated with HPV(^1^)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td>35.5%</td>
<td>57.7%</td>
</tr>
<tr>
<td>Males</td>
<td>8.6%</td>
<td>17.7%</td>
</tr>
<tr>
<td>% Women who had pap tests age 21-65(^9)</td>
<td>86.5%</td>
<td>TBD*</td>
</tr>
</tbody>
</table>

* Recommendations have changed recently and awaiting BRFSS data changes

### Cervical Cancer Strategies
- Conduct targeted outreach using evidence-based strategies to increase cervical cancer screening among groups of women who experience high mortality rates from cervical cancer.
- Coordinate with stakeholders to develop a messaging campaign to increase the awareness of the public of the importance of recommended HPV vaccines.
- Partner with NCBCCCP and WISEWOMAN providers and other agencies to improve data sharing and patient tracking to assure that eligible patients get appropriate screening and treatment services for cervical cancer.
- Promote the use of the guidelines and recommendations of the N.C. Advisory Committee on Cancer Coordination and Control.
Skin cancer forms in the tissues of the skin. There are several types of skin cancer: melanoma forms in the skin cells that make pigment; basal cell cancer forms in the outer layer of the skin and squamous cell cancer forms in the flat cells that form the surface of the skin. Melanoma is the most serious form of skin cancer and causes 72.8 percent of all skin cancer deaths. Left untreated, it can spread to other organs and is difficult to control.

The rate of new melanoma diagnoses in North Carolina is rising rapidly— with an average increase of more than five percent per year from 1995 to 2011.1 Basal cell and squamous cell cancers are less serious types and make up 95 percent of all skin cancers.1

### Risk Factors

Risk factors vary for different types of skin cancer. For melanoma, the major risk factors include a personal or family history of melanoma and the presence of large, irregularly shaped or numerous moles, i.e., more than 50.

The primary risk factor for other forms of skin cancers is exposure to ultraviolet radiation from the sun and other sources such as tanning beds and sun lamps. Other risk factors for all types of skin cancers include sun sensitivity such as sun burning easily, a history of excessive unprotected sun exposure, the use of tanning booths, diseases or treatments that suppress the immune system and a history of skin cancer.7

Skin cancer is more common among people with a light (fair) skin tone. However, skin cancer is not limited to people with fair skin.

### Prevention

Research shows that there is a correlation between sunburns acquired during childhood and increased risk of some skin cancers later in adulthood. Protection from UV radiation is important all year round, not just during the summer or at the beach. It is important that prevention and education strategies be emphasized for all ages.

### Treatment

Melanoma treatment options include surgery, chemotherapy, immunotherapy and/or radiation therapy. Basal cell and squamous cell cancers are highly curable when treated early. Several methods of treatment include surgical incision, cryosurgery, chemotherapy, tissue destruction by electric current and/or radiation therapy.

### Melanoma Skin Cancer Objectives

1. Reduce the mortality rate due to melanoma.
2. Reduce the incidence rate due to melanoma

### Melanoma Cancer Strategies

- Promote education and policies in schools and recreational and tourism settings that can improve sun safety behaviors such as, limiting unprotected exposure to ultraviolet light.
- Support policy changes that require parental approval for adolescents to use artificial sun tanning facilities and other sources of ultraviolet light.

### Measures

<table>
<thead>
<tr>
<th></th>
<th>Base Line</th>
<th>2020 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanoma cancer mortality rate14</td>
<td>2.7/100,000</td>
<td>2.2/100,000</td>
</tr>
<tr>
<td>*Melanoma cancer incidence rate15</td>
<td>21.5/100,000</td>
<td>27.9/100,000</td>
</tr>
</tbody>
</table>

* Note: While the target is an increase over the base line, it actually reflects an over ten percent decrease in the incidence growth rate.
behavioral, attitudinal, environmental and structural data, cancer surveillance informs the development, implementation and evaluation of early detection, educational and other cancer-related programs.

Cancer Surveillance Focus

Promote the use of cancer surveillance data to support a broad range of analyses at the state, regional and local levels.

Plans for reducing the cancer burden in North Carolina depend greatly on having timely, high quality and complete cancer data. Data can help identify possible causes for cancer, determine where greater prevention efforts are needed and identify which strategies are most effective in reducing cancer mortality.

The core functions of cancer surveillance are the measurement of cancer incidence, morbidity, survival and mortality for persons with cancer. It also includes the assessment of genetic predisposition, environmental and behavioral risk factors, screening practices and the quality of care from prevention through palliation. The availability of statewide cancer data enables health researchers and policy makers to analyze demographic and geographic factors that influence cancer risk, early detection and effective treatment of cancer patients. Combined with

Cancer Surveillance Strategies

- Collaborate with regional coalitions to determine county and region specific data needed.
- Work with the N.C. State Center for Health Statistics and others to plan and implement training opportunities for potential users of cancer data.
- Develop data sources for those objectives and strategies for which baseline data are not currently available.
- Partner with the N.C. State Center for Health Statistics and others to support and utilize monitoring and surveillance systems and data sources for tracking cancer outcomes, risk factors and health behaviors.
- Promote the development of North Carolina cancer specific screening registries.
- Identify and/or create opportunities for data sharing/data linkage with partners and other stakeholders in accordance with Health Insurance Portability and Accountability Act (HIPAA) standard.
- Seek opportunities to share data from systems such as the N.C. Central Cancer Registry and the Behavioral Risk Factor Surveillance (BRFSS) system with partners and other interested parties.
Cancer Plan Evaluation

Evaluation is a critical and central component of the implementation of the North Carolina Comprehensive Cancer Control Plan. The evaluation process:

- monitors activities,
- measures progress and
- establishes a foundation for future cancer control work.

Measuring the outcomes of specific initiatives and tracking progress in meeting targets in the Cancer Plan are essential to achieving the goals of the Advisory Committee. Without evaluation, time and resources may be misspent and more strategies that are successful may be overlooked. Evaluation also includes assessing success in engaging partner organizations and determining their satisfaction with the activities and implementation of the Cancer Plan.

In order to monitor progress toward implementing the plan, a regular review of strategies will be conducted. This review will be reported to the Advisory Committee and its subcommittees and work groups to ensure implementation of the plan is on track. A systematic review provides an opportunity to update and revise plans as necessary.

Cancer Plan Evaluation Strategies

- Assess the degree to which the Cancer Plan strategies are implemented.
- Disseminate evaluation reports and documents including survey summaries, and implementation assessments to the Advisory Committee, subcommittees and N.C. Cancer Partnership members and other stakeholders.
- Develop and/or expand partnerships that provide evaluation and program feedback.
- Maintain and modify as needed reporting mechanisms that document progress.

Process evaluation monitors implementation of programs and activities. The focus of process evaluation is on progress toward implementing planned strategies and interventions directly linked to goals and objectives. Process evaluation will determine if the plan is implemented as intended as well as identify areas that can be modified or improved. Process evaluation will also assess the partner’s level of engagement and satisfaction with the Cancer Plan development and implementation process.

Outcome evaluation monitors the long-term progress of Cancer Plan goals and objectives. Changes in outcome measures such as cancer incidence and mortality occur slowly. These measures will be monitored and reported annually, using the data sources and targets listed in the Cancer Plan.

Cancer Plan Evaluation Focus

Create, conduct and disseminate evaluation studies and survey data to monitor and assess change in knowledge, attitude and behavior of North Carolinians.
Evaluation Areas

The evaluation will focus on the following areas and include education and policy development data measures.

**Policy development**

Policy development and promotion includes state and local laws, regulations and ordinances, as well as institutional policies and practices.

Policy development evaluation involves tracking types and implementation of health-related policies (treatment/management protocols, public policies, evidence-based standards, organizational wellness and risk factor awareness/prevention), to include:

- level of impact (state, local, organizational);
- population sector(s) affected and partners involved.

**Education**

Education and awareness programs, initiatives and campaigns for both public and professional audiences are important components of the implementation of the Cancer Plan.

Education evaluation will involve two components.

- The documentation of the development and distribution of:
  - treatment/management protocols,
  - toolkits,
  - media campaigns,
  - Web site pages and
  - fact sheets.

- An assessment of the cultural and linguistic appropriateness of the materials or workshops for the intended audiences.

**Systems changes**

Systems changes to improve healthcare delivery and accessibility include electronic records and monitoring systems to validate adherence to recommended treatment guidelines, protocols to facilitate coordination of care across specialty areas and transitions between settings.

Evaluation will monitor:

- documentation of current screening and treatment protocols in healthcare settings,
CALL TO ACTION

Everyone has a part in the fight against cancer

palliative care prevention care and treatment obesity collaboration
tobacco use lung incidence physical activity viral exposures

tobacco use burden exposure to secondhand smoke

mortality priority cancers exposure to secondhand smoke

ultraviolet radiation exposures physical inactivity burden

environmental exposures colorectal cancer alcohol use melanoma

tobacco use sun protection radon testing partnerships

mortality early detection cervical patient navigation

tobacco use good nutrition overweight evaluation

defense cervical survival breast

defense cervical survival breast

risk factors physical activity good nutrition sun protection radon testing partnerships
defense cervical survival breast
Summary

Cancer is a complex disease that makes cancer prevention and control multifaceted. This 2014-2020 North Carolina Comprehensive Cancer Control Plan provides not only a description of the current state of cancer in North Carolina but guidance for statewide coordination of cancer prevention and care efforts for a broad group of institutions, agencies, community groups and individuals across the state.

The overarching goals of the plan are to:

- prevent new cancers,
- detect cancer at its earliest stages,
- treat all cancer patients with the most appropriate and effective therapy,
- enhance the quality of life for every person affected by cancer and
- reduce cancer-related disparities in North Carolina.

The Cancer Plan is organized using the cancer continuum: prevention, early detection, care and treatment. It focuses on specific cancers including lung, prostate, breast, colorectal, cervical and melanoma and non-melanoma skin cancers. The Cancer Plan with additional references and resources is available on http://public.health.nc.gov/chronicdiseaseandinjury.

A companion community brochure is available on the upcoming Web site. This brochure can be copied and used for community outreach.
References


28. Target data were established using the Healthy North Carolina 2020 methodology. This target-setting method determined what the 2020 target would be if the average annual percentage change was maintained. This target was found by first calculating the percentage change between each year from 2001 to the current year available which is 2011 for incidence data and 2012 for mortality data to get an average annual percentage change. This average annual percentage change was used to calculate a 2020 value. Then the target was set by making a 10 percent improvement in the 2020 value.
Appendices
Appendix A  
N.C. Cancer Prevention and Control Branch

North Carolina Cancer Prevention and Control Branch

The North Carolina Cancer Prevention and Control Branch strives to reduce the overall cancer burden in North Carolina by:

• planning, directing and supporting cancer control efforts through collaborations with partners in state and federal health agencies, academic institutions, and national, voluntary and private organizations;
• providing screening services and follow-up services for low-income uninsured and under-insured women;
• identifying problems, needs and opportunities related to modifiable behavioral and other risk factors and
• recommending priorities for health promotion, health education and cancer risk reduction activities for professionals and the public.

The Branch consists of several programs that work to ensure a comprehensive and collaborative approach in addressing the state’s cancer burden. For information on these programs, call: 919-707-5300 or http://publichealth.nc.gov/chronicdiseaseandinjury

North Carolina Comprehensive Cancer Program

The North Carolina Comprehensive Cancer Program (NCCCP) staffs the North Carolina Advisory Committee on Cancer Coordination and Control, assesses the burden of cancer, determines priorities and develops and facilitates the implementation of the state cancer plan adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. NCCCP facilitates opportunities in communities to promote healthy lifestyles and recommended cancer screenings, educates people about cancer symptoms, increases access to quality cancer care and enhances cancer survivors’ quality of life.

North Carolina Breast and Cervical Cancer Control Program

The North Carolina Breast and Cervical Cancer Control Program (NCBCCCP) provides free or low-cost breast and cervical cancer screenings and follow-up to eligible women in North Carolina. NCBCCCP services are offered at most local health departments as well as some local health centers and hospitals across the state.

Well-Integrated Screening and Evaluation for Women Across the Nation

The Well-Integrated Screening and Evaluation for Women Across the Nation Project (WISEWOMAN) provides cardiovascular disease screening, intervention, counseling and referral services to NCBCCCP-enrolled women. WISEWOMAN services are offered in conjunction with NCBCCCP services at approximately 40 local health departments and local health centers across the state.

North Carolina Central Cancer Registry

The North Carolina Central Cancer Registry (NCCCR) is part of the N.C. State Center for Health Statistics. It collects, processes and analyzes data on all cancer cases diagnosed among North Carolina residents to inform the planning and evaluation of cancer control efforts.

For cancer data requests, call 919-733-4728 or http://www.schs.state.nc.us
Appendix B
Scientific Information Resources

General Cancer Information
American Cancer Society
http://www.cancer.org
Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov
Healthy North Carolina 2020
http://publichealth.nc.gov/hnc2020/objectives.htm
Healthy People 2020
http://www.healthypeople.gov/2020
National Cancer Institute
http://www.cancer.gov
World Health Organization. Social Determinants of Health
http://www.who.int

Evidence-Based Strategies
Cancer Control P.L.A.N.E.T.
http://cancerplanet.cancer.gov
Guide to Community Preventive Services
http://www.thecommunityguide.org
N.C. Institute of Medicine (NCIOM)
http://www.ncbiom.org

Research-Tested Interventions Programs (RTIPS)
http://www.cancer.gov/rtips/index/nutrition_guidelines

Healthy Lifestyle
Eat Smart Move More NC
http://www.EatSmartMoveMoreNC.com
NC Tobacco Prevention and Control Branch
http://www.tobaccopreventionandcontrol.ncdhhs.gov
NC Tobacco Free Schools Initiative
http://www.NCTobaccoFreeSchools.org
QuitLineNC.com
http://www.quitlineNC.com

U.S. Department of Health and Human Services. 2008 Physical Activity Guidelines for Americans
US Preventive Services Task Force (USPSTF)
http://www.uspreventiveservicestaskforce.org

Screening Guidelines
Advisory Committee on Cancer Coordination and Control
American Cancer Society
http://www.cancer.org
Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov
US Preventive Services Task Force (USPSTF)
http://www.uspreventiveservicestaskforce.org
Cancer and Surveillance

State Center for Health Statistics, Cancer
http://www.schs.state.nc.us/data/cancer.cfm

CDC Wonder, United States Cancer Statistics Data
http://wonder.cdc.gov/cancer.html

Cancer Prevalence and Cost of Care Projections, NIH
http://costprojections.cancer.gov

Dartmouth Atlas of Health Care

North American Association of Central Cancer Registries
http://www.naaccr.org

SEER (Surveillance, Epidemiology, and End Results Program)
http://seer.cancer.gov

National Program of Cancer Registries (NPCR)
http://apps.nccd.cdc.gov/uscs

North Carolina Community Health Information Portal (NC-HIP)
https://nchip.n3cn.org

HealthStats for North Carolina
http://healthstats.publichealth.nc.gov

County Health Rankings and Roadmaps
http://www.countyhealthrankings.org

Clinical Trials in North Carolina

ClinicalTrials.Gov Research Information
www.clinicaltrials.gov

CenterWatch – Clinical Trials Listing Service
http://www.centerwatch.com

Coalition of Cancer Cooperative Groups
www.cancertrialshelp.org

Project CONNECT: The Bridge to Healthy Communities Through Research
www.connect.unc.edu

metaRegister of Controlled Trials (free registration required)
http://www.controlled-trials.com/mrct

Duke Health.org
http://www.dukehealth.org/clinicaltrials

The Carolina Center for Clinical Trials
http://www.med.unc.edu/ccct

Wake Forest Comprehensive Cancer Center Clinical Trials
http://www1.wfubmc.edu/cancer/Clinical+Trials
Appendix C
Commission on Cancer Accredited Programs Information and Maps

As of September 30, 2013, North Carolina had 39 Commission on Cancer-accredited cancer programs. The Commission on Cancer (CoC) was established by the American College of Surgeons in 1922. The CoC-Accreditation Program encourages hospitals, treatment centers and other facilities to improve their quality of patient care through various cancer-related programs. These programs focus on prevention, early diagnosis, pretreatment evaluation, staging, optimal treatment, rehabilitation, surveillance for recurrent disease, support services and end-of-life care.

CoC-accreditation by a cancer program ensures its patients will have access to the full scope of services. For the patient and community, the quality standards established by the CoC for cancer programs ensure:

- quality care close to home;
- comprehensive care that includes a complete range of state-of-the-art services and equipment,
- a multidisciplinary team approach to coordinate the best available treatment options,
- access to cancer-related information and education,
- information about ongoing cancer clinical trials and new treatment options,
- a cancer registry that offers lifelong patient follow-up, and
- ongoing monitoring and improvements in cancer care.

Each CoC-accredited facility is assigned to a cancer program category based on the type of facility or organization, services provided and case load. Accredited programs may have different requirements for specific standards based on their cancer program category.

North Carolina has

- 3 NCI-designated comprehensive cancer program centers,
- 15 community cancer program centers,
- 13 comprehensive community cancer program centers,
- 6 integrated network cancer program centers, and
- 2 academic comprehensive cancer program centers.

A collaborative of the American Cancer Society (ACS) and the CoC-accredited cancer centers will be sharing the state cancer plan with each local cancer program committee. This will support goals identified in the state plan, leverage limited resources and leverage the synergies between the ACS, CoC and the Comprehensive Cancer Program to work on cancer control activities that support each community.

The following cancer program information can be found at: https://www.facs.org/search/cancer-programs?state=NC.
NCI Designated Comprehensive Cancer Program

NI Designated Comprehensive Cancer Programs are designated by the National Cancer Institute and offer a full range of diagnostic and treatment services provided. Staff physicians are available. The programs participate in basic and clinical research. No minimum caseload is required for this category.

Duke University Hospital
Duke Cancer Institute
2301 Erwin Road
Durham, NC 27710-0001
Phone: 888-275-3853
http://www.dukecancerinstitute.org

University of North Carolina Hospitals
Lineberger Comprehensive Cancer Center
101 Manning Drive
Chapel Hill, NC 27514-4220
Phone: 919-966-4131
www.unchealthcare.org

Wake Forest University Baptist Medical Center
Outpatient Comprehensive Cancer Center
Medical Center Boulevard
Winston-Salem, NC 27157-1001
Phone: 336-716-2011
www.wakehealth.edu

Academic Comprehensive Cancer Programs

Academic Comprehensive Cancer Programs provide postgraduate medical education in at least four program areas, including internal medicine and general surgery. Programs serve more than 500 newly diagnosed cancer cases each year and offer a full range of diagnostic and treatment services either on-site or by referral.

New Hanover Regional Medical Center
Zimmer Cancer Center
2131 South 17th Street
Wilmington, NC 28402-9000
Phone: 910-343-7000
www.nhrmc.org

Additional Campuses:
- Cape Fear Memorial Hospital, Wilmington
- New Hanover Regional Medical Center, Wilmington

Vidant Medical Center
Vidant Medical Center Cancer Care
2100 Stantonsburg Road
PO Box 6028
Greenville, NC 27834
Phone: 252-847-7867
http://vidanthealth.com

Integrated Network Cancer Program

Integrated Network Cancer Programs are a part of a joint venture with multiple facilities providing integrated cancer care and comprehensive services. At least one facility in the category is a hospital, and all facilities that are part of the Network are CoC-accredited cancer programs. They participate in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or by referring patients. They have no minimum caseload requirements.

Carolinas Healthcare System
Blumenthal Cancer Center
1000 Blythe Boulevard
Charlotte, NC 28203
Phone: 704-355-2000
www.carolinashealthcare.org
**Additional Campuses:**
Carolinas Medical Center  
- Union, Monroe  
- Main Campus, Charlotte  
- Mercy, Charlotte  
- NorthEast, Concord  
- Pineville, Charlotte  
- University, Charlotte

Cape Fear Valley Health System  
Cape Fear Valley Cancer Center  
1638 Owen Drive  
Fayetteville, NC 28304-3424  
Phone: 910-615-4000  
www.capefearvalley.com

CarolinaEast Medical Center  
CarolinaEast Cancer Care  
2000 Neuse Boulevard  
New Bern, NC 28560-3499  
Phone: 252-633-8111  
www.carolinaeasthealth.com

Catawba Valley Medical Center  
Comprehensive Cancer Center  
810 Fairgrove Church Road Southeast  
Hickory, NC 28602-9643  
Phone: 828-326-3000  
www.catawbavalleymc.org

Cone Health  
Cone Health Cancer Center  
1200 N Elm Street  
Greensboro, NC 27401  
Phone: 336-832-7000  
www.conehealth.com

**Comprehensive Community Cancer Program**
Comprehensive Community Cancer Programs offer a full range of diagnostic and treatment services provided either on-site or by referral. Programs serve more than 500 newly diagnosed cancer cases each year. They participate in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or by referring patients.

Alamance Regional Medical Center  
Alamance Regional Cancer Center  
1240 Huffman Mill Road  
Burlington, NC 27215  
Phone: 336-538-7000  
www.armc.com
Community Cancer Programs

Community Cancer Programs offer a full range of diagnostic and treatment services provided, but referral for a portion of diagnosis or treatment may occur. Programs serve more than 100 but fewer than 500 newly diagnosed cancer cases each year. They participate in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or by referring patients.

Blue Ridge HealthCare System
2201 South Sterling Street
Morganton, NC 28655
Phone: 828-580-5000
www.blueridgehealth.org

Additional Campuses:
• Grace Hospital, Morganton
• Valdese Hospital, Valdese
Vidant Edgecombe Hospital
Vidant Oncology-Tarboro
123 Hospital Drive
Tarboro, NC 27886-2011
Phone: 252-641-7714
www.vidanthealth.com/edgecombe

Watauga Medical Center
Seby B. Jones Cancer Center
336 Deerfield Road
Boone, NC 28607-2600
Phone: 828-262-4332
www.apprhs.org

Wilson Medical Center
Wilson Regional Cancer Center
1705 Tarboro Street Southwest
Wilson, NC 27893
Phone: 252-399-8040
www.wilmed.org
Body mass index (BMI) is a measure of body fat, based on height and weight that applies to adult men and women. BMI is an estimate of body fat and a good gauge of your risk for diseases that can occur with more body fat. The higher the BMI, the higher the risk for certain diseases such as heart disease, high blood pressure, type 2 diabetes, gallstones, breathing problems, and certain cancers. Although BMI can be used for most men and women, it does have some limits:

- It may overestimate body fat in athletes and others who have a muscular build.
- It may underestimate body fat in older persons and others who have lost muscle.

**BMI Categories:**

- Underweight = <18.5
- Normal weight = 18.5 – 24.9
- Overweight = 25–29.9
- Obesity = BMI of 30 or greater
### Appendix E

**N.C. Cancer Plan Table of Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>2020 Target</th>
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</thead>
<tbody>
<tr>
<td>Cancer mortality rate&lt;sup&gt;1&lt;/sup&gt; (2012)</td>
<td>170.5 / 100,000</td>
<td>134.9 / 100,000</td>
</tr>
<tr>
<td>Cancer incidence rate&lt;sup&gt;2&lt;/sup&gt; (2011)</td>
<td>476.7 / 100,000</td>
<td>431.4 / 100,000</td>
</tr>
<tr>
<td>Lung cancer mortality rate&lt;sup&gt;1&lt;/sup&gt; (2012)</td>
<td>49.9 / 100,000</td>
<td>38.5 / 100,000</td>
</tr>
<tr>
<td>Lung cancer incidence rate&lt;sup&gt;2&lt;/sup&gt; (2011)</td>
<td>68.5 / 100,000</td>
<td>60.7 / 100,000</td>
</tr>
<tr>
<td>Estimated number of homes mitigated for radon from 10/2010 to 03/2013&lt;sup&gt;3&lt;/sup&gt;</td>
<td>6,886</td>
<td>Increase by 25%</td>
</tr>
<tr>
<td>Colorectal cancer mortality rate&lt;sup&gt;1&lt;/sup&gt; (2012)</td>
<td>14.3 / 100,000</td>
<td>10.1 / 100,000</td>
</tr>
<tr>
<td>Colorectal cancer incidence rate&lt;sup&gt;2&lt;/sup&gt; (2011)</td>
<td>37.8 / 100,000</td>
<td>26.4 / 100,000</td>
</tr>
<tr>
<td>% adults who had sigmoidoscopy or colonoscopy colorectal screening&lt;sup&gt;4&lt;/sup&gt; (2012)</td>
<td>70.6%</td>
<td>81.4% BRFSS</td>
</tr>
<tr>
<td>Breast cancer mortality rate&lt;sup&gt;1&lt;/sup&gt; (2012)</td>
<td>21.4 / 100,000</td>
<td>16.8 / 100,000</td>
</tr>
<tr>
<td>Stage III and IV breast cancer rate&lt;sup&gt;5&lt;/sup&gt; (2011)</td>
<td>46.3 / 100,000</td>
<td>40.9 / 100,000</td>
</tr>
<tr>
<td>% Women over age 50 who had mammograms within the past two years&lt;sup&gt;6&lt;/sup&gt; (2012)</td>
<td>79.4%</td>
<td>TBD (75.0% 2020 Projection)</td>
</tr>
<tr>
<td>Prostate cancer mortality rate&lt;sup&gt;1&lt;/sup&gt; (2012)</td>
<td>21.0 / 100,000</td>
<td>13.0 / 100,000</td>
</tr>
<tr>
<td>% men who have talked to health care provider about advantages and disadvantages of PSA test&lt;sup&gt;7&lt;/sup&gt; (2012)</td>
<td>31.6%</td>
<td>Increase by 10%</td>
</tr>
<tr>
<td>Cervical cancer mortality rate&lt;sup&gt;1&lt;/sup&gt; (2012)</td>
<td>2.0 / 100,000</td>
<td>1.3 / 100,000</td>
</tr>
<tr>
<td>Cervical cancer incidence rate&lt;sup&gt;2&lt;/sup&gt; (2011)</td>
<td>7.3 / 100,000</td>
<td>6.1 / 100,000</td>
</tr>
<tr>
<td>% of population ages 13-17 vaccinated with ≥ 3 doses HPV&lt;sup&gt;8&lt;/sup&gt; (2012)</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td></td>
<td>35.5%</td>
<td>8.6%</td>
</tr>
<tr>
<td>% Women who had pap tests age 21-65&lt;sup&gt;9&lt;/sup&gt; (2012)</td>
<td>86.5%</td>
<td></td>
</tr>
<tr>
<td>Melanoma cancer mortality rate&lt;sup&gt;1&lt;/sup&gt; (2012)</td>
<td>2.7 / 100,000</td>
<td>2.2 / 100,000</td>
</tr>
<tr>
<td>Melanoma cancer incidence rate&lt;sup&gt;2&lt;/sup&gt; (2011)</td>
<td>21.5 / 100,000</td>
<td>27.9 / 100,000</td>
</tr>
</tbody>
</table>
2020 Target Methodology:

We used the NC Healthy People 2020 methodology in setting incidence and mortality targets. First, we calculated the average change from 2001 to 2011. Then, we used the average rate of change to project incidence and mortality until 2020. Finally, we took that projection and calculated a 10 percent improvement.


Other NC Healthy People 2020 methodologies include using the measures of the best states as goals. The Cancer Plan did this with the HPV measure as recommended by the NC Immunization Branch. Rhode Island had the best 2012 HPV rates for both males and females. Most BRFSS targets were set using the calculated rate of linear change using data from 2000 and 2001 through 2010. The 2012 BRFSS measure was not included in this calculation due to BRFSS methodological changes that do not allow for comparisons of data before 2011 (BRFSS cancer measures mainly occur in even years.). We projected the linear rate of change from the current 2012 BRFSS measure until 2020. This projection also provided our 2020 target measure.

The BRFSS sigmoidoscopy and colonoscopy screening targets were set using the calculated rate of quadratic/curvilinear change using data from 2000 and 2001 through 2010. The 2012 BRFSS measure was not included in this calculation due to BRFSS methodological changes that do not allow for comparisons of data before 2011 (BRFSS cancer measures mainly occur in even years.). We projected the quadratic/curvilinear rate of change from the current 2012 BRFSS measure until 2020. This projection also provided our 2020 target measure.

Sources:
7. North Carolina Division of Public Health, State Center for Health Statistics. Special data query based on 2012 BRFSS Survey Results: North Carolina Prostate Cancer Screening (Males, Age 40+). http://www.schs.state.nc.us/SCHS/brfss/2012/nc/all/topics.html#pcs
   Immunization target measures set using best state method, Rhode Island (2012 data), according to a standard used in NC Immunization Branch based on 3/28/14 phone conversation with Amy Grimshaw. They set a 90% goal when a vaccine is required.
Appendix F
North Carolina Cancer Maps

North Carolina
All Cancer Incidence Rates
2007-2011

Age Adjusted Rates
per 100,000 Population

- 427.1 - 470.0
- 470.1 - 496.7
- 496.8 - 525.7
- 525.8 - 584.2

Note: Information is subject to change as files are updated.
North Carolina
All Cancer Mortality Rates
2008-2012

Age Adjusted Rates
per 100,000 Population
- 131.3 - 162.4
- 162.5 - 177.6
- 177.7 - 192.9
- 193.0 - 251.0
North Carolina Lung Cancer Incidence Rates 2007-2011

Age Adjusted Rates per 100,000 Population

- 51.0 - 65.2
- 65.3 - 75.8
- 75.9 - 85.5
- 85.6 - 112.5

Note: Information is subject to change as files are updated.
North Carolina Lung Cancer Mortality Rates 2008-2012

Age Adjusted Rates per 100,000 Population
- 27.2 - 43.7
- 43.8 - 54.0
- 54.1 - 61.2
- 61.3 - 72.7
North Carolina Colon Cancer Incidence Rates 2007-2011

Age Adjusted Rates per 100,000 Population

- 26.6 - 36.9
- 37.0 - 43.1
- 43.2 - 51.8
- 51.9 - 67.5

*Rates based on small numbers [fewer than 16 cases] are unstable and should be interpreted with caution.

Note: Information is subject to change as files are updated.
North Carolina Colon Cancer Mortality Rates 2008-2012

Age Adjusted Rates per 100,000 Population
- 7.6 - 12.9
- 13.0 - 16.0
- 16.1 - 19.7
- 19.8 - 28.5
North Carolina Female Breast Cancer Incidence Rates 2007-2011

Age Adjusted Rates per 100,000 Female Population

- 113.8 - 135.5
- 135.6 - 152.4
- 152.5 - 169.9
- 170.0 - 216.4

Note: In situ cases are included. Information is subject to change as files are updated.
North Carolina Prostate Cancer Incidence Rates 2007-2011

Age Adjusted Rates per 100,000 Male Population

- 80.2 - 113.1
- 113.2 - 140.4
- 140.5 - 166.8
- 166.9 - 225.2

*Rates based on small numbers (fewer than 16 cases) are unstable and should be interpreted with caution.

Note: Information is subject to change as files are updated.

February 2014
North Carolina
Prostate Cancer Mortality Rates
2008-2012

Age Adjusted Rates per 100,000 Male Population
- 5.4 - 15.0
- 15.1 - 22.3
- 22.4 - 32.2
- 32.3 - 46.0

North Carolina Resident Data
Appendix G
Glossary

**Behavioral Risk Factor Surveillance System (BRFSS)** is a randomized telephone survey of state residents, aged 18 and older in households with telephones, that captures the health behavior and preventive health practices related to the leading causes of death or disability.

*Cancer*, also called malignancy, is a term for diseases in which abnormal cells divide without control and can invade nearby tissues. Cancer cells can also spread to other parts of the body through the blood and lymph systems. There are several main types of cancer. Carcinoma is a cancer that begins in the skin or in tissues that line or cover internal organs. Sarcoma is a cancer that begins in bone, cartilage, fat, muscle, blood vessels, or other connective or supportive tissue. Leukemia is a cancer that starts in blood-forming tissue, such as the bone marrow, and causes large numbers of abnormal blood cells to be produced and enter the blood. Lymphoma and multiple myeloma are cancers that begin in the cells of the immune system. Central nervous system cancers are cancers that begin in the tissues of the brain and spinal cord. (National Cancer Institute)

**Care and treatment** include diagnosis of the disease and prompt treatment. Cancer treatment and care consists of timely completion of the diagnostic evaluation of the tumor and related areas and prompt implementation of evidence-based treatments including management of treatment side effects. Since cancer care may involve a combination of surgery, chemotherapy and radiation, it is best treated by a multi-disciplinary team of medical, surgical and radiation oncologists.

**Cultural competence** refers to an ability to interact effectively with people of different cultures and socio-economic backgrounds, particularly in the context of human resources, non-profit organizations, and government agencies whose employees work with persons from different cultural/ethnic backgrounds. Cultural competence comprises four components: (a) awareness of one’s own cultural worldview, (b) attitude towards cultural differences, (c) knowledge of different cultural practices and worldviews and (d) cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with and effectively interact with people across cultures.

**Disparity population** refers to groups of people who are unequal as in age, race, sex, education, social economic status, geography, etc. Cancer rates for diagnosis, treatment and mortality vary among different population groups. Identifying population groups and determining the factors that cause disparities in cancer rates are key to reducing these rates.
**Early detection** includes screening assessments to detect disease at an early stage when treatment can be most effective. Early detection screenings for cancer include: Pap tests for cervical cancer, mammograms for breast cancer, FIT, FOBT, sigmoidoscopy and colonoscopy for colorectal cancer, and prostate-specific antigen (PSA) and/or digital rectal examination (DRE) for prostate cancer. Screening tests can be provided to large groups of people, one at a time.

**Evidence-based** is a process for making decisions about a program, practice or policy that is grounded in the best available research evidence and informed by experiential evidence from the field and relevant contextual evidence.

**Food deserts** are defined as urban neighborhoods and rural towns without ready access to fresh, healthy and affordable food. The lack of access contributes to a poor diet and can lead to higher levels of obesity and other diet-related diseases.

**Health Disparity** is the difference in the incidence, prevalence, mortality and survival of a disease and the related adverse health conditions that exist among specific population groups.

**Health Equity** occurs when every person has the opportunity to attain his or her full health capability and no one is disadvantaged from achieving this capability because of his or her social position or other socially determined circumstance.

**Incidence Rate** is the rate at which new cases of a disease are occurring in a population.

**Morbidity** is a measurement of ill health.

**Mortality Rate** is a measurement of death in a population.

**Palliative care** begins at the time of diagnosis and specializes in the relief of pain, symptoms and stress of serious disease. The goal is to prevent and relieve suffering and to improve the quality of life for patients of all ages and their families and loved ones. Palliative care helps to make patients more comfortable at every stage of the disease – from time of diagnosis, throughout survivorship and at end of life.

**Prevalence rate** is the proportion of a population that has a disease or health characteristic at a given point in time, including both new and previously diagnosed cases. It is a snapshot of all the people who have a disease at that one moment.

**Primary prevention** is aimed at preventing the occurrence of disease and promoting health. Primary prevention of cancer includes healthy eating habits, regular physical activity, smoking cessation, and reducing exposure to secondhand smoke. Evidence shows that the risk of breast, colorectal and prostate cancers may be increased when individuals are overweight or obese.
Social Determinants of Health are life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education and health care, whose distribution across populations effectively determines length and quality of life.

Survivorship focuses on improving the quality of health and life of a person with a disease until the end of life. It covers the physical, psychosocial and economic issues of a disease, beyond the diagnosis and treatment phases. In cancer, survivorship may include issues related to the accessibility of healthcare and follow-up treatment, continued effects of treatment, additional cancers and quality of life. Family members, friends, and caregivers play an important role in the survivorship experience.
# North Carolina Cancer Plan Contributors

<table>
<thead>
<tr>
<th>Name</th>
<th>Position or Title</th>
</tr>
</thead>
<tbody>
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<td>Cancer Survivor Representative</td>
</tr>
<tr>
<td>Honorable Don Davis</td>
<td>N.C. Senate Representative</td>
</tr>
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<td>N.C. House of Representatives Representative</td>
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<tr>
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</tr>
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</tr>
<tr>
<td>Bill Jollie</td>
<td>Cancer Survivor Representative</td>
</tr>
<tr>
<td>Honorable Bert Jones</td>
<td>N.C. House of Representatives Representative</td>
</tr>
<tr>
<td>Chase Jones</td>
<td>Cancer Survivor Vs. Cancer Foundation At-Large Member</td>
</tr>
<tr>
<td>Honorable Susan Martin</td>
<td>N.C. House of Representatives Representative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
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<td>Adesola Awomolo, M.D.</td>
<td>New Hanover Regional Medical Center Physicians Group Oncologist Old North State Medical Society Representative</td>
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<td>Honorable Tamara Barringer</td>
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</tr>
<tr>
<td>Renee Batts</td>
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</tr>
<tr>
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<td>Cancer Survivor Representative</td>
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</tr>
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<td>Medical Director Community Care of the Lower Cape Fear Primary Care Physician Representative</td>
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<tr>
<td>Cathy Coggins Rimmer</td>
<td>Director of Cancer Registry Novant Health Forsyth Medical Center Association of N.C. Cancer Registrars Representative</td>
</tr>
</tbody>
</table>
North Carolina Advisory Committee on Cancer Coordination and Control Subcommittees

**Prevention Subcommittee**

- Bill Jollie, Co-Chair
- Deborah “Hutch” Allen, Co-Chair
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- Jordon Bostic
- Robert S. Cline
- Angela M. Esteva
- Neasha Graves
- Sally Herndon
- Anita Holmes
- Amadou Jallow
- Anna P. Jones
- Bert Jones
- Mike Lunsford
- Deborah Mayer
- Christina Minard
- Neda Padilla
- Ruth Petersen
- Kathy Pollak
- William S. Robinson
- Laura Wallenta
- Fred Wyand

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- Nadine Barrett, Co-Chair
- Joni Aldrich
- Mary Anderson
- Latanja Avery
- Molly Black
- Tim Carney
- Pat Curl
- Jenni Danai
- Morgan Daven
- Dusty Donaldson
- Phil Harris
- Leigh Hayden
- M.J. (Susie) Lavender
- Suzanne Lea
- Maria K. Long
- Schatzi H. McCarthy
- Peggy Messick
- Bruce Thoreson
- Suzanne Tompkins
- Diane Taylor Torrent
- Brenda Stone-Wiggins
- Emmanuel Zervos

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- Kelcy Walker

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  Division of Surgical Oncology  
  E.C.U., Brody School of Medicine Representative

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  N.C. Cancer Prevention and Control Branch

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  Wake Forest School of Medicine Representative

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  Secretary, Department of Environment and Natural Resources  
  Ex-Officio

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  Oncology Nurse  
  N.C. Nurses Association Representative

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  N.C. Senate Representative

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Tara Ballard
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Cori Davis
Dev Desai
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