IMPLEMENTING THE NEW MEXICO CANCER PLAN IN NATIVE AMERICAN COMMUNITIES

NEW MEXICO CANCER PLAN 2020 › 2024
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 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.

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’ahjii’ee 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).
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. 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 to the IHS, 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).

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/).

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 Zunis and Hopis, 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: Chino 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).
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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 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).

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).


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. Adapting 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 (CHRIs) provide community-based healthcare, health promotion and disease prevention services. They connect directly with the community since they come from the communities they serve. CHRIs are essential to the provision of tribal community-based healthcare services.
- The Fruit and Vegetable Prescription Program (FVRx®), 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. CHRIs 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 1.5 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.

Objective 1.6 Increase Access to Healthy Food
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. 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 “Shà’bèk’ègha As’ah Oodiå’; 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

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

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.

OBJECTIVE 3.7  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.
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.
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.

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

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 “Navigators” who can translate cancer terminology from English into Native languages.
- Create a resource directory of Native healers who treat cancer patients.

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

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 Chairman’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

Mayo Clinic Cancer Center
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

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

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

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

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.

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 (CCCNP)
cccnationalpartners.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

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