

# Reducing the Burden of Cancer in California Tribal Communities

**2018-2023**

## CALIFORNIA TRIBAL COMPREHENSIVE CANCER CONTROL PLAN



California Rural Indian Health Board, Inc.



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# ACKNOWLEDGMENTS

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## INTRODUCTION

The California Rural Indian Health Board, Inc. (CRIHB) has been working with Tribes and Tribal, state, and local public health organizations to build networks that allow for the appropriate implementation of cancer control activities in California Tribal communities. As a network of Tribal Health Programs, which are controlled and sanctioned by Indian people, and their Tribal Governments, CRIHB is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California. CRIHB does this by providing advocacy, shared resources, training, and technical assistance that enhances the delivery of quality comprehensive health-related services.

The California Tribal Epidemiology Center (CTEC), housed within CRIHB, was established in 2005 to assist in collecting and interpreting health information for American Indian and Alaska Natives (AIANs) in California. CTEC's mission is to work directly with Tribes and Tribal health programs to monitor the health status of Indian people in California and develop effective public health services that respect cultural values and traditions of our communities.

The California Tribal Comprehensive Cancer Control Program (CTCCCP) has supported California Tribal communities in implementing cancer control and prevention activities since 2017. The CTCCCP has strategically recruited members across California Tribal health programs, California Tribes, Tribal organizations, and organizations serving Tribal communities to participate in the CTCCCP Coalition (Coalition). These members have a stake in improving the lives of AIAN people across California. They have been especially instrumental in identifying the most pressing needs of California Tribal communities and assessing the impact of cancer within those communities. CRIHB and CTCCCP have relied on their Coalition members to assist in the development of this California Tribal Comprehensive Cancer Control Plan, hereinafter referred to as the Cancer Control Plan.

The Cancer Control Plan explains the cancer burden and impact among Tribal communities and the specific goals of CTCCCP in combatting cancer among AIANs. The Cancer Control Plan does not focus on one particular type of cancer. It provides an overall set of specific objectives, evidence-based

interventions, and activities that are credible and effective per the Centers for Disease Control and Prevention (CDC) and the National Comprehensive Cancer Control Program (NCCCP).

The Cancer Control Plan works to expand the effectiveness and reach of cancer control and prevention activities among Tribal communities by collaborating with Tribal, state, and local health agencies. The goal is to increase cancer awareness among our Tribal communities and increase prevention and screening efforts, improving cancer survivors' quality of life and increasing health equity as it relates to cancer control.

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With this Cancer Control Plan, the Coalition intends to build and seek collaborative opportunities with a diverse number of groups. CTCCCP's vision is for Coalition members to support one another by sharing funding, knowledge, services, and staff, based on the identified community needs. We see the Coalition leveraging the voice of Tribal communities to strengthen advocacy to improve access to culturally relevant services that build self-sufficient communities that promote the use of holistic and spiritual care regarding cancer control. We see CTCCCP promoting the health and well-being to all, including the families and communities of the survivors who have had to overcome the hardships of cancer.

CTCCCP and its Coalition are aware of the impact cancer has on the California AIAN population and recommend the use of this Cancer Control Plan as a resource in implementing comprehensive cancer control activities in Tribal communities.

# AMERICAN INDIAN AND ALASKA NATIVE CANCER BURDEN/RISK FACTORS IN TRIBAL COMMUNITIES

The cancer burden among AIANs in California is much higher in comparison to other racial and ethnic groups. The risk of developing cancer is presumably higher for AIANs due to a variety of contributing factors. These risks can be attributed to an individual's socioeconomic status, aging, tobacco use, family history, alcohol use, poor diet, lack of physical activity, and being overweight or obese.<sup>1</sup>

## KNOWN CANCER RISK FACTORS:



Smoking: 24.2% of AIANs in California are current smokers.<sup>2</sup>



Human Papillomavirus (HPV) immunizations: 18.2% of AIAN women in California reported having received the HPV vaccine.<sup>3</sup> Statewide estimates show that 71.9% of California teens (all races) have received at least one dose of the HPV vaccine.<sup>4</sup>



Poverty: 16.0% of AIANs in California live below the federal poverty line.<sup>5</sup>

# CALIFORNIA TRIBAL HEALTH EQUITY

## Health disparities persist in California Tribal communities

The AIAN population in California is comprised of California-based Tribal people and AIANs who have relocated to California from other areas of the United States. There are 109 federally recognized Tribes in the state of California. Tribes in California are diverse geographically, historically, and culturally. The beliefs of AIANs are deeply rooted in tradition and culture. However, due to the relocation, lack of trust of medical professionals, and the historical and current trauma, they now experience more significant health disparities compared with the general population and have a high rate of lower socioeconomic status. Additionally, AIANs have much higher rates of tobacco use, obesity, diabetes, physical inactivity, heart disease, suicide, and many other chronic diseases compared with white populations.<sup>6</sup>

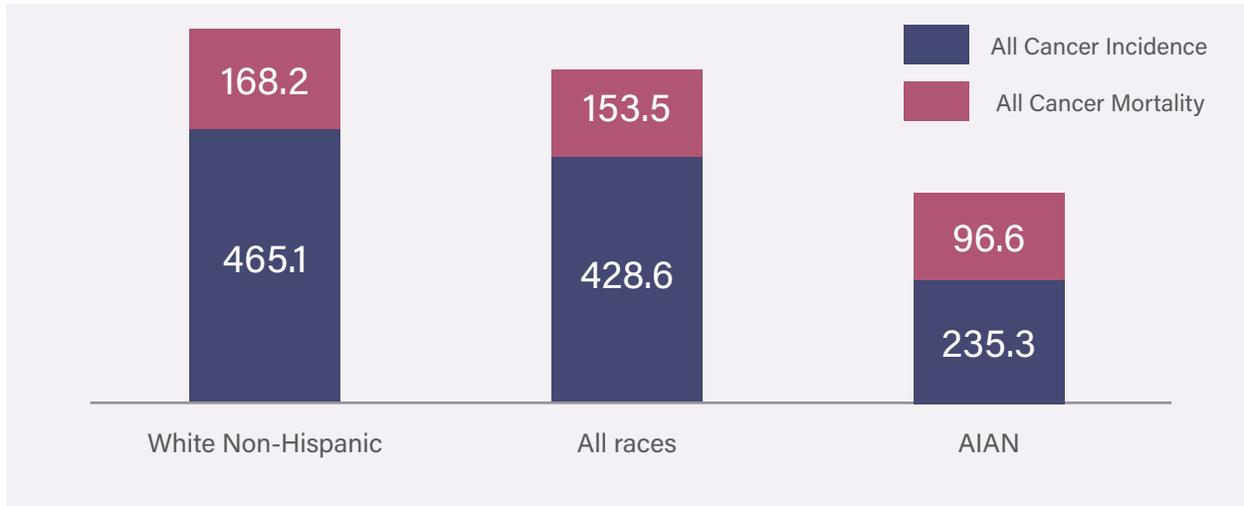
According to the CDC, AIAN individuals experience the highest mortality rates of cancer than any other group in California.<sup>7</sup> They are profoundly impacted by cancer; it is the second leading cause of death after heart disease. Limited access to health care contributes to a more significant statewide systemic problem in which a system of partners is necessary for assisting this particular group in accessing prompt health care services, more specifically, cancer-related services. AIANs living in rural areas travel long distances for screening and treatment services, which significantly deters the ability for timely diagnosis and treatment of life-threatening cancers and diseases.

Finally, when considering the cultural aspects, the subject of cancer is often taboo, and speaking of or screening for cancer can be viewed as inviting it into the body.<sup>8</sup> Additionally, many AIANs experience what is known as provider mistrust and hesitate to be screened or talk about symptoms with their doctor. In both the short and long-term, these cultural, historical, and geographical disparities combined leave AIANs at an increased risk of late-stage cancer diagnoses, increased susceptibility to cancer-related deaths, and significantly lower cancer survival rates compared to other populations.

Improvements in health equity are achievable when access to good health care are equal for all. The CTCCCP will work to combat these issues. CRIHB serves the needs of these rural communities across California. The CTCCCP will continue to provide services to eight subcontractors across California to further understand the burden of cancer in AIAN communities. With this knowledge, CTCCCP intends to provide support and conduct evaluation to serve the needs of California AIANs.

## INCIDENCE/MORTALITY

### California Incidence and Mortality Rates for All Cancers, 2000-2015



**Figure 1 Age-Adjusted Rates Expressed as Cases per 100,000**

Source of Data: Surveillance, Epidemiology, and End Results (SEER) Program ([www.seer.cancer.gov](http://www.seer.cancer.gov)) SEER\*Stat Database: Incidence - SEER 18 Regs Research Data + Hurricane Katrina Impacted Louisiana Cases, Nov 2017 Sub (2000-2015), National Cancer Institute, DCCPS, Surveillance Research Program, Surveillance Systems Branch, released April 2018, based on the November 2017 submission.

While AIANs appear to have lower rates of cancer overall, they experience higher rates of mortality within those cases, Figures 1-2. This discrepancy can be largely attributed to the stage at which the diseases are diagnosed. Cancer tends to be diagnosed at a much later stage in AIANs than the general population.<sup>9</sup>

## CANCERS BY GENDER

### California Cancer Incidence per 100,000, 2000-2016

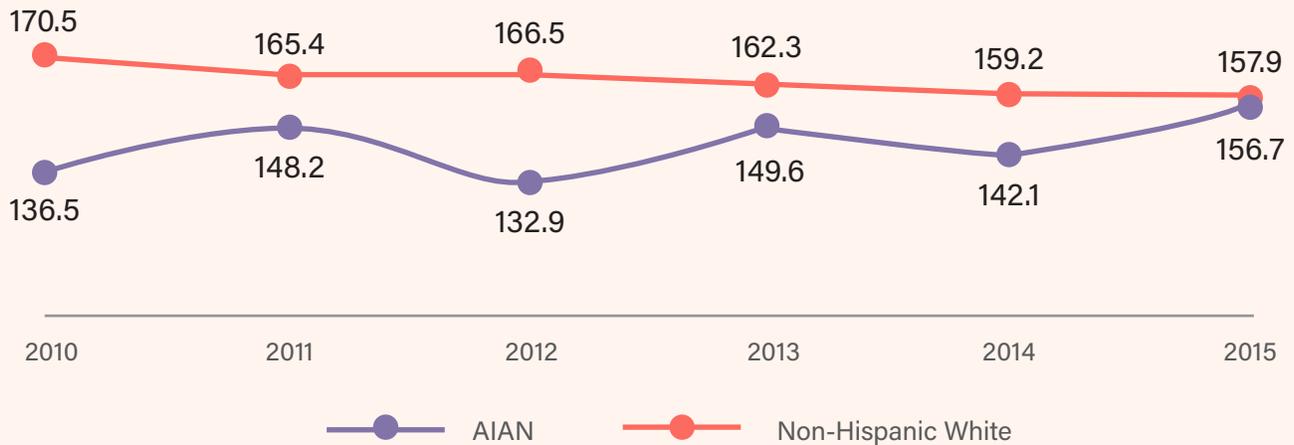


**Figure 2 Male and Female Cancers by Incidence**

Source of Data: Surveillance, Epidemiology, and End Results (SEER) Program ([www.seer.cancer.gov](http://www.seer.cancer.gov)) SEER\*Stat Database: Incidence - SEER 18 Regs Research Data + Hurricane Katrina Impacted Louisiana Cases, Nov 2018 Sub (2000-2016) <Katrina/Rita Population Adjustment> - Linked To County Attributes - Total U.S., 1969-2017 Counties, National Cancer Institute, DCCPS, Surveillance Research Program, released April 2019, based on the November 2018 submission.

# MORTALITY

## All Invasive Cancer Mortality in California by Race and Year



**Figure 3 Cancer Mortality AIAN vs. Whites per 100,000**

Source of Data: Surveillance, Epidemiology, and End Results (SEER) Program ([www.seer.cancer.gov](http://www.seer.cancer.gov)) SEER\*Stat Database: Incidence - SEER 18 Regs Research Data + Hurricane Katrina Impacted Louisiana Cases, Nov 2017 Sub (2000-2015) , National Cancer Institute, DCCPS, Surveillance Research Program, Surveillance Systems Branch, released April 2018, based on the November 2017 submission.

While mortality from all cancer sites has been slowly declining for non-Hispanic White populations, AIAN populations have not seen the same decrease in mortality, Figure 3. Tables 1-4 illustrate cancer mortality and the top 20 cancers among AIANS.

## TOP CANCERS BY MORTALITY

### AIAN Cancer Mortality per 100,000, 2010-2015

Cancer Sites	Count	Age-Adjusted Rate
All Cancer Sites Combined	1,728	144.6
Lung and Bronchus	393	33.9
Female Breast	106	15.7
Prostate	91	20.4
Liver	138	10.2
Colon excluding Rectum	128	10.9
Miscellaneous	124	10.3
Pancreas	116	9.7

**Table 1 Male and Female Cancers in Relation to Mortality**

Source of Data: Surveillance, Epidemiology, and End Results (SEER) Program ([www.seer.cancer.gov](http://www.seer.cancer.gov)) SEER\*Stat Database: Incidence - SEER 18 Regs Research Data + Hurricane Katrina Impacted Louisiana Cases, Nov 2018 Sub (2000-2016) <Katrina/Rita Population Adjustment> - Linked To County Attributes - Total U.S., 1969-2017 Counties, National Cancer Institute, DCCPS, Surveillance Research Program, released April 2019, based on the November 2018 submission.

**Table 2**  
**Age-Adjusted**  
**Incidence Rates**  
**and Rate Ratios**  
**for the Top**  
**20 Cancers**  
**among AIAN**  
**and Whites**  
**in California,**  
**2000-2016:**  
**Females**

Cancer Type	AIAN		White		Rate Ratio AIAN/White	p-value
	Rate	N	Rate	N		
All Cancers	506.1	12,100	657.9	1,667,531	0.77	<0.001
Female Breast	135.7	1,822	198.6	258,439	0.68	<0.001
Lung & Bronchus	64.8	1,440	80.5	209,418	0.8	<0.001
Prostate	122.3	1,333	187.5	228,748	0.65	<0.001
Colon & Rectum	51.6	1,186	59.7	154,106	0.87	<0.001
Colon	35.9	796	42.8	111,336	0.84	<0.001
Rectum and Rectosigmoid	15.8	390	16.8	42,770	0.94	0.230
Liver & Intrahepatic Bile Duct	21.9	587	8.6	22,459	2.56	<0.001
Kidney & Renal Pelvis	23.6	585	19.1	48,416	1.24	<0.001
Corpus & Uterus, NOS	18.9	484	35.5	48,169	1.00	0.998
Non-Hodgkin Lymphoma	20.9	480	28.4	71,544	0.73	<0.001
Urinary Bladder	17.2	374	32.5	85,112	0.53	<0.001
Oral Cavity & Pharynx	13.7	348	17.5	44,594	0.78	<0.001
Leukemia	13.9	325	17.9	45,467	0.78	<0.001
Myeloid/Monocytic Leukemia	7.4	174	8.1	20,267	0.92	0.292
Pancreas	13.8	314	16.6	43,575	0.83	0.002
Thyroid	12.1	311	15.7	34,391	0.77	<0.001
Melanoma of the Skin	12.1	298	45.8	111,152	0.26	<0.001
Stomach	9.4	213	8	20,590	1.18	0.026
Cervix Uteri	14.4	191	9.6	10,188	1.51	<0.001
Ovary	14.2	186	18.9	25,052	0.75	<0.001
Myeloma	7.7	175	7.7	20,091	1.00	1.000
Brain and Other Nervous System	5.7	137	9.3	22,257	0.92	<0.292

Source of data: California Cancer Registry, California Department of Public Health. Prepared by the California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program, Institute for Population Health Improvement, UC Davis Health.

**Table 3**  
**Age-Adjusted**  
**Incidence Rates**  
**and Rate Ratios**  
**for the Top**  
**20 Cancers**  
**among AIAN**  
**and Whites**  
**in California,**  
**2000-2016:**  
**Males**

Cancer Type	AIAN		White		Rate Ratio AIAN/White	p-value
	Rate	N	Rate	N		
All Cancers	536.1	5,854	731.9	859,096	0.73	<0.001
Prostate	122.3	1,333	187.5	228,748	6.5	<0.001
Lung & Bronchus	72.1	714	90	105,130	0.8	<0.001
Colon & Rectum	54.9	585	68	79,180	0.81	<0.001
Colon	37.1	383	47.4	54,837	0.78	<0.001
Rectum and Rectosigmoid	17.8	202	20.6	24,343	0.86	0.052
Liver & Intrahepatic Bile Duct	33.8	435	13.1	16,206	2.58	<0.001
Kidney & Renal Pelvis	29.1	336	26.9	31,737	1.08	0.192
Urinary Bladder	29.1	282	56.8	65,494	0.51	<0.001
Non-Hodgkin Lymphoma	24.8	265	34.7	39,832	0.71	<0.001
Oral Cavity & Pharynx	21.5	257	26.3	31,612	0.82	0.002
Pancreas	15.8	163	19	22,362	0.83	0.026
Leukemia	15.2	165	23.5	26,951	0.65	<0.001
Myeloid/Monocytic Leukemia	7	78	10.2	11,584	0.68	<0.001
Lymphocytic Leukemia	6.7	74	12.2	14,243	0.55	<0.001
Melanoma of the Skin	14.9	168	59.2	68,111	0.25	<0.001
Stomach	12.6	134	11.5	13,374	1.1	0.339
Testis	9.2	119	10.2	9,627	9	0.293
Esophagus	9.2	102	10.8	12,860	0.85	0.132
Myeloma	8.1	91	10	11,692	0.82	0.073
Brain & Other Nervous System	6.6	78	11.3	12,736	0.59	<0.001
Thyroid	5.9	74	8.6	9,619	0.68	0.001
Larynx	5.7	67	6.8	8,130	0.83	0.177

Source of data: California Cancer Registry, California Department of Public Health. Prepared by the California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program, Institute for Population Health Improvement, UC Davis Health.

*Table 4 Average Annual Percent Change and 95% Confidence Intervals (CI) in Age-Adjusted Incidence Rates for the top ten cancers among AIANs and Whites in California, 2000-2015*

Cancer Type	AIAN			White		
	AAPC	95% CI		AAPC	P-Value	
All Cancers	2.7	2.2, 3.3	↑	-0.9	-1.5, -0.4	↓
Colon and Rectum	1.7	0.8, 2.6	↑	-2.2	-3.2, -1.3	↓
Liver	6.2	3.4, 9.1	↑	3.5	2.6, 4.4	↑
Lung	1.5	0.3, 2.7	↑	-2.4	-2.7, -2.1	↓
Female Breast	3.8	2.7, 5.1	↑	-0.7	-1.2, -0.2	↓
Uterus	5.9	3.7, 8.1	↑	0.4	-0.5, 1.4	-
Prostate	-1.5	-3.0, 0.1	-	-4.2	-5.3, -3.0	↓
Urinary Bladder	2.6	-0.1, 5.3	-	-0.8	-1.2, -0.3	↓
Kidney	4.7	2.5, 7.1	↑	1.8	1.3, 2.3	↑
Non-Hodgkin Lymphoma	2.3	-0.7, 5.4	-	-0.2	-0.4, 0	-
Oral and Pharynx	2.9	0.7, 5.4	↑	0.5	-0.4, 1.4	-

Source of data: California Cancer Registry, California Department of Public Health. Prepared by the California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program, Institute for Population Health Improvement, UC Davis Health.

Table 4 shows the average annual percent change (AAPC) in incidence rates for the top ten cancers among AIANs. Incidence rates among AIANs increased between 2000 and 2016, averaging 1.5 and 1.7 percent per year for lung and colorectal cancers. Female breast, uterus, kidney, and liver cancers increased, on average, from 3.8 percent per year (female breast cancer) to 6.2 percent per year (liver cancer).

*Figure 4 Trends in Age-Adjusted Cancer Incidence Rates among AIANs and Whites in California, 2000-2015*

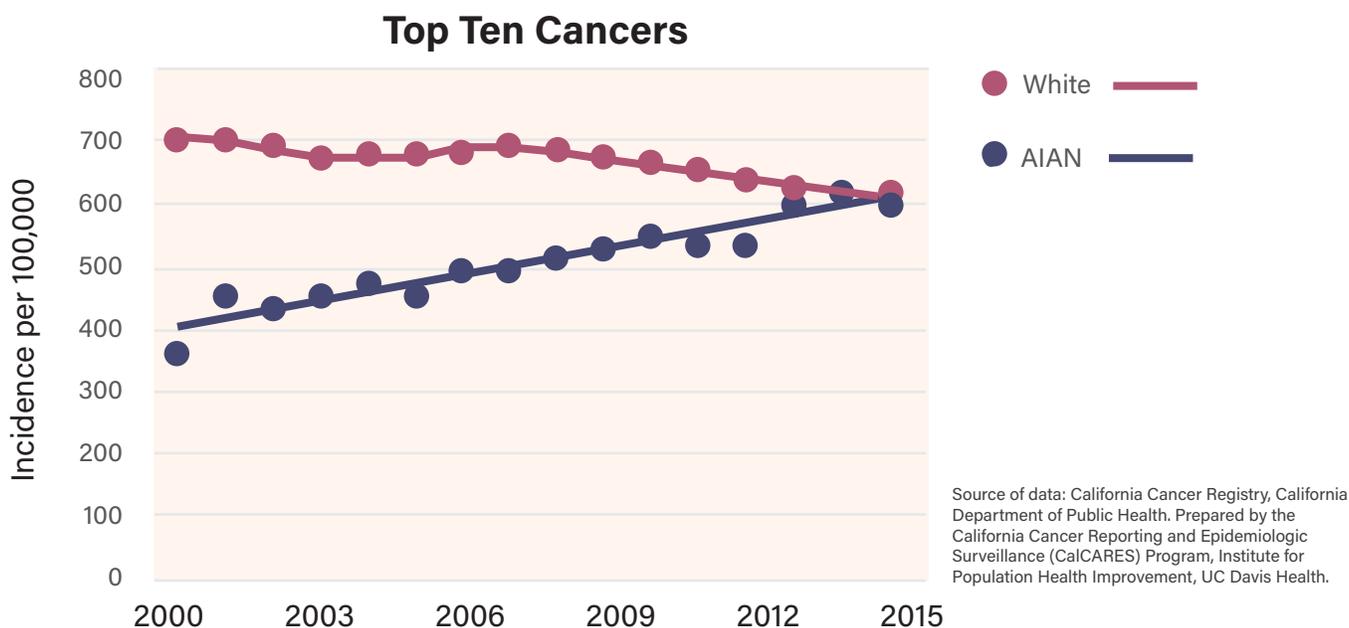


Figure 4 shows age-adjusted incidence rates and trendlines for the top ten cancers by year of diagnosis in the AIAN and White populations in California.

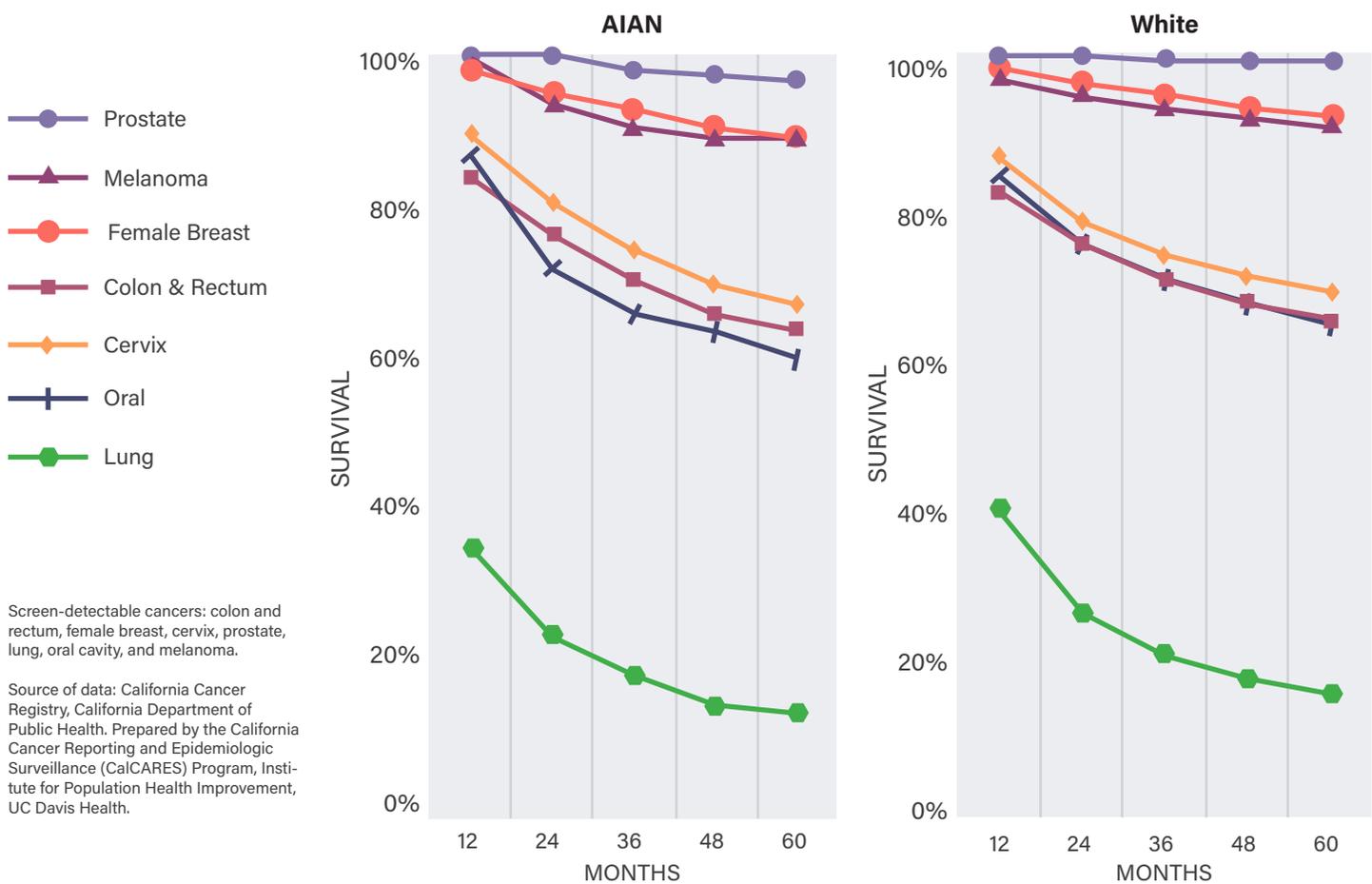
*Table 5 Percent of AIAN and White Patients Diagnosed with a Screen-detectable Cancer at Late Stage in California, 2000-2016*

Cancer Site	AIAN		White		p-value
	AIAN	% Late	N	% Late	
Female Breast	1,008	35.3	154,094	30	<0.001
Colon and Rectum	1,055	61.6	172,762	58.5	0.012
Prostate	532	30	106,383	26.7	0.002
Cervix	151	22.7	9,734	19.4	0.033
Melanoma	85	14.5	26,138	10.1	<0.001
Oral	327	69.7	45,672	60.5	<0.001
Lung	1,668	84.2	307,533	82.1	0.01
Total	4,826	48.1	822,316	71.8	<0.001

Source of data: California Cancer Registry, California Department of Public Health. Prepared by the California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program, Institute for Population Health Improvement, UC Davis Health.

Table 5 shows that AIANs had a significantly higher proportion of cancers diagnosed at late stage.

*Figure 5 Relative Survival among White and AIANs Diagnosed with Screen-detectable Cancers in California, 2000-2016*

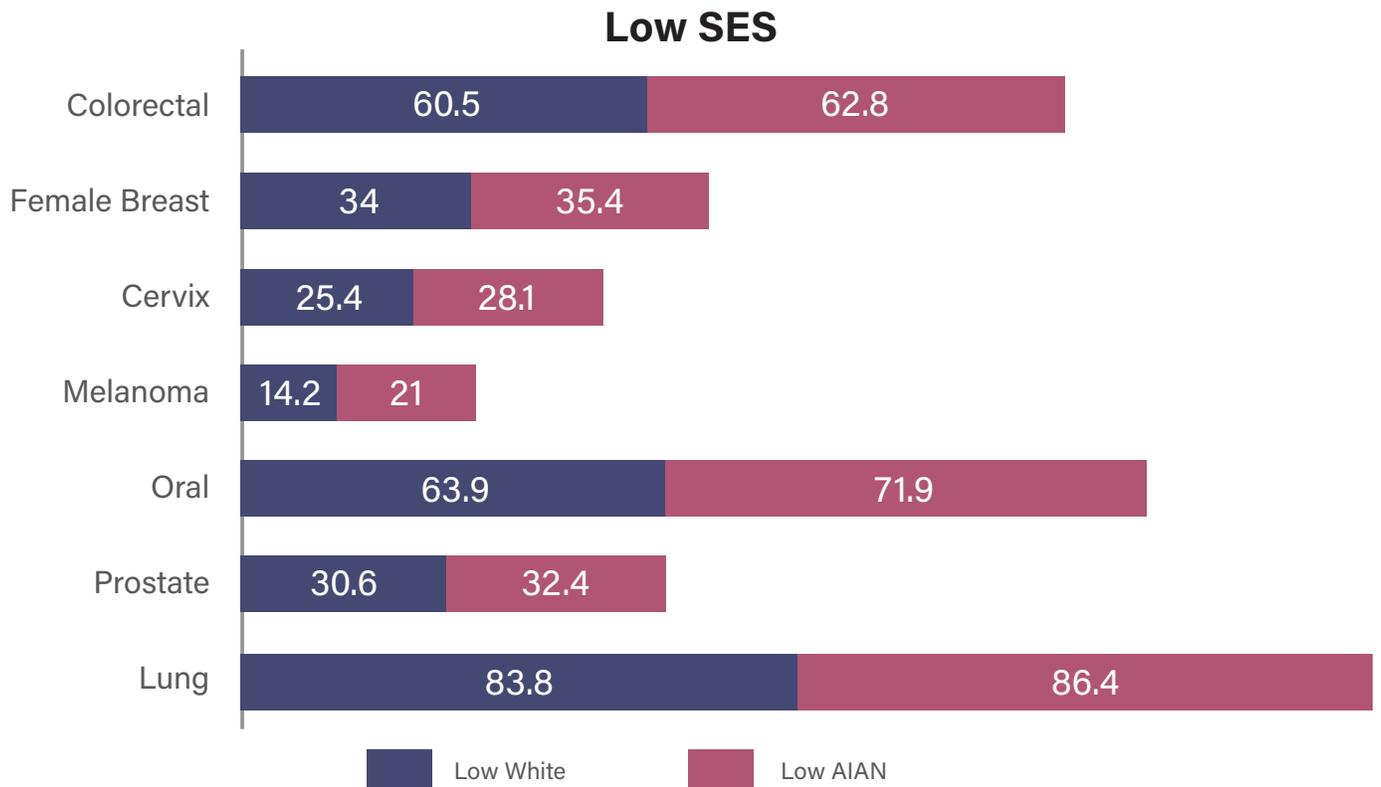


Screen-detectable cancers: colon and rectum, female breast, cervix, prostate, lung, oral cavity, and melanoma.

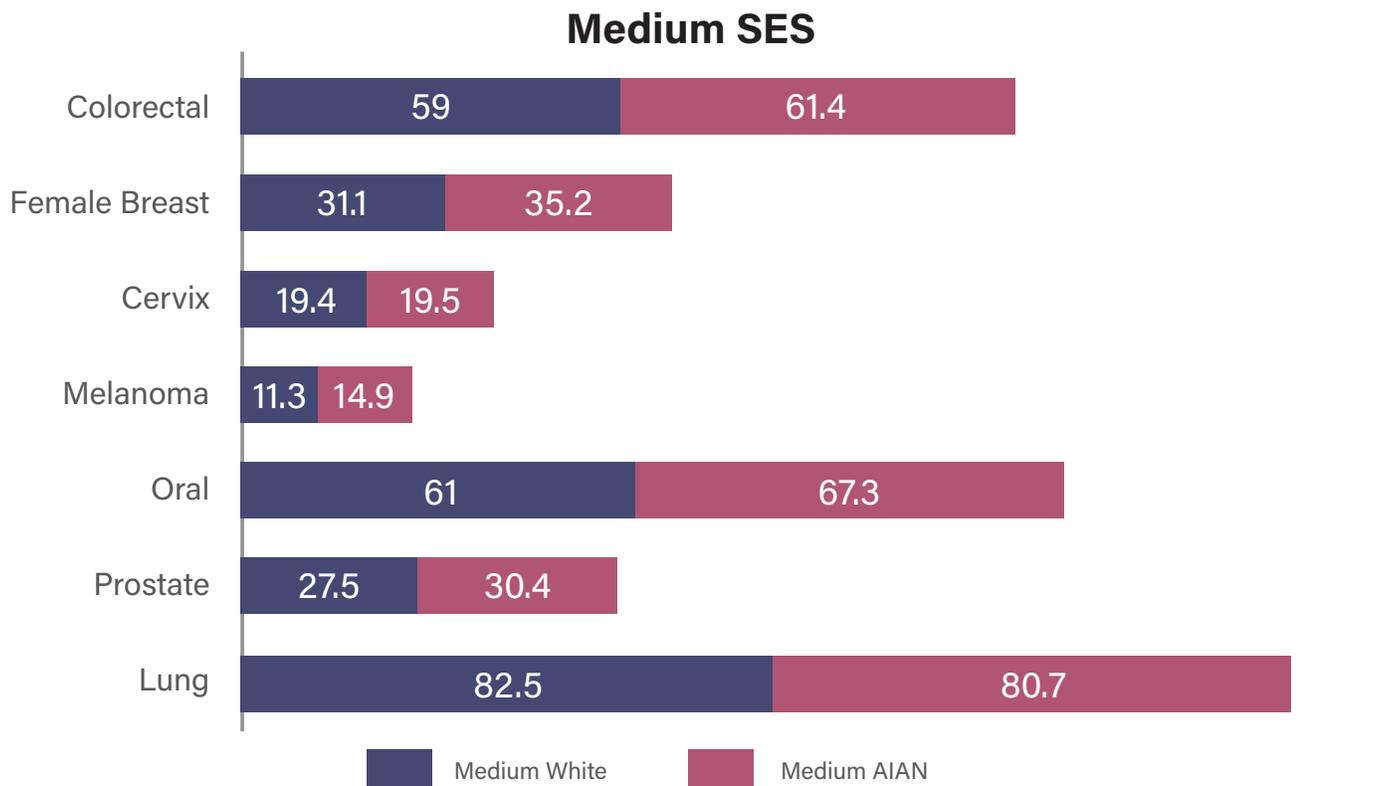
Source of data: California Cancer Registry, California Department of Public Health. Prepared by the California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program, Institute for Population Health Improvement, UC Davis Health.

Figure 5 shows that compared with White patients, survival over five years after the diagnosis of screen-detectable cancers was lower among AIANs.

Figure 6 Percent of AIAN and White Persons Diagnosed with Screen-detectable Cancer at a Late Stage by Type of Cancer and Socioeconomic Status (SES), 2000-2016

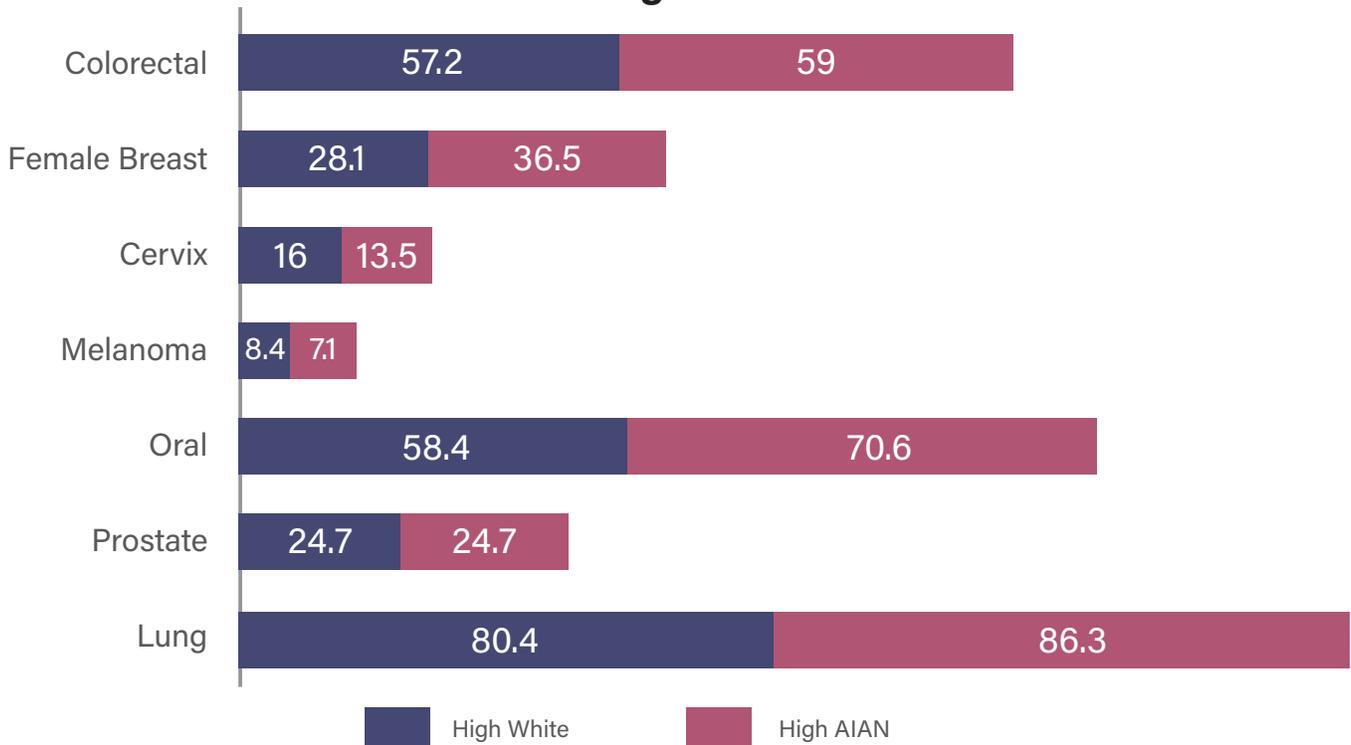


Source of data: California Cancer Registry, California Department of Public Health. Prepared by the California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program, Institute for Population Health Improvement, UC Davis Health.



Source of data: California Cancer Registry, California Department of Public Health. Prepared by the California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program, Institute for Population Health Improvement, UC Davis Health.

## High SES



Source of data: California Cancer Registry, California Department of Public Health. Prepared by the California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program, Institute for Population Health Improvement, UC Davis Health.

Figure 6 examines late stage at diagnosis, for screen-detectable cancers, by SES. Results by neighborhood SES levels indicate that AIANs appear to be diagnosed at late stage more frequently than Whites. Differences in late stage at diagnosis between AIANs and Whites living in low SES areas were significant for melanoma (21.0 vs. 14.2 percent), oral (71.9 vs. 63.9 percent), and lung cancers (86.4 vs. 83.8 percent). Compared with Whites, AIANs in more affluent areas were also more likely to be diagnosed late with oral (70.6 vs. 58.4 percent), lung (80.4 vs. 86.3 percent), and breast cancer (28.0 vs. 36.1 percent). Melanoma and cancers of the cervix and prostate were diagnosed at a late stage more frequently in poorer areas than affluent areas.



# CALIFORNIA TRIBAL COMPREHENSIVE CANCER CONTROL PLAN EVALUATION

Program evaluation is a well ordered method for collecting, analyzing, and using data to improve the effectiveness and efficiency of a program. Evaluation is conducted continually using a combination of quantitative (numerical) and qualitative (non-numerical) data collection methods. By measuring both quantitative and qualitative indicators, evaluators can improve and build upon the desired outcomes and impacts of a program.

One method used to evaluate this program is utilizing data sources collected from partners and Tribal health programs. The CTCCCP team will access data sources and gather information to understand the cancer needs of California AIAN individuals. Data sources include the Behavior Risk Factor Surveillance System (BRFSS), California Health Interview Survey (CHIS), baseline values from eight subcontractors across California, feedback from the Coalition, and the CTEC California Tribal Behavior Risk Factor Survey (TBRFS). With this data, the CTCCCP will monitor the effectiveness of cancer and survivorship related evidence-based interventions implemented through California Tribal communities.

Next, the CTCCCP evaluation plan was developed based on feedback from the Coalition. The Coalition contributed the development and selection of the goals and objectives included in this plan. The objectives include current baseline figures, according to eight different subcontractors across California. The information provided by the Coalition will guide improvements to the Cancer Plan and CTCCCP.

The CTCCCP will continue to evaluate educational materials, training, and outreach to provide the best resources for AIAN individuals. Revisions will be made to the Cancer Control Plan to reflect the most recent values and rates, adjustments to objectives, and progress toward goals. The ultimate goal of the Cancer Control Plan is to reduce the prevalence, incidence, and rates of mortality due to cancer in AIAN individuals living in California. This ongoing evaluation conducted with the participation of various cancer entity partnerships, subcontractors, the Coalition, and AIAN community members will contribute to the continual improvement of the Cancer Control Plan throughout the upcoming years.

# GOAL AND OBJECTIVES

## Objective 1A - Emphasize Primary Prevention of Cancer: Tobacco Component

**TARGET:** *By 2023, decrease the percent of American Indian and Alaska Native adults who are current smokers, from the current baseline of 14.3% to 10%.*

### Objective 1A:

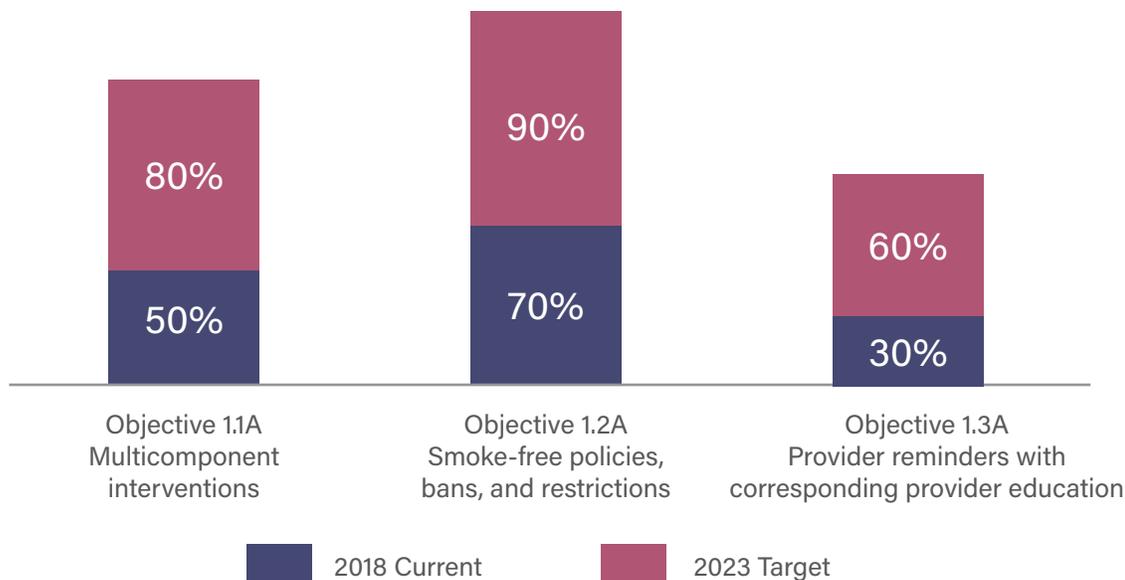
#### **Decrease the percent of adult smoking prevalence.**

Many California Tribal communities use tobacco for medicinal, spiritual, and ceremonial purposes. It is essential to note the difference between commercial and traditional tobacco use when implementing the following strategies. The interventions found in this Cancer Control Plan focus on commercial tobacco usage, which may include cigarettes, flavored tobacco, tobacco vaporizers (vapes), and chewing tobacco.

The use of commercial tobacco significantly affects our Tribal communities. Compared to other racial and ethnic groups in California, AIANs have the highest prevalence of cigarette use. The California Department of Public Health reports that 24.2% of American Indian adults smoke in California compared with 13.0% of white adults.<sup>2</sup> Smoking is a risk factor for a variety of chronic diseases.

Various studies have shown that smoking can lead to the development of lung cancer; however, it is the most preventable cause of cancer.<sup>9</sup> For AIANs, lung cancer is the number one cause of cancer death. AIANs are at a greater risk of experiencing chronic diseases due to the high rates of commercial tobacco use presented.<sup>10</sup>

## Objective 1A: By 2023, Decrease Adult Smoking Prevalence from 14.3% to 10%



### Three strategies to complete Objective 1A:

**1**

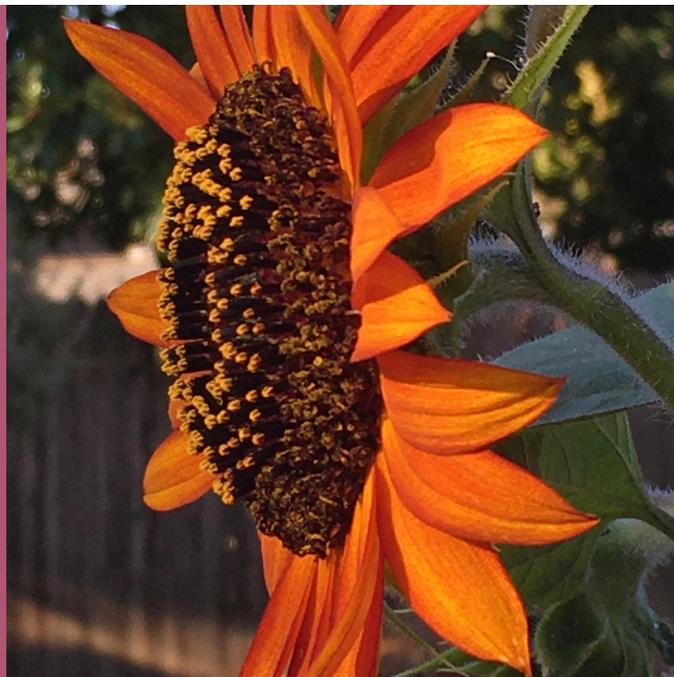
Support the use of multicomponent interventions to increase tobacco use cessation.

**2**

Implement smoke-free policies, bans, and restrictions to reduce secondhand smoke exposure.

**3**

Utilize provider reminders with corresponding provider education to increase tobacco use cessation.



# 1

## Support the use of multicomponent interventions to increase tobacco use cessation.

### Activities to support the use of multicomponent interventions:

#### Implement the use of community outreach and education programs in Tribal health program settings and at community events.

- ◆ Storytelling led by committee members, community champions, Tribal councils, and or staff members through group education, support groups, counseling sessions, and talking circles.
- ◆ Encourage Tribal health programs to collaborate with behavioral health programs, as well as state and local health departments, and tobacco cessation programs that are already providing group education.

#### Adoption of tobacco cessation programs among Tribal health programs by using small and mass media campaigns.

- ◆ Promote use of local, statewide, and nationwide campaigns (Tips From Former Smokers Campaign and California Smokers' Helpline 1-800-NO-BUTTS).
- ◆ Development of community-centered tobacco prevention and awareness campaigns.

#### Improve organizational culture by reducing structural and cultural barriers.

- ◆ Increase the community's access to tobacco-use cessation services by increasing staff training to improve the knowledge and skills of health care staff, providing tobacco cessation services and information.
- ◆ Build Tribal health programs' infrastructure to provide cessation services in-house by increasing partnerships with behavioral health departments and Special Diabetes Program for Indians (SDPI).
- ◆ Identify available tobacco cessation coverage and resources at the state, local, and county levels to reduce client out-of-pocket costs.

### Current Measure:

50% of collaborating CTCCCP Tribal health programs have implemented the use of multicomponent interventions at their site.

### Target:

By the year 2023, 80% of collaborating CTCCCP Tribal health programs will implement the use of multicomponent interventions at their site.

*Multicomponent interventions refer to the combination of two or more intervention approaches.*

## 2

## Implementation of smoke-free policies, bans, and restrictions to reduce secondhand smoke exposure.

### Current Measure:

70% of collaborating CTCCCP Tribal health programs have implemented the use of smoke-free policies, bans, and restrictions to reduce secondhand smoke exposure.

### Target:

By the year 2023, 90% of collaborating CTCCCP Tribal health programs will implement the use of smoke-free policies, bans, and restrictions.

*Smoke-free policies and restrictions refer to the development, implementation, and maintenance of policies, regulations, laws or ordinances that protect the public of smoke exposure in areas where people eat, live, learn, play, shop, and work. These bans or restrictions can decrease exposure to first, second, and third-hand smoke in public areas or workplaces.*

### Activities to support the utilization of smoke-free policies, bans, and restrictions:

#### Identify Tribe's readiness in implementing the use of smoke-free policies, bans, and restrictions by introducing the use of readiness assessments through key informant interviews, surveys, and focus groups.

- ◆ Use readiness assessments to identify the parameters of the proposed policy.

#### Create awareness of the need for smoke-free policies, bans, and restrictions to reduce secondhand smoke exposure among Tribally operated establishments.

- ◆ Implement the use of community outreach and education, providing information on current cancer burden identified in the community, the adverse effects of smoking, flavored tobacco, spit tobacco, and vaping.

#### Development of smoke-free policies, bans, and restrictions based on readiness assessments.

- ◆ Enforce policies and no-smoking rules to promote the widespread use of smoke-free policies, bans, and restrictions, distinguishing between commercial tobacco and traditional tobacco usage.
- ◆ Policies should enforce no-smoking rules within 25 feet of building entries, promote the use of butt containers and designated smoking areas, and include educational components about evidence-based cessation interventions.

#### Maintain enforcement of smoke-free policies, bans, and restrictions among Tribal health programs.

- ◆ Delegate administrative staff to maintain enforcement.
- ◆ Provide ongoing information, resources, and reminders to staff, public, and Tribal leaders.

## Utilize provider reminders with corresponding provider education to increase tobacco use cessation.

# 3

### Activities to support the use of provider reminders:

#### Increase provider delivery of tobacco use screening, documentation, and cessation services.

- ◆ Establish procedures that set reminders on medical chart notes, electronic health record systems, checklists, or patient intake forms.

#### Expand on coding methods to identify patient's tobacco use and cessation efforts.

- ◆ Increase health care provider training on varying coding methods to track the number and type of cessation services offered. For example, monitor quit attempts, track cessation services, and disseminate quit kits and educational resources to maximize Medicaid and Medicare billing.

#### Increase Train the Trainer education to health care providers for the implementation of evidence-based tobacco screening interventions.

- ◆ Use Train the Trainer intervention based on models such as Ask, Advise, and Refer (AAR); Ask, Advise, Assess, Assist, or Arrange (5A's); and Relevance, Risks, Rewards, Roadblocks, and Repetition (5R's) methodologies.



#### Current Measure:

30% of collaborating CTCCCP Tribal health programs have implemented the use of provider reminders to increase tobacco use cessation.

#### Target:

By the year 2023, 60% of collaborating CTCCCP Tribal health programs will implement the use of provider reminders to increase tobacco use cessation.

*The goal of utilizing provider reminders is to develop effective health systems procedures that prompt health care providers to identify patients' current tobacco usage, quit attempts, and cessation services utilized.*

# Objective 1B - Emphasize Primary Prevention of Cancer: Nutrition and Obesity Component

**TARGET:** *By 2023, decrease the percent of adult obesity prevalence, from 72.1% to 60%.*

## Objective 1B:

### Decrease adult obesity prevalence.

By 2023, increase the percentage of consumption of fruits and vegetables from 73.8% to 83%. Individuals who are outside of a healthy Body Mass Index (BMI) range (greater than 25) experience a far greater number of health risks, including cancer. Overweight, obese, and morbidly obese individuals are at risk of developing at least 13 different types of cancers. These cancers may also negatively affect the body's immune system, levels of certain hormones/proteins, and other factors contributing to cell growth.

A high proportion of AIANs are overweight and obese per the BMI guidelines. CTEC self-report data indicate that approximately 29.3% of AIANs are overweight, and 51.8% are obese; together that amounts to 81.1% of the population.<sup>3</sup>

### Objective 1B: By 2023, Decrease Adult Obesity Prevalence from 72.1% to 60% by 2023



## Three strategies to complete Objective 1B:

# 1

Limit unhealthy food and drink availability to improve healthy behavior.

# 2

Signage for healthy vs. less healthy items to improve healthy behavior.

# 3

Increase healthy food and drink availability to improve healthy behavior.

# 1

## Limit unhealthy food and drink availability to improve healthy behavior.

### Activities to limit unhealthy food and drink availability:

#### Establish Policy, System, and Environmental (PSE) changes that reduce access to unhealthy food and drinks in Tribally operated establishments.

- ◆ Develop written wellness policies that limit the sale and distribution of sugar-sweetened beverages and high-calorie snacks with little to no nutritional value.
- ◆ Develop ordinances, including increased beverage taxes for sugar-sweetened beverages, alcoholic beverages, and high caloric drinks.
- ◆ Promote ordinances by providing education to the public on cancer risk related to the consumption of alcohol and sugar-sweetened beverages.
- ◆ Lower the cost of healthier food and beverages, compared to sugar-sweetened food and beverages.

#### Promote environmental changes that decrease access to unhealthy food and drink.

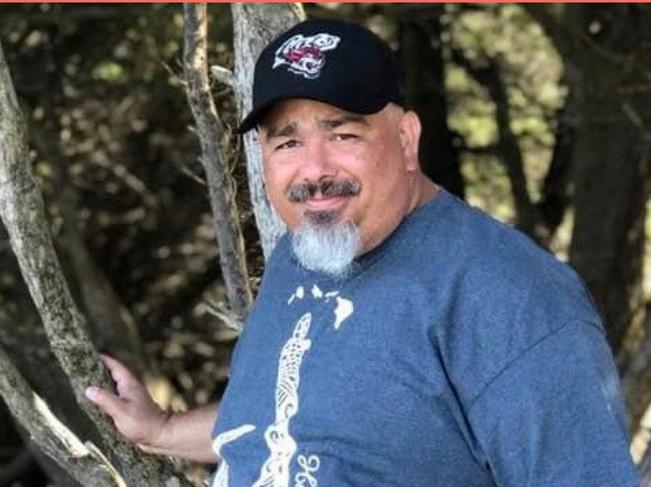
- ◆ Remove of unhealthy beverages and high caloric snacks with little to no nutritional value in vending machines.
- ◆ Ensure access to free, clean, and safe drinking water by installing water stations in Tribally operated buildings.
- ◆ Display culturally desirable and healthier food options in storefronts, near registers, and at checkouts.

#### Current Measure:

15% of collaborating CTCCCP Tribal health programs have established activities that limit access to unhealthy food and drink availability.

#### Target:

By the year 2023, 45% of collaborating CTCCCP Tribal health programs will establish activities that limit access to unhealthy food and drink availability.





## 2

### **Signage for healthy vs. less healthy items to improve healthy behavior.**

**Activities to support the use of signage for healthy vs. less healthy items to improve healthy behavior:**

**Promote the use of evidence-based education and signage that distinguishes between healthy and non-healthy food items.**

- ◆ Identify culturally relevant small media campaigns that promote healthy eating practices.
- ◆ Distribute Native-specific health education materials, cookbooks, nutrition facts pamphlets, and traditional food options.
- ◆ Encourage Tribal health programs to collaborate with local, statewide, and nationwide programs that promote campaigns for the limitation of consumption of sugar-sweetened beverages.

**Use of or development of Native Foods Guide to promote the consumption of traditional Native foods specific to the region.**

- ◆ Develop recipes specific to the region to be showcased in a Native cookbook for distribution among the community.

**Use of Good Health TV services to provide media-based nutrition education.**

- ◆ Collaborate with Information Technology (IT) departments to set up media loops in patient waiting areas, where people work, play, learn, and convene.

#### **Current Measure:**

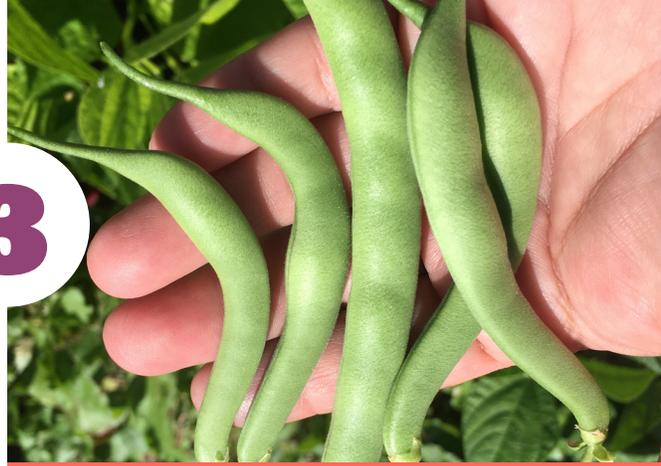
80% of collaborating CTCCCP Tribal health programs have implemented the use of signage for healthy vs. less healthy items.

#### **Target:**

By the year 2023, 100% of collaborating CTCCCP Tribal health programs will implement the use of signage for healthy vs. less healthy items.

## Increase healthy food and drink availability to improve healthy behavior.

3



### Activities to support an increase in healthy food and drink availability:

#### Implement and maintain the use of community gardens, home gardens, and container gardens.

- ◆ Collaborate with local nutrition and obesity prevention programs, master gardeners, and wellness programs to provide education on effective gardening practices.

#### Increase healthy food and drink retail opportunities, particularly in rural and underserved AIAN communities, by supporting healthy product procurement, placement, and pricing strategies.

- ◆ Encourage purchasing healthy food and drink alternatives, including displaying healthy signage.

#### Provide alternatives to sugar-sweetened beverages at all Tribal events.

- ◆ Use of fruit-infused waters, use of smoothie, and use of water dispensers.
- ◆ Share healthy drink recipes among community members and health care staff.
- ◆ Promote the use of water refill stations at schools, clinics, and casinos.

#### Increase the use of food demonstrations to promote the consumption of healthy food and drinks.

- ◆ Collaborate with nutrition and obesity prevention programs providing education on: the use of traditional foods, preserved foods, seasonal fruits, vegetables, and foods available at local farmers' markets.

#### Incorporate wellness policies suggesting all food and drink available at Tribally operated buildings, events, and meetings must follow specific nutritional guidelines.

- ◆ For example making a vending machine policy that requires inclusion of water and lower-sugar options.

#### Current Measure:

70% of collaborating CTCCCP Tribal health programs have implemented activities to increase healthy food and drink availability to improve healthy behavior.

#### Target:

By the year 2023, 85% of collaborating Tribal health programs will implement activities to increase healthy food and drink availability to improve healthy behavior.

*Establish PSE changes that increase access to healthy food and drink options in Tribally operated establishments, including where people eat, live, learn, play, shop, and work.*

## Objective 2 - Facilitate Screening and Early Detection of Cancer

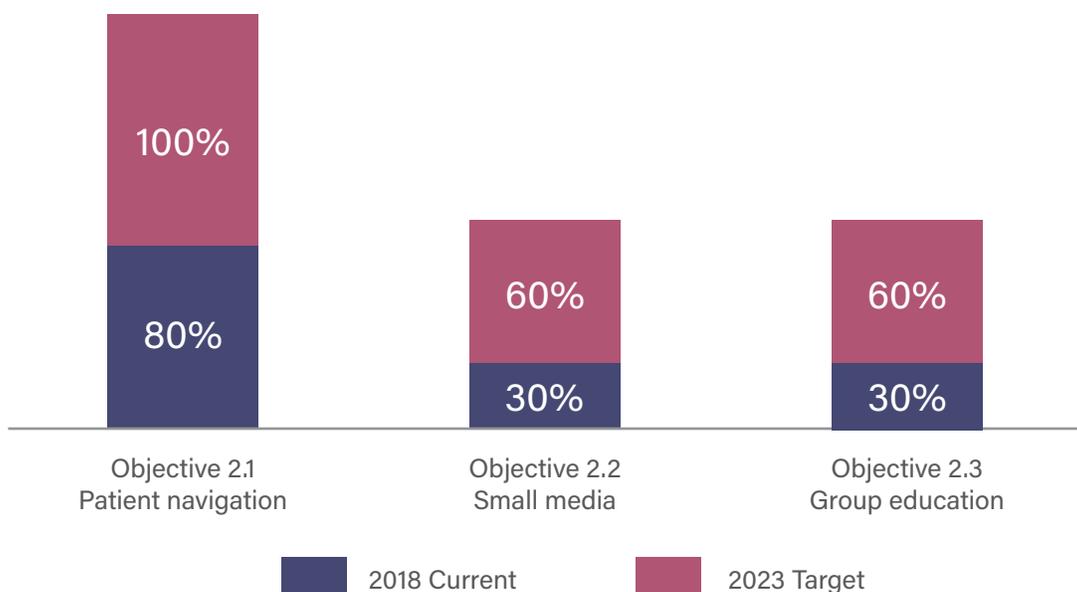
**TARGET:** *By 2023, increase the percentage of provider referrals for screening based on national guidelines.*

### Objective 2:

#### Increase the percent of adoption of evidence-based tools.

Screening and early detection of cancer significantly increase the chances of successful treatment and survival. Screening refers to the use of simple tests to identify individuals who may have a disease like cancer, but have not yet exhibited symptoms. Early detection of cancer often allows for more exceptional treatment options and better outcomes for some cancers.

#### Objective 2: Increase Provider Referrals for Screening



#### Three strategies to complete Objective 2:

1

Use patient navigation to facilitate timely access to screening.

2

Use small media to increase community demand for cancer screening services.

3

Use group education to increase community demand for cancer screening services.

# 1 Use patient navigation to facilitate timely access to screening.

## Current Measure:

80% of collaborating CTCCCP Tribal health programs have implemented the use of patient navigation to facilitate timely access to screenings.

## Target:

By the year 2023, 100% of collaborating CTCCCP Tribal health programs will implement the use of patient navigation to facilitate timely access to screenings.

*Patient navigators help guide patients through a series of health care systems, including but not limited to screening, diagnosis, treatments, and follow-up of a medical condition. Additionally, patient navigators can be involved in assisting patients with medical tests, scheduling of appointments, and financial, legal, and social support. These individuals can also be the patient's advocate in obtaining medical services.*

## Activities to support the use of patient navigators to facilitate timely access to screening:

### Improve organizational culture by reducing structural and cultural barriers to screening services.

- ◆ Provide training, education, and ongoing guidance to providers and patient navigators specific to cancer screening protocols and early detection of cancer to increase timely access to screening.
- ◆ Ensure that staff is made aware of evidence-based cancer-screening guidelines such as the United States Preventive Services Task Force (USPSTF) guidelines, the National Comprehensive Cancer Network (NCCN), and the American Cancer Society (ACS), and the Government Performance and Results Act (GPRA) goals.
- ◆ Assist patient navigators in collaborating with community-based organizations to reduce barriers to obtaining cancer-screening services for patients. Barriers may be financial, cultural, structural, or regional.

### Implement health systems policies regulating the review of electronic health record reminder systems and screening reminders.

- ◆ Collaborate with medical directors and Tribal health boards to develop policies requiring that all medical staff, including patient navigators review screening, alerts on medical charts, provider notes, electronic health record systems, checklists, or patient intake forms.
- ◆ Outline policies that use community health representatives, medical assistants, and patient navigators as the front-line staff to introduce cancer-screening services to patients due for screening.

### Use of community health representatives, medical assistants, and patient navigators to support the distribution of screening reminders.

- ◆ Disseminate reminder cards, conduct follow-ups via text, email, and phone. Pair reminder systems with birthdays and national cancer screening campaigns.
- ◆ Community health representatives, medical assistants, and patient navigators to conduct follow up calls and review of appointments.

## 2

### Use small media to increase community demand for cancer screening services.

**Activities to support the use of small media to increase community demand for cancer screening services:**

**Promote the use of evidence-based education and signage to increase community demand for cancer screening services.**

- ◆ Identify culturally relevant small media campaigns that promote cancer-screening services.
- ◆ Develop a small media campaign, using local community members, champions, or Tribal leaders sharing available cancer screening and survivorship services.
- ◆ Distribute media highlighting cancer-screening services that are available at local wellness centers, partnering clinics, and hospitals.
- ◆ Collaborate with established cancer prevention-related organizations to co-brand small media materials.

**Use of culturally tailored infographics/educational materials providing information on cancer screening recommendations available at all Tribally operated establishments.**

- ◆ Disseminate of brochures, pamphlets, videos, and newsletters.
- ◆ Share educational cancer screening videos with patients using iPad, tablets, and lobby TVs to increase demand for cancer-screening services.

**Use of Good Health TV services providing media-based cancer screening and prevention education.**

- ◆ Collaborate with IT departments to set up media loops in patient waiting areas, where people work, play, learn, and convene.



#### **Current Measure:**

30% of collaborating CTCCCP Tribal health programs have implemented the use of small media to increase community demand for cancer screening services.

#### **Target:**

By the year 2023, 60% of collaborating CTCCCP Tribal health programs will implement the use of small media to increase community demand for cancer screening services.

## Use group education to increase community demand for cancer screening services.

# 3

**Activities to support the use of group education to increase community demand for cancer screenings:**

**Deliver culturally tailored one-on-one or group education conducted by survivors, health professionals, trained staff, or behavioral health staff to motivate individuals to seek screenings.**

- ◆ Set up talking circles incorporating the use of storytelling (ensure that staff is familiar with the topic while guiding the talking circles). Topics to focus on include the benefits of screening, what to expect during screening services, financial, cultural, structural, and regional aspects.
- ◆ Provide group education at community events paired with the use of mobile services, travel providers, screening camps, and community screening days.

**Provide group education of cancer burden in the community.**

- ◆ Collaborate with survivors to share their experiences at community events, with clinic staff, and health care providers.

**Current Measure:**  
30% of collaborating CTCCCP Tribal health programs have implemented the use of group education to increase community demand for cancer screenings.

**Target:**  
By the year 2023, 60% of collaborating CTCCCP Tribal health programs will implement the use of group education to increase community demand for cancer screenings.



## Objective 3 - Improve Cancer Survivors' Quality of Life

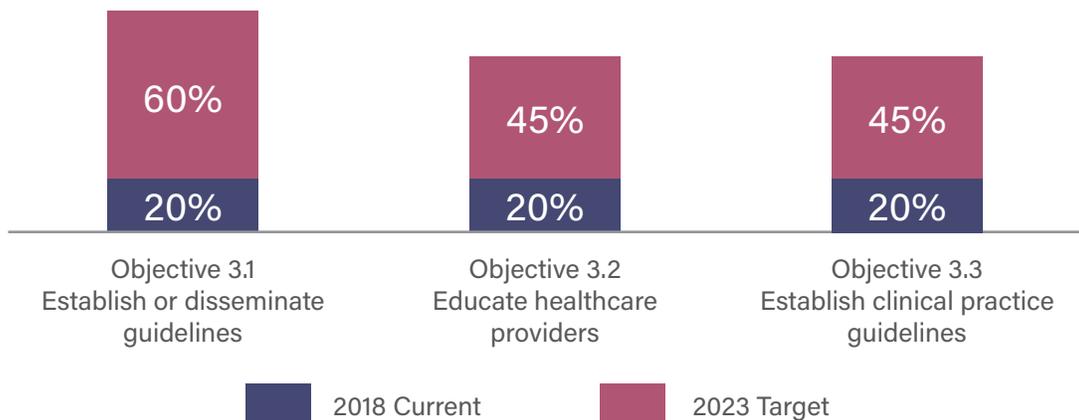
**TARGET:** *By 2023, increase the percent of the public's knowledge of the burden of cancer survivorship and issues faced by survivors.*

### Objective 3:

#### Increase the percent of trainings on cancer survivorship for health professionals and paraprofessionals.

Upon diagnosis, cancer survivors face many challenges that follow them along the course of their treatment and beyond. These challenges may require physical, financial, mental, spiritual, and social support. As the cancer mortality rate drops, it is essential to provide a variety of services that meet the needs of this growing population.

#### Objective 3: Increase Public Knowledge About the Burden of Cancer Survivorship



#### Three strategies to complete Objective 3:

**1**

Establish or disseminate guidelines that support quality and timely service provision to cancer survivors.

**2**

Educate health care providers about cancer survivorship issues from diagnosis through long-term treatment effects and end-of-life care.

**3**

Establish clinical practice guidelines for each stage of cancer survivorship.

# 1

## Establish or disseminate guidelines that support quality and timely service provision to cancer survivors.

**Activities to support the establishment or dissemination of guidelines that support quality and timely service provision to cancer survivors:**

**Improve organizational culture by reducing structural and cultural barriers to support quality and timely service provision to cancer survivors.**

- ◆ Disseminate guidelines that provide case management for survivors, including follow up care, transportation services, tobacco cessation services, and services improving overall health and wellness.
- ◆ Disseminate guidelines that encourage collaboration with medical staff, referral agencies, oncology centers, behavioral health programs, and statewide comprehensive cancer centers to provide support and assistance to survivors after treatment.
- ◆ Disseminate guidelines that request survivorship care plans from patients and treatment centers, utilize patient navigators and case management staff to communicate the patients' follow up care needs effectively.
- ◆ Disseminate guidelines that increase telehealth capacities at Tribal health programs to provide timely access to follow-up care and support for survivors in rural areas.
- ◆ Disseminate guidelines that provide virtual and web-based support groups to survivors unable to attend in-person.
- ◆ Establish practices that create linkages among community members experiencing the varying stages of cancer survivorship to serve as support systems for survivors, family members, and staff involved with patients.
- ◆ Establish practices that create linkages to traditional, spiritual, and religious partners to provide support.
- ◆ Provide ongoing support to survivors by distributing care guidelines, access to incentives for follow-up care, and setting up survivorship appreciation days.

### Current Measure:

20% of CTCCCP Tribal health programs have established and/or disseminated guidelines that support quality and timely service provision to cancer survivors.

### Target:

By the year 2023, 60% of collaborating CTCCCP Tribal health programs will establish and/or disseminate guidelines that support quality and timely service provision to cancer survivors.

## 2

### **Educate health care providers about cancer survivorship issues from diagnosis through long-term treatment effects and end-of-life care.**

#### **Current Measure:**

20% of collaborating CTCCCP Tribal health programs have provided education to health care providers about cancer survivorship issues from diagnosis through long-term treatment effects and end-of-life care.

#### **Target:**

By the year 2023, 45% of collaborating CTCCCP Tribal health programs, including CRIHB, will provide education to health care providers about cancer survivorship issues from diagnosis through long-term treatment effects and end-of-life care.

**Activities that support increased education for health care providers about cancer survivorship issues from diagnosis through long-term treatment effects and end-of-life care:**

**Ensure quality care for survivors by requiring ongoing trainings regarding cancer control and prevention.**

- ◆ Identify appropriate training modules about cancer survivorship, using resources such as the American Cancer Society, George Washington Cancer Center, and local comprehensive cancer centers.
- ◆ Training should target both cancer and non-cancer health professionals, family and community members, and support staff about cancer survivorship issues, guidelines, cultural sensitivity, palliative care and end-of-life care via online webinar training, in-person training, workshops, and facilitated sessions.
- ◆ Training should highlight the stages of cancer survivorship. For example, living with cancer, living through cancer, and living beyond cancer.

**Provide trainings on proper data collection of cancer diagnoses, common cancers, and patient survival rates to inform educational sessions.**

- ◆ Partner with CRIHB's Health Systems Development Department, IT, and CTEC to identify proper data collection and sharing methods.

**Collaborate with local cancer survivors to share their experiences of their journey through cancer.**

- ◆ Partner with community champions and survivors to educate local providers, wellness center staff, and other Tribal members for improving quality of life.

## Establish clinical practice guidelines for each stage of cancer survivorship.

# 3

### Activities to support the use of clinical practice guidelines for each stage of cancer survivorship:

#### Implement clinical practice guidelines that improve cancer survivorship through the stages of cancer survivorship. Guidelines can vary based on the cancer type.

- ◆ Identify provider champions to support the implementation of clinical practice guidelines.
- ◆ Collaborate with local cancer survivors to consult in establishing clinical practice guidelines that meet their needs.
- ◆ Identify the number of cancer diagnoses, common cancers, and patient survival rates, needs, and priorities to inform the development of survivorship guidelines.

#### Partner with medical directors, physicians, and Tribal health boards to establish holistic, spiritual, and culturally sensitive guidelines for each stage of cancer survivorship.

- ◆ Guidelines should focus on the survivors' needs. Guidelines should address recurrence, care coordination, screening for secondary cancers, and assessing the survivor's physical and psychological state.
- ◆ Treatment options to consider should include access to therapies, including holistic and spiritual care, access to clinical trials, alternative therapies to manage side effects of treatment, medication management, as well as emotional and financial support.
- ◆ Guidelines should focus on team-based care and collaboration with referral agencies, oncology centers, behavioral health programs, and statewide comprehensive cancer centers to monitor survivors after treatment.

#### Current Measure:

20% of collaborating CTCCCP Tribal health programs have implemented the use of clinical practice guidelines for each stage of cancer survivorship.

#### Target:

By the year 2023, 45% of collaborating CTCCCP Tribal health Programs will use clinical practice guidelines for each stage of cancer survivorship.



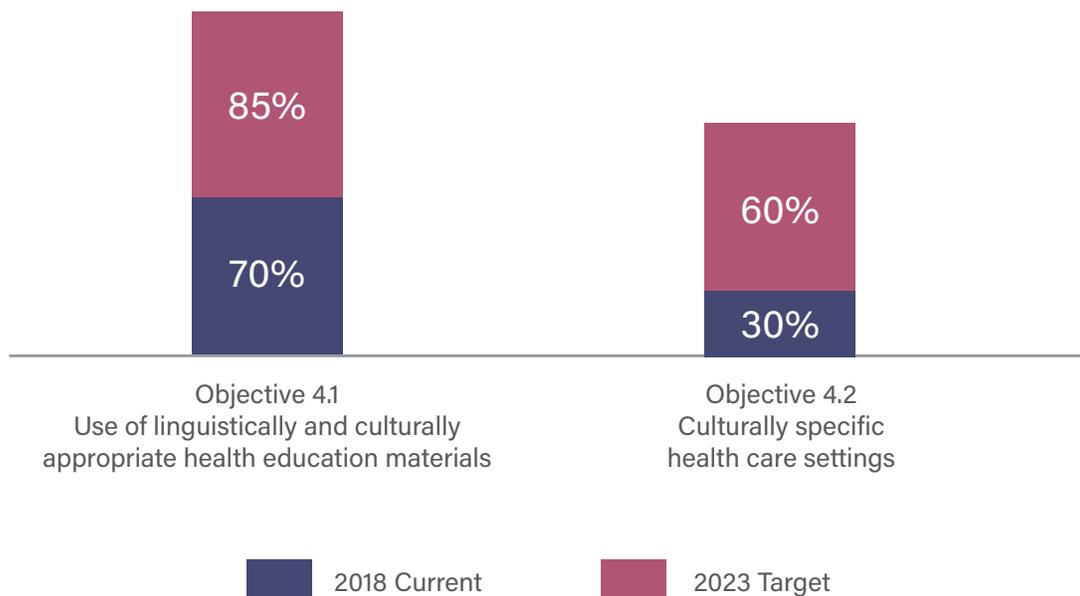
## Objective 4 - Promoting Cancer Health Equity

**TARGET:** *By 2023, increase the percentage of access to quality care for all, but especially underserved populations.*

### Objective 4:

**Increase the percent of the population with a regular health care provider.**

### Objective 4: Increase Access to Quality Care for All



### Two strategies to complete Objective 4:

**1**

Use of linguistically and culturally appropriate health education materials to promote health equity.

**2**

Culturally specific health care settings to promote health equity.

# 1

## Use of linguistically and culturally appropriate health education materials to promote health equity.

**Activities to support the use of linguistically and culturally appropriate health education materials to promote health equity:**

**Collaborate with medical directors, physicians, and Tribal health boards to establish the use of linguistically and culturally appropriate health education materials.**

- ◆ Use of community champions, health care providers, and support staff to share and distribute materials at the Tribal health program, community, and health fair events.

**Design culturally relevant health education materials that promote health equity.**

- ◆ Materials should be designed to include the local cultural practices, relevant to the Tribal population.
- ◆ Materials should reflect statistical data that is relevant to the community.
- ◆ Materials should include cultural, holistic, and spiritual health practice alternatives.

**Develop digital media and stories of cancer survivors in the community sharing their survivorship journey.**

- ◆ Collaborate with survivors, family members, caregivers, and other support systems who have worked through the stages of cancer survivorship to develop AIAN specific media campaigns.

### Current Measure:

70% of collaborating CTCCCP Tribal health programs have implemented activities to increase access to linguistically and culturally appropriate health education materials to promote health equity.

### Target:

By the year 2023, 85% of collaborating CTCCCP Tribal health programs will implement activities that increase access to linguistically and culturally appropriate health education materials to promote health equity.

*Promote the use of AIAN specific health education materials among all Tribally operated establishments.*

## 2 Create culturally specific healthcare settings to promote health equity.

### Current Measure:

30% of collaborating CTCCCP Tribal health programs have implemented the use of small media to increase community demand for cancer screening services.

### Target:

By the year 2023, 60% of collaborating CTCCCP Tribal health programs will implement the use of small media to increase community demand for cancer screening services.

**Activities to support culturally specific health care settings that promote health equity:**

**Provide ongoing education to health care providers on cultural, holistic, and spiritual practices of the Native community.**

- ◆ Identify local community members, champions, elders, or Tribal leaders that maintain the use of traditional practices.
- ◆ Develop culturally relevant trainings by collaborating with local community members, champions, elders, or Tribal leaders to share their knowledge of cultural, spiritual, and holistic practices pertinent to the community.
- ◆ Collaborate with traditional healers, spiritual, and church-based educators to lead presentations with health care staff on cultural practices.

**Encourage health care providers and support staff to inquire about the patient's beliefs.**

- ◆ Avoid stereotyping patients based on their beliefs and individualize the patient's health care while incorporating traditional Native practices.

**Encourage healthcare providers to act as champions in establishing culturally specific health care settings.**

- ◆ Involve medical directors, quality assurance coordinators, case managers, and other support staff to act as champions that are knowledgeable in cultural, holistic, and spiritual practices.



Everyone has a place in the circle  
of cancer prevention and control.  
This Cancer Plan aims to support  
AIAN cancer survivors.

**We can make a difference, and  
this difference begins with you.**



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We would like to acknowledge those  
community members and cancer survivors  
who allowed us to use their images in the  
CTCCCP Cancer Plan.

They reflect the beauty and strength of our  
Native communities.



