

New Mexico Cancer Plan Implementation

2010 Survey Results

Introduction

The New Mexico Cancer Council (Council) plays a vital role in the development and implementation of the New Mexico Cancer Plan (Plan). Each year Council members are invited to complete a survey in which they report on activities conducted to implement the Plan for that year. This report summarizes the survey results from the 2010 survey. To access this report online, visit the New Mexico Cancer Council Web site at www.cancernm.org/cancercouncil.

The purpose of the New Mexico Cancer Plan survey is to help determine the extent to which Council members have addressed the Plan's primary objectives, as listed in the *New Mexico Cancer Plan 2007 – 2011*. Specifically, this survey considered four primary objectives. The fifth objective is addressed with data collected through the Behavioral Risk Factor Surveillance System. The survey responses also provide important information to help evaluate progress to implement the Plan, inform the next revision of the Plan, and determine future priority activities of the Council.

The 2010 survey consisted of 28 questions. The questions inquired about implementation of the Plan's objectives and evidence-based interventions as well as provision of in-kind support and policy advocacy. Specifically, the first question described who actually participated in the survey. Questions 2 to 6 looked at reducing cancer disparities; questions 7 to 10 considered access to cancer treatment; questions 11 to 14 addressed quality of life work; and questions 15 to 16 revolved around collaboration. Evidenced-based interventions were surveyed in questions 17 to 20, and questions 21 to 26 inquired about in-kind support. Lastly, question 27 concerned policy work while question 28 elicited additional feedback regarding the Plan's implementation. What follows is a closer examination of the survey results.

Please see the Appendix to review all "Additional Comments" contributions.

Respondent Information

- A total of **22** out of a potential **114** Council members **responded to the survey**, for a **19.3% response rate**.
- **63.6%** (14/22) **identified as Council members**
- **36.4%** (8/22) of the respondents **identified as Executive Committee members**.

Cancer Disparities

- **84.2%** (16/19) of respondents indicated that their **organizations work to reduce cancer disparities** that exist among different populations in New Mexico.
- **Priority populations identified by respondents as disparate include:**
 - Uninsured or underinsured
 - Indigent and low-income
 - Rural population
 - Low-education levels
 - Hispanics
 - Native Americans
 - Lesbian, gay, bi-sexual and transgendered (LGBT)
 - Undocumented residents
 - Adult women and men
 - School-aged children with a parent affected by cancer

- **Table 1 lists programs and activities developed or implemented by Council members and organizations to reduce cancer disparities** among different populations in New Mexico. Also included in **Table 1** are the **outcomes attributed to the identified programs or activities**.
- A total of **72.7%** (16/22) respondents **listed programs/activities**, while **68.2%** (15/22) respondents **identified outcomes**. Each box in the table below contains information provided by one respondent. In some cases, respondents reported more than one program or activity.

Table 1: Programs to Reduce Cancer Disparities and Their Outcomes

Programs/Activities	Outcomes
1) Worked to change public policy	1) Federal health care reform legislation (Affordable Care Act); Increase in state cigarette tax to \$0.91/pack
2a) Monitored tobacco-cessation quit line call data to ensure target population is being reached; 2b) Provided anti-oppression model training to all program contractors; 2c) Created program guidelines to emphasize working with populations experiencing disparities	2a) Data analysis confirms target population is being reached; 2b) All program staff and contractors trained on anti-oppression model; 2c) Contracts rewritten with a focus on serving and reaching priority populations
3) Research and coalition building	3) None reported
4) Grants to organizations serving women	4) Reached at least 100 women
5a) Gave colorectal screening information to hospital employees; 5b) Working to get this information out to wider community	5a) 25% of employees over the age of 50 had an FIT; 5b) None reported
6a) Offered cancer clinical trials to New Mexicans; 6b) Educational programs	6a) Enrolling patients on clinical trials 6b) None reported
7a) Offered free mammograms in certain locations using mobile mammography van; 7b) Gave tobacco cessation training to providers	7a) Over 200 women received mammograms; 7b) 80% of patients seen by providers asked if they smoked, and those that do receive brief intervention assistance to stop using tobacco
8) Community booths/educational presentations	8) Difficult to evaluate
9) Provide bilingual patient services manager to increase access to patient services for limited English proficient (LEP) patients	9) Increased number of LEP patients accessing patient services
10a) Promoted cancer awareness months—cervical, colon and breast; 10b) Direct mail campaigns encouraging screenings; 10c) Educated girls 11-18 about Gardisal vaccine.	10a) Completed over 600 mammograms—found 4 breast cancer cases; 10b) Increased HEDIS for colon cancer screening by 5%; 10c) 18% response rate for Gardisal initiative.
11a) Researched disparities and outcomes in women with breast cancer in New Mexico; 11b) Provided mammography van to screen populations with limited access to healthcare.	11a) Research in early phase; 11b) Women with limited access to screening received mammograms.
12a) Legal, Insurance and Paperwork Assistance program (LIPA); 12b) Family cancer retreats focused on managing treatment and survivorship	12a) LIPA served 480 clients, with the majority being low-income and un-or underinsured, and 45% living in rural communities; 12b) Served over 500 clients at retreats, with 1/3 coming from rural areas and increased participation from Native American populations. Average participant rating of retreat’s value was 4.8 (on a scale of 5).

Programs/Activities	Outcomes
13a) Supported provision of cancer education to LEP population; 13b) Supported research to gather data on perceived barriers to CRC screening among insured Hispanics aged 50-64	13a) Demonstrated an increase in knowledge across key measures; 13b) Collected valuable data to assist in planning for future program activities.
14) Education programs targeted Native American and LGBT populations	14) Increased participation in communities not previously served.
15a) Offered socialization activities such as potlucks; 15b) Presented during school assemblies.	15a) Reduced cancer disparities among men who tend to shun support groups; 15b) Discovered an avenue to reach children and parents in different ways

Access to Cancer Treatment

- **61.1%** (11/18) of respondents indicated that their **organizations work to increase access to cancer treatment** among New Mexicans diagnosed with cancer.
- **Table 2** captures **programs and activities developed or implemented by Council members and organizations designed to increase access to cancer treatment**, and the **outcomes affiliated** with some of those programs.
- **59.1%** (13/22) of respondents **identified programs or activities**, while **45.5%** (10/22) **reported on the outcomes** attributed to the identified programs.

Table 2: Programs to Increase Access to Cancer Treatment and Their Outcomes

Programs	Outcomes
1) Worked on federal health care reform	1) Resulted in positive policies that improve access to care
2) Grants to organizations	2) Reached over 25 women
3) Hospitality house available for long-distance patients to stay during treatment; 2) Funds available in certain designated funds	3) No response
4) Supported infrastructure for statewide clinical trial programs	4) Enrolled patients in clinical trials; increased new physician participation in Southern NM
5) Provided mobile mammography van in rural areas	5) No response
6) Educated one-on-one through home visits, phone calls, and letters	6) Difficult to evaluate
7) Developed new referral channels to established services outside scope of organization	7) Quicker access to care and navigation
8) Utilized RN case managers to help beneficiaries	8) Increased access to care and knowledge of the disease process
9) Provided mammography van for screening populations with limited access to healthcare.	9) Women with limited access to screening received mammograms.
10a) LIPA programs to assist the uninsured and underinsured in getting coverage; 10b) Family cancer retreats provided education on treatment options	10a) Many uninsured and underinsured patients got coverage that allowed them to receive critical treatments. In some instances, patients who had stopped treatment due to financial issues were able to resume lifesaving therapies. 10b) Served over 500 clients at retreats, with 1/3 coming from rural areas and increased participation from Native

Programs	Outcomes
	American populations. Average participant rating of retreat's value was 4.8 (on a scale of 5).
12a) Funded patient navigation program activities; 12b) Funded housing program for people in treatment	12a,b) No response
13) Provided access to gas cards and financial support for car payments	13) Allowed 35 individuals to continue their treatment

Quality of Life

- **73.7%** of respondents (14/19) indicated that their **organizations work to address quality of life issues for cancer survivors**.
- Table 3 lists the programs and activities developed or implemented by Council members that provided cancer survivors with resources to improve their quality of life, and the outcomes affiliated with some of those programs.
- **63.6%** (14/22) respondents identified **programs or activities**, while **40.9%** (9/22) of respondents reported on the outcomes attributed to the identified programs or activities.

Table 3: Quality of Life Programs and Their Outcomes

Program	Outcomes
1) Supported educational initiatives for people newly diagnosed with cancer and their families; Supported emotional support services for people diagnosed with all types of cancer and at various stages of illness.	1) Participants reported experiencing an improvement in their overall sense of well being; receiving useful information; and being better able to cope with their situation. Also, participants said that the services helped them make informed decisions; impacted them in a positive way; and they would recommend the same services to others.
2) Worked on federal health care reform	2) The Affordable Care Act contains policies that improve the quality of life for persons living with cancer.
3) Grants to support groups	3) Unknown
4) Nurse navigators work with patients	4) No response
5) Trained 14 peer support facilitators to provide support groups and one-on-one support	5) A support helpline was established and 100 people were provided support group services; another 50 were provided with one-on-one services
6) Provided open clinical trials that address quality of life	6) No response
7) Educated future nurses to raise awareness of special needs of survivors	7) No response
8) Did not create any programs/activities for cancer survivors but referred them to proper organizations	8) No response
9) Offered peer-to-peer support groups, information and disease specific materials, and education and programming	9) No response
10a) Offered look good/feel better program; individual psychologist appointments as needed; and support groups for survivors, families, and	10a-e) Did not have access to outcome data

Program	Outcomes
<p>caretakers. 10b) ACS office onsite at the new CRTC offered prosthesis and wig samples and information. Lymphedema specialists available as needed. 10c) Offered free yoga for cancer survivors, etc. through partnerships with local businesses and community services. 10d) Social workers assisted with financial questions and access to services. 10e) Formal patient navigator program assisted patients with connecting to needed services.</p>	
<p>11) Provided family cancer resource bags—free information kits that help newly diagnosed parents discuss the cancer journey with their children. 11b) Held Zoo Day for Kids with Cancer (a free event for pediatric cancer patients/survivors and their loved ones)</p>	<p>11a) Nearly 100 families received resource bags with vital information that discussed the impact of a parent's cancer on the family. 11b) Zoo Day—425 pediatric cancer patients/survivors/loved ones enjoyed a fun-filled days with opportunities to share and learn from others coping with similar challenges. 90+% of participants rate our programs/services as valuable</p>
<p>12a) Created peer support volunteer guidelines. 12b) Collaborated with Council workgroup to complete medical records survivorship fact sheet. 12c) Funded 4 survivorship programs</p>	<p>12a,b) Distributed two survivorship documents statewide. 12c) No response</p>
<p>13a) Added support groups, provided crisis intervention counseling and added socialization activities, like potlucks. 13b) Offered cancer support services, which include support groups, one-to-one support, workshops, and outreach.</p>	<p>13a,b) Crisis intervention counseling provided additional emotional support to 50 clients who otherwise couldn't afford it, despite treatment protocol including emotional support. Clients have been encouraged by medical team to seek psychosocial support.</p>

Collaboration

- **68.3%** (15/22) of the respondents described a **successful collaboration they engaged in as a result of their participation in the Council in 2010**. **One respondent** described a collaboration that was **not successful**, while another respondent explained why they did not engage in collaboration.
- 22.7% (5/22) those respondents indicated they would be **willing to share details about their successful collaboration in future publications**.
- **Table 4 describes the reported collaborations.**

Table 4: Collaboration Descriptions

Collaboration
<p>Partnered with Nuestra Salud, the UNM Cancer Center and the UNM School of Medicine's Master of Public Health program to coordinate a training on finding and adapting evidence-based interventions for members of the New Mexico Cancer Council during the organization's annual retreat in November 2010</p>
<p>Presented information about the Affordable Care Act at the annual Cancer Council meeting. Tobacco tax work benefitted the strategic plan for NM Dept of Health's TUPAC program.</p>
<p>Provided stands and information cards about the tobacco cessation quit line to other programs, who then distributed the cards to providers and at conferences.</p>

Collaboration
Reached other cancer organizations to support legislation
Began developing collaborations in December 2010 so in embryonic stage
Participated in joint educational events with other NMCC members
Collaborated with Comadre and the state screening program for the past several years.
Being on the Council has strengthened the collaboration on the mobile mammography project—at least 5 different agencies are involved.
Did not participate in collaboration due to supervisor not willing to permit travel for a whole day, as meetings are in ABQ. Do not have capabilities to participate through technology as schedule is busy
Met People Living Through Cancer and started a new support group with that organization; developed a great partnership for ACONS and their 2011 symposium.
Networking with all the agencies allows me to gain resources for our beneficiaries.
Ongoing relationships with ACS, other council members, and as liaison with UNM programs through July 2010.
Conducted the statewide NM Cancer Services Survey (results to be published in 2011), worked closely with oncology providers, and conducted surveys of over 500 cancer patients and families in 20 clinics throughout the state.
Worked with Hugo Vilchis, NMSU, on cancer research collaboration—now just beginning to plan our work.
Developed peer support guidelines through cooperation of survivorship groups throughout the state.
We partnered with LLS to provide specialized support group for blood cancers.
None. Additionally, I would consider participation in the development of the CRC White Paper to be a failed collaboration.

Evidence-based Activities

- **54.5%** (12/22) respondents reported on the **number of interventions their organization implemented in support of the New Mexico Cancer Plan**, and **45.5%** (10/22) of respondents reported on the **number of those interventions that were evidence-based**. **50%** (11/22) of respondents **described an evidence-based intervention implemented by their organization**. **Table 5 lists the above information**.
- **Chart 1** shows the different **levels of evidence in support of the reported initiatives as cited by respondents**. **54.5%** of respondents indicated **Level 1**—evidence-based guidelines/recommendations; **18.2%** of respondents cited both **Level 4**—evidence-informed program/program evaluation/practice-based evidence and **Level 5**—other; and **9.1%** of respondents indicated **Level 3**—individual peer-reviewed published studies. No one (**0%**) cited **Level 2**.

Table 5: Evidenced-Based Activities in Support of Cancer Plan

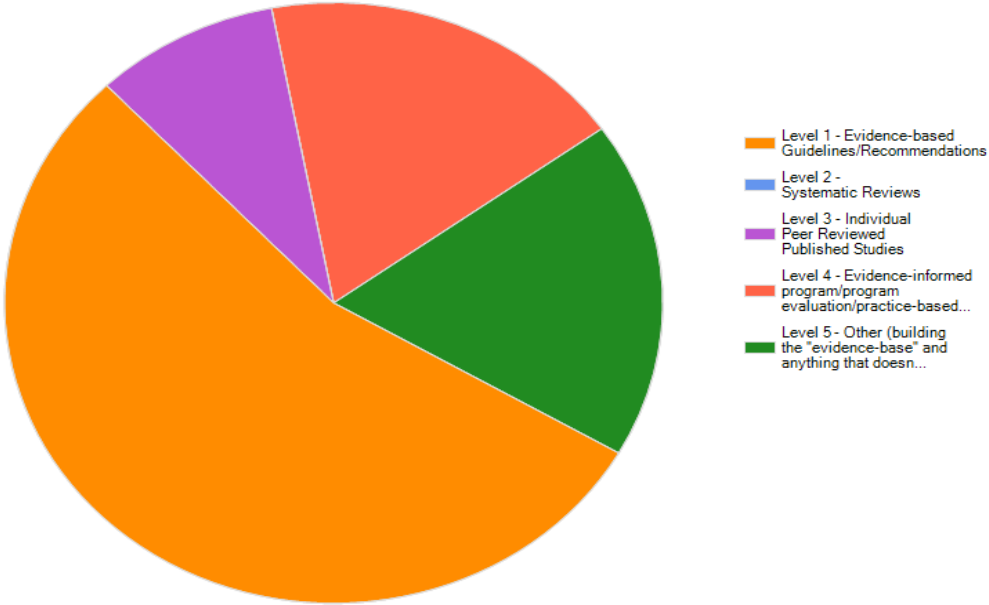
Number of Interventions Supporting Cancer Plan	Number of Evidenced-based Interventions	Intervention Description
Dozens	All interventions are evidence-based	Level 1: Increase tobacco taxes to decrease tobacco use and increase tobacco use quit attempts
Wide-variety to reduce tobacco related morbidity and	All interventions based on CDC's Best Practices for Comprehensive Tobacco Control	Level 1: Telephone-based tobacco cessation services that meet CDC/Office of Smoking and Health guidelines and include marketing the service using mass media

Number of Interventions Supporting Cancer Plan	Number of Evidenced-based Interventions	Intervention Description
mortality	Programs, Guide to Community Preventive Services, and other evidence-based guidance documents from the CDC/Office of Smoking and Health	
Not a direct service org.	None	Level 4
2	2	Level 1: Peer support group interventions use guidelines and recommendations found in Australian Govt. support group studies.
Over 100 clinical trials	All are evidence-based	Level 3
Patient education, support, navigation	Not sure if evidence-based as used in NM for many years.	Level 4
3	3	Level 1
6	3	No response
4	2	Level 1: Conducts sun safety educational activities in elementary schools using evidence-based curricula. The Task Force on Community Preventive Services recommends educational and policy approaches in primary schools to improve children's "covering up" behavior based on sufficient evidence of effectiveness
5	5	Level 1: Wide range of cancer support services, in accordance with the Institute of Medicine's 2007 report "Cancer Care for the Whole Patient", pg. 195. Illness self-management is defined as an individual's ability to manage the symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent in living with a chronic condition. Given the diverse physical, psychological and social challenges posed by cancer, its treatment, and its sequelae, providing patients and their caregivers with knowledge, skills, abilities, and support in managing the psychosocial and biomedical dimensions of their illness and health is critical to effective health care and health outcomes for these patients.
1—CRC Workgroup	None. The CRC White Paper was decidedly not an evidenced-based intervention. Additionally, there is strong suggestion that	Peer reviewed published studies were cited in the CRC White Paper; however, the validity of the statements made in the cited papers was not examined against the methods used, and the results reported, in the cited papers

Number of Interventions Supporting Cancer Plan	Number of Evidenced-based Interventions	Intervention Description
	the CRC Workgroup will not adopt an evidence-based approach in the conduct of its business.	
None	None	Level 5: Convene the Cancer Council and provide support for Council activities
None	None	Level 5
None	No response	No response

Chart 1: Distribution of Levels of Evidence in Support of Initiatives as Cited by Survey Respondents

Please briefly describe one of the evidence-based interventions your organization implements and select the level of evidence that supports the initiative. (Please see the Reporting Guideline Processes document for a description of each level of evidence.)



In-Kind Contribution Estimates in Support of Council and Plan

- **31.8% (7/22)** of respondents estimated the total **in-kind staff support their organizations have provided to NM Cancer Council efforts**. Respondents were asked to calculate their estimates using the following formula: hourly rate plus fringe benefits multiplied by the number of hours contributed, with fringe benefits usually calculated 25% – 30% of salary. Respondents were asked to not include any funds received through contracts or grants from the New Mexico Department of Health's cancer programs in order to avoid duplication of

funds, since the Department’s cancer programs are part of the Council. **Table 6** below lists total in-kind staff support estimates.

- **36.4%** (8/22) of respondents estimated the **mileage per month** for all activities associated with the New Mexico Cancer Council. Respondents were asked to not include mileage that was reimbursed by the Cancer Council. **Table 6** below lists mileage per month estimates.
- Respondents were asked to describe and estimate yearly costs for any additional in-kind contributions in support of the Council and its activities. One respondent replied with \$0.

Table 6: In-Kind Contributions in Support of Cancer Council Work

In-Kind Staff Support	Mileage per Month
\$116,630	No response
\$75,000 (covers the work of 4 staff based in NM: grassroots manager; grassroots director; state gov't relations director; and VP of gov't relations)	Average of 100 miles
Approximately 25% of program resources devoted to addressing disparities	N/A
No response	20 miles
\$750	150 miles
\$9,463	0 miles
No response	20 miles
\$3,550	5 miles
\$0	0 miles
Total: \$205,393	Total: 295 miles

- **27.3%** of respondents (6/22) estimated their yearly costs for **other in-kind contributions in support of NM Cancer Council efforts**. The categories respondents were asked to report on were: space for meetings, trainings, and events; food for meetings, trainings, and events; telephone costs for conference calling services and long-distance charges; materials such as paper, copying, printing, artwork or other supplies; and professional services including advertising, facilitating, legal services, or other services. **Table 7** shows the other in-kind contributions broken down according to these categories, including the aggregate total per category.

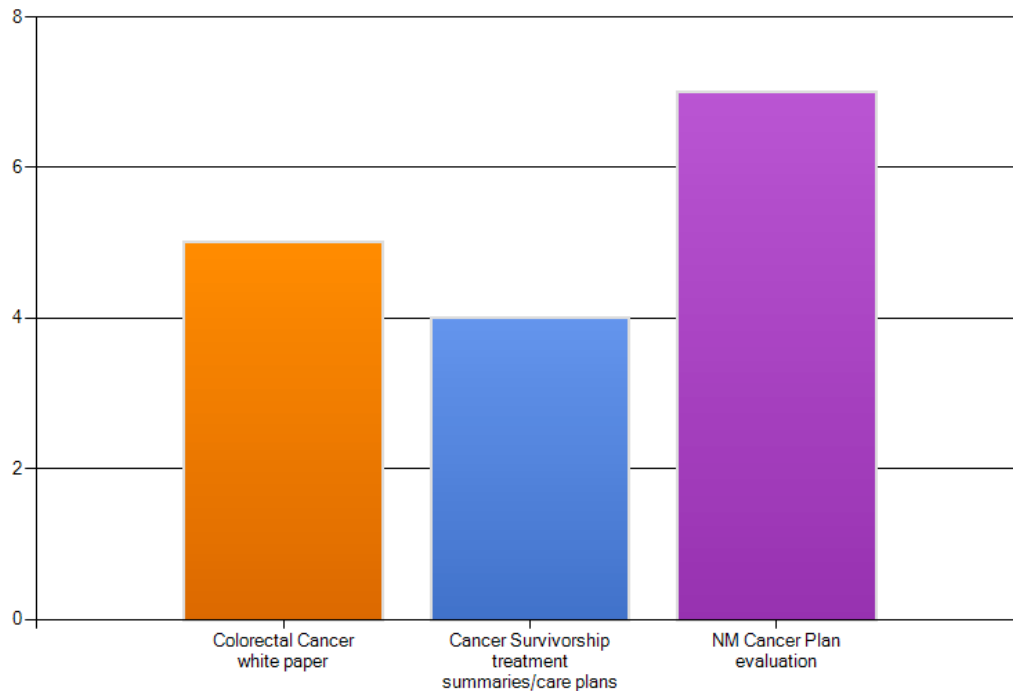
Table 7: Estimated Yearly Costs for Other In-Kind Contributions in Support of Cancer Council Efforts

Space	Food	Telephone	Materials	Prof. Services
\$1,000	\$4,000	\$1,000	\$1,000	\$60,000
\$400	\$0	\$50	\$50	\$0
\$400	\$20	\$0	\$0	\$0
\$0	\$0	\$322	\$112	\$0
Total: \$1,800	Total: \$4,020	Total: \$1,372	Total: \$1,162	Total: \$60,000

- **40.9%** (9/22) of respondents cited the **Council priorities to which their organization provided in-kind support**. Of the three Council priorities, **77.8%** indicated the **Plan evaluation**; **55.6%** indicated the **colorectal cancer white paper**; and **44.4%** indicated the **cancer survivorship treatment summaries/care plans**. **Chart 2** shows this breakdown.

Chart 2: In-Kind Support for Cancer Council Priorities

For the Cancer Council priorities below, please check the one(s) for which your organization has provided in-kind support.



- 31.8% (7/22)** of respondents **estimated their organizations' yearly costs allocated to implementing Plan objectives**. This amount varied from organization to organization and may be dependent on the size of an organization and/or scope of its services. **Table 8 lists the indicated yearly costs cited by respondents.**

Table 8: Yearly Costs Allocated to Implementation of Cancer Plan Objectives.

\$50,000 (PPACA implementation)
\$1.9 million (for addressing disparities and quit lines)
\$15,000
\$200,000
\$276,250
\$450,000
Total: \$2,891,250

Policy

- **31.8%** (7/22) of respondents indicated that their **organizations worked on cancer-related policy changes** in 2010. Of the policy categories respondents were asked to report on, 3 respondents cited tobacco, nutrition/physical activity/obesity, or early detection/screening; 2 respondents indicated “other”; and one respondent cited sun safety/UV exposure, treatment and care, and infrastructure/funding. No respondents selected surveillance. **Table 9** shows the results.

Table 9: Policy Change by Category

Tobacco	Nutrition; Physical Activity; Obesity	Sun Safety; UV Exposure	Surveillance	Early Detection; Screening	Treatment; Care	Infrastructure; Funding	Other
Increased state cigarette tax	Affordable Care Act			Affordable Care Act	Affordable Care Act	Affordable Care Act	
Expand clean indoor air policies							
							Information; Emotional support
							Clinical Trials
Tobacco Cessation Class	Weight Mgmt. Program	UV Awareness		Breast Cancer Awareness/ Cervical Cancer Awareness			
	Nutrition and Exercise			Colorectal			

Conclusion

Less than 20% of New Mexico Cancer Council members contributed to the Survey and even fewer actually completed the entire survey. The small sample size provides an inadequate picture of Council member progress towards implementing the New Mexico Cancer Plan. For example, while 84.2% of respondents affirmed that their organizations were working to reduce cancer disparities, that number represents just 14% of Council members. Such a small representation makes it difficult to form any conclusive statements on the extent to which Council members have addressed the Plan’s primary objectives.

In addition, some of the survey questions were meant to elicit descriptive responses on the programs and activities Council members conducted to implement the Plan as well as any outcomes that resulted from their efforts. Because of the nature of these questions, the responses were individuated and not appropriate to report on as an aggregate. Reading the detailed

responses, which are listed in the tables throughout this report, provides a glimpse into some of the activities performed by a handful of Council members and as such may prove to be of value.

It is interesting to note that over 84% of respondents identified their organizations as working to reduce cancer disparities that exist among different populations in New Mexico. This piece of information suggests that a high percentage of Council members work to reduce disparities, which may be reflective of a specific value that is common among many Council members.

Recommendations

The responses collected in this survey provide little meaningful insight into how the Council is implementing the New Mexico Cancer Plan. Recommendations, therefore, are directed towards investigating why there was a low survey response rate with an eye towards improving the survey instrument and its administration in order to collect more information that will help to guide the Plan. The recommendations are as follows:

1. Examine the survey instrument objectively to ensure the questions asked were appropriate considering the survey goals. For example, one respondent commented that the in-kind section of the survey was too detailed and refrained from answering those questions. In fact, this section of the survey drew the fewest responses compared with other sections.
2. Consider the length of time needed to complete the survey. Were Council members given adequate time to respond to the survey?
3. Consider the ease of the survey questions. Were the questions worded in a way that Council members could respond to easily?
4. Administer the survey in a way that ensures a high response rate.
5. Examine how the survey was promoted. Was the nature of the survey communicated clearly to Council members? Was the importance of Council member participation underscored? Was the importance of the survey to the implementation of the Plan discussed?
6. Ask Council members who did not participate in the survey why they chose not to complete the survey in order to determine any barriers.
7. Develop strategies to ensure Council member participation in and completion of the survey.

Appendix—Additional Comments

Cancer Disparities

Six respondents gave additional comments as follows:

- The survey does not apply to my organization within educations...do not function like many of the council organizations.
- Does not offer direct services.
- New organization will operate in 2011.
- Coordinated breast cancer awareness week on a college campus.
- Listed a contact number on letters sent to beneficiaries so they could speak to an RN if they had any questions.
- NMCP is the plan of NMCC; it is not anyone else's plan. No one has been solicited to subscribe to the goals and objectives of NMCP. If NMCC wants others to adopt the goals and objectives of NMCP, clearly this is the case; NMCC should solicit others to adopt specific NMCP goals and objectives into their plans, and to report progress in achieving the adopted goals and objectives to NMCC.

Access to Treatment

Three respondents gave additional comments as follows:

- Primary focus is support
- Organization does not offer direct services; and
- NMCP is the plan of NMCC; it is not anyone else's plan. No one has been solicited to subscribe to the goals and objectives of NMCP. If NMCC wants others to adopt the goals and objectives of NMCP, clearly this is the case, NMCC should solicit others to adopt specific NMCP goals and objectives into their plans, and to report progress in achieving the adopted goals and objectives to NMCC.

Quality of Life

Two respondents gave additional comments as follows:

- Organization does not offer direct services
- NMCP is the plan of NMCC; it is not anyone else's plan. No one has been solicited to subscribe to the goals and objectives of NMCP. If NMCC wants others to adopt the goals and objectives of NMCP, clearly this is the case; NMCC should solicit others to adopt specific NMCP goals and objectives into their plans, and to report progress in achieving the adopted goals and objectives to NMCC.

Evidence-based Activities

Two respondents gave additional comments as follows:

- Townsend, et al, reviewed reference to evidence based interventions and screening recommendations for CRC in Comprehensive Cancer Control Plans in Preventing Chronic Disease, a publication of CDC (access at: www.cdc.gov/pcd/issues/2009/oct/08_0223.htm). In this paper they reported 54 of 55

plans referred to evidence based recommendations or interventions, 76% contained evidence based material in background, 65% contained evidence base material in goals, objectives, or strategies, 53% of evidence based content related to screening guidelines, and 30% of evidence based content related to an evidence based intervention recommended in the plan. Unfortunately, the authors did not consider evidenced based evaluation of the evidence-based materials to which the plans referred. My own impression is that there is very little understanding of the principles and practice of evidence based medicine, or public health, among health care professionals, policy makers, the media, and the public. As evidence based approaches are a high priority of CDC, which funds the CCC plans, I believe we should include the term evidence based in the title of the next version of the NMCP (suggestion: NMCC Strategic Plan for Community Oriented, Evidenced Based, Comprehensive Cancer Control) and we should identify: the development of an understanding, and the application, of the principles of evidence based medicine and public health to the practice of comprehensive cancer control through out New Mexico; as an over-all goal of the next version of the plan.

- According to the descriptions of each level of guidance provided to NMCC members, recommendations provided by the Guide to Community Preventive Services are considered "Level 1" evidence. However, I noticed that the Community Guide uses systematic reviews to locate, appraise and synthesize the evidence for a particular topic, including sun safety in primary schools. According to the description of the levels of evidence document, systematic reviews are "Level 2" evidence and thus, our sun safety activities may actually be based on "Level 2" evidence! I think it's important to recognize that many additional resources for evidence-based or evidence-informed programs and interventions exist. Recognizing those programs that are modeled after "promising practices" or that are innovative and designed to fill a "gap" in existing evidence are very valuable, as well, and their importance should not be minimized. After all, a lack of innovation leads to stagnation which serves no one well!

Implementation of NM Cancer Plan

Six respondents gave additional comments, however, 2 respondents merely indicated "no". The other four comments were:

- Was not able to participate and probably will continue to perform activities for local community to educate on cancer prevention.
- The in-kind contributions section of this survey were too detailed and as an organization declined to answer.
- I no longer work at UNM as of August 2010, and no longer have access to the information needed to complete the last part of this survey.
- I think the NMCC is doing a great job of putting careful thought into how the next version of the Cancer Plan can be a better resource for the state. Including measurable objectives and evidence-based activities in the next version will be beneficial by resulting in a more credible and accepted document!