



# NEW MEXICO CANCER PLAN

2020 > 2024

**A document to guide collaborative cancer  
control efforts throughout the state**





## DEDICATION

The **New Mexico Cancer Plan 2020-2024** is dedicated to the memory of **Gena Love**, a tireless advocate for New Mexicans affected by cancer.



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## NEW MEXICO CANCER PLAN 2020 > 2024

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### New Mexico Cancer Council Workgroups >

The New Mexico Cancer Council is a collaborative effort of diverse public and private partners working together to reduce the burden of cancer in New Mexico through the development, implementation and evaluation of the New Mexico Cancer Plan. Our goal is to increase access to information, prevention and treatment using innovative and effective programs and policies thus reducing the human and economic burden of cancer and improving the outcomes and quality of life for New Mexicans.

The goals and objectives of the New Mexico Cancer Plan are advanced through the dedicated efforts of Council workgroups. Workgroup members are volunteers who share a common interest relevant to cancer-related work in New Mexico. At the time of this writing, the following workgroups participated in the Cancer Plan creation process.

**Albuquerque Cancer Coalition** – A coalition of cancer support agencies, hospital treatment centers and governmental agencies uniting to inform the community of resources, to educate, to advocate and to meet the needs of cancer patients and their families. The group produces the Albuquerque Cancer Coalition Cancer Support & Treatment Directory.

**Colorectal Cancer Workgroup** – Works collaboratively to reduce the burden of colorectal cancer in New Mexico and supports initiatives that align with national efforts, including the National Colorectal Cancer Roundtable.

**Native American Workgroup** – Identifies the needs of Native American communities to provide guidance to the New Mexico Cancer Council regarding New Mexico Native American cancer issues and how the New Mexico Cancer Plan's goal areas may better relate to these issues.

**New Mexico Cancer Patient Navigation Network** – Focused on improving access to cancer-related services through expansion of community-based patient navigation services.

**Rural Health Equity Workgroup** – Aims to identify and address the cancer burden of rural and frontier communities in New Mexico through outreach and partnerships among providers and other healthcare stakeholders.

**Viva la Vida!** – Supports efforts to improve the quality of life for cancer patients and their families by focusing on relieving the pain, stress and other symptoms of cancer and its treatment, and by making palliative care an option for all cancer patients at the time of diagnosis.

Special thanks and appreciation are extended to the **Colorado Cancer Coalition** for their valuable guidance in the crafting of the **NEW MEXICO CANCER PLAN 2020 • 2024**.

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# CONGRESS OF THE UNITED STATES

DELEGATION OFFICE  
STATE OF NEW MEXICO  
HART SENATE OFFICE BUILDING  
WASHINGTON, D.C. 20510

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July 7, 2020

Dear New Mexicans:

We are pleased to share with you the 2020 – 2024 New Mexico Cancer Plan. This Cancer Plan is the culmination of a multi-year effort by the New Mexico Cancer Council and its state, regional, and local partners to develop a comprehensive strategy to address the impact of cancer on communities throughout our state.

Cancer is the second leading cause of death in New Mexico today. The American Cancer Society estimates that approximately 3,700 New Mexicans will die from a form of cancer and as many as 9,500 will receive a new diagnosis this year. Cancer affects every community in our state and exerts a profound impact on individuals, families, and friends long after it is first diagnosed.

The New Mexico Cancer Plan contains actionable measures to address this public health challenge across a continuum of care by improving cancer prevention, screening, access to quality treatment, and the availability of palliative care. It reflects the diversity of approaches needed to address this issue across New Mexico by highlighting the important role of community health workers and by developing a culturally responsive strategy to lessen the heavy burden of cancer in Indian Country.

We offer our sincere thanks to the members of the Cancer Council and their partners who have dedicated their time and expertise to developing this plan for our state. We hope you find this document beneficial in your efforts to make a difference in the fight against cancer in New Mexico and vow to continue advocating for cancer patients and their families in Washington.

Sincerely,

/s/ Tom Udall  
United States Senator

/s/ Ben Ray Luján  
United States Representative

/s/ Martin Heinrich  
United States Senator

/s/ Deb Haaland  
United States Representative

/s/ Xochitl Torres Small  
United States Representative

## EXECUTIVE SUMMARY

Cancer is New Mexico's second leading cause of death and a major cause of illness and suffering. One out of five deaths in New Mexico is caused by cancer. The New Mexico Cancer Plan 2020-2024 serves as a blueprint for cancer control in our state. The plan includes goals, objectives and strategies that span a broad continuum of care encompassing prevention, early detection and screening, improving access to care, enhancing the quality of life for cancer survivors and drawing upon the strengths and skills of patient navigators to improve cancer outcomes. Strategies to support cancer control in Native American communities are also included in the plan.

The goals and priorities of the plan have been garnered from the heartfelt contributions of time and expertise from a wide-ranging group of committed individuals representing community organizations, medical facilities, treatment centers, cancer survivors, public health professionals and other interested stakeholders. The process evolved via regularly held meetings, consultations with content area experts and collaboration among statewide organizations. Members of the New Mexico Cancer Council and its Executive Committee and Workgroups provided invaluable insight and input.

### The following 9 GOAL AREAS OF FOCUS were developed for inclusion in the plan:

- GOAL 1:** Increase Healthy Behaviors and Improve Health Status
- GOAL 2:** Reduce Initiation and Use of Tobacco Products
- GOAL 3:** Decrease Environmental Factors That Lead to Cancer
- GOAL 4:** Decrease Mortality from Screenable Cancers
- GOAL 5:** Ensure Consistent Access to High-Quality Diagnostic and Treatment Services
- GOAL 6:** Increase Awareness of and Access to High-Quality Cancer Clinical Trials
- GOAL 7:** Improve Quality of Life for All New Mexicans Facing Cancer
- GOAL 8:** Improve Survivorship Care Planning Services
- GOAL 9:** Enhance Patient Navigation Across the Cancer Care Continuum

The objectives, strategies and measures associated with each goal were carefully crafted to impart direction and guidance for the implementation of the nine overarching areas of concern. The plan strives to provide the reader with a clear, concise and accessible picture of what can realistically be accomplished by the year 2024 to reduce the burden of cancer in New Mexico.

The plan also intends to support greater collaboration and coordination among stakeholders in order to reduce the cancer burden in the state. No agency or profession can solve the problem alone. Developing key partnerships is essential to achieving successful outcomes. By working together and coordinating efforts, gaps in treatment and services to under-resourced populations are addressed and real progress is made to reduce the burden of cancer and health inequities in New Mexico.

The plan is a multipurpose resource to be utilized in cancer control. Some ways to use the Cancer Plan include: referencing information about cancer in New Mexico; identifying gaps in cancer control and prevention; guiding program development; and developing educational materials and funding proposals. By using the Cancer Plan as a guiding document, those engaged in cancer control efforts will become part of a statewide, unified effort to fight cancer.

# THE NEW MEXICO CANCER PLAN

The New Mexico Cancer Plan serves as a blueprint for cancer control in our state. The plan resulted from many months of work and thoughtful contributions by the Cancer Plan Revision Committee, the New Mexico Cancer Council Executive Committee and numerous valued partners and stakeholders throughout the state.

Development of the plan was guided by the Socio-Ecological Model. The Socio-Ecological Model is the theory which suggests that an individual's social, physical and economic environments affect one's health. This model proposes that individual, interpersonal, community, organizational and societal factors should be taken into account when planning and implementing health promotion interventions, because they have direct and indirect influences on lifestyle, behavior choices and health.<sup>1,2</sup>



The plan includes goals, objectives and strategies that span a continuum of cancer control encompassing prevention, early detection and screening, informed decision-making, elimination of disparities, access to care, quality of life and effective coordination and collaboration among cancer control organizations.

A separate section focuses on the cancer-related needs specific to members of New Mexico's Native American communities. This section has been created by the New Mexico Cancer Council's Native American Workgroup.

The plan is intended to be a relevant, timely, user-friendly and valuable tool that can be used by a broad audience including public health practitioners, advocates, educators, medical providers and others involved in all areas of cancer control in New Mexico. The plan includes support for cancer-related initiatives and collaborative efforts among groups regarding specific areas of interest and statewide efforts.

**Table 1:** A Description of Social Ecological Model (SEM) Levels

| SEM Level             | Description  |
|-----------------------|--|
| <b>Public Policy</b>  | Local, state, national and global laws and policies, including policies regarding the allocation of resources for maternal, newborn and child health and access to healthcare services, restrictive policies (e.g., high fees or taxes for health services) or lack of policies that require childhood immunizations         |
| <b>Community</b>      | Relationships among organizations, institutions and informational networks within defined boundaries, including the built environment (e.g., parks), village associations, community leaders, businesses and transportation  |
| <b>Organizational</b> | Organizations or social institutions with rules and regulations for operations that affect how, or how well, for example, services are provided to an individual or group  |
| <b>Interpersonal</b>  | Formal and informal social networks and social support systems that can influence individual behaviors, including family, friends, peers, coworkers, religious networks, customs or traditions   |
| <b>Individual</b>     | Characteristics of an individual that influence behavior change, including knowledge, attitudes, behavior, self-efficacy, developmental history, gender, age, religious identity, racial/ethnic identity, sexual orientation, economic status, financial resources, values, goals, expectations, literacy, stigma and others |

Socio-Ecological Model; Adapted from CDC *The Social-Ecological Model: A Framework for Prevention*.<sup>3</sup>

## Cancer Plan Evaluation >

The 2020-2024 New Mexico Cancer Plan contains measurable objectives and targets that align with state and national goals, and are based on current trends. New Mexico will track progress regularly and share results with stakeholders and partners, allowing the state and its partners to gauge progress, identify gaps and change direction as needed.

A variety of data sources, including New Mexico surveillance data, were used to determine baseline measures for objectives. In some cases, where no data source or baseline is identified, one may need to be established to support the plan's implementation.

**Albuquerque Cancer Coalition** – A coalition of cancer support agencies, hospital treatment centers and governmental agencies uniting together to inform the community of resources, to educate, to advocate and to meet the needs of cancer patients and their families. The ACC updates the Cancer Support and Treatment Directory, which provides information about member services and is dedicated to the thousands of families across New Mexico who are struggling with cancer.

**Behavioral Risk Factor Surveillance System (BRFSS)** – an annual telephone survey that collects data about health-related behaviors, chronic health conditions and use of preventive services.

**Census Bureau's Small Area Health Insurance Estimates (SAHIE)** – a source of data for single-year estimates of health insurance coverage status for all counties in the U.S. by selected economic and demographic characteristics.

**Environmental Public Health Tracking Program (EPHTP)** – a source for environmental information integrated with health information in an effort to track and understand how the environment might affect the health of New Mexicans.

**National Immunization Survey (NIS) Teen and Children** – an annual national survey used to monitor vaccine coverage in relation to the Advisory Committee on Immunization Practices for children 6 months to 17 years. The NIS consists of two parts, a phone survey for parents and a questionnaire for providers of the phone respondent's children to collect vaccination records.

**National Palliative Care Registry (NPCR)** – a registry that provides data on the composition, operations and outcomes of palliative care programs by service setting. Data are collected by module and include service setting metrics, patient demographics, patient visits, screening and referral, diagnosis categories, discharge disposition, length of stay, staffing and certification.

**New Mexico Tobacco Evaluation Survey (NMTES)** – a survey administered by the New Mexico Department of Health (NMDOH) Tobacco Use Prevention and Control Program (TUPAC) and its external evaluators on a biannual basis (2014, 2016 and 2018). It is a random digit-dial telephone statewide survey of about 1,000 New Mexico adults, including landline and cell-phone-only households, with an oversample of young adults. Topics surveyed include behavioral and attitudinal data related to tobacco policy, surveillance of tobacco product use including emerging products, awareness of existing media campaigns and other health topics that intersect with tobacco.

**New Mexico Tumor Registry (NMTR)** – the statewide cancer surveillance program that collects and reports data on cancer incidence and mortality, including type, stage at diagnosis and five-year survival rates.

**New Mexico Youth Risk and Resiliency Survey (YRRS)** – a tool used to assess the health risk behaviors and resiliency (protective) factors of New Mexico high school and middle school students. The YRRS is part of the national CDC Youth Risk Behavior Surveillance System (YRBSS).

## New Mexico: Language, Literacy and Culture >

New Mexico has a diverse population, made up of many different cultures. Culture reaches beyond race and ethnicity to include age, gender, sexual orientation, disability, religion, spiritual beliefs, income level, education and geography. Almost half the population of the state is Hispanic, in addition to a significant Native American population.<sup>4</sup> While smaller in numbers, African Americans and Asian Americans also represent part of the population. Geographically, the state is largely made up of rural and frontier communities with few urban hubs and ranks as one of the highest poverty rates in the United States.<sup>5</sup>

For many New Mexicans, English may not be their first or preferred language. Many non-English and English speakers alike may have difficulty understanding medical terms, especially those involving the complexities of cancer and navigation of the healthcare system.<sup>6</sup> Low medical literacy among all populations can adversely affect cancer incidence, mortality and quality of life as it may lead to the delay of recommended screenings and treatment, difficulties navigating the healthcare system, poor communication with healthcare providers and lack of access to the best available treatment.<sup>6,7</sup>

It is important that all services, programs and educational materials intended to address cancer are culturally and linguistically appropriate and that individuals know they have the right to an interpreter during all stages of the continuum of care. Evidence has shown that when providers are trained in communicating health-related information effectively and attending to cultural values and customs, adherence improves, leading to more positive outcomes.<sup>8</sup>

An overarching theme of New Mexico Cancer Plan goals, objectives and strategies is to address health needs of all New Mexicans. This is done through effective, equitable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.<sup>9</sup>



NEW MEXICO CANCER PLAN 2020 > 2024

# INTRODUCTION



# INTRODUCTION

For the past 20 years, cancer has been either the leading or second leading cause of death in New Mexico, establishing itself as a serious public health concern.<sup>10</sup> Every year, an estimated 9,590 new cases of cancer are diagnosed in New Mexico and approximately 3,671 New Mexicans die from the disease.<sup>10</sup> Addressing the human and economic burden of cancer is a priority for the state of New Mexico.

The New Mexico Cancer Council first convened in 2005 to guide the development and implementation of the New Mexico Cancer Plan, which had been addressing the burden of cancer in New Mexico since 1996. The Cancer Council is a collaborative effort of diverse public and private partners working together to increase access to information, prevention and treatment using innovative and effective programs and policies to improve the outcomes and quality of life for New Mexicans.

The science and understanding of all aspects of cancer prevention and control is constantly evolving. The New Mexico Cancer Plan is a living document that is reviewed and revised every five years to include new research, best practices and successful programs. The 2020-2024 plan describes the state's cancer burden, including the challenges of access to rural healthcare and the disparate impact cancer has on low-income, uninsured, underinsured and racial/ethnic populations.

Many individuals from across the state, representing community organizations, experts in the field of cancer and public health, as well as state and local health agencies developed the plan's goals, objectives and strategies.

The plan is supported by the Centers for Disease Control and Prevention (CDC) and the National Comprehensive Cancer Control Program (NCCCP) and has been written by New Mexico Cancer Council members and approved by its Executive Committee.

The goals and objectives of this plan address New Mexico's cancer burden by focusing on priority areas which were identified by utilizing data from established state and national sources. The result is a roadmap of broad goals, specific objectives and strategies organized into the areas of prevention, screening, diagnosis and treatment, survivorship and end-of-life care and enhancing access to care through patient navigation.

All New Mexicans are impacted by cancer, either directly or through their families and communities. The New Mexico Cancer Plan strives to guide our state cancer control and prevention efforts and enhance collaboration between public and private agencies and organizations through 2024.

## New Mexico Cancer Burden

Cancer is a leading cause of illness and death in New Mexico. In 2020, an estimated 9,800 new cancer cases and 3,730 cancer deaths will occur in our state.<sup>11</sup> The most common types of invasive cancer diagnosed in our state are female breast (15.8%), prostate (11.0%), lung and bronchus (10.9%), and colon and rectum (8.9%). Cancer can occur at any age but is most often diagnosed among adults who are over 50 years of age. During the period 2011-2015, for example, more than 85% of cases were diagnosed in New Mexicans older than 50 years of age. Overall, women have lower incidence rates of cancer (361.3 per 100,000) compared to men (382.9 per 100,000).

Cancer incidence and mortality rates vary, sometimes dramatically, among the diverse racial/ethnic groups in New Mexico. Cancer rates in non-Hispanic whites are generally similar to rates observed nationwide. For many of the most common types of cancer, such as female breast, prostate and lung cancer, rates are highest among non-Hispanic whites. In contrast, rates for some less common cancers such as stomach, liver, gallbladder and kidney are higher in Hispanics and American Indians than in non-Hispanic whites.

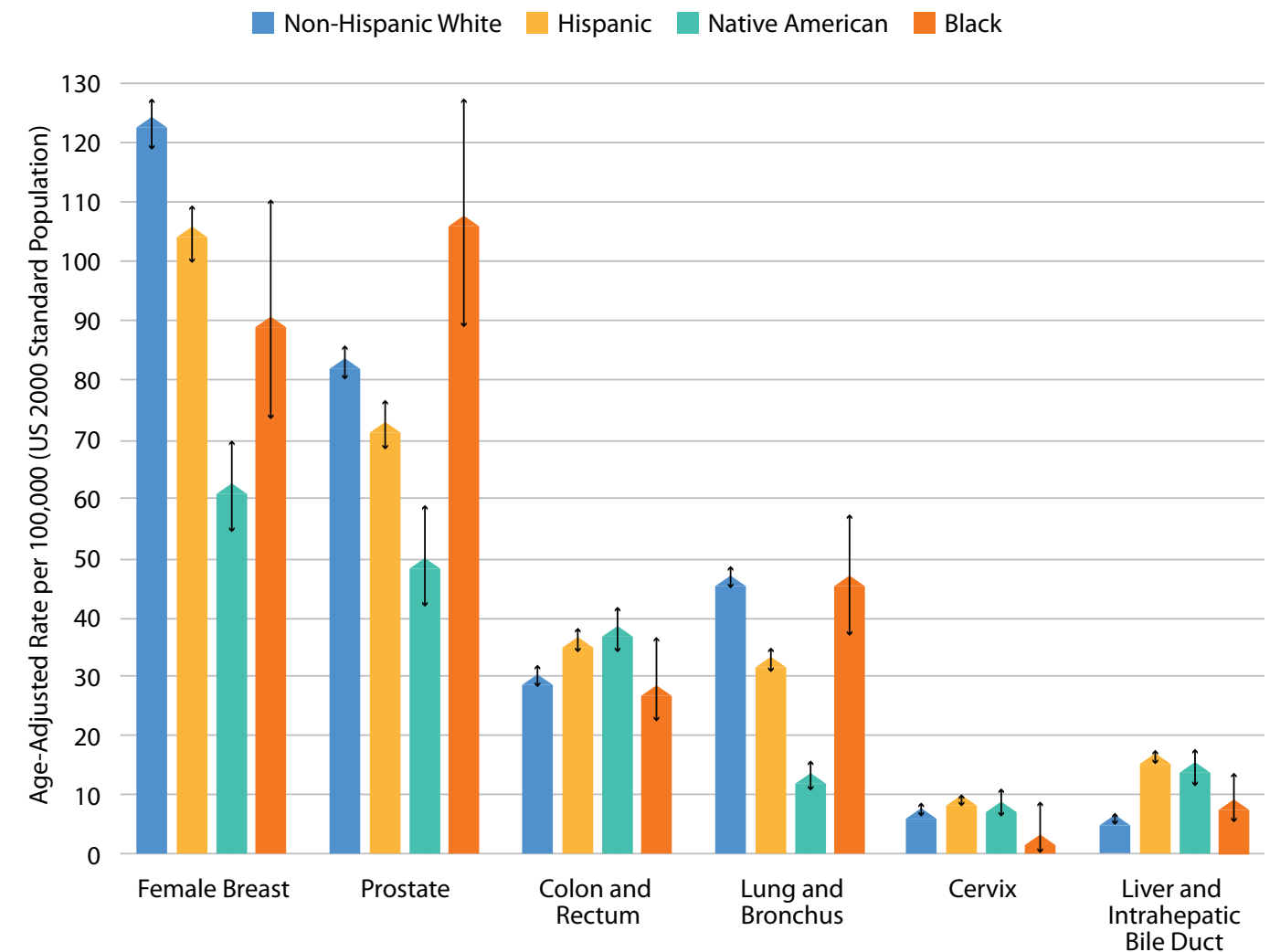
Hispanics and American Indians are often less likely to be screened for cancer and, as a result, tend to be diagnosed at later stages of screen-detectable cancers than non-Hispanic whites.<sup>12</sup> Survival rates for many cancers in Hispanics and American Indians are lower than for non-Hispanic whites.<sup>13</sup> There is also evidence of rural/urban disparities in cancer-directed care and resulting financial hardship in New Mexico.<sup>14</sup> The reasons for these disparities are not fully understood, underscoring the need for more in-depth investigation.

Breast cancer is the most common type of malignant cancer diagnosed among women of all races/ethnicities in New Mexico. Non-Hispanic white women have the highest incidence rates of breast cancer in New Mexico (123.0 per 100,000). Lower incidence rates are observed in Hispanics (104.8 per 100,000), Blacks (90.4 per 100,000) and American Indians (62.4 per 100,000). Incidence rates declined in non-Hispanic white women in recent years but remained relatively stable in other racial/ethnic groups. Breast cancer mortality rates are highest among Blacks (21.9 per 100,000) and non-Hispanic whites (21.3 per 100,000) and lower

among Hispanics (16.9 per 100,000) and American Indians (12.1 per 100,000). Several factors are known to influence the risk of developing breast cancer, including increasing age, number of live births and use of hormone replacement therapy. Heritable factors including the BRCA1 and BRCA2 genes increase the risk of breast cancer in some families<sup>15</sup>. Screening by mammography can reduce the risk of death from this disease by diagnosing women at earlier stages of the disease, when it is more amenable to treatment. National recommendations promote screening mammography for individuals at average risk of breast cancer, although age of screening initiation and frequency differ by organization.<sup>16,17</sup> It is important to ensure that all women have information about breast cancer screening options and access to screening services.

Prostate cancer is the most common type of malignant cancer among men of all races/ethnicities in New Mexico. The highest incidence rates are observed among Blacks (106.6 per 100,000), followed by non-Hispanic whites (83.0 per 100,000), Hispanics (72.0 per 100,000) and American Indians (50.3 per 100,000). Prognosis from prostate cancer is generally favorable when the disease is diagnosed at early stages of the disease. National screening organizations vary in their screening recommendations for men at average risk, but support informed decision-making that addresses the potential harms and benefits of screening.<sup>18</sup> The causes of prostate cancer are not well understood, but inheritable factors increase the risk of the disease in a relatively small proportion of all cases.<sup>19</sup>

Figure 2: Cancer Incidence Among New Mexico Residents • 2012-2016





## INTRODUCTION

Non-Hispanic whites and Hispanics have historically had the highest rates of colorectal cancer in New Mexico. However, colorectal cancer incidence rates declined among both non-Hispanic whites and Hispanics in recent years, while rates among American Indians increased. As a result, American Indians now have the highest rate of colorectal cancer in the state (38.4 per 100,000) compared to 36.4 per 100,000 for Hispanics, 30.5 per 100,000 for non-Hispanic whites, and 28.4 per 100,000 for Blacks. Mortality rates are similar among these racial/ethnic groups, although the rate for Hispanics is slightly above those of other groups.

Colorectal cancer can be effectively treated, especially when it is diagnosed at an early stage, before it has spread beyond the colon. There are several screening tests that can detect colorectal cancer long before symptoms of the disease develop. Colorectal cancer screening is very effective because it can save lives in two ways. The screening tests can prevent colorectal cancer by finding precancerous polyps that can be removed before cancer ever develops. Screening also can find colorectal cancer early, when treatment is most effective. Although increasing age is the most significant risk factor in the development of colorectal cancer, lifestyle factors, including tobacco and alcohol use, consumption of processed meats, overweight and obesity and physical inactivity contribute to increased risk. There are several heritable factors that increase the risk of colorectal cancer, including genes that lead to Hereditary Non-Polyposis Colon Cancer (HNPCC, also known as “Lynch Syndrome”) and Familial Adenomatous Polyposis (FAP). The combination of known heritable factors, however, accounts for less than 10 percent of all colorectal cancer cases.

Cancers of the lung and bronchus are highest among non-Hispanic whites and Blacks (46.5 per 100,000 and 46.4 per 100,000, respectively). American Indians in New Mexico have the lowest rate in the state (13.2 per 100,000) and one of the lowest rates in the country. Incidence rates are decreasing for non-Hispanic white, Hispanic and American Indian men, and are somewhat stable for Black men, non-Hispanic white and American Indian women. Unfortunately, Hispanic white women are experiencing a slight increase. Habitual cigarette smoking of commercial tobacco accounts for 70-90 percent of lung cancer cases in the United States, which makes lung cancer the most preventable of all cancers.<sup>20,21</sup> For this reason, smoking cessation and prevention remain high priorities for improving public health in

New Mexico. Radon gas is the second leading cause of lung cancer<sup>22</sup> and is thought to be responsible for 10-20 percent of all cases of lung cancer, nationwide.<sup>23</sup> Local geologic formations and building materials may emit radon gas into indoor spaces. In-house radon levels can be determined using test kits, and there are ways to renovate buildings with high radon levels to reduce exposure.

Lifelong heavy smokers are at much higher risk for developing lung cancer than are nonsmokers, light/occasional smokers and former smokers.<sup>20</sup> Screening procedures are now available to identify lung cancer early in its development, when it is most amenable to treatment. National organizations recommend screening for adults with a history of heavy smoking using low-dose Computed Tomography (CT) to assist in identifying lung cancer in its early stages. Age ranges and other screening criteria vary by organization.

Several decades ago, incidence rates for invasive cervical cancer were nearly three times higher in Hispanics and American Indians than in non-Hispanic whites in New Mexico. Widespread access to effective screening greatly diminished the rates of cervical cancer over time. Today, incidence and mortality rates for invasive cervical cancer are much lower than in the past and are about the same in all racial/ethnic groups in New Mexico. Improvements in cervical cancer screening techniques and the advent of vaccination for Human Papilloma Virus (HPV), the primary cause of cervical cancer, are expected to further reduce the burden of this disease.

Incidence rates for cancers of the liver and intrahepatic bile duct are rising across the United States and in many countries worldwide.<sup>24,25</sup> Rates in New Mexico are rising among Hispanics (3.4% per year) and non-Hispanic whites (2.4% per year), largely driven by increasing rates among men. Liver cancer incidence rates remain high among American Indians, but the rate of increase in these populations has not been as high as non-Hispanic whites and Hispanics in recent years. Chronic inflammation of the liver can lead to liver cancer, and factors that contribute to such inflammation include Hepatitis C, Hepatitis B, alcohol abuse and obesity.<sup>26</sup>

## Health Equity >

In a report designed to increase consensus around the meaning of health equity, the Robert Wood Johnson Foundation (RWJF) provides the following definition:

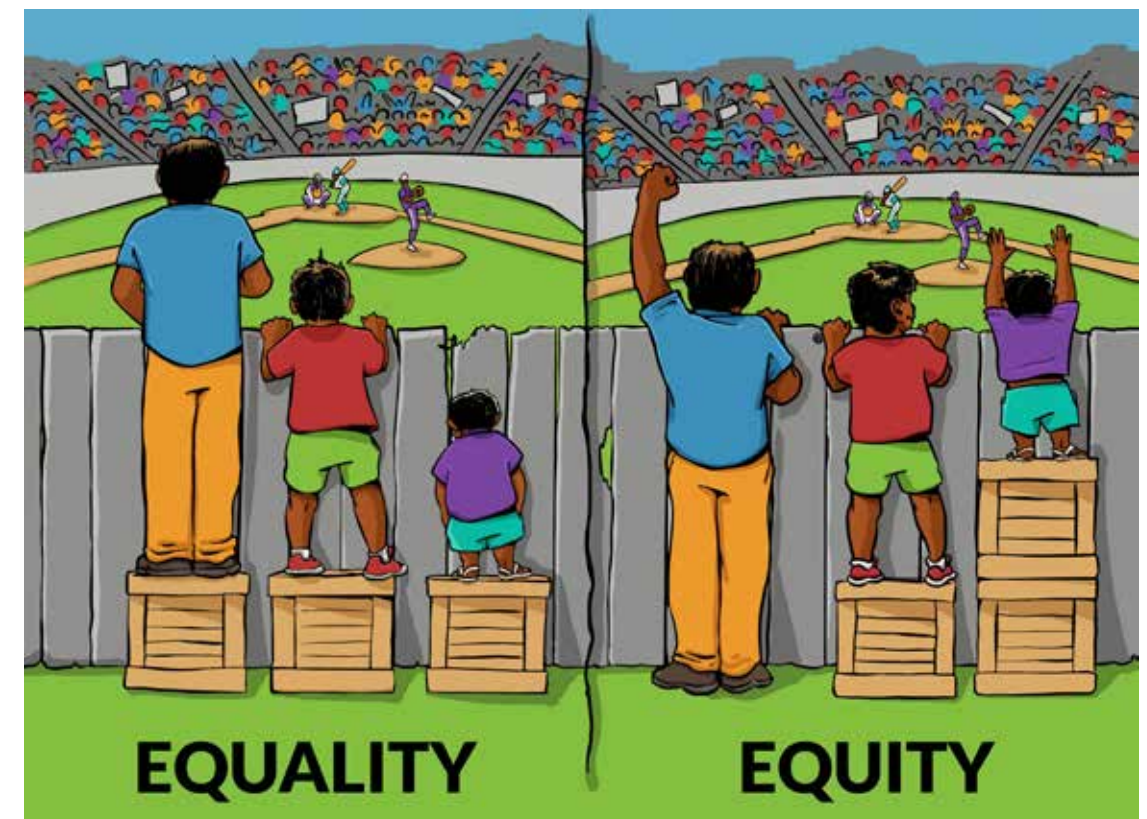
Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination and their consequences, including powerlessness, lack of access to good jobs with fair pay, quality education and housing, safe environments and health care.<sup>27</sup> These upstream variables are sometimes referred to as social determinants of health. Health inequities, or disparities, result in differences in how groups of people experience disease, become ill or die from the disease.

Disparities occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status, sexual orientation and gender identity.<sup>28</sup> Health inequities as they relate to cancer care in New Mexico are seen in every stage of the cancer continuum from cancer incidence, stage of diagnosis, treatment, survivorship, mortality and quality of life.<sup>28</sup>

According to the National Cancer Institute, lack of health coverage and low socioeconomic status are factors that contribute to the observed disparities in cancer incidence and death among racial, ethnic and underserved groups. Studies have found that socioeconomic status, more than race or ethnicity, predicts the likelihood of an individual's or a group's access to education, certain occupations, health insurance and living conditions. Socioeconomic status may also play a role in influencing behavioral risk factors for cancer such as tobacco use, physical inactivity, obesity and excessive alcohol intake, and may impact decisions to follow cancer screening recommendations.

The majority of New Mexicans belong to at least one population group at high risk of experiencing health disparities. To improve the overall health of New Mexico residents, including reducing the burden of cancer, the advancement of health equity and reduction of health disparities must be actively addressed. The objectives in the New Mexico Cancer Plan focus on removing barriers to preventing cancer, and increasing access to screening, treatment and support for patients and families throughout the cancer experience.

Figure 3: Health Equity<sup>29</sup>



## INTRODUCTION

### What You Can Do >

Everyone can have a role in preventing and controlling cancer and making a positive difference in the lives of all New Mexicans affected by cancer. The success of the Plan will depend on the cooperation, collaboration and resources of many stakeholders across our state.

#### LOCAL PUBLIC HEALTH ENTITIES and COMMUNITY-BASED ORGANIZATIONS CAN:

- Collaborate to remove barriers to cancer prevention, screening, treatment and support
- Provide or host cancer support groups
- Assist community members with signing up for health coverage
- Provide culturally sensitive cancer information and resources

#### PROVIDERS and HEALTHCARE SYSTEMS CAN:

- Offer patient navigation for screening, treatment and survivorship
- Refer to or integrate mental health services for those affected by cancer
- Use electronic medical records and other systems to keep individuals up to date on cancer screenings and vaccinations
- Implement interventions to improve individual health behaviors

#### CANCER EXPERTS CAN:

- Provide public and professional education
- Participate in the New Mexico Cancer Council and its workgroups
- Participate in speakers' bureaus to raise awareness about cancer-related topics and issues

#### HEALTH INSURERS and POLICYMAKERS CAN:

- Support access to and coverage of smoking cessation classes, nutrition programs, palliative care services, mental health services and cancer treatment drugs
- Ensure that all recommended cancer screenings and immunizations are provided without cost
- Improve access and reduce costs to participants in cancer research, including clinical trials
- Support policies that encourage healthy choices and reduce exposure to environmental carcinogens

#### EMPLOYERS CAN:

- Educate the public, employees and policymakers about best practices for cancer screening, treatment and survivorship support
- Support employees who are dealing with cancer
- Offer employee benefits that encourage wellness
- Provide paid leave for recommended cancer screenings and immunizations

#### THERE ARE THINGS ANY NEW MEXICAN CAN DO TO REDUCE THEIR PERSONAL AND FAMILY CANCER RISK:

- Quit tobacco use and support smoke-free environments
- Maintain a healthy weight by eating well and moving more
- Get screened for cancer according to national recommendations
- Stay safe in the sun and refrain from indoor tanning



## NEW MEXICO CANCER PLAN 2020 > 2024

# GOALS, OBJECTIVES and STRATEGIES

### Objective 1.1 > Increase Physical Activity

| Measures  | Baseline            | 2024 Target  |
|---|---------------------|--------------|
| Percent of adults who achieved recommended physical activity (achieved 150 minutes or more of aerobic physical activity per week) | 54.0% (BRFSS, 2017) | <b>55.6%</b> |
| Percent of high school students who reported being physically active at least 5 out of 7 days for at least 60 minutes             | 51.2% (YRRS, 2017)  | <b>52.7%</b> |
| Percent of middle school students who reported being physically active 5 days per week  | 60.7% (YRRS, 2017)  | <b>62.5%</b> |

#### Strategies

- Support healthy community design initiatives, such as increasing opportunities for physical activity, to make it easier for people to live healthy lives
- Promote shared-use policies and agreements between schools, communities, parks and recreation, state and local governments and other groups to increase physical activity opportunities in the community
- Support worksites in developing policies and programs to promote healthy behaviors

#### PHYSICAL ACTIVITY TO LOWER CANCER RISK<sup>30, 31</sup>

There is substantial evidence that higher levels of physical activity are linked to lower risks of several cancers, including colon, breast and endometrial. For several other cancers, there is more limited evidence of a relationship with physical activity, but evidence does demonstrate a reduced risk for esophageal adenocarcinoma, liver cancer, gastric cardia cancer (a type of stomach cancer), kidney cancer, myeloid leukemia, myeloma and cancers of the head and neck, rectum and bladder. In addition to reducing cancer risk, physical activity may play a role in survivorship by helping to prevent weight gain after cancer treatment, improve quality of life including improving emotional well-being, anxiety, fatigue, body image/self-esteem and pain. In addition, physical activity after a cancer diagnosis is linked to better cancer specific outcomes for several cancer types. According to the National Cancer Institute, exercise has a number of biological effects on the body, some of which have been proposed to explain associations with specific cancers, including:

- Lowering the levels of hormones, such as insulin and estrogen, and of certain growth factors that have been associated with cancer development and progression
- Helping to prevent obesity and decreasing the harmful effects of obesity, particularly the development of insulin resistance (failure of the body's cells to respond to insulin)
- Reducing inflammation
- Improving immune system function
- Altering the metabolism of bile acids, resulting in decreased exposure of the gastrointestinal tract to these suspected carcinogens
- Reducing the amount of time it takes for food to travel through the digestive system, which decreases gastrointestinal tract exposure to possible carcinogens

### Objective 1.2 > Increase Access to Healthy Food

| Measures   | Baseline            | 2024 Target  |
|--|---------------------|--------------|
| Percent of adults who reported consuming 5+ servings of fruits and vegetables per day                        | 16.4% (BRFSS, 2017) | <b>16.9%</b> |
| Percent of high school students who ate vegetables 3 or more times a day                                     | 17.8% (YRRS, 2017)  | <b>18.3%</b> |
| Percent of high school students who consumed three or more servings of fruits per day, excluding fruit juice | 11.7% (YRRS, 2017)  | <b>12.1%</b> |

#### Strategies

- Support healthy community design initiatives, such as increasing opportunities for access to healthy foods, to make it easier for people to live healthy lives
- Support worksites in developing policies and programs to promote healthy behaviors



### Objective 1.3 > Promote Healthier Weight

| Measures  | Baseline            | 2024 Target           |
|---|---------------------|-----------------------|
| Percent of NM adults with a normal BMI categorical rating                   | 30.5% (BRFSS, 2018) | Maintain <b>30.5%</b> |
| Percent of high school students who are a healthy weight/have a healthy BMI | 64.7% (YRRS, 2017)  | Maintain <b>64.7%</b> |

#### Strategies

- Collaborate with the New Mexico Chronic Disease Prevention Council (CDPC) to implement the *New Mexico Shared Strategic Plan* strategies that promote healthier weight
- Promote healthcare coverage of individual and group counseling for weight reduction for people living with excess weight regardless of comorbidities
- Support efforts that reduce the stigma associated with excess weight by communicating the injustice of penalizing people living with excess weight with higher healthcare premiums
- Promote education for healthcare providers and the public about the link between excess weight and certain cancers
- Support efforts for a tax on sugar-sweetened beverages

#### OBESITY AND CANCER<sup>32, 33</sup>

Only one half of Americans know that overweight and obesity can fuel cancer development. There is consistent evidence that higher amounts of body fat are associated with increased risk of a number of cancers, including thyroid, premenopausal breast, gallbladder, stomach, liver, pancreatic, kidney, ovarian, uterine, colon, rectal and esophageal, as well as meningioma and multiple myeloma. Aside from not smoking, maintaining a healthy weight is the single largest step a person can take to lower cancer risk. The National Cancer Institute and the Centers for Disease Control and Prevention offer additional, detailed information on obesity as a risk factor for cancer.

### Objective 1.4 > Decrease the Proportion of Adults Exceeding Dietary Guidelines for Moderate Drinking

| Measures  | Baseline            | 2024 Target  |
|---|---------------------|--------------|
| Percent of men in New Mexico age 21+ exceeding dietary guidelines for moderate drinking   | 36.7% (BRFSS, 2018) | <b>35.6%</b> |
| Percent of women in New Mexico age 21+ exceeding dietary guidelines for moderate drinking | 27.9% (BRFSS, 2018) | <b>27.1%</b> |

#### Strategies

- Support efforts to educate the public on cancer risk related to alcohol use
- Support an increased purchase price of alcohol
- Promote healthcare provider awareness and use of alcohol screening and brief behavioral counseling interventions to facilitate delivery of personalized feedback about risks and consequences of excessive drinking

#### ALCOHOL AND CANCER<sup>34</sup>

There is a strong scientific consensus of an association between drinking alcohol and developing several types of cancer (head and neck, esophageal, liver, breast, colorectal). The National Toxicology Program of the US Department of Health and Human Services lists consumption of alcoholic beverages as a known human carcinogen. The research evidence indicates that the more alcohol a person drinks — particularly the more alcohol a person drinks regularly over time — the higher their risk of developing an alcohol-associated cancer. If alcohol is consumed, it should be in moderation — up to one drink per day for women and up to two drinks per day for men — and only by adults of legal drinking age.

### Objective 1.5 > Decrease Overexposure to Sun and Ultraviolet (UV) Radiation

| Measures | Baseline | 2024 Target |
|----------|----------|-------------|
|----------|----------|-------------|

NM Cancer Council will explore data source options and determine baseline and target measures

TBD\*

TBD\*

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.

#### Strategies

- Support communitywide interventions to prevent skin cancer
- Support education about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer
- Increase education to promote awareness among the public and healthcare professionals about the risk of melanoma associated with UV exposure from the use of tanning bed and booths
- Support policy changes that influence UV protective behaviors



### Objective 1.6 > Increase HPV and Hepatitis B Vaccinations

| Measures  | Baseline               | 2024 Target |
|---|------------------------|-------------|
| Percent of male adolescents ages 13-17 who are up to date* with HPV vaccination   | 55.6% (NIS-Teen, 2018) | <b>80%</b>  |
| Percent of female adolescents ages 13-17 who are up to date* with HPV vaccination   | 58.4% (NIS-Teen, 2018) | <b>80%</b>  |
| Achieve and maintain an effective coverage level of a birth dose of hepatitis B vaccine 0 to 3 days between birth date and date of vaccination, reported by annual birth cohort | 71.7% (NIS, 2017)      | <b>85%</b>  |

\*HPV up to date includes those who received  $\geq 3$  doses, and those who received 2 doses when the first HPV vaccine dose was initiated before age 15 years and the time between the first and second dose was at least 5 months minus 4 days.

#### Strategies

- Educate healthcare providers about current immunization practices and recommendations regarding HPV vaccination
- Encourage healthcare providers to utilize client reminder/recall systems for vaccinations
- Support public awareness and education campaigns targeted to parents, adolescents and populations most at risk for HPV infection regarding the link between HPV and cancer
- Support school-based clinics that offer the HPV vaccine

### Objective 1.7 > Decrease Chronic Cases of Hepatitis C

| Measures   | Baseline | 2024 Target |
|--|----------|-------------|
| Number of chronic cases of hepatitis C in New Mexico | TBD*     | <b>TBD*</b> |

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.

#### Strategies

- Promote evidence-based harm reduction through syringe exchange service programs
- Promote safer healthcare practices to reduce exposure of patients and healthcare workers to hepatitis viruses
- Support the implementation of standing provider orders for hepatitis C testing of adults born 1945-1965 and those considered high risk
- Support access to treatment of hepatitis C



**Objective 2.1** > Decrease Tobacco Product Use

| Measures  | Baseline            | 2024 Target  |
|---|---------------------|--------------|
| Current adult, 18+, smokeless tobacco user prevalence   | 4.5% (BRFSS, 2018)  | <b>3.0%</b>  |
| Current adult, 18+, cigarette smoking prevalence  | 15.2% (BRFSS, 2018) | <b>14%</b>   |
| Current high school youth, grades 9-12, tobacco use (cigarettes, chewing tobacco, cigars, hookah or e-cigarettes) | 32.7% (YRRS, 2017)  | <b>28.0%</b> |
| Current high school, grades 9-12, youth cigarette smoking prevalence  | 10.6% (YRRS, 2017)  | <b>8.0%</b>  |

**Strategies**

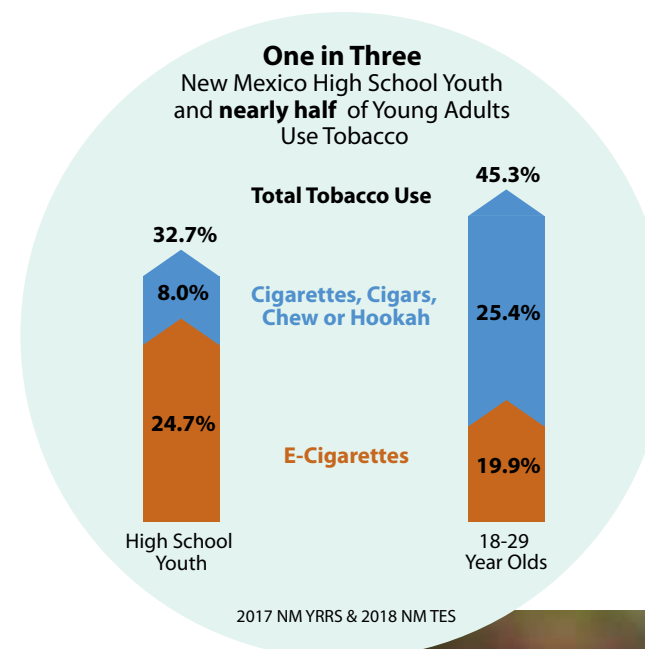
- Support the development and enforcement of laws prohibiting the sale and restricting the marketing of tobacco products to minors
- Promote education of youth and young adults on the risks of all tobacco product use, including e-cigarettes
- Support increasing taxes on tobacco products to increase the purchase price
- Support community outreach and educational programs to reduce all forms of tobacco use

**CANCER AND TOBACCO USE<sup>38</sup>**

Tobacco use is the leading preventable cause of cancer and cancer deaths. Tobacco use causes many types of cancer, including cancer of the lung, larynx (voice box), mouth, esophagus, throat, bladder, kidney, liver, stomach, pancreas, colon and rectum, and cervix, as well as acute myeloid leukemia. People who use smokeless tobacco (snuff or chewing tobacco) have increased risks of cancers of the mouth, esophagus and pancreas. Smoking presents many risks, including for those who have, or have had, cancer.

People who quit smoking, regardless of their age, have substantial gains in life expectancy compared with those who continue to smoke. Also, quitting smoking at the time of a cancer diagnosis reduces the risk of death.

**Figure 4:** Tobacco Use Among High School Youth and Young Adults<sup>4, 35</sup>



**E-CIGARETTES: AN EVOLVING LANDSCAPE<sup>36, 37</sup>**

E-cigarettes are still fairly new, and more research is needed over a longer period of time to know what the long-term health effects may be. Scientists are still learning about how e-cigarettes affect health when they are used for long periods of time. It is known that the aerosol from e-cigarettes is not harmless. It can contain harmful chemicals, including nicotine, flavoring compounds, benzene and heavy metals such as nickel, tin and lead. These various chemicals are known to cause eye, nose and throat irritation; headaches; nausea; liver, kidney and nervous system damage; lung disease; and cancer.





**Objective 2.2** > Decrease Exposure to Secondhand Smoke from Tobacco Products

| Measures   | Baseline                                | 2024 Target  |
|--|---|--------------|
| Percent of nonsmoking adults exposed to secondhand smoke living in multiunit housing | 39.0% (Tobacco Evaluation Survey, 2018) | <b>30.0%</b> |
| Percent of youth exposed to secondhand smoke indoors in the past week                | 34.2% (YRRS, 2017)                      | <b>30.0%</b> |

**Strategies**

- Support the development, implementation, monitoring and expansion of policies that protect New Mexicans from secondhand smoke in homes, vehicles, outdoor public places, workplaces and multiunit housing
- Support enforcement of state and local clean indoor air policies
- Support the modernization of clean indoor air policies to include e-cigarettes



**Objective 2.3** > Increase Quit Attempts Among Tobacco Product Users

| Measures   | Baseline  | 2024 Target  |
|--|---|--------------|
| Percent of adults who attempted cessation in the past 12 months                              | 55.7% (BRFSS, 2018)                                 | <b>60.0%</b> |
| Percent of QUIT NOW enrollees who successfully quit using tobacco by their 7-month follow-up | 32.0% (TUPAC Cessation Services FY17 Annual Report) | <b>34.0%</b> |

**Strategies**

- Support expanded access to and use of evidence-based tobacco cessation services
- Support media campaigns with cessation messages to reach populations disproportionately impacted by tobacco use
- Support the standardized use of screening for tobacco use and referral to evidence-based interventions within healthcare settings

**THE BENEFITS TO CANCER SURVIVORS OF STOPPING SMOKING<sup>38</sup>**

A cancer diagnosis is typically a time of tremendous stress and anxiety, and quitting smoking or other tobacco use may seem impossible. However, quitting smoking for long-term or newly diagnosed survivors is always beneficial.

- Cancer survivors who quit smoking improve their long-term survival
- Stopping smoking, even at diagnosis, significantly reduces the chance of developing other cancers
- Complications from surgery are reduced and wounds heal faster
- There is less likelihood of developing other diseases associated with smoking, such as heart disease and stroke
- Smoking while receiving radiation therapy or chemotherapy can increase side effects and make these treatments less effective
- Family and friends also breathe cleaner air, which protects them from an increased risk of cancer and other diseases



**Objective 3.1** > Support Education and Enhanced Community Infrastructure to Decrease Exposure to Radon

| Measures   | Baseline                                  | 2024 Target                         |
|--|---|-------------------------------------|
| Number of times the radon information page on the NMDOH website was accessed | 162 page views in 2018 (NMDOH-EPHT, 2019) | Maintain <b>162 page views/year</b> |

**Strategies**

- Support efforts to educate the New Mexico public, homeowners, building owners, sellers, realtors and policymakers about lung cancer risk from radon and the benefits of radon testing and implementing radon-resistant features in new construction
- Promote environmental equity through radon testing and mitigation programs and outreach efforts within underresourced communities
- Educate the public on secondhand smoke combined with radon as an increased cancer risk

**WHAT IS RADON?**<sup>39, 40, 41</sup>

**Radon** is an odorless, colorless, naturally occurring radioactive gas resulting from the radioactive decay of uranium, which exists in most soils. Radon enters homes and buildings from the soil under the slab, from the crawlspace, basement, etc. Radon can also be found in some water supplies entering the home or building. Because radon is radioactive, its breakdown to other elements releases alpha, beta and gamma radiations which can be physically damaging. When radon and especially these decay elements are inhaled, the lungs can be seriously damaged by this radiation. Studies have determined that as a result of this damage, radon is the overall second-leading cause of lung cancer and the risk is significantly higher for smokers than for nonsmokers. Radon is also believed to be the number one cause of lung cancer among nonsmokers. More than 85% of radon-induced lung cancer deaths occur among smokers.

The only way to determine the presence of radon is through testing. Short- and long-term detectors are available to measure radon levels. Because radon levels can vary from day to day and over time, a long-term test is a better indicator of an average radon level. A state or local radon official can explain the differences between testing devices and recommend an appropriate test for a person's needs and conditions. More information about radon is also available online from the New Mexico Environment Department or the Environmental Protection Agency.

**Objective 3.2** > Increase Testing for Concentration of Arsenic in Private Well Water

| Measures  | Baseline              | 2024 Target |
|---|-----------------------|-------------|
| Percent of water samples tested for arsenic at free state-run private well testing events | 0% (NMED/NMDOH, 2018) | <b>50%</b>  |

**Strategies**

- Support efforts to collect, analyze and apply data related to drinking water quality, arsenic exposure and health outcomes potentially related to arsenic exposure
- Support enhanced accessibility to services designed to increase water testing
- Promote educational efforts for private well owners about preventing excessive arsenic exposure

**ARSENIC IN WATER**<sup>42</sup>

**Arsenic** is found in some drinking water sources, especially groundwater sources in areas known to have high levels of arsenic in the rocks and soil. Long-term exposure may be associated with skin or circulatory system problems. It is also associated with certain cancers, such as skin, bladder and lung.

Private well owners in New Mexico are advised to test their drinking water for arsenic at least once. In terms of drinking water quality, the safe drinking water concentration for arsenic is 10 micrograms per Liter (mcg/L), sometimes referred to as 10 parts per billion (ppb). If arsenic levels are high, consider arsenic removal using an appropriate treatment/filtration system or consuming water from different sources. Water that comes from a public water supply will be tested regularly for arsenic.

The New Mexico Department of Health, through its Environmental Health Epidemiology Bureau, works on various projects to collect data about drinking water quality and arsenic exposure to help New Mexicans better understand potential exposure. Additional information about reducing exposure to arsenic can be found at the New Mexico Environmental Public Health Tracking website.





**Objective 4.1** Promote Adherence to Evidence-Based Screening and Early Detection Recommendations and the Adoption of Best Practices

| Measures  | Baseline            | 2024 Target           |
|---|---------------------|-----------------------|
| Percent of adults ages 50-75 years who are current with colorectal cancer screening recommendations | 66.8% (BRFSS, 2018) | <b>70.5%</b>          |
| Percent of women ages 21-65 who have had a Pap test within the past 3 years                         | 76.8% (BRFSS, 2018) | Maintain <b>76.8%</b> |
| Percent of women ages 50-74 years who have had a mammogram within the past 2 years                  | 71.7% (BRFSS, 2018) | Maintain <b>71.7%</b> |

**Strategies**

- Support education of primary care providers and the general public on the importance of adhering to nationally recognized screening recommendations
- Support health systems and healthcare providers to implement policies, system changes and evidence-based interventions to improve quality and performance measures for screening, tracking and follow-up
- Ensure receipt of screening results and appropriate follow-up care for abnormalities identified
- Build relationships with advocates who can facilitate enrollment in public and private healthcare coverage and educate Medicaid-eligible New Mexicans about covered preventive services
- Partner with community-based organizations and rural hospitals to reduce barriers (i.e., financial, cultural, structural, regional) to obtain cancer screening services or follow-up diagnostic services
- Collaborate with insurers and payers to implement evidence-based interventions to increase uptake of evidence-based screening interventions, especially for newly insured members who are rarely or never screened
- Support implementation of evidence-based practices through engagement of patient navigators, community health workers and community health representatives to conduct one-on-one education to overcome barriers to screening
- Support the development and utilization of culturally and linguistically appropriate materials for early detection of screenable cancers

**Objective 4.2** Increase the Adoption of Informed Decision-Making for Screenable Cancers

| Measures  | Baseline | 2024 Target |
|---|----------|-------------|
| NM Cancer Council will explore data source options and determine baseline and target measures | TBD*     | <b>TBD*</b> |

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.

**Strategies**

- Offer tools such as decision-making guides and risk-assessment tools to primary care providers to engage patients in making informed decisions about cancer screening
- Modify performance measures for cancer screening such that patients who elect not to participate in screening after completing an informed decision-making process are not included in calculations of referral and completion rates
- Promote efforts to educate patients to know their cancer family history and discuss this history with their healthcare provider when making cancer screening decisions
- Support efforts to connect patients at increased risk for hereditary cancer to appropriate resources for counseling on genetic testing options
- Promote the use of nationally recognized surveillance and screening recommendations for high-risk populations including patients with a personal history of cancer or other chronic diseases
- Support community health workers, community health representatives, patient navigators and other partners in providing education about the possible harms and benefits of cancer screening
- Support the development and utilization of culturally and linguistically appropriate materials about informed decision-making

**WHAT ARE THE BENEFITS AND HARMS OF SCREENING?<sup>43</sup>**

The goal of screening is to reduce deaths from cancer. Screening may also find cancer early, when it is easier to treat. Every screening test has benefits and harms, which is why it is important to talk to a healthcare provider before getting any screening test.

Potential harms of screening can include false positive test results, when a doctor sees something that looks like cancer, but is not. This can lead to more tests, which can be expensive, time-consuming and may cause anxiety. Tests also can lead to overdiagnosis, when doctors find something that could possibly become cancer, or a cancer that won't get any larger or any worse, or even may go away on its own. This could lead to getting unnecessary treatments, which is called overtreatment. Overtreatment can include unnecessary surgery, chemotherapy or radiation therapy. This can cause unnecessary and unwanted side effects that might have been avoided. A screening test may also miss some cancers.

Sometimes it can be difficult to decide about getting a screening test. Speaking with one's healthcare provider to understand the possible benefits and harms can help an individual to make the best decisions.



**Objective 4.3** Increase Use of Data to Identify Cancer Disparities in New Mexico

| Measures   | Baseline   | 2024 Target           |
|--|--|-----------------------|
| Number of views of cancer indicator reports on the New Mexico Indicator-Based Information System (NM-IBIS) website | 2,359 (NMDOH Epidemiology and Response Division, 2019) | Maintain <b>2,359</b> |

**Strategies**

- Increase partnerships with organizations to encourage the distribution and utilization of current data to identify focus areas for targeted efforts to reduce cancer inequities in New Mexico
- Increase awareness about cancer health disparities by regularly distributing cancer statistics comparing different demographic groups
- Utilize data to leverage funding that supports local and targeted efforts to increase screening in regions/counties that have the lowest screening rates in New Mexico
- Utilize data to leverage resources to increase access to follow-up diagnostic and treatment services

**WHY ARE ONLY SOME CANCERS SCREENABLE?**<sup>43</sup>

Screening refers to the process of looking for cancer, or another disease, in people who do not have symptoms. Screening aims to find cancer in its early stages when it is easier to treat. For some cancers, screening can find precancerous conditions that can be treated, which can prevent cancer altogether.

The intent of screening is to reduce deaths from cancer. The most effective screening tests:

- Find cancer early
- Reduce the likelihood that someone who gets regular screenings will die from the cancer
- Have more potential benefits than potential harms

**Objective 4.4** Focused Outreach on the Importance of Early Detection to Decrease Advanced Diagnosis of Screenable Cancers

| Measures   | Baseline                                      | 2024 Target                       |
|--|---|-----------------------------------|
| Creation of a cancer specialty track for New Mexico Department of Health Community Health Worker Certification program | No specialty track to-date (NMDOH OCHW, 2019) | <b>One cancer specialty track</b> |
| Number of Certified Community Health Workers trained in the cancer specialty track                                     | 0 (NMDOH OCHW, 2019)                          | <b>TBD*</b>                       |
| Number of educational initiatives in community settings to promote evidence-based screening                            | TBD*  | <b>TBD*</b>                       |
| Number of worksite wellness initiatives focusing on screenable cancers   | TBD* (NM Cancer Council, 2019)                | <b>TBD*</b>                       |

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.

**Strategies**

- Support Community Health Workers and Community Health Representatives in providing education in rural and other underserved communities on the importance of early detection
- Promote the development of culturally and linguistically appropriate materials and tailored messages for education in populations with the highest rates of late-stage diagnoses
- Promote cancer specialty track training to community health workers
- Promote cancer screening in community settings (e.g., community centers and places of worship)
- Promote worksite wellness policies that support evidence-based, employer-driven interventions in collaboration with health plans and payers to increase screening rates for employees and their families



### Objective 5.1 > Improve Access to Cancer Care

| Measures   | Baseline  | 2024 Target  |
|--|---|--|
| Percent of adults 18 years of age and older who were unable to get medical care due to cost  | 13.0% (BRFSS, 2018)   | Maintain rate below pre-Affordable Care Act level – <b>18.1%</b> (BRFSS, 2013)         |
| Percent of uninsured New Mexicans ages 18-64   | 13.4% (SAHIE, 2017)   | Maintain rate at or below post-Affordable Care Act levels – <b>16.5%</b> (SAHIE, 2015) |
| Number of transportation service providers listed in the Albuquerque Cancer Coalition (ACC) Cancer Support and Treatment Directory | Albuquerque Area – 13<br>Outside of Albuquerque Area – 6<br>(ACC Directory, 2019) | Albuquerque Area – <b>15</b><br>Outside of Albuquerque Area – <b>7</b>                 |
| Number of Project ECHO cancer care programs available to New Mexico healthcare providers   | 27 (Project ECHO, 2019)   | <b>28</b>  |

#### Strategies

- Engage patient navigators and care coordinators to assist patients in overcoming barriers to care
- Support educating decision-makers regarding barriers to obtaining health plan coverage, including pharmacy benefits to access treatment services
- Support efforts to understand and address clinical barriers to care (e.g., lack of cancer specialists, patient health literacy and technology)
- Support efforts to understand and address nonmedical barriers to care (e.g., transportation, language and interpretation services, financial, geographic, cultural, and self-advocacy and education)
- Collaborate with insurers to address coverage gaps that lead to disparities in cancer care
- Promote access to affordable targeted therapies for individuals whose cancer treatment may benefit from them
- Promote health coverage options, including those available via the *Be Well New Mexico* website (bewellnm.com)
- Utilize data to leverage resources to increase access to follow-up diagnostic and treatment services

#### ADHERENCE TO NATIONALLY RECOGNIZED STANDARDS<sup>44</sup>

Some essential elements of high-quality treatment programs include:

- Access to state-of-the-art clinical services and equipment for all phases of the cancer prevention and control continuum, (e.g., primary prevention, screening/early detection, diagnostics, treatment, rehabilitation and support services)
- A multidisciplinary team approach to coordinate patient care
- Up-to-date clinical trials and treatment information for patients
- A cancer registry and database that follows patients throughout life
- Ongoing monitoring and evaluation of patient outcomes

### Objective 5.2 > Promote Informed Decision-Making About Cancer Treatment

| Measures   | Baseline                 | 2024 Target        |
|--|--------------------------|--------------------|
| Number of cancer treatment facilities providing patient navigation services listed in the Cancer Support and Treatment Directory | 16 (ACC Directory, 2019) | Maintain <b>16</b> |

#### Strategies

- Support patient navigation processes to educate patients and caregivers on the importance of making informed decisions related to the impact of cancer treatment, including financial burden, preservation of fertility and long-term effects
- Support the development and distribution of materials that follow health literacy standards for patients in order to promote informed decision-making regarding cancer treatment
- Support the development and utilization of culturally and linguistically appropriate materials about informed decision-making related to cancer treatment

#### WHAT IS AN INFORMED DECISION?<sup>45</sup>

An informed decision is one where the patient partners with his/her healthcare providers to make decisions that are consistent with the patient's needs, values and preferences.

After a cancer diagnosis, people with cancer and their families have to make a number of decisions about treatment. These decisions are complicated by feelings of anxiety, unfamiliar words, statistics and a sense of urgency. However, unless the situation is extremely urgent, it is possible to take time to research options, ask questions and talk with family and/or trusted friends.

Decisions about cancer treatment are personal, and patients need to feel comfortable with their choices, but many people do not know where to start. Here are some helpful steps to begin the process to make the best decisions:

- Understand the diagnosis and the disease
- Learn about treatment options to determine the best potential outcome
- Understand the goals of treatment to ensure realistic expectations
- Ask about the side effects of each treatment option
- Weigh the benefits and risks of each treatment option
- Inquire about the possibility of joining a clinical trial
- Get a second opinion
- Speak with a patient navigator or oncology social worker for assistance in navigating the healthcare system



**Objective 6.1** > Promote Education About Cancer Clinical Trials Among Patients, Caregivers and Providers

| Measures   | Baseline | 2024 Target |
|--|----------|-------------|
| Number of annual education initiatives about cancer clinical trials for providers, patients and caregivers | TBD*     | TBD*        |

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.

**Strategies**

- Support creation and distribution of patient- and caregiver-focused educational materials on clinical trials
- Collaborate with organizations currently using educational resources to help patients, caregivers and healthcare providers make informed decisions regarding clinical trials
- Support healthcare provider-focused educational training on available clinical trials and ways to improve provider/patient communication about clinical trials
- Support and participate in community events intended to increase awareness about cancer clinical research
- Support processes to systematically inform and encourage newly diagnosed patients and caregivers about the availability of clinical trials as a potential component of treatment planning

**WHAT IS A CLINICAL TRIAL?**<sup>46</sup>

Clinical trials are research studies designed to evaluate a screening, diagnostic or treatment intervention to gain approval for use in society. Through strict processes, testing and constant monitoring, clinical trials are the primary method for researchers to determine if a new intervention such as a diagnostic test or new drug is safe, tolerable and effective in the people that are intended to use it. Often a clinical trial is used to learn if a new treatment is more effective and/or has less harmful side effects than the current standard treatment.

There are four phases of clinical trials: Phases I-III evaluate the safety, tolerability and effectiveness of a new drug or new device. Phase IV is often referred to as a post-marketing phase and is used to monitor long-term effectiveness and safety.

Clinical trials can be a treatment option for someone diagnosed with cancer. Participation in clinical trials is voluntary, adds to the overall knowledge of cancer care and can improve cancer screening, diagnosis and treatment for future patients.

**Objective 6.2** > Sustain or Increase the Availability and Utilization of Cancer Clinical Trials by Rural and Other Underserved Populations

| Measures   | Baseline           | 2024 Target          |
|--|--------------------|----------------------|
| Number of clinical trial sites in New Mexico open through the NMCCA, as listed on NMCCA website database | 393 (NMCCA, 2018)  | Maintain <b>393</b>  |
| Percent of adults who have been diagnosed with cancer that participated in a clinical trial              | 7.7% (BRFSS, 2010) | Maintain <b>7.7%</b> |

**Strategies**

- Support increasing referrals for participation in clinical trials by patients from rural and underserved areas of the state
- Build trust between healthcare providers and underserved populations by educating providers on the history of clinical trials within these communities
- Support the development and utilization of culturally and linguistically appropriate materials about clinical trials

**TESTIMONIAL**

When I was asked to consider participating in a clinical trial for breast cancer, the surgeon's nurse reached out to me immediately so that I could begin to understand the impact that my participation might have. She was thorough, knowledgeable about the trial and about my history, and extremely kind and considerate. She made certain I was fully informed of the options available to me and any potential side effects I may experience. I am thankful to the medical staff for making this opportunity possible for me to 'give back' and for the expertise and care they have shown throughout my journey with cancer.

I am participating in a clinical trial because I understand the findings from this research trial will benefit future breast cancer patients. I am not participating in this trial with an expectation of a direct benefit to myself, but naturally will be delighted if it turns out positively for me. In consideration of whether or not to participate in the trial, I realized that each of us who seeks medical care and/or takes any type of medication, even 'over the counter' medicines, has benefited from others who were willing to take a risk and participate in a clinical trial. I am especially grateful to the women who came before me who were willing to participate in clinical trials testing the chemotherapy drugs as well as radiation procedures I received during my breast cancer treatments. Gathering data from a broad spectrum of patients can provide valuable insight into a treatment's potential for effectiveness. Even negative results can lead to positive outcomes in terms of safety measures needed to ensure effectiveness of the treatment, dose recommendations and other factors. It is an honor for me to be able to 'pay it forward' while giving back in a small way to help others in the future.

**Jennifer**



**DEFINITIONS OF QUALITY OF LIFE TERMS<sup>44, 47-51</sup>**

**Quality of Life**

Quality of Life describes an individual’s overall enjoyment of life and includes all emotional, mental, social and physical aspects.

**Palliative Care versus Hospice Care**

There are many misunderstandings among healthcare providers and patients about palliative care. Both palliative care and hospice focus on improving quality of life. However, palliative care can be provided from the time of diagnosis, while hospice is reserved for those with limited life expectancy. Palliative care can be provided alongside curative treatment, such as radiation, chemotherapy and surgery, while hospice is only provided once curative treatment has ended. Hospice is a type of palliative care, but not all palliative care is hospice.

**Palliative Care (Whole Patient Supportive Care)**

Palliative care focuses on the quality of life of patients who have a serious or life-threatening disease, such as cancer. The goal of palliative care is to relieve any distressing physical symptoms related to the disease and its treatment, in addition to addressing the related psychological, social and spiritual concerns. It is patient- and family-centered, as it incorporates the unique needs, values, beliefs and culture of each patient in the medical decision process.

Palliative care is a whole patient supportive care approach that helps to provide the best possible quality of life for patients and their families, regardless of the stage of disease or the need for other therapies. It can be given in conjunction with curative cancer treatment.

Palliative care is often provided by a multidisciplinary team that may include a doctor, nurse, spiritual advisor, navigator, social worker, pharmacist, dietician, occupational therapist, respiratory therapist, physical therapist and volunteers. Palliative care teams can be professionals within the treating cancer facility or from outside referral resources or both. Palliative care can greatly improve a cancer patient’s quality of life regardless of diagnosis and stage of disease.

**Hospice and End-of-Life Care**

Hospice is an intensive program that enhances comfort and promotes quality of life for individuals and their families facing limited life expectancy (i.e., prognosis of six months or less). Although hospice care has the same principles of comfort and support as palliative care, a person receiving hospice does not continue receiving treatment intended to cure the disease.

It may not be possible to cure a serious illness, or a patient may choose not to undergo certain curative treatments. At that point, hospice recognizes that a peaceful and comfortable death is an essential goal of healthcare. A key tenet of hospice is that death is an integral part of the life cycle and that focusing on pain relief, comfort and quality of life are appropriate goals for the terminally ill.

Hospice care teams include the individual and family, trained volunteers, caregivers and clinical professionals that may include spiritual advisors. This approach focuses on the individual’s physical symptoms and the emotional and spiritual concerns of the patient and family. Many patients and families are unaware that if a person is on hospice but improves in health status, they are able to exit the hospice program and resume curative treatment.

**Objective 7.1** > **Address Financial Barriers for Individuals Receiving Cancer Treatment**

| Measures  | Baseline   | 2024 Target  |
|---|--|--|
| Cancer survivors, excluding those diagnosed with skin cancer, who were unable to get medical care in the last 12 months due to cost** | 12.7% (BRFSS, 2018)  | Maintain rate below pre-Affordable Care Act levels <b>18.0%</b> (BRFSS, 2013)        |
| Percent of adults ages 18-64 years who do not have any form of healthcare coverage  | 13.4% (SAHIE, 2017)  | Maintain rate at or below post-Affordable Care Act levels <b>16.5%</b> (SAHIE, 2015) |
| Number of organizations in ACC Cancer Support and Treatment Directory who offer financial assistance                                  | 22 Total; 13 outside of Albuquerque metro area (ACC Directory, 2019) | Maintain <b>22</b>   |

\*\* Nonmelanoma skin cancer is routinely excluded from studies on cancer survivors because it is relatively common and usually nonfatal. Because it was not possible to distinguish between melanoma and nonmelanoma skin cancers in the 2018 BRFSS data, all skin cancers were excluded from the analysis.

**Strategies**

- Encourage cancer care facilities to provide financial education and assistance onsite or by referral
- Support efforts to educate New Mexicans on healthcare benefits, coverage and enrollment
- Support efforts to educate and connect uninsured New Mexicans with resources to access quality cancer treatment and address basic needs
- Engage clinical and community-based patient navigators, financial counselors, community health workers, community health representatives and promotoras to assist patients with overcoming financial barriers
- Promote efforts to inform decision-makers (e.g., legislators, policymakers) about financial barriers and potential solutions to accessing treatment services





**Objective 7.2** > Promote Understanding of the Benefits of Early Palliative Care

| Measures   | Baseline                            | 2024 Target       |
|--|-------------------------------------|-------------------|
| Number of annual educational initiatives for healthcare providers                    | 0 (New Mexico Cancer Council, 2019) | <b>1</b>          |
| Number of annual educational initiatives for patients, family members and caregivers | 2 (New Mexico Cancer Council, 2019) | Maintain <b>2</b> |

**Strategies**

- Create and distribute educational materials for consumers and providers
- Implement education and outreach to increase consumer and provider awareness and understanding of palliative care
- Conduct educational initiatives with healthcare providers



**Objective 7.3** > Improve Access to and Utilization of Palliative Care at Time of Diagnosis and Throughout the Cancer Continuum

| Measures  | Baseline  | 2024 Target             |
|---|---|-------------------------|
| Number of hospitals in New Mexico with 0-49 beds that offer a palliative care program   | 2 of 13 (National Palliative Care Registry, 2015)** | Maintain <b>2 of 13</b> |
| Number of hospitals in New Mexico with 50-150 beds that offer a palliative care program   | 5 of 9 (National Palliative Care Registry, 2015)**  | <b>6 of 9</b>           |
| Number of hospitals in New Mexico with 151-300 beds that offer a palliative care program  | 1 of 3 (National Palliative Care Registry, 2015)**  | Maintain <b>1 of 3</b>  |
| Number of hospitals in New Mexico with 300+ beds that offer a palliative care program   | 2 of 2 (National Palliative Care Registry, 2015)**  | Maintain <b>2 of 2</b>  |
| Number of outpatient treatment centers offering palliative care services  | TBD*  | <b>TBD*</b>             |
| Percent of cancer survivors who report that they are currently experiencing inadequately controlled pain caused by their cancer and/or cancer treatment | 3% (BRFSS, 2010)                                    | <b>&lt;3%</b>           |

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.  
 \*\* Indicates hospitals with an established/identified palliative care program.

**Strategies**

- Support the identification of barriers to accessing palliative care at diagnosis and early stages of disease
- Support advocacy efforts to improve affordable access to and utilization of palliative care
- Support the development of best practice models for patient referral to palliative care through partnerships with cancer care facilities statewide
- Preserve access to pain management medications



**Objective 7.4** > Improve Emotional Well-Being Among Cancer Patients and Survivors

| Measures | Baseline | 2024 Target |
|----------|----------|-------------|
|----------|----------|-------------|

|  |                     |   |
|--|---------------------|---|
| Percent of cancer survivors, excluding those diagnosed with skin cancer, who report frequent (14 or more days per month) bad mental health** | 15.0% (BRFSS, 2018) | Maintain rate at or below <b>18.3%*</b> |
|--|---------------------|---|

\* Due to the relatively small number of cancer survivors in the sample, the annual estimates for this measure vary from year to year, so the target was set to the average value over the most recent five-year time period (2014-2018) to specify at least maintenance of this average.

\*\* Nonmelanoma skin cancer is routinely excluded from studies on cancer survivors because it is relatively common and usually nonfatal. Because it was not possible to distinguish between melanoma and nonmelanoma skin cancers in the 2018 BRFSS data, all skin cancers were excluded from the analysis.

**Strategies**

- Support efforts to improve access to psychosocial support and behavioral health services, including telehealth
- Promote nationally recognized interventions, provided in and outside clinical settings, to improve mental and emotional health (e.g., yoga, meditation, art therapy, peer mentorship and support programs)
- Support education for employers, healthcare providers and community groups about the behavioral health needs of cancer survivors and their loved ones and resources available to support them
- Encourage the use of nationally recognized guidelines and screening tools for patients, at pivotal points of care, for addressing symptom control, pain management and psychosocial distress assessments where appropriate
- Promote increased utilization of the consolidated statewide cancer resource directory



**Objective 7.5** > Improve Physical Well-Being Among Cancer Patients and Survivors

| Measures | Baseline | 2024 Target |
|----------|----------|-------------|
|----------|----------|-------------|

|  |                     |   |
|--|---------------------|---|
| Percent of cancer survivors, excluding those diagnosed with skin cancer, who report frequent (14 or more days per month) bad physical health** | 30.3% (BRFSS, 2018) | Maintain rate at or below <b>29.4%*</b> |
|--|---------------------|---|

|  |                     |              |
|--|---------------------|--------------|
| Percent of cancer survivors, excluding those diagnosed with skin cancer, who are current smokers** | 12.6% (BRFSS, 2018) | <b>12.2%</b> |
|--|---------------------|--------------|

|   |                     |                       |
|---|---------------------|-----------------------|
| Percent of cancer survivors, excluding those diagnosed with skin cancer, who have a normal categorical BMI rating** | 36.0% (BRFSS, 2018) | Maintain <b>36.0%</b> |
|---|---------------------|-----------------------|

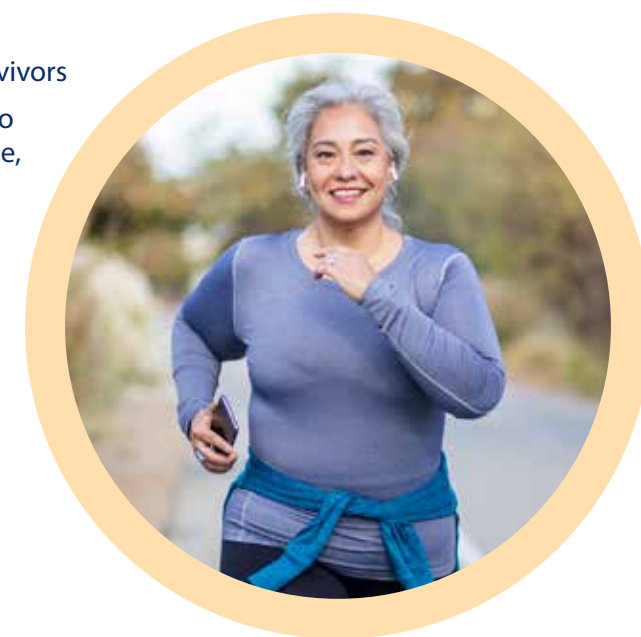
|  |                     |              |
|--|---------------------|--------------|
| Percent of cancer survivors, excluding those diagnosed with skin cancer, who meet the 150+ minutes (or vigorous equivalent minutes) of physical activity recommendations** | 49.7% (BRFSS, 2017) | <b>51.2%</b> |
|--|---------------------|--------------|

\* Due to the relatively small number of cancer survivors in the sample, the annual estimates for this measure vary from year to year, so the target was set to the average value over the most recent five-year time period (2014-2018) to specify at least maintenance of this average.

\*\* Nonmelanoma skin cancer is routinely excluded from studies on cancer survivors because it is relatively common and usually nonfatal. Because it was not possible to distinguish between melanoma and nonmelanoma skin cancers in the 2018 BRFSS data, all skin cancers were excluded from the analysis.

**Strategies**

- Promote healthcare coverage of supportive services for cancer survivors
- Support efforts to educate cancer patients and survivors on ways to maintain a healthy lifestyle to decrease the risk of cancer recurrence, side effects and reduce long-term effects from treatment
- Support efforts to educate employers and providers on the physical needs of cancer patients and survivors



**Objective 7.6** Improve Access to Hospice and End-of-Life Care

| Measures  | Baseline  | 2024 Target        |
|---|---|--------------------|
| Number of New Mexico counties with at least 1 hospice provider                                      | 24 (NM Association for Hospice & Home Care, 2018)*                                | Maintain <b>24</b> |
| Average number of days cancer patients spend on hospice in New Mexico in comparison to U.S. average | NM = TBD*;<br>U.S. = 46 (National Hospice and Palliative Care Organization, 2017) | <b>TBD*</b>        |

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.

**Strategies**

- Support education and outreach efforts to increase awareness and understanding of hospice and end-of-life care, including options and benefits
- Support advocacy efforts to improve early access to and utilization of hospice and end-of-life care
- Support the development of best practice models for patient referral to on-site or community-based hospice and end-of-life care using multidisciplinary care approaches



**Objective 8.1** Promote Survivorship Care Planning for People Diagnosed with Cancer

| Measures  | Baseline | 2024 Target |
|---|----------|-------------|
| Number of educational initiatives for people with cancer and their families/caregivers regarding survivorship care planning | TBD*     | <b>TBD*</b> |
| Number of education initiatives for providers regarding survivorship care planning  | TBD*     | <b>TBD*</b> |

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.

**Strategies**

- Promote efforts to activate and empower survivors at the time of diagnosis to participate in their treatment decisions and acknowledge that patient choices are based on individual needs and preferences
- Support dissemination of survivor and caregiver materials regarding the importance of follow-up care, patient empowerment and following care recommendations
- Promote efforts to assess barriers to survivorship/surveillance follow-up care across the survivorship continuum

**WHO IS A CANCER SURVIVOR?<sup>52</sup>**

An individual is considered a cancer survivor from the time of diagnosis through the balance of his or her life. Family members, friends and caregivers are also impacted by the survivorship experience and are therefore included in this definition.







**Objective 8.2** Increase Survivorship Care Planning for Newly Diagnosed and Long-Term Cancer Survivors

| Measures   | Baseline          | 2024 Target |
|--|-------------------|-------------|
| Number of Commission on Cancer (CoC) or National Accreditation Program for Breast Centers (NAPBC) accredited facilities that meet or exceed CoC survivor care plan delivery rate requirement | TBD*              | <b>TBD*</b> |
| Number of initiatives to educate oncology providers on the development and/or delivery of survivorship care plans  | TBD*              | <b>TBD*</b> |
| Percent of cancer survivors who report receiving a written summary of all cancer treatments they received  | 44% (BRFSS, 2010) | <b>50%</b>  |
| Percent of cancer survivors who report having received written instructions from a healthcare provider regarding routine checkups after completing cancer treatment                          | 51% (BRFSS, 2010) | <b>60%</b>  |

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.

**Strategies**

- Encourage initiation of proactive survivorship care planning at the time of diagnosis, the time at which a patient is considered a survivor
- Support education of newly diagnosed and long-term survivors, healthcare providers and healthcare organizations about the benefits of survivorship care plans
- Support advocacy efforts to reimburse costs associated with development and provision of survivorship care plans
- Promote continuing education opportunities for healthcare providers about late and long-term effects associated with cancer treatment, development of survivorship care plans and potential barriers to care plan implementation
- Promote efforts to inform decision-makers (e.g., legislators, policymakers, insurance companies) about the importance of payments to providers for the development of survivorship care plans
- Promote the adoption of survivorship care plan utilization and delivery in Commission on Cancer and National Accreditation Program for Breast Centers’ accredited and non-accredited cancer treatment facilities

**WHAT IS SURVIVORSHIP?**<sup>53</sup>

Survivorship is the journey of living with a cancer diagnosis through and after treatment, remission and short- or long-term disease management. Survivorship is also living with the emotional, physical, psychosocial and spiritual needs of the survivor. These issues can affect the survivor’s family, caregivers and friends as well.

**Objective 8.3** Increase Adherence to Nationally Recognized Follow-Up Care Guidelines

| Measures   | Baseline | 2024 Target |
|--|----------|-------------|
| Number of initiatives supporting educating primary care physicians on the utilization of survivorship care plans to promote optimal care | TBD*     | <b>TBD*</b> |
| Number of initiatives to educate oncology providers on the development and/or delivery of survivorship care plans                        | TBD*     | <b>TBD*</b> |

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.

**Strategies**

- Support provision of resources and training for oncology providers to ensure adherence to nationally recognized best practice guidelines for development and delivery of survivorship care plans
- Support education for primary care providers regarding the use of survivorship care plans with their patients
- Support efforts to provide survivors with information from evidence-based practice guidelines on an expected course of treatment, appropriate surveillance and recommended follow-up care guidelines

**WHAT IS SURVIVORSHIP CARE PLANNING?**<sup>54, 55</sup>

Survivorship care planning involves assessing and addressing the individual needs of the survivor throughout their journey to improve their health and well-being through end of life. This planning is provided by doctors or patients may make their own. Survivorship care planning includes information about short- and long-term side effects of the disease and the treatment of the disease, ensuring survivors know when and whom to call if symptoms develop. The care plan also helps the survivor understand the importance of keeping follow-up appointments and can aid in the transition of the survivor from the oncologist to a primary care physician. The survivorship care plan empowers the survivor with information and guidance throughout this lifelong journey to become an active participant in care.



### Objective 9.1 > Promote Understanding and Implementation of Patient Navigation Programs

| Measures   | Baseline                 | 2024 Target        |
|--|--------------------------|--------------------|
| Number of initiatives to educate community members, cancer survivors and caregivers about the value of patient navigation and how to access these services | TBD*                     | <b>TBD*</b>        |
| Number of organizations in ACC Cancer Support and Treatment Directory listed who offer patient navigation services   | 22 (ACC Directory, 2019) | Maintain <b>22</b> |

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.

#### Strategies

- Support efforts to educate oncology providers and other healthcare decision-makers about the value of patient navigation services
- Support efforts to educate community members, cancer survivors and caregivers about the value of patient navigation and how to access these services
- Support advocacy efforts for reimbursement of patient navigator services

### Objective 9.2 > Increase Training and Certification of Patient Navigators

| Measures  | Baseline                    | 2024 Target |
|---|-----------------------------|-------------|
| Number of free patient navigation training opportunities available to New Mexicans  | 1 (NM Cancer Council, 2018) | <b>TBD*</b> |
| Number of opportunities for patient navigation certification available to New Mexicans by nationally recognized organizations | TBD*                        | <b>TBD*</b> |

\* NM Cancer Council will consult with key stakeholders to determine baseline and target measures.

#### Strategies

- Support nationally recognized training and certification for navigation programs in New Mexico
- Support continued partnerships with national organizations that provide certification and trainings on patient navigation
- Support collaboration with community colleges and state universities to offer evidence-based training and certification on patient navigation
- Support solutions to overcome training and certification barriers

### Objective 9.3 > Promote Collaboration Among Patient Navigators

| Measures   | Baseline  | 2024 Target        |
|--|---|--------------------|
| Number of navigators participating in statewide networking meetings and activities | 36 (NM Cancer Patient Navigation Network, 2018) | Maintain <b>36</b> |

#### Strategies

- Promote the participation of rural and urban patient navigators in statewide networking activities
- Encourage partnerships with newly implemented patient navigator programs
- Support outreach efforts using technology platforms for increased collaboration and networking

#### THE ROLE OF THE PATIENT NAVIGATOR<sup>56, 57</sup>

Patient navigators provide one-on-one guidance and assistance to individuals as they move through the healthcare continuum from prevention to end-of-life care. The principal function of the navigator is to help patients overcome barriers to timely screening, diagnosis, treatment and supportive care. Navigators act as the support hub for all aspects of patients' movement through the healthcare system and the cancer experience. The navigator's role is to promote smooth and timely continuity of care to the point of resolution and to individualize services to suit each person's unique situation.

Patient navigators provide services within clinical settings and/or through community-based organizations. Navigators may have a broad spectrum of qualifications, from trained lay navigators to professionals such as nurses and social workers. Navigators located within medical facilities help patients through the steps of scheduling and understanding treatment protocols. Community-based navigators assist patients and families to access nonmedical resources such as food, utilities, transportation, etc. Community-based navigators include community health representatives, community health workers and promotoras. Important characteristics of patient navigators include compassion, patience, communication skills, cultural sensitivity, problem-solving skills and a thorough knowledge of available resources.



**NEW MEXICO CANCER PLAN** 2020 > 2024

**IMPLEMENTING  
THE NEW MEXICO CANCER PLAN  
IN NATIVE AMERICAN COMMUNITIES**

## Introduction >

The New Mexico Cancer Plan presents a comprehensive approach to controlling cancer and reducing the burden of cancer within the State. The Cancer Plan's overarching goals, objectives and strategies promote the concept that health is affected by one's physical, emotional, mental, psychological, spiritual and financial well-being. The Native American section of the Cancer Plan reinforces this concept by acknowledging inherent cultural assets that differentiate each tribal community. Cultural strengths, traditions, family relationships, ties to the land and spiritual beliefs may serve as protective factors while enhancing overall health and wellness. The fact that not all Native Americans maintain a strong cultural connection to their tribe/nation of origin cannot be overlooked. So, those who seek to implement the Cancer Plan must be cautioned that an approach that works for one community may not work for another, even if located in close proximity to one another.

The Native American section also recognizes challenges that can make implementation of the Cancer Plan a complex undertaking. Cultural norms, attitudes and health beliefs are firmly rooted and slow to change. Awareness of and education about cancer risk factors have spurred movement toward adoption of healthy lifestyles among most tribal communities. However, transportation, a lack of Native providers, healthcare eligibility and systemic racism remain major barriers to screening, care and treatment for many tribal members.

### CHALLENGES

Twenty years into the 21st century, cancer continues to be a topic not openly discussed among many tribal communities.

Efforts to implement the Cancer Plan in Native communities must honor and respect the health beliefs, traditions and practices of the Navajo Nation, one Apache Nation, two Apache tribes and 19 Pueblos of New Mexico. This section of the Cancer Plan reflects the collective voice of tribal communities, thereby ensuring the strategies are culturally and linguistically relevant for Native communities in New Mexico. It offers practical ideas and tools for tribal and nontribal staff who can use the Cancer Plan to achieve their programmatic goals and objectives related to cancer control, prevention and early detection.

The New Mexico Cancer Council Native American Workgroup convened to develop content for the Native American section of the 2020-2024 Cancer Plan. This workgroup is comprised of professionals and paraprofessionals representing various tribal communities in New Mexico. The workgroup reviewed the 2012-2017 New Mexico Cancer Plan and agreed that major components of the previous Native American section were still relevant.

Throughout this section, American Indian, Native American and Native terminology are used interchangeably.



## Overview of Native Americans in New Mexico >

New Mexico is the ancestral home of 23 tribes/nations: 19 Pueblos, two Apache tribes and one Apache Nation, plus the Navajo Nation. Each tribe/nation is culturally distinct with its own sovereign government, relationships and cultural identity. The 19 Pueblos include the Pueblos of Acoma, Cochiti, Isleta, Jemez, Laguna, Nambe, Ohkay Owingeh, Picuris, Pojoaque, Sandia, San Felipe, San Ildefonso, Santa Ana, Santa Clara, Santo Domingo (Kewa), Taos, Tesuque, Zia and Zuni. The Apache tribes include the Fort Sill Apache, Mescalero Apache and the Jicarilla Apache Nation. The Navajo Nation has lands in Northwest New Mexico located near Farmington, Gallup, Shiprock and Crownpoint. The Alamo, Ramah and To'hajiilee Bands

of Navajo reside in the vicinity of the Indian Health Service (IHS) Albuquerque Area.

In the 2010 United States (U.S.) Census, 228,400 Native Americans, or 10.9% of New Mexico's population, identified themselves as American Indian or Alaska Native (AI/AN) [U.S. Census Bureau (2010)]. A total of eight languages are spoken by tribal members in New Mexico: Jicarilla Apache, Keres, Mescalero Apache, Navajo, Tewa, Tiwa, Towa and Zuni. Of the total Native population in the State, approximately 68,924 reside in the Albuquerque metropolitan area (U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Survey).

## The Federal Trust Responsibility and Tribal Sovereignty >

The federal trust responsibility stems from the relationship between the federal government and Indian tribes in which the federal government undertook the obligation to ensure the survival of Indian tribes. In return for Indian tribes ceding millions of acres of land that make the U.S. what it is today, the federal government acknowledged its duty to protect tribes' right to self-government and their right to exist as distinct peoples on their own lands. The federal trust responsibility is a legally enforceable fiduciary obligation on the part of the U.S. to protect tribal treaty rights, lands, assets and resources, and to provide federal assistance to ensure the success of tribal communities. The U.S. Constitution, treaties, statutes, executive orders and judicial decisions recognize the United States' trust relationship with tribes (Administration for Native Americans, Fact Sheet, March 19, 2014).

Each tribe is a sovereign nation with its own government, traditions and culture, and each tribe has a unique government-to-government relationship with the United States. Tribal sovereignty is a legal term for the concept that a tribe has the right to self-governance. Over the years, the U.S. Supreme Court, the President and Congress have repeatedly affirmed that tribes retain this inherent right to govern themselves. Federal authority

is not necessary to permit a tribal government to act, but rather, tribal governments are presumed to have the right to act because their authority derives from their preexisting status as sovereign nations. The underpinnings of tribal sovereignty are continually being scrutinized and sometimes diminished by the actions of the federal government. This includes the U.S. Supreme Court, which has gradually moved away from the concept of inherent tribal sovereignty that predated the coming of Europeans, and has adopted the view that tribal sovereignty and the perception that freedom of the tribes from meddling by the states, exists only because Congress has chosen to confer some protections on the tribes. (Administration for Native Americans, Fact Sheet, March 19, 2014).

### TRIBAL SOVEREIGNTY

Tribal sovereignty is a legal term for the concept that a tribe has the right to self-governance. Tribal governments are presumed to have the right to act because their authority derives from their preexisting status as sovereign nations.

## Historical Perspective on Native Americans and Healthcare >

Treaties and laws serve as the foundation for the federal government's responsibility to provide certain rights, protections and services to American Indians and Alaska Natives (AI/AN), including healthcare.

The principal legislation authorizing federal funds for health services to Native American tribes is the Snyder Act of 1921, wherein the federal government stated its intention to provide appropriations "for the benefit, care, and assistance of the Indians throughout the United States...for the relief of distress and the conservation of health" [Pub. L. 67-85, 25 U.S.C. 13 (1921)]. Congress created a process for transferring Bureau of Indian Affairs (BIA) and Indian Health Service (IHS) health programs to tribal governments through the Indian Self-Determination and Education Assistance Act of 1975 [Pub. L. 93-638 25 U.S.C. 45 et. seq. (1975)]. In doing so, Congress noted the past inadequacies of Native American healthcare and reaffirmed its intention to involve tribes in healthcare programs through tribal self-governance. Under this Act, tribes, tribal organizations and urban Indian health centers can choose to receive funds directly from the federal government; tribal healthcare facilities and programs that receive funds in this manner are unofficially referred to as "638 facilities/ programs."

In 1976, Congress enacted the Indian Health Care Improvement Act (IHCIA) "to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services" [Pub. L. 94-437, 25 U.S.C. 1601 (1976)]. In passing the act, Congress noted the government's policy, "in fulfillment of its special

trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy" [Pub. L. 94-437, §3, 25 U.S.C. 1602 (1976)]. The IHCIA, the cornerstone of legal authority for the provision of healthcare to AI/AN, was made permanent when President Obama signed the bill on March 23, 2010, as part of the Patient Protection and Affordable Care Act [Pub. L. 111-148, 42 U.S.C. §1800 et. seq. (2010)]. Although the IHS and 638 facilities/programs are the primary structures through which the federal government provides health services to Native Americans, chronic underfunding for IHS and other barriers often limit their access to healthcare. Currently, the Patient Protection and Affordable Care Act offers opportunities to increase health coverage and care of AI/AN, and reduce the longstanding disparities they face. Annual appropriations for the IHS assume that healthcare delivered by the IHS and 638 facilities/programs will be provided in combination with public programs such as Medicare and Medicaid, for which Native Americans qualify as U.S. and state citizens. However, access to public programs by Native Americans is often denied or delayed based on the erroneous belief that AI/AN are only entitled to IHS healthcare. Erratic funding of the IHCIA has made it difficult for the IHS to fulfill its goals of providing Native Americans with the best care necessary to attain the highest possible health status (*Indian Health Service, Fact Sheet, January 2015*).

### INDIAN HEALTH CARE IMPROVEMENT ACT OF 1976

The Indian Health Care Improvement Act of 1976 was enacted "to provide the quality and quantity of health services which will permit the health status of Indians to be raised to the highest possible level" in fulfillment of the federal government's responsibility to Indians.

## Current Options for Native American Healthcare Access in New Mexico >

The Albuquerque Area IHS (AAIHS), headquartered in Albuquerque, provides healthcare to AI/AN in New Mexico, Colorado and Texas. The AAIHS delivers care through four hospitals, 11 health centers and 12 field clinics that are administratively divided into 10 Service Units (SU). Two urban health centers also deliver care to patients in Albuquerque and Denver. The New Sunrise Regional Treatment Center provides residential treatment services for Native youth with substance abuse problems. The Albuquerque Indian Dental Clinic provides dental services for children, teens and young adults. Tribal members who live, work or go to school in the urban centers of the Area also have access to IHS-operated health facilities ([www.ihs.gov/retention/retentionstrategies/recruitmenttools/](http://www.ihs.gov/retention/retentionstrategies/recruitmenttools/)).

The Navajo Area IHS (NAIHS) delivers health services to a user population of more than 244,000 American Indians in five Federal Service Units on and near the Navajo Nation. The Navajo Nation is one of the largest Indian reservations in the United States. It consists of more than 25,000 contiguous square miles and includes three satellite communities, extending into portions of Arizona, New Mexico and Utah. NAIHS primarily delivers health services to members of the Navajo Nation and the San

Juan Southern Paiute Tribe. NAIHS also provides services to other Native Americans, including Zuni and Hopi, as well as other AI/AN beneficiaries. The five Navajo Service Units are located in Chinle, Crownpoint, Gallup, Kayenta and Shiprock.

The NAIHS provides inpatient, emergency, outpatient, public health and other services at four hospitals: Chinle Comprehensive Health Care Facility, Crownpoint Health Care Facility, Gallup Indian Medical Center and Northern Navajo Medical Center in Shiprock. These inpatient facilities comprise a total of 222 hospital beds. The NAIHS also has seven full-time health centers providing outpatient, community health, preventive health and other services. There are also five part-time health centers (<https://www.ihs.gov/navajo>).



Sculpture by: Arlo Namingha; Photo by: Nicole Namingha -2019.

## Healthcare Access Challenges for Native Americans in Urban Areas >

Tribal members who relocate to a city (e.g., Albuquerque) in pursuit of job opportunities or higher education may face challenges in accessing healthcare. Urban Natives who reside in the Albuquerque metropolitan area are eligible to receive healthcare at the Albuquerque Indian Health Center and First Nations Community Health Source. In addition to these sources of healthcare, urban Natives may access Medicaid benefits or participate in employer-sponsored health insurance programs.

Tribal members who reside in cities throughout New Mexico also encounter challenges when accessing specialized healthcare for themselves and their families. The IHS operates a Purchased/Referred Care Program (PRC), which focuses on purchasing services from private healthcare providers in situations where: 1) no IHS or tribal direct care facility exists; 2) the existing direct care element is incapable of providing required emergency and/or specialty care; 3) utilization in the direct care element exceeds existing staffing; and 4) supplementation of alternate resources (e.g., Medicare, Medicaid or private insurance) is required to provide comprehensive healthcare to eligible tribal members ([www.ihs.gov/forpatients/prc](http://www.ihs.gov/forpatients/prc)).

The combination of increasing tribal population, limited funding, inflation and limited competitive pricing requires strict adherence to PRC guidelines to ensure the most effective use of resources. The PRC guidelines, which apply to medical priorities of care and eligibility requirements, are often stricter than those for IHS direct care. As the payer of last resort, the IHS and 638 facilities/programs require patients to exhaust all healthcare resources available to them from private insurance, state health programs and other federal programs before the PRC program can provide payment. The program guidelines may cause an urban Native, although he/she is an enrolled member of a New Mexico Tribe or Pueblo, to be ineligible for specialized healthcare through the PRC program (*Bernalillo County Off-Reservation Native American Health Commission, November 2010*).



## Indigenous Data Sovereignty >

Cancer-related data that is tribal-specific and for American Indians in urban settings are needed to help with planning and to determine if statewide cancer control efforts are making a difference for American Indians in New Mexico. However, existing cancer-related data provide an incomplete picture of the unequal burden of cancer experienced by AI/AN due to limitations of available data. These limitations are influenced by racial misclassification of patients diagnosed with cancer, undercounting that is also due in part to racial misclassification, smaller population sizes and geographic differences that provide a limited understanding of cancer experienced by American Indians across the comprehensive cancer control spectrum [(Briant K. J., Garrett Hill T, Northwest Portland Area Indian Health Board's Northwest Tribal Comprehensive Cancer Project. (2011). *Cancer 101: A Cancer Education and Training Program for American Indians and Alaskan Natives, Version 2 (Rev. ed)*]. Data collected must provide timely, accurate and useful information for tribal nations to make informed decisions that contribute to the well-being of their citizens.

Advocacy efforts of the global Indigenous Data Sovereignty movement that is working to reclaim Indigenous peoples' rights related to data are relevant for statewide comprehensive cancer control efforts. The U.S. Indigenous Data Sovereignty Network states that "Indigenous data sovereignty is the right of a tribe to govern the collection, ownership and application of its own data that derives from their inherent right to govern its peoples, lands and resources" (<https://usindigenousdata.arizona.edu/about-us-0>).

Currently, tribal nations are not always included in determining what health data they need and are often challenged with accessing health data about their citizens (*Walter, M. & Suina, M., Indigenous data, indigenous methodologies and indigenous data sovereignty, International Journal of Social Research Methodology, DOI: 10.1080/13645579.2018.1531228*).

Furthermore, epidemiological quantitative health data construct a deficit-based statistical narrative of Indigenous peoples, including American Indians, and blames them for the health disparities they face (*Walter, M., & Andersen, C. Indigenous statistics: A quantitative research methodology. New York, Routledge Walter and Andersen, 2013*).

Available American Indian health data do not provide a thorough understanding of the underlying historical, social and political factors that contribute to the unequal burden of cancer experienced by American Indians, nor do they consider how American Indians conceptualize health (*M Walter and M Suina, 2018*).

Tribal nations must be involved in determining what data are going to provide them with information that will contribute to all aspects of tribal governance, including the provision of and/or access to culturally appropriate health promotion and disease prevention programs, healthcare and resources for their citizens when cancer is diagnosed.



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## Overview >

The 2020-2024 Cancer Plan identifies nine goals, with separate objectives and strategies. Workgroup members selected five goals from the Cancer Plan for inclusion in the Native American section that best reflect their tribal communities' areas of interest and that they deemed as achievable. Cultural considerations and existing resources that support the goals and selected objectives are discussed, as well as challenges that could affect implementation of the plan. This section summarizes some efforts of New Mexico tribal communities that are already addressing the stated goals, objectives and strategies; however, it does not provide an exhaustive review of current or anticipated initiatives.

## CANCER PLAN GOAL 1 > INCREASE HEALTHY BEHAVIORS

### CULTURAL CONSIDERATIONS

Every tribal leader, administrator and healthcare provider has confronted the issue of determining which health and wellness interventions are the best fit for their communities (i.e., whether they are culturally and linguistically appropriate for them). Respecting the sovereignty of each tribe is of critical importance in providing health and prevention services. Adopting the mindset of cultural humility can be helpful to ensure that interventions meet the needs of a specific tribal community. Cultural humility requires a lifelong commitment to self-evaluation and self-critique to correct power imbalances and to develop mutually beneficial relationships on behalf of individuals and communities (M. Tervalon & J. Murray-Garcia. "Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education." *J Health Care Poor Underserved*. Vol. 9, No. 2. 1998. p. 117-25). A Native American Workgroup member cautioned providers to be prepared to explain things more than once, "...using everyday language that the People can understand."

### STRENGTHS AND RESOURCES

Most Native communities have ongoing programs that not only support healthy lifestyles but also reduce the risk of developing cancer. Many tribal communities receive grant funding through the Special Diabetes Program for Indians. Diabetes prevention programs aim to increase levels of physical activity and improve dietary intake, both of which aid in reducing the risk of developing cancer. Dialogue with community members about shared risk factors for cancer, diabetes and heart disease can accomplish multiple outcomes and maximize tribal health resources. Examples of existing strengths and resources are cited for selected objectives.

#### Objective 1.1 > Increase Physical Activity

- Pueblo Crossroads is a coalition of community-based running clubs that hosts monthly runs and walks; it currently draws participation from 18 of the 19 Pueblos.
- Running Medicine is a running club funded by the Native Health Institute; Running Medicine events attract tribal participants throughout northwest New Mexico.
- Other events that encourage and support healthy lifestyles are the annual Jim Thorpe Run, Just Move It, WINGS of America Summer Camps, Healthy Beverage Summit and the annual Santo Domingo Pueblo Mud Volleyball Tournament.
- Many tribal communities have fully equipped fitness centers that serve adults and children; Zumba, Tai Chi and yoga sessions are offered in some communities.

#### Objective 1.2 > Increase Access to Healthy Food

- MoGro (Mobile Grocery), an initiative of the Santa Fe Community Foundation, supports sustainable local food systems and eliminates barriers to affordable healthy food. MoGro has served the Pueblos of Cochiti, Jemez, Laguna, San Felipe and Santo Domingo.
- New Dawn Program, operated by the Navajo Department of Health, educates individuals, families and communities about nutrition, exercise, education and horticulture techniques.
- Navajo Technical University offers free gardening workshops to increase the knowledge base in the Navajo Nation about healthy and culturally appropriate food produced through ecologically sound methods. The culinary program at Navajo Technical University incorporates indigenous foods in its curriculum.
- Community health representatives (CHRs) provide community-based healthcare, health promotion and disease prevention services. They connect directly with the community since they come from the communities they serve. CHRs are essential to the provision of tribal community-based healthcare services.
- The Fruit and Vegetable Prescription Program (FVRx<sup>®</sup>), operating on the Navajo Nation, serves new and expectant mothers with gestational diabetes and overweight, or obese children from three to six years of age. CHRs help identify families with these health risks, and doctors give prescriptions, in the form of vouchers, for a month's worth of free fruits and vegetables for their families.

#### Objective 1.3 > Promote Healthier Weight

- The Healthy Diné Nation Act applies a 2% tax on sugar-sweetened beverages and foods that have been stripped of essential nutrients and are high in salt, saturated fat and sugar.
- Many Native communities use the Physical Activity Kit (PAK) to promote healthy lifestyles. The PAK is based on best and promising practices to increase physical activity with the goal of increasing the time community members spend in medium to high physical activity for all ages across the lifespan.
- Many tribal communities offer cooking classes to promote the preparation of healthy meals using foods readily available at local grocery stores.

#### Objective 1.4 > Decrease the Proportion of Adults Exceeding Dietary Guidelines for Moderate Drinking

- Alcohol and substance abuse-prevention programs operated by the IHS and 638 facilities/programs use holistic approaches and an evidence-based method: Screening, Brief Intervention and Referral to Treatment to reduce incidence and prevalence levels to those below or equal to the U.S. population.

#### Objective 1.6 > Increase HPV and Hepatitis B Vaccinations

- The IHS and 638 facilities/programs use reminders in patient electronic health records to encourage providers to recommend hepatitis B vaccinations for adult patients 19-59 years who have been diagnosed with diabetes, and HPV vaccinations for females age 11 or 12 years through age 26, and males age 11 or 12 years through age 21; males age 22 through 26 may also be vaccinated.

# IMPLEMENTING THE NEW MEXICO CANCER PLAN IN NATIVE AMERICAN COMMUNITIES

## Objective 1.7 > Decrease Chronic Cases of Hepatitis C

- Providers at some IHS hospitals and 638 facilities/programs work with Project ECHO (Extension for Community Health Outcomes) at the University of New Mexico to provide telehealth and teleconsultation services in order to treat IHS, tribal and urban patients on-site, rather than referring them to facilities far away from their support systems and communities.

### OPPORTUNITIES

There are ample opportunities for tribal communities to improve their approaches to culturally appropriate interventions to increase healthy behaviors, improve health status and reduce the risk of developing cancer. Workgroup members offered the following ideas:

- Use one's Native language when explaining medical conditions and interpretive services for tribal members who are not fluent in the English language.
- Emphasize traditional teachings about health and wellness.
- Create safe outdoor walking paths.
- Allow tribal employees time off to participate in wellness activities offered during the workday.
- Adopt smoke-free policies for all public spaces: community parks, workplaces, schools, health facilities, restaurants, casinos, housing, wellness centers, recreational facilities and tribal administration buildings.
- Design fitness activities to meet the needs of older members or those with limited mobility.
- Create printed newsletters that address wellness topics; on-air public service announcements are not always free.

## CANCER PLAN GOAL 3 > DECREASE ENVIRONMENTAL FACTORS THAT LEAD TO CANCER

### CULTURAL CONSIDERATIONS

Environmental risk factors are a major consideration among New Mexico Native communities. From the threat of water pollution caused by a wastewater spill to environmental effects of methamphetamine production on tribal lands to smoke in tribally owned casinos, tribal leaders and public health personnel are charged with the responsibility of decreasing environmental factors that lead to cancer. Confronting the issue of risk factors from secondhand or thirdhand smoke among tribes that operate casinos may require a diplomatic approach, since gaming revenue may fund essential programs. Although uranium mining has ceased on tribal lands, community members residing on or near former mining sites could experience potential health effects including lung cancer, bone cancer and impaired kidney function ([www.epa.gov/navajo-nation-uranium-cleanup](http://www.epa.gov/navajo-nation-uranium-cleanup)). Listening to patients express their feelings of helplessness or lack of control in confronting an invisible risk factor can encourage their self-empowerment and willingness to focus on ways of reducing their risk for developing cancer due to other environmental factors.

### STRENGTHS AND RESOURCES

Native healthcare providers and health educators continuously seek ways to increase health literacy, self-management and cultural competency in healthcare and public health settings. The Navajo Area IHS, in partnership with cultural experts, philosophers and traditional healers, developed a Navajo Wellness Model curriculum titled "Shá'bek'ehgo As'ah Oodááł, A Journey with Wellness and Healthy Lifestyle Guided by the Journey of the Sun." It is designed to increase awareness, knowledge and understanding among healthcare and public health providers of core Navajo teachings about personal and family health, healthy communities and a healthy environment. The IHS and 638 facilities/programs partner with CHRs to educate tribal community members about environmental risk factors.

Workgroup members identified the following examples of existing strengths and resources:

## Objective 3.1 > Increase Knowledge and Community Infrastructure to Decrease Exposure to Radon

- The Navajo Birth Cohort Study investigates the effects of environmental exposure of uranium and other toxicants on pregnancy.
- Living Healthy, the Native Way provides a forum for community members to discuss environmental health topics.
- The New Mexico Indoor Radon Outreach Program provides radon test kits for use by independent tribal environmental/health departments who are solely responsible for their use and resultant data.

## Objective 3.2 > Increase Testing for Concentration of Arsenic in Private Well Water

- The IHS and some 638 facilities/programs offer technical assistance and training to support the efforts of tribal environmental health departments to routinely test the quality of public and private water sources on tribal lands.

### OPPORTUNITIES

Raising awareness about radon and arsenic may be challenging because both are tasteless and odorless. Local health educators and CHRs can assist providers in developing culturally and linguistically appropriate educational materials. Workgroup members proposed some methods for addressing the threat posed by environmental risk factors:

- Actively pursue ways to incorporate traditional teachings about respect for Mother Earth.
- Encourage tribal leaders to seek resources to properly seal abandoned uranium mines.
- Advocate for smoke-free areas in casinos with separate ventilation systems.
- Explore ideas for reducing language barriers so discussions about environmental risk factors can occur.





## CANCER PLAN GOAL 4 DECREASE MORTALITY FROM SCREENABLE CANCERS

### CULTURAL CONSIDERATIONS

Providers may unwittingly alienate patients or their caregivers by their choice of words or nonverbal cues. To improve communication with those they serve, and to improve cancer screening rates, providers can draw upon the wisdom and experience of CHRs for guidance in creating culturally and linguistically appropriate talking points to increase detection of screenable cancers. Lack of trust that confidentiality will be assured by tribal healthcare providers may contribute to low screening rates. Allaying patients' concerns about confidentiality is important.

### STRENGTHS AND RESOURCES

All IHS facilities offer the fecal occult blood test for colorectal cancer screening and some hospitals contract the services of mobile mammogram units to provide on-site mammography for their patients. Two goals of the IHS and 638 facilities/programs are to expand training in flexible sigmoidoscopy for colorectal cancer screening and cervical cancer colposcopy for diagnostic services. Health education about cancer screening is routinely conducted by tribal health educators and CHRs, and local health fairs provide a convenient venue for encouraging dialogue with tribal members about cancer screening. The Navajo Nation Community Outreach and Patient Empowerment (COPE) Program uses the Circle of Life to educate community members about cancer prevention and early detection. The Circle of Life is a health education curriculum developed by the American Cancer Society for AI/AN communities.

Other ways tribal communities are increasing detection of screenable cancers are listed below:

#### Objective 4.1 > Increase Adherence to Evidence-Based Screening and Early Detection Recommendations and the Adoption of Best Practices

- All IHS and 638 facilities/programs have adopted the U.S. Preventive Services Task Force recommendations for cancer screenings.
- The Navajo Breast and Cervical Cancer Prevention Program follows the Centers for Disease Control and Prevention (CDC) screening recommendations for cervical and breast cancer using mobile mammography.
- COPE staff developed an app that allows CHRs to access the Circle of Life curriculum while in the field.
- Tribal health educators and CHRs in most Pueblos provide cancer prevention and early detection education in both small and large group sessions.

#### Objective 4.3 > Increase Use of Data to Identify Cancer Disparities in New Mexico

- The IHS Division of Epidemiology and Disease Prevention shares cancer surveillance data through partnerships with CDC and National Cancer Institute-supported central cancer registries by conducting linkages with IHS patient registration data and improving cancer case data sets for AI/AN using IHS encounter data.
- The Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC) supports tribal public health data improvement efforts and helps tribes develop epidemiology and surveillance systems for cancer and other diseases.
- The Navajo Epidemiology Center's primary objectives are data collection, analysis and interpretation; health surveillance; disease control and prevention; and data sharing for all diseases, including cancer.

#### Objective 4.4 > Conduct Focused Outreach on the Importance of Early Detection to Decrease Advanced Diagnosis of Cancer

- Cancer terminology glossaries and digital stories are heavily utilized by new Navajo CHRs, since there is no designated interpreter at IHS facilities.
- The Santa Fe IHS conducts community outreach to Native community members to inform them about resources for cancer screening.
- The Patient and Family Advisory Council (PFAC) established by COPE helps select culturally appropriate images and interpretation for cancer terminology; the PFAC consists of cancer survivors, present/former caregivers and community stakeholders across the Navajo Nation.
- The COPE Cancer Coalition, comprised of providers and stakeholders, delivers health education related to cancer on the Navajo Nation and hosts an annual Navajo Cancer Survivorship Conference.

### OPPORTUNITIES

Tribal leaders and healthcare providers unanimously endorse low-cost or no-cost approaches to increase detection of screenable cancers. It may be helpful to ask tribal community members for their input when planning community events designed to raise awareness of cancer prevention campaigns. Workgroup members suggest the following strategies for increasing early detection of screenable cancers including:

- Invite survivors to speak about their experiences at events.
- Train tribal community members to present basic cancer education to their peers.



## CANCER PLAN GOAL 5 ENSURE CONSISTENT ACCESS TO HIGH-QUALITY DIAGNOSTIC AND TREATMENT SERVICES

### CULTURAL CONSIDERATIONS

Tribal leaders can help ensure that their community members have consistent access to high-quality diagnostic and treatment services. As representatives of sovereign tribes/nations, they can engage in government-to-government dialogue with state and federal entities to address institutional barriers such as the Indian Health Service (IHS) Purchased/Referred Care Program, which causes some urban tribal members to be ineligible for specialized healthcare, including cancer screening and treatment. Educating tribal leaders about the Cancer Plan is vital, as their support and endorsement can facilitate implementation of the Cancer Plan. Native American patients and their caregivers must be informed about all options for diagnosis and treatment so they can be active participants in their cancer care. No assumption should be made that a Native American patient may be unable to follow a complex mode of treatment or regimen of care. Respectful dialogue in a private setting can create trust and encourage communication. A tribal elder offered the following advice, "Providers need to listen and be present with you and not just look at the computer."

### EXISTING STRUCTURES, STRENGTHS AND RESOURCES

Most IHS clinics and hospitals offer cancer prevention and control services, including Pap tests, mammography, colorectal cancer screening and tobacco cessation programs. Providers may refer patients for specialized or advanced diagnostic services. CHRs who are certified as community health workers (CHWs) also have advanced knowledge about cancer and chronic diseases that are prevalent in their communities. Healthcare providers who are fluent in their Native languages have the advantage of being able to translate information about the technical aspects of diagnostic tests and treatment, thereby helping to improve dialogue about options for cancer screening and treatment.

Workgroup members identified the following examples of community structures that support this goal of detection of screenable cancers.

### Objective 5.1 > Increase Access to Cancer Care

- Health educators are adept at explaining how patients can access services from managed care organizations.
- Barriers to accessing cancer care are frequently decreased when healthcare is provided by tribal professionals.
- Transportation is provided by CHRs or tribally based transport agencies.

### Objective 5.2 > Promote Informed Decision-Making About Cancer Treatment

- Healthcare providers and CHRs aid oncologists by explaining treatment options to newly diagnosed patients and their caregivers.
- Members of ongoing cancer support groups in Fort Defiance, Shiprock and Isleta Pueblo willingly share their cancer experiences with patients who are newly diagnosed.

### OPPORTUNITIES

Elders can be excellent sources of knowledge about traditional health and wellness beliefs and, if they are included in early discussions about screening and treatment options, they can be empowered to be more involved in decisions affecting their healthcare. Providers can demonstrate respect by allowing ample time for tribal members to consult with family members about treatment options and regimens of care. Workgroup members also recommended the following:

- Require healthcare providers to undergo cultural awareness and cultural sensitivity training if their training programs did not include this component.
- Encourage the inclusion of traditional healers in the informed decision-making process.



## CANCER PLAN GOAL 9 ENHANCE PATIENT NAVIGATION ACROSS THE CANCER CARE CONTINUUM

### CULTURAL CONSIDERATIONS

Cultural and linguistic appropriateness is critical when addressing patient navigation across the entire spectrum of cancer care, from prevention to end of life. Those who are newly diagnosed, cancer survivors and family members supporting their loved ones, deserve to be treated with the utmost care and respect. Healthcare providers can rely on CHRs or tribal staff to provide guidance on cultural protocols or terminology to enhance honest and respectful dialogue about cancer. A workgroup member noted, “The more you educate, the more it lessens the taboos associated with speaking about cancer.” Truthful discussions about cancer diagnosis and survivorship using basic terminology will always be appreciated by patients and their support persons.

### STRENGTHS AND RESOURCES

Among the many community strengths and resources within tribal communities, CHRs are indispensable members of the health team; they are often viewed as patient navigators by tribal members. Families and Native healers collectively represent another source of community strength and are valuable resources who can enhance patient navigation across the cancer care continuum.

Other strengths and resources are cited below:

#### Objective 9.1 > Promote Understanding and Implementation of Patient Navigation Programs

- Tribal health educators provide education for all primary caregiver(s), family and other caregivers.
- Medical transportation is available for patients who are Medicaid-eligible.
- Palliative care in the Navajo Area IHS is delivered by three board-certified providers who rely on CHRs and local healthcare providers for guidance on developing culturally and linguistically appropriate talking points with newly diagnosed patients and their caregivers.

#### Objective 9.2 > Increase Training and Certification of Patient Navigators

- Many CHRs are certified by the state as CHWs, which enhances their professional credibility and increases their foundation of knowledge.
- Identify community-based navigators in each IHS facility. Ensure that navigators are well-versed in the resources that are available in each community.

### OPPORTUNITIES

Due to the fragmented nature of healthcare delivery in Native communities, coordination of healthcare, including cancer care, does not flow smoothly. The absence of actual patient navigators in the IHS and 638 facilities/programs frequently requires CHRs to assume that role, but this burdens them unfairly since they already have a prescribed scope of work.

Workgroup members identified the following opportunities that may enhance patient navigation across the cancer care continuum:

- Provide opportunities for continuing education on cancer for CHRs and CHWs.
- Advocate for the Circle of Life curriculum to be endorsed by the New Mexico Office of Community Health Workers.
- Continue to include CHRs as an integral member of a patient’s support team for appointments, interpretation and treatment care plans until patient navigators are hired in tribal communities.
- Provide transportation that meets the unique needs of patients and family who are dealing with cancer — a critical need for everyone, not only for those who are Medicaid-eligible.
- Build a network for cancer patients who live in Native areas.
- Encourage more collaboration with local hospitals to follow patients who have been discharged after cancer treatment.
- Create a team of “Navegators” who can translate cancer terminology from English into Native languages.
- Create a resource directory of Native healers who treat cancer patients.

### TABOOS ASSOCIATED WITH SPEAKING ABOUT CANCER

“People who are diagnosed with cancer in my tribe go through it quietly. Family members care for them. They don’t want people to talk about them.”

**Tribal elder**

### Summary >

The 2020-2024 Cancer Plan serves as a blueprint for cancer control in New Mexico, and it outlines numerous strategies for achieving the nine goals. The Native American section came to life with the breath of everyone who offered their input for the section. Native American Workgroup members, tribal members and healthcare professionals provided valuable ideas and tools for all who wish to use the Cancer Plan to achieve their programmatic goals and objectives related to cancer control and prevention. Successful implementation of the Cancer Plan will require a commitment by all healthcare providers and program staff to embrace the suggestions and recommendations presented in the Cancer Plan.

## Native American Cancer Resources >

### Albuquerque Area Southwest Tribal Epidemiology Center

The mission of the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC) is to collaborate with the 27 American Indian tribes in the Albuquerque area to provide high-quality health research, surveillance and training to improve the quality of life of American Indians. The AASTEC implements the Tribal Colorectal Health Program, funded by the Centers for Disease Control and Prevention, in cooperation with the national Indian Health Service Division of Epidemiology and Disease Prevention. The primary objectives of this program are to:

- Build knowledge and skills among Community Health Representatives (CHRs).
- Establish multidisciplinary colorectal health teams in participating tribes.
- Develop culturally appropriate colorectal health education materials.
- Share successful strategies with tribal communities throughout the country.
- Explore promising tribal colorectal cancer control interventions.

For more information, visit the web page at [www.aastec.net](http://www.aastec.net)

### Cancer Support Leadership Training

The Indian Health Service Division of Epidemiology and Disease Prevention, the Centers for Disease Control and Prevention and the Great Plains Tribal Chairmen's Health Board offer tribal community-based healthcare providers and cancer survivors who are interested in starting a cancer support group an opportunity to acquire basic cancer knowledge and experience in group facilitation. Cancer Support Leadership Training is a three-day training process that provides a safe and supportive learning environment for participants who want to help people affected by cancer in their local communities. For more information, email [richard.mousseau@gptchb.org](mailto:richard.mousseau@gptchb.org)

### Mayo Clinic Cancer Center

#### Native Cancer Information Resource Center and Learning Exchange

The Native Cancer Information Resource Center and Learning Exchange (Native CIRCLE) is a resource center that provides cancer and non-cancer related materials to healthcare professionals and lay people involved in the education, care and treatment of AI/AN. Culturally appropriate educational materials are essential tools for community outreach. This organization was established in 1999 within the Mayo Clinic Comprehensive Cancer Center. It develops, disseminates and maintains culturally appropriate cancer, diabetes, and health and wellness materials for AI/AN educators, providers and students.

For more information, visit the web page at [www.nativeamericanprograms.org/index-circle](http://www.nativeamericanprograms.org/index-circle)

### Native American Cancer Research

The mission of Native American Cancer Research (NACR) is to reduce cancer incidence and increase survival among American Indians and Alaska Natives (AI/AN). NACR develops and tests primary, secondary and tertiary interventions and influences the early adoption of prevention and cancer control initiatives among Native Americans. NACR partners with native and non-native organizations to provide training opportunities related to these areas.

For more information, visit the web page at [www.natamcancer.org/index](http://www.natamcancer.org/index)

### Navajo Nation Community Outreach and Patient Empowerment

Navajo Nation Community Outreach and Patient Empowerment (COPE) is a partnership with the Navajo Nation Community Health Representative Outreach Program. It aims to improve the lives of those living with chronic diseases by developing programs in Navajo that address structural barriers to good health, respond to the burden of disease and bridge gaps in the healthcare system identified by providers, patients and families.

For more information, visit the web page at [www.copeprogram.org](http://www.copeprogram.org)

### Navajo Nation Breast and Cervical Cancer Prevention Program

The mission of the Navajo Nation Breast and Cervical Cancer Prevention Program (NNBCCPP) is to educate and provide cancer screening to low-income, uninsured or underinsured women. The NNBCCPP seeks to improve the quality of life on the Navajo Nation through the prevention of breast and cervical cancers. It targets women ages 40-64 years for breast cancer with priority given to women over age 50, and ages 21-64 years for cervical cancer. Case management is included in the program's menu of services.

For more information, visit the web page at [www.nmdoh.org/bccp.html](http://www.nmdoh.org/bccp.html)

### Northwest Portland Area Indian Health Board Northwest Tribal Comprehensive Cancer Project

The Northwest Portland Area Indian Health Board (NPAIHB) administers a broad range of health programs to fulfill its mission of assisting Northwest tribes to improve the health status and quality of life of member tribes and AI/AN people in their delivery of culturally appropriate and holistic healthcare. One of the projects it operates is the Northwest Tribal Cancer Control Project. With funding from the CDC, staff developed a curriculum designed to assist health educators in delivering cancer education in tribal communities.

**Cancer 101: A Cancer Education and Training Program for American Indians and Alaskan Natives, Version 2** (Rev. ed.) is available at: <http://cancer101curriculum.wordpress.com/cancer-101-ai-an-version/>. This curriculum provides basic information about cancer and is intended for community members, CHRs and staff on Indian health programs.



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## ACRONYMS

|               |  |
|---------------|--|
| AAIHS         | Albuquerque Area Indian Health Service                                     |
| AASTECC       | Albuquerque Area Southwest Tribal Epidemiology Center                      |
| ACC           | Albuquerque Cancer Coalition   |
| AI/AN         | American Indian/Alaska Native  |
| BIA           | Bureau of Indian Affairs   |
| BMI           | Body Mass Index  |
| BRFSS         | Behavioral Risk Factor Surveillance System                                 |
| CDC           | Centers for Disease Control and Prevention                                 |
| CDPC          | Chronic Disease Prevention Council   |
| CHR           | Community Health Representative  |
| CHW           | Community Health Worker  |
| CoC           | Commission on Cancer   |
| COPE          | Community Outreach and Patient Empowerment                                 |
| ECHO          | Extension for Community Healthcare Outcomes                                |
| FAP           | Familial Adenomatous Polyposis   |
| HNPCC         | Hereditary Nonpolyposis Colorectal Cancer (also known as Lynch Syndrome)   |
| HPV           | Human Papillomavirus   |
| IHCIA         | Indian Health Care Improvement Act   |
| IHS           | Indian Health Service  |
| NACR          | Native American Cancer Research  |
| NAIHS         | Navajo Area Indian Health Service  |
| NAPBC         | National Accreditation Program for Breast Cancers                          |
| Native CIRCLE | Native Cancer Information Resource Center and Learning Exchange            |
| NCCCP         | National Comprehensive Cancer Control Program                              |
| NIS           | National Immunization Survey   |
| NMCCA         | New Mexico Cancer Care Alliance  |
| NMDOH         | New Mexico Department of Health  |
| NMDOH OCHW    | New Mexico Department of Health Office of Community Health Workers         |
| NMDOH TUPAC   | New Mexico Department of Health Tobacco Use Prevention and Control Program |
| NMED          | New Mexico Environment Department  |
| NMEPHT        | New Mexico Environmental Public Health Tracking                            |
| NM-IBIS       | New Mexico's Indicator-Based Information System                            |
| NNBCCPP       | Navajo Nation Breast and Cervical Cancer Prevention Program                |
| NPAIHB        | Northwest Portland Area Indian Health Board                                |
| PFAC          | Patient and Family Advisory Council  |
| PRC           | Purchased/Referred Program   |
| PSA           | Prostate-Specific Antigen  |
| RWJF          | Robert Wood Johnson Foundation   |
| SAHIE         | Small Area Health Insurance Estimates                                      |
| SEM           | Socio-Ecological Model   |
| TBD           | To Be Determined   |
| USPSTF        | United States Preventive Services Task Force                               |
| UV            | Ultraviolet  |
| YRRS          | Youth Risk and Resiliency Survey   |

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## RESOURCES

### Cancer Resources >

**Albuquerque Cancer Coalition (ACC) Cancer Support & Treatment Directory**  
nmcancercouncil.org

**American Cancer Society**  
cancer.org

**American College of Surgeons Commission on Cancer (CoC)**  
facs.org/quality-programs/cancer

**American Society of Clinical Oncology (ASCO)**  
asco.org

**Centers for Disease Control and Prevention (CDC)**  
cdc.gov

**Comprehensive Cancer Control National Partnership (CCNP)**  
ccnationalpartners.org

**Guide to Community Preventive Services**  
thecommunityguide.org

**National Cancer Institute (NCI)**  
cancer.gov

**National Coalition of Cancer Survivorship**  
canceradvocacy.org

**National Comprehensive Cancer Network (NCCN)**  
nccn.org

**National Institutes of Health (NIH)**  
nih.gov

**New Mexico Cancer Council**  
nmcancercouncil.org

**United States Preventive Services Task Force (USPSTF)**  
uspreventiveservicestaskforce.org



## NEW MEXICO CANCER PLAN 2020 > 2024

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