

YOU FIRST

Screening and support for heart disease, breast and cervical cancer.

Expanding Impact Through Chronic Disease Partnerships

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VERMONT
DEPARTMENT OF HEALTH

Program Collaboration in VT

NBCCEDP and WISEWOMAN

- Shared program application
- Shared staff
- Integrated office visits
- Shared communications materials
- Joint staff meetings
- Shared data system
- Combined reminders
- Joint patient navigation

YOU FIRST

Screening and support for heart disease, breast and cervical cancer.

Program Collaboration in VT

NBCCEDP and CRCCP

- Shared QI/EBI clinic partners
- Shared TA support
- Shared staff (data manager, evaluation)
- Joint staff meetings
- Joint subrecipient monitoring and reporting

VTAAC
Vermonters Taking Action Against Cancer

YOU FIRST
Screening and support for heart disease, breast and cervical cancer.

802 QUITS

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Aligning Goals and Activities

NBCCEDP and WISEWOMAN serve the same population

Both prioritize the same populations

Same barriers to preventative care like insurance, transportation, language, misconceptions

Navigation and follow-up support

NBCCEDP and CRCCP have the same EBIs

Stronger Together: Benefits of Collaboration

Program Management	Program Participant
Maximized resources	Easier access to services
Shared patient navigation	Less paperwork, less duplication
Wider community reach	More comprehensive prevention
Aligned messaging and outreach	One program point of contact
Stronger partnerships	More touchpoints with primary care
Streamlined grant management	Better program engagement

Actionable Ideas!



Have a partnership mindset.



Get to know the other program managers and directors.



Get a list of all funded partners in the state.



Map out overlapping priorities.

Thank you!











YOU FIRST



Prevention to Elimination

Collaborating to End Cervical Cancer in Louisiana

LOUISIANA CANCER PREVENTION & CONTROL PROGRAMS

CONSIDERATIONS FOR SUCCESSFUL PARTNERSHIPS

- ☑ Align on shared goals and engage partners early.
- ☑ Leverage complementary strengths and identify opportunities for synergy.
- ☑ Maintain open, transparent, and trust-based communication.
- ☑ Establish regular touchpoints to sustain engagement and accountability.
- ☑ Bring concrete, actionable ideas that advance mutual objectives.



CERVICAL CANCER COLLABORATION

- Training community health workers and other community partners on breast & cervical cancer early detection, HPV vaccination, and referrals to clinical services.
- Collaborating to increase adoption of HPV self-collection.
  - Developed HPV self-collection materials including clinic guidance, patient-facing educational materials, and an instructional video.
  - Identifying potential health systems for implementation.
  - Partnering with an LBCHP clinic on a QI project to increase cervical cancer screening through HPV self-collection (Scaling What Works).
- Cervical cancer elimination plan.



CERVICAL CANCER ELIMINATION

2024 Cervical Cancer Elimination Summit



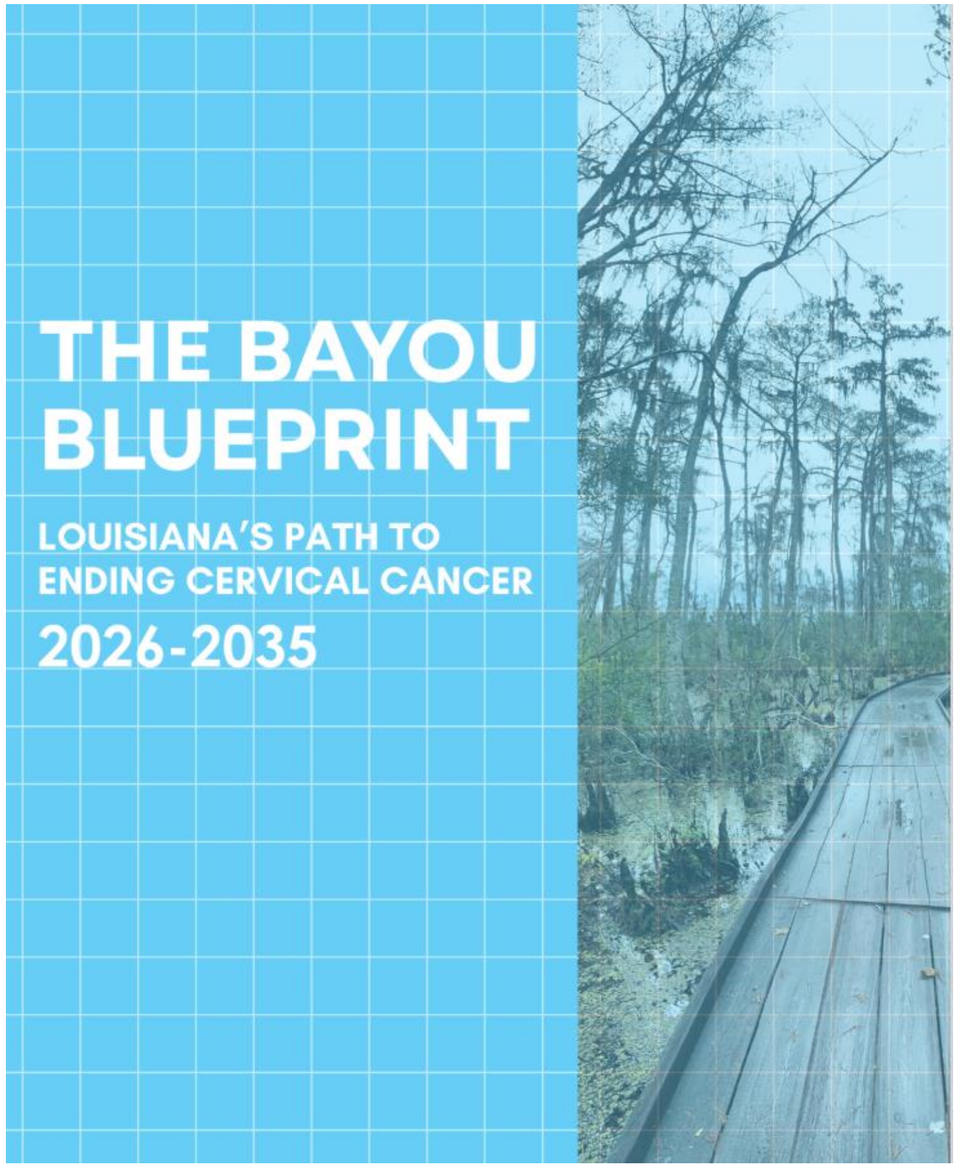
CERVICAL CANCER ELIMINATION

The Bayou Blueprint is a coordinated, community-driven plan to eliminate cervical cancer as a public health problem in Louisiana.

What's inside the Plan:

- **Strategic pillars:** Vaccination, screening, and follow-up care
- **Data-driven guidance:** Relevant local data to inform responsive, community-based efforts
- **Voices from Louisiana**: Stories and insights from across the state
- **Tailored strategies:** Multiple entry points for engagement based on your unique role





LOUISIANA CANCER PREVENTION & CONTROL PROGRAMS

CERVICAL CANCER ELIMINATION

Prevention

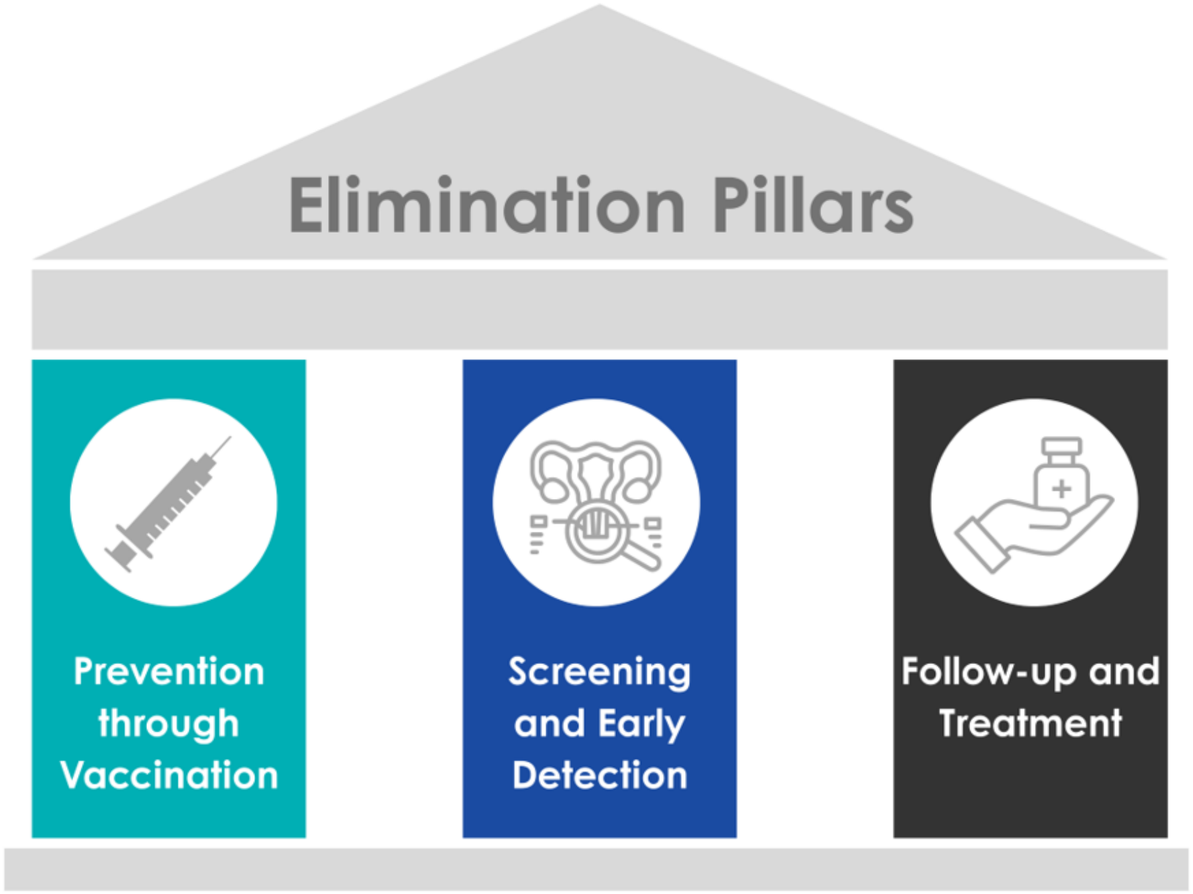
- Talk to family and friends about the importance of HPV vaccination as cancer prevention and the benefits of starting at age 9 to build strong immunity.

Screening

- Train community health workers (CHW) on educating community members about cervical cancer, screening guidelines & HPV self-collection.

Follow-up

- Increase the number of trained advanced practice nurses and other clinicians who can perform colposcopies and treatment for precancers, especially those working in rural areas.



Thank you

Alabama's OPERATION WIPE OUT

&

HPV Vaccination Roundtable of the Southeast

LOUISIANA CANCER PREVENTION & CONTROL PROGRAMS

Expanding Impact through Chronic Disease Partnerships: A BCCCP Perspective

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Chronic Disease and Injury Section
Division of Public Health
NC Department of Health and Human Services

Expanding Impact through Chronic Disease Partnerships Panel • August 19, 2026

Presentation Overview

01 North Carolina’s Chronic Disease Overview

02 North Carolina’s Chronic Disease Partnerships

03 Opportunities: Scaling and Growth

01

North Carolina’s Chronic Disease Overview

North Carolina’s cancer and chronic disease landscape

North Carolina Landscape

Geography & Scale

- 2nd largest rural population in the nation
- Uneven access to specialists, screening, and follow-up care
- 10.8M people across 100 counties
- 85 of 100 counties rural or semi-rural

Population Complexity

- Communities that have historically experienced a disproportionate burden of disease
- Lumbee Tribe in Robeson County — largest tribe east of the Mississippi
- Rural poverty and access barriers shape prevention needs

Economic & Environmental Context

- Legacy tobacco economy continues to influence cancer burden
- Environmental exposures remain active concerns
- Agriculture and manufacturing: industrial exposure risks

Research & Institutional Capacity

- Major prevention research infrastructure: Duke, UNC Lineberger
- NC Central Cancer Registry: 30+ years of surveillance data
- NC Advisory Committee on Cancer Coordination and Control (ACCCC): legislatively mandated coalition with 100+ partners

NC Cancer and Chronic Disease Burden

Cancer burden in NC

#2 — **Leading cause of death**
Cancer remains a major driver of mortality statewide.

16% — **Higher mortality**
Eastern NC compared with the rest of NC.

1.4× — **Breast cancer mortality**
All minority compared with white women

1.7× — **Cervical cancer mortality**
All minority compared with white women

Shared chronic disease / risk-factor burden linked to cancer risk

Measure	NC	U.S.	Benchmark note
Obesity	34.5%	34.2%	Similar to national; linked to 13 cancer types
Diagnosed diabetes	13.2%	12.0%	Above U.S.; metabolic risk overlaps with cancer risk
No leisure-time physical activity	20.2%	21.8%	Slightly better than U.S.; still a major shared risk
Current smoking	11.5%	11.6%	Similar to U.S.; tobacco remains a leading preventable cancer risk
Excessive drinking	14.3%	17.0%	Below U.S.; alcohol is linked to multiple cancers

Priority early-onset trends

Breast • Colorectal • Oropharyngeal HPV-related cancers

Why this matters

Cancer prevention cannot be separated from chronic disease prevention. NC's strategy must use chronic disease infrastructure to reduce tobacco use, obesity, physical inactivity, alcohol-related risk, diabetes/metabolic risk, and infection-related cancer risk.

Sources: NC SCHS Vital Statistics; NC Central Cancer Registry / NC Cancer Plan; American Lung Association State of Lung Cancer; America's Health Rankings 2024 BRFSS-based estimates; CDC cancer risk factor guidance; HHS Surgeon General Alcohol and Cancer Risk Advisory.

02

North Carolina’s Chronic Disease Partnerships

NC BCCCP’s collaboration with other CDC-Funded Chronic Disease Programs

SHARED RISK → SHARED PATHWAY

Organizing Around Shared Risk

The chronic disease partnership frame works best when it starts with shared risk and protective factors — not with separate program names.

1
Enroll & assess
Single intake; eligibility + CVD risk factors captured together

→

2
Screen in-visit
Breast/cervical screening + blood pressure, glucose, lipid, tobacco

→

3
Intervene
HBSS coaching (OARS/MI), referrals: DPP, QuitlineNC, community resources

→

4
Document & track
Both services to Med-IT; monitored on one aligned framework

One
whole-health encounter

Shared Risk and Protective Factors

- Tobacco use
- Hypertension
- Diabetes risk
- Physical inactivity
- Nutrition insecurity
- HPV vaccination
- Screening gaps
- Limited follow-up access

Positioning BCCCP Within a Connected, Reciprocal Prevention Network

The partnership case is stronger when we show what other CDC-funded programs gain from BCCCP, and what women gain when those programs connect back.



Partnership message: BCCCP helps other CDC-funded programs reach the right population, and those programs help BCCCP close risk-factor gaps it cannot solve alone.

The NC Partnership Network: Shared Infrastructure Across CDC-Supported Programs

CARDIOVASCULAR

WISEWOMAN

CVD risk, hypertension, glucose, cholesterol

Required CVD screening layered into the BCCCP encounter.

COLORECTAL

CRCCP / NC PICCS

Colorectal screening gaps and follow-up access

EBIs and referral pathways ride the same provider network.

COALITION

Comprehensive Cancer Control

Tobacco, HPV, nutrition, physical activity, survivorship

The Cancer Plan gives every partner one shared language and table.

TOBACCO

QuitlineNC / Tobacco Prevention

Tobacco use, lung cancer risk, cardiovascular risk

Cessation referral becomes part of the same whole-health pathway.

DIABETES

Chronic Disease Programs

Diabetes risk, BP control, lifestyle supports

DPP, SMBP, pharmacists, and community-clinical links plug in after abnormal findings.

NC BCCCP and WISEWOMAN: Integrated Prevention and Early Detection

NC's FY27 model: WISEWOMAN cardiovascular screening is a **required component of every BCCCP visit** — codified through the Agreement Addendum, not left to provider discretion.

One enrollment

A woman enrolls once. Cancer screening and CVD risk screening happen in the same encounter — no second appointment, no second eligibility hurdle.

One care pathway

Abnormal results route into a single follow-up loop: diagnostics, Health Behavior & Lifestyle Support Sessions (HBSS), QuitlineNC, and community resources.

One record

Both services document to Med-IT against the same participant, so the state sees the whole encounter — not two disconnected data streams.

ADD YOUR PROOF POINT: *a single NC number lands harder than any framing — e.g. "___% of eligible BCCCP participants received a CVD risk screen in FY26," or # of women reached, or CVD risks newly identified. Insert your cleanest verified metric here.*

Translating Integration into Operational Expectations

Partnerships become durable when the same expectation shows up in the workplan, the agreement, the TA, the data, and the monitoring conversation.

1

Shared workplan objectives

Name the cross-program objective and the shared population; do not leave the partner role implied.

2

Agreement / AA language

Put the integrated activity in the funded provider agreement so it survives turnover and competing priorities.

3

Joint provider TA

Use recurring Lunch & Learns, toolkits, and scripts so clinic staff know what to do in a real visit.

4

Aligned data + monitoring

Track the integrated pathway and ask about it during PET, monitoring, and follow-up TA.

The operational test: would a new clinic employee know this partnership is required, how to complete it, where to document it, and how performance will be reviewed?

A Shared Road Map: NC Comprehensive Cancer and The Cancer Plan

ACCCC

Legislatively mandated advisory body with 100+ partners that supports implementation, coordination, and accountability across the cancer continuum.

Comprehensive Cancer Control Program

CDC-funded infrastructure for statewide planning, coalition support, partner alignment, implementation tracking, and priority cancer strategies.

2025–2030 NC Cancer Plan

Focuses on six detectable or preventable cancers: breast, colorectal, HPV-related, lung, prostate, and skin/melanoma.

Strategic Goals

01 **Reduce cancer risk**

02 **Increase screening + early detection**

03 **Improve treatment access + care coordination**

04 **Improve provider + public knowledge**

Sources: NC Advisory Committee on Cancer Coordination and Control; 2025–2030 NC Cancer Plan; ACCCC Annual Report to the DHHS Secretary, SFY 2024–2025.

How BCCCP Mobilizes Prevention Through ACCCC and the Cancer Plan

BCCCP extends its impact beyond direct screening by partnering with Comprehensive Cancer Control and ACCCC to help advance policy, systems, and environmental strategies across the cancer continuum.

How BCCCP Uses This Infrastructure:

Represent screening in subcommittees

BCCCP staff participate in ACCCC and Cancer Plan workgroups.

Ensures screening priorities are represented across the continuum.

Expand beyond direct services

Links screening operations to statewide prevention, education, and survivorship work.

Uses coalition partners to extend reach outside the clinic visit.

Advance policy, systems, and environmental change

Brings BCCCP's clinical and operational perspective to broader strategies.

Supports evidence-based changes that improve access and follow-up.

Strengthen statewide capacity + alignment

Connects BCCCP to shared planning, implementation tracking, and partner accountability.

Builds impact through common infrastructure rather than siloed efforts.

BCCCP + Comprehensive Cancer Control partnership: By embedding staff in ACCCC and Cancer Plan subcommittees, BCCCP helps shape prevention and systems strategies while ensuring breast and cervical cancer screening is represented along the full cancer continuum.

Data To Understand Where We Are — and Where Partnerships Can Move the Needle

Data Source / Funding Stream	What It Captures	How We Use It Together
NC Cancer Registry (CDC NPCR-funded)	Cancer incidence, stage at diagnosis, tumor characteristics, treatment patterns, and mortality linkages	Shows the population-level cancer burden and helps identify communities, cancer sites, and stage-at-diagnosis patterns where earlier detection and follow-up systems need strengthening.
Registry ↔ BCCCP Partnership (linkage + shared interpretation)	Matched BCCCP service records with registry outcomes, including cancers diagnosed among BCCCP participants, stage at diagnosis, and treatment patterns	Moves the story beyond service counts: validates impact, identifies missed opportunities, and gives BCCCP and the Registry a shared evidence base for planning.
Vital Statistics + BRFSS (CDC-supported surveillance)	Leading causes of death, county-level chronic disease patterns, screening behaviors, and population risk behaviors	Places BCCCP and Registry findings in community context and shows where cancer, CVD, diabetes, and tobacco-related risks cluster together.
Other CDC-Funded Program Data (WISEWOMAN, CRCCP/PICCS, CCC, Tobacco/QuitlineNC)	CVD risk screening, CRC systems-change work, cessation referrals, HBSS/DPP/SMBP referrals, coalition priorities, and policy/environmental strategies	Shows where funded infrastructure overlaps so programs can braid referrals, TA, provider relationships, and shared risk-factor strategies instead of building parallel systems.

North Carolina Partnership to Increase Colorectal Cancer Screening

BCCCP and NC PICCS use the same provider network, workflow improvement tools, and screening pathways to extend colorectal cancer prevention and early detection.

QUALITY IMPROVEMENT

EBI Projects

Many NC PICCS and BCCCP sites share the same providers.

Successful evidence-based interventions (EBIs) can be adapted across programs.

EHR and workflow changes can improve colorectal, breast, and cervical screening together.

The programs use a similar improvement model:

- Aim statements
- Process maps
- Gap analysis
- PDSAs

SCREENING POLICY

Colorectal Cancer Screening Policy

All age-eligible NC BCCCP participants are assessed for colorectal cancer screening.

If a participant is not up to date, they are encouraged and supported to obtain screening.

BCCCP + Tobacco Prevention: Connecting Screening to Cessation

Tobacco use cuts across cancer, cardiovascular disease, and diabetes risk. BCCCP uses the screening encounter to connect participants to cessation supports and broader prevention strategies.

SHARED RISK

Risk is already in the room

Tobacco risk is addressed during the whole-health visit.

The same participant may face screening gaps, lung cancer risk, and CVD risk.

BCCCP providers are trusted points for brief intervention.

REFERRAL PATHWAY

Connect to QuitlineNC

Ask, advise, and refer during BCCCP/WISEWOMAN encounters.

QuitlineNC provides statewide cessation support.

Referral turns identification into action.

PSE REACH

Extend beyond direct screening

Tobacco partners support provider education, policies, and systems strategies.

BCCCP brings patient-navigation and clinic workflow insight.

Prevention extends beyond one visit.

BCCCP + QuitlineNC / Tobacco Prevention partnership: BCCCP brings access to a priority population and trusted clinical providers; tobacco partners bring cessation expertise, QuitlineNC infrastructure, referral workflows, and policy/system strategies that extend impact beyond direct screening.

03

Opportunities

Wins and Challenges connecting across Chronic Disease

What Worked and What Was Challenging

Wins

Framing the shared population — “Same woman, same visit” beat every abstract case for integration.

Requiring, not encouraging — The AA made integration the default; voluntary versions stalled.

Equal-weight program identity — WISEWOMAN written as a co-equal program, never a BCCCP appendage.

Aligning contracts + monitoring — Moving the incentive, not just the instruction, changed provider behavior.

Provider TA that repeats — Recurring Lunch & Learns turned a mandate into a routine.

Lessons Learned

Contract timelines — Procurement was the dominant bottleneck — a ~154-day median that delays every integrated build.

Provider capacity — Small clinics can’t absorb a longer visit without staffing and workflow help.

Two divisions, two systems — Cross-division data and reporting don’t line up cleanly.

Sustainability — Reusing infrastructure is efficient, but funding uncertainty threatens the base everything plugs into.

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