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# 2021 - 2025 COLORADO CANCER PLAN

THE ROADMAP TO REDUCING THE BURDEN OF CANCER IN COLORADO



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Prepared by the Colorado Cancer Coalition

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# LETTER FROM THE EXECUTIVE DIRECTOR

Cancer is the leading cause of death in Colorado. Over 23 Coloradans die a day from cancer. The Colorado Cancer Coalition exists to help bring that number to 0.

For 25 years, the Colorado Cancer Plan has guided our success in reducing the burden of cancer for all Coloradans and improving the quality of life for cancer survivors. The goals, strategies, and objectives in this new five year plan may look similar to the last plan. This is intentional, so we can more easily track progress over time.

The plan lays out a roadmap for the next five years, building on our previous success, measuring the gains we make along the way and relying on our long tradition of collaboration to reduce the impact of cancer on Colorado families. No one entity can implement this entire plan, but by working together and leveraging our resources, we can make a greater impact and see faster gains in eliminating the burden of cancer in Colorado.

The 2021-2025 Colorado Cancer Plan provides a clear set of goals, objectives and strategies across the cancer continuum of care: prevention, screening and early detection, treatment and survivorship. It calls for addressing the risk factors for cancer by reducing obesity and tobacco use, improving air and water quality, and integrating health systems to improve quality of care and survivorship.

**Everyone can make a difference in improving the lives of all Coloradans touched by cancer.**

Thank you to those who have taken the time to get screened for cancer, participate in a clinical trial, support a friend through treatment, or celebrate remission and survivorship with loved ones. And I thank the more than 100 experts across Colorado who generously gave their time, knowledge and passion to develop this plan.

Working together as we have for the past 25 years, we can use this new plan to continue to reduce the burden of cancer on all Colorado families.

*Christi Cahill*

Colorado Cancer  
Coalition, Executive Director



## THIS IS A LIVING PLAN

In the coming weeks, you will see new web content with measures, priorities and a partner map to show who is implementing the cancer plan all across the state.

Stay tuned here for the latest updates: <https://www.coloradocancercoalition.org/colorado-cancer-plan/>

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# COLORADO CANCER PLAN AT A GLANCE

1

**PREVENTION**

Decrease tobacco use among youth and adults

2

**PREVENTION**

Increased prevalence of healthy behaviors

3

**PREVENTION**

Increased uptake of clinical interventions to prevent cancer

4

**PREVENTION**

Decreased environmental exposures that lead to cancer

5

**SCREENING & EARLY DETECTION**

Increased high quality cancer screening and early detection rates

6

**TREATMENT**

Consistent access to quality diagnostic and treatment services adherent with nationally recognized standards

7

**TREATMENT**

Increased participation in high quality clinical trials

8

**SURVIVORSHIP AND END-OF-LIFE**

Improve physical, mental, emotional, behavioral, and financial well-being among people affected by cancer

9

**CROSS-CUTTING**

Increased Patient Engagement and Health Literacy

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## FIND US ONLINE



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[@CoCancerFund](https://twitter.com/CoCancerFund)



[@ColoradoCancerCoalition](https://www.instagram.com/ColoradoCancerCoalition)

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# ACKNOWLEDGEMENTS

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## Cancer Plan Revision Steering Committee, Core Members

**John Arend**, Colorado Department of Public Health and Environment, Cancer Registry  
**Rebecca Daniels**, San Luis Valley Health  
**Tami Ford**, Survivor and Advocate  
**Nichol Huckins**, UC Health  
**Shannon Lawrence**, Colorado Department of Public Health and Environment, Cancer Evaluator  
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**Sandy Priester**, LifeSpark Cancer Resources  
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**Peggy Thomas**, Penrose Cancer Center  
**Christine Weber**, Survivor and Advocate

*In memoriam and with gratitude, Dennis Ahnen*

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## Cancer Plan Revision First Round Reviewers and Contributors, continued

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**Stephanie Wasserman**, Immunize Colorado



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Thank you to the 2020 Colorado Cancer Coalition Leadership Team and Steering Committee for providing guidance and subject matter expertise for the plan.

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## HPV Vaccination Task Force Members

**Co-Chair: Heather Deis**, University of Colorado - Children's Hospital

**Co-Chair: Jennifer Lansing**, Colorado Department of Public Health and Environment

## Survivorship and Palliative Care Task Force Members

**Co-Chair: Carlin Callaway**, University of Colorado Cancer Center

**Co-Chair: Jeanice Hansen**, Steps Through OC

## Lung Cancer Task Force Members

**Co-Chair: James Fenton**, National Jewish Health

**Co-Chair: Tim Kennedy**, Retired Pulmonologist

**Co-Chair: Morgan Shan**

## Colorado Cancer Coalition Leadership

**Christi Cahill**, Colorado Cancer Coalition

**Allie Bain**, American Cancer Society

**Andrea (Andi) Dwyer**, University of Colorado Cancer Center

**Debra Dyer**, National Jewish Health

**Becky Selig**, Colorado Department of Public Health and Environment



## ABOUT THE COLORADO CANCER COALITION

We are the statewide, nonpartisan, multidisciplinary, coalition providing education, networking, best practice sharing, and partnership opportunities for those working in oncology care and support. We are committed to providing a neutral space for dialogue from diverse perspectives to further improve cancer outcomes in Colorado.

In addition, we support the needs of Coloradans to prevent cancer, detect cancer early, and enhance quality of life for survivors and their caregivers by disseminating education, cancer resources, and connecting patients and their caregivers to opportunities to advocate for better cancer outcomes in Colorado.

### MISSION

To engage, facilitate, expand and strengthen the statewide network dedicated to improving Colorado lives touched by cancer.

### VISION

Eliminate the cancer burden in Colorado

## OBJECTIVES

Objectives to implement the 2021-2025 Cancer Plan

- Strengthen and expand the statewide network of cancer stakeholders
- Promote and implement strategies that aid in the prevention of cancer
- Enhance and increase screening and early detection of cancer
- Educate and support efforts for high quality diagnosis and treatment of cancer, including cancer clinical research
- Promote and strengthen clinical and community approaches to cancer survivorship, including palliative and end-of-life care
- Eliminate barriers across the continuum of cancer prevention and care

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# INTRODUCTION



The Colorado Cancer Plan has guided the prevention, treatment and control of cancer statewide for more than 25 years. The 2021-25 state cancer plan continues in that tradition, providing a five-year framework to reduce the risk, incidence and mortality associated with cancer in Colorado. This plan represents a shared approach to overcoming Colorado's cancer challenges through primary prevention, early detection, effective treatment and support for survivors from the time of diagnosis until the end of life.

This five-year plan is built on a strong foundation. It describes the state's cancer burden, including the disparate impact cancer has on Colorado's low-income, uninsured and racial/ethnic populations. It paints a picture of a state health care climate conducive to reducing that burden, building on the contributions and opportunities from health care reform and the challenges from COVID-19. And it traces the history of cancer control in Colorado and the evolution of the collaborative statewide efforts to reduce the impact cancer has on Coloradans.

The process for developing the state's cancer plan relied on contributions from individuals across Colorado, support from the U.S. Centers for Disease Control and Prevention (CDC) National Comprehensive Cancer Control Program (NCCCP), and the expertise and commitment of state and local health agencies. This plan challenges Colorado's cancer community to think strategically about new partnerships and collective efforts to expand the plan's reach and effectiveness.

Effective collaboration starts with common goals, objectives and measures. The plan's objectives are organized along the cancer continuum of care rather than by type of cancer. It is not a detailed action plan, but rather a roadmap of broad goals, specific objectives, and evidence-based strategies organized into these five areas of focus:

- **Prevention:** Encourage healthy behaviors and a less harmful environment to lower the risk of cancer.
- **Screening:** Promote the benefits and increased coverage of appropriate screening tests to ensure early and effective diagnosis.
- **Diagnosis and Treatment:** Reduce the barriers to early diagnosis and treatment, ensure best practices and encourage participation in clinical trials.
- **Survivorship And End-Of-Life Care:** Ensure services and resources necessary to support the continued physical and mental health of a growing number of cancer survivors.
- **Cross-Cutting:** Support the integration and training of patient navigators and community health workers and promote awareness of available insurance coverage.

Cancer has an impact on all Coloradans. The Colorado Cancer Coalition recommends the Colorado Cancer Plan as a roadmap to preventing and controlling cancer. All Coloradans are touched by cancer. By working together we can reduce the burden of cancer in our state and make sure Colorado is the healthiest state in the nation.

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# COLORADO CANCER BURDEN



In order to outline a comprehensive strategy for tackling cancer in Colorado, it was important for the collaborators behind the plan to identify the parameters of the problem and note critical Colorado-specific patterns in the incidence, prevalence, mortality and underlying risk factors.

The long-term goal of developing and implementing a state cancer plan is to reduce the incidence and mortality of cancer in Colorado. We have identified state trends in risk factors, cancer prevalence and mortality. Colorado Cancer Plan objectives and strategies target risk factors, cancer screening behaviors, access to public or private health insurance, and systemic and individual support for cancer survivors and their family members. By implementing these and related strategies over time, we will reduce the burden of cancer in Colorado.

## ENVIRONMENTAL AND GENETIC RISK FACTORS

Lifestyle, genetic and non-genetic factors, independently or in combination, can increase an individual's risk of developing cancer. Changes in lifestyle, including reduction in tobacco use, modification of the diet to reduce fat and increase fiber consumption, and clinical interventions such as immunizations or removing a polyp during a colonoscopy, can significantly reduce mortality from some cancers. Reductions in cancer incidence achieved through risk factor interventions may also reduce cancer morbidity and mortality. State cancer data (1) reveal the following risk factors that impact the burden of cancer in Colorado:

- Tobacco use: 13.9 percent of adults in Colorado are current smokers (2019).
  - 18.6 percent of adults in Colorado used e-cigarettes, cigarettes, or smokeless tobacco in the past 30 days (2019).
- HPV Immunizations: 75.6 percent of adolescent males and 85.1 percent of adolescent females have received at least one dose of HPV vaccine (2019).
  - 56.9 percent of adolescent males and 70.0 percent of adolescent females have received three doses of HPV vaccine (2019).
- Radon: 45.9 percent of adults have tested their home for radon (2016).
- Genetics: 5-10 percent of cancers are associated with a genetic disposition.
- Age: An estimated 55 percent of new cancer cases occur in those over 65. Colorado's median age increased from 26.2 in 1970 and to 37.1 in 2019.
- Poverty: 9.3 percent of Coloradans lived in poverty in 2019.
- Age and Poverty: Only 60.5 percent of 50-74 year olds in poverty (<250%FPL) were up to date with colorectal cancer screening guidelines (2018).

(1) Colorado Central Cancer Registry



# INCIDENCE



In 2018, 24,916 Coloradans were diagnosed with cancer. While state and national incidence rates have decreased since 1992, Colorado continues to have lower incidence and mortality rates than the national average. The incidence of cancer varies by gender, race/ethnicity and type of cancer, as noted in the data below. The data suggest that strategies may need to be tailored to appropriately address variations in need across different groups in the state.

## GENDER

Men have a higher incidence rate of cancer (414.3 per 100,000) than women (385.2 per 100,000), except for lung cancer, where the gap in incidence between men and women has narrowed in recent years.

## RACE

Black men (422.4 per 100,000) had the highest cancer incidence rate, followed in order by White men (409.3 per 100,000), White women (387.6 per 100,000), Black women (324.0 per 100,000), Asian/Pacific Islander women (269.0 per 100,000), Asian/Pacific Islander men (265.9 per 100,000), American Indian/Native Alaskan men (219.0 per 100,000), and American Indian/Native Alaskan women (231.8 per 100,000).

- The incidence of breast cancer was significantly higher in White women (129.6 per 100,000) than that for Black women (107.9 per 100,000), Asian/Pacific Islander women (83.0 per 100,000), and American Indian/Native Alaskan women (69.3 per 100,000).
- The lung cancer incidence was highest among Black men (49.3 per 100,000) followed by White men (42.4 per 100,000), White women (38.4 per 100,000), Asian/Pacific Islander men (38.4 per 100,000), American Indian/Native Alaskan men (36.9 per 100,000), Black women (33.3 per 100,000), Asian/Pacific islander women (31.1 per 100,000), and American Indian/Native Alaskan women (27.5 per 100,000).
- The incidence of prostate cancer in Black men (135.7 per 100,000) is significantly higher than that for White men (86.9 per 100,000), Asian/Pacific Islander men (49.1 per 100,000), and American Indian/Native Alaskan men (29.3 per 100,000).
- Colorectal cancer incidence was highest among Black men (40.0 per 100,000) followed by Asian/Pacific islander men (35.5 per 100,000), White men (35.3 per 100,000), Black women (34.2 per 100,000), White women (28.4 per 100,000), American Indian/Native Alaskan men (24.0 per 100,000), Asian/Pacific Islander women (23.4 per 100,000), and American Indian/Native Alaskan women (20.5 per 100,000).

# INCIDENCE



## ETHNICITY

Non-Hispanic men (420.5 per 100,000) had the highest cancer incidence rate, followed in order by non-Hispanic women (390.3 per 100,000), Hispanic women (349.6 per 100,000), and Non-Hispanic men (348.6 per 100,000).

- The incidence of breast cancer in non-Hispanic women (132.4 per 100,000) was significantly higher than that for Hispanic women (102.3 per 100,000).
- The lung cancer incidence was highest among non-Hispanic men (43.3 per 100,000) followed by non-Hispanic women (39.1 per 100,000), Hispanic men (36.0 per 100,000), and Hispanic women (32.3 per 100,000).
- The incidence of prostate cancer in non-Hispanic men (94.5 per 100,000) was significantly higher than that for Hispanic men (66.9 per 100,000).
- Colorectal cancer was diagnosed in Hispanic men (41.1 per 100,000) significantly more than in non-Hispanic men (35.5 per 100,000), Hispanic women (30.8 per 100,000), and White non-Hispanic women (28.8 per 100,000).

# PREVALENCE

## **Nearly 315,000 Coloradans are alive with active cancer or a history of cancer.**

Of those recently diagnosed, 67 percent are expected to live five years or longer, greater than the 63 percent survival rate for those diagnosed during 1996-2000. Survival improvements are especially noteworthy for those persons diagnosed in later stages when comparing rates from 1996-2000 and 2011-2015: Regional stage survival increased from 62 percent to 71 percent and distant stage survival climbed from 21 percent to 32 percent.

However, survival varies substantially for different types of cancers. For those diagnosed between 2011 and 2015, 91 percent of men with prostate cancer survived five years or more, while 91 percent of women with breast cancer survived at least that long. Only 53 percent of women with ovarian cancer survived five years or longer. Colorado's cancer survival rates have improved consistently since the state began developing and implementing cancer plans; however, more work is still needed and the plan highlights opportunities to further improve survivorship data.

# MORTALITY



Cancer has been the leading cause of death in Colorado since 2004. In 2019, there were 7,970 cancer deaths in Colorado, for a mortality rate of 123.9 per 100,000. From 2015-2019, lung, colorectal and breast were the leading causes of cancer death in Colorado.

There are racial differences as well, with Blacks having higher cancer mortality rates than non-Hispanic, and Hispanics having lower cancer mortality rates than non-Hispanic. For specific cancer sites, there also are gender and racial differences.

## **Lung cancer, 2015-19**

- Hispanic women (16.5 per 100,000) had a significantly lower mortality rate than non-Hispanic women (23.5 per 100,000).
- Black men (38.0 per 100,000) had a higher mortality rate than all other races .
- Hispanic men (23.2 per 100,000) had a lower mortality rate than non-Hispanic men (28.2 per 100,000).

## **Colorectal cancer, 2015-19**

- Black men (19.3 per 100,000) had a higher mortality rate than all other races.
- Hispanic men (16.3 per 100,000) had a higher mortality rate than non-Hispanic men (12.5 per 100,000).

## **Prostate cancer, 2015-19**

- Black men (41.6 per 100,000) had a significantly higher mortality rate than all other races.
- Hispanic men (17.5 per 100,000) had a lower mortality rate than non-Hispanic men (20.9 per 100,000).

## **Breast cancer, 2015-19**

- Black women (24.0 per 100,000) had a higher mortality rate than all other races.
- Hispanic women (16.2 per 100,000) had a lower mortality rate than non-Hispanic women (18.7 per 100,000)

The reasons for these variations in outcomes by race, gender, and ethnicity are complex. Understanding the factors that create these disparities allows implementers of the cancer plan to target interventions that can improve survival and narrow outcome gaps.

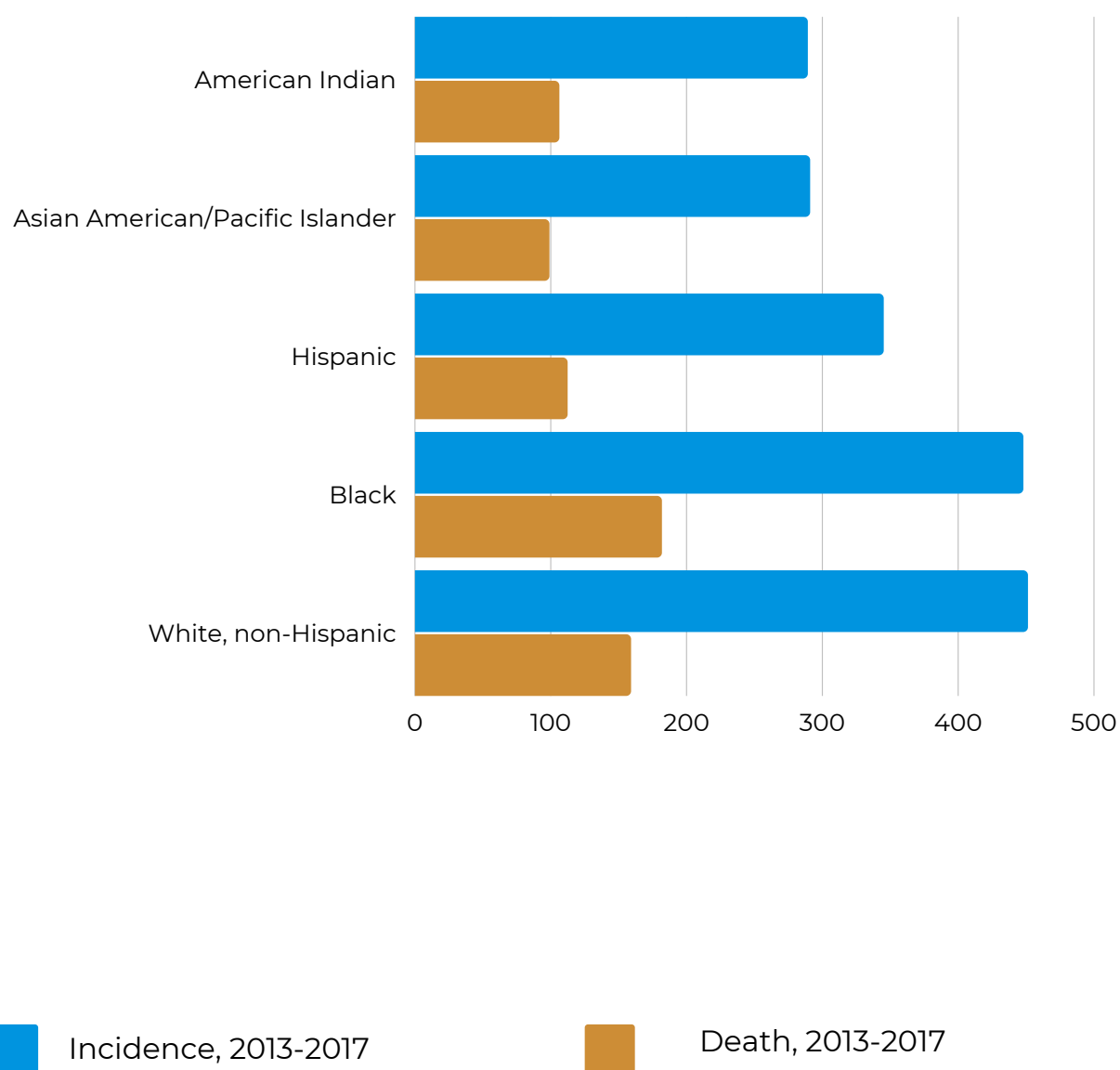
# MORTALITY



## FIGURE 1: INCIDENCE AND MORTALITY - 2013-2017 BY RACE/ETHNICITY

Colorado Five-Year Annual Average, Age-Adjusted Incidence and Death Rates by Race/Ethnicity

Figure 1 illustrates age-adjusted incidence and death rates by race/ethnicity. Based on a five year annual average, **Blacks have the highest death rate and the second highest incidence rate.**



Source: Colorado Central Cancer Registry (2013-2017)

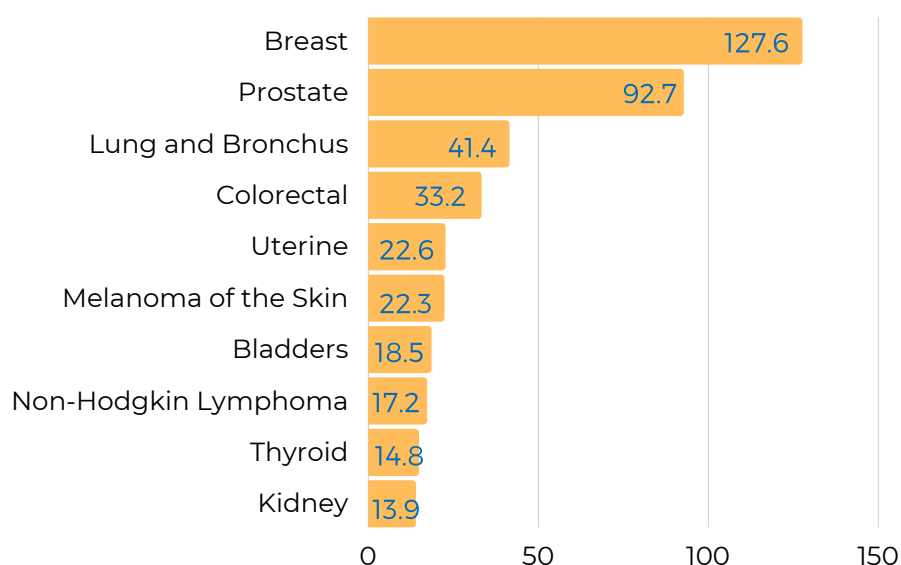


# TOP CANCERS IN COLORADO

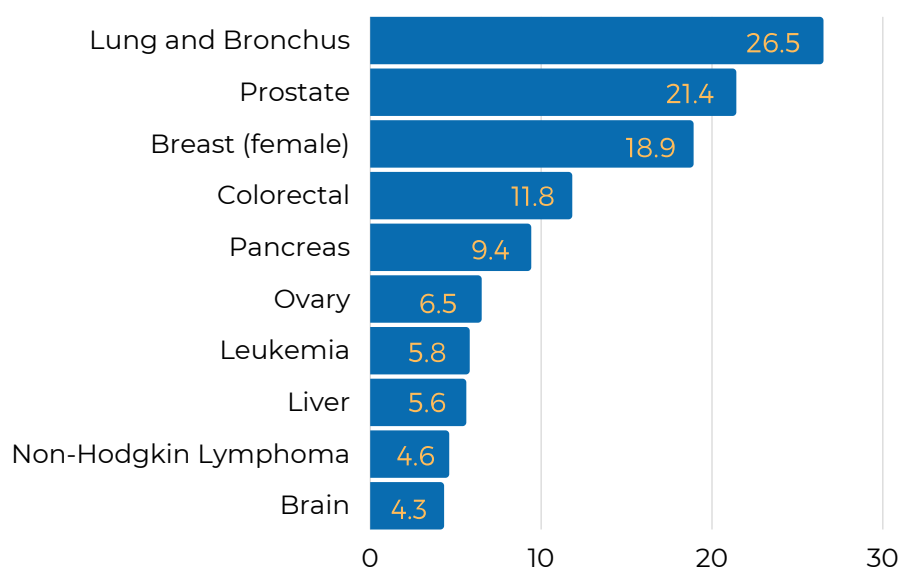


Table 1 lists the top 10 cancer sites by incidence (2013-2017) and mortality (2014-2018). Four cancers in particular - lung, colorectal, breast and prostate - are the most common cancers and the most lethal.

## BY INCIDENCE RATE, 2013-2017



## BY DEATH RATE, 2014-2018



Source: [ACS Cancer Statistics Center](https://seer.cancer.gov/statistics/html/totals)

# HEALTH EQUITY



Health disparities persist in Colorado. Poverty and race affect where people live and work, the toxins to which they are exposed and their levels of chronic stress from the daily struggle of living with systemic injustice. Coloradans in poverty are less likely to have access to healthy foods, physical activity and affordable health care. Socioeconomic status, race/ethnicity and gender are important factors in determining the relationship between cancer risk and outcomes.

Poverty is an important contributor to the racial/ethnic disparities evident in the burden of cancer, which is unsurprising because racial/ethnic minority groups in Colorado bear a disproportionate burden of poverty as well (Cancer and Poverty: Colorado 2001–2012). Because of this disparity, poverty, race and ethnicity constitute important risk factors for cancer incidence, stage of diagnosis and mortality. In 2019, only 7.0 percent of non-Hispanic whites lived in poverty, compared to 8.2 percent of Asian/Pacific Islanders, 18.1 percent of American Indian/Alaska Natives, 19.7 percent of Blacks, and 14.3 percent of Hispanics (1). The relationships between poverty and cancer emerge from the differences between socioeconomic groups in their use of tobacco, screening for cancer and access to appropriate cancer treatment.

- For most cancers, Coloradans who lived in poorer neighborhoods and were uninsured were more likely to have had a more advanced stage of cancer at the time of diagnosis.
- Cancers among those younger than 65 years were more likely to be diagnosed early in those with private insurance compared to those who had no insurance or Medicaid.
- For most cancers, Coloradans who lived in poorer neighborhoods were more likely to die within the first five years following cancer diagnosis.

Improvements in health equity emerge when paths that lead to good health are equally available to all. The objectives in the cancer plan focus on removing barriers that stand in the way of preventing cancer, getting high- quality and timely screenings, having access to the right treatment and receiving the right care and support during treatment and survivorship.



The ACS has health equity resources to help guide cancer plan implementation activities.

**MORE INFO**



(1) 2008-2019 American Community Survey, 1-Year Estimates

# AFFORDABLE CARE ACT IMPLICATIONS

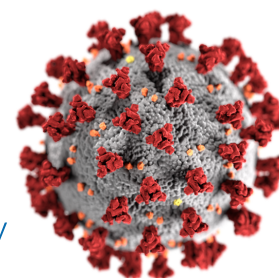


While the Affordable Care Act (ACA) expanded health care coverage under private insurance and Medicaid and removed the pre-existing conditions policies, there are still significant financial obstacles and barriers. According to the Colorado Health Institute's (CHI) 2019 Health Access Survey, there are still 6.5% of Coloradans who are uninsured, which is statistically unchanged since 2015 after the Affordable Care Act (ACA) took effect. And while 97% of children in Colorado were insured in 2017 that number has started to drop, particularly with Hispanic/Latinx children, who's uninsured rate dropped from 2.4% in 2017 to 7.9% in 2019.

Additionally, cost, financial obstacles and medical debt continue to be a barrier for insured Coloradans. CHI's Health Access Survey found that despite being insured, many still don't seek care due to costs.

Approximately, 11.1% of employer-sponsored enrollees, 15.7% of individual enrollees, 7.5% of Medicare enrollees and 14.9% of Medicaid enrollees did not get specialist care in 2019 due to cost.

## COVID-19 IMPACT



In March 2020, the United States government declared a national emergency as an attempt to slow the spread of COVID-19. As states announced stay-at-home orders and health systems prioritized combatting the pandemic, many medical providers across the country immediately halted most "non-essential" care, including cancer screening and some cancer treatments (1). Patients postponed or were unable to access clinically recommended age-determined screening tests that diagnose cancer when it is most treatable. The impact was immediate. By spring 2020, screening tests for breast, lung and colon dropped, respectively, by: 87%, 39%, and 90%.

Adding to the delays and cancellations experienced across the country, the COVID-19 pandemic created a staggering loss of employment and associated loss of employer-sponsored health insurance. An estimated 14.6 million Americans (2) lost their health insurance in summer 2020 due to COVID-related job loss, further preventing adherence to recommended screening guidelines. Cancer screening rates among the uninsured are typically 40-50% lower than the insured.

The National Cancer Institute conservatively estimates that we may see 10,000 additional preventable cancer deaths across the U.S. from breast and colorectal cancer alone due to COVID-related screening delays.

\*Thank you to the American Cancer Society for contributions to this section.\*

(1) <https://www.cms.gov/newsroom/press-releases/cms-releases-recommendations-adult-elective-surgeries-non-essential-medical-surgical-and-dental>

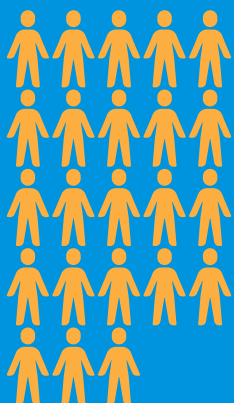
(2) <https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/how-many-lost-jobs-employer-coverage-pandemic>

# 2021 by the numbers

**28,630**  
new cases  
expected

.....

**8,420**  
deaths  
expected



That is **23**  
Coloradans  
a day

## Colorado Cancer Plan: The History



**1996**

Colorado's first five  
year Cancer Plan is  
published



**1998**

CDC established the National  
Comprehensive Cancer Control  
Program (NCCCP) to support states'  
efforts to achieve their cancer goals  
and implement evidence-based  
strategies



**2000**

Goals for the year  
2010 were  
established



**2004**

Amendment 35 Passed

Tobacco tax revenue from  
Amendment 35 supports  
preventive health and  
education initiatives

**2005**

Updated 2005-  
2010 Colorado  
Cancer Plan  
published

**2010**

Updated 2010-2015  
Colorado Cancer  
Plan published

**Colorado  
Cancer Plan**

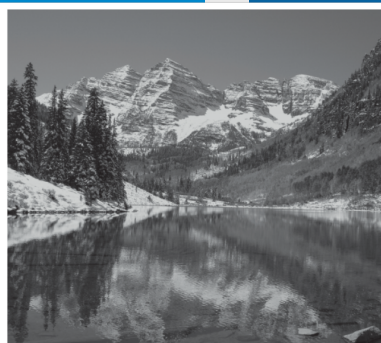
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**2016**

Updated 2016-2020  
Colorado Cancer Plan  
published

**2021-2025**

Current Version of  
Colorado Cancer  
Plan



2016 - 2020  
**COLORADO  
CANCER PLAN**

The Roadmap to Reducing the Burden of Cancer in Colorado





# THE COLORADO CANCER PLAN PROCESS



The 2021-2025 Colorado Cancer Plan revision process took place over two years, from May 2019 through June 2021. It was designed to gather feedback from cancer stakeholders at multiple points in time for the purpose of developing and refining a comprehensive plan. A cancer plan steering committee oversaw the revision and made recommendations and decisions regarding the plan's structure, format, content and timeline.

The Cancer Plan Revision Committee (CPRC) was formed to help determine and oversee the revision process. The Colorado Cancer Coalition task forces (colorectal, lung, skin, HPV vaccination, and survivorship & palliative care) and 26 other identified subject matter experts and teams from around the state reviewed the 2016-2020 goals, objectives, and strategies to determine and ensure that they still accurately capture the work needed to reduce the burden of cancer in Colorado and made recommendations for revisions, as necessary. Once the first round of revisions were completed, the draft plan was shared for public comment. During this time, approximately 60 comments from 12 individuals and organizations were submitted and additional revisions were made. The final plan contains 9 goals and 28 objectives.



Although the reasons for declining cancer rates over the years are multifaceted, **efforts guided by the Colorado Cancer Plan have played an integral part in this progress.** The 2021-2025 Colorado Cancer Plan is intended as a framework for continued improvements by the year 2025 and grows from the long and successful history of cancer control in Colorado.

# CANCER DATA

## SMART GOALS AND PRIORITIZATION

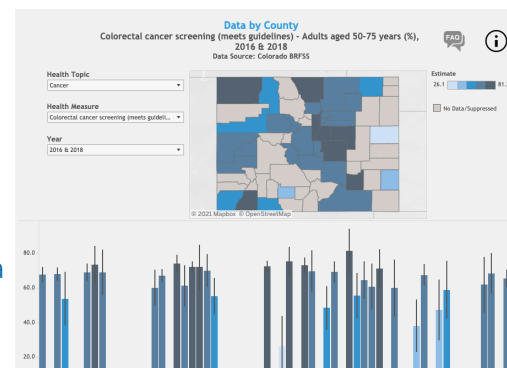


The 2021-2025 Colorado Cancer Plan is grounded in evidence and provides a roadmap to reduce the burden of cancer in Colorado. As you identify the strategy(ies) you will implement, it is important to ask the following questions:

- **WHAT** are we going to do?
- **WHY** is it important for us to accomplish this activity?
- **WHO** is going to be responsible for the activities?
- **WHEN** do we want this to be completed?
- **HOW** are we going to do these activities?

Once you have answered the questions listed above, use data to define your SMART objectives to move those ideas into action. SMART objectives are:

- **Specific:** Concrete, detailed, and well defined so that you know where you are going and what to expect when you arrive
- **Measureable:** Numbers and quantities provide means of measurement and comparison
- **Achievable:** feasible and easy to put into action
- **Realistic:** Considers constraints such as resources, personnel, cost, and time frame
- **Time-Bound:** A time frame helps to set boundaries around the objective



## DATA SOURCES AND RESOURCES

Data for assessing burden, setting measurable SMART objectives, and subsequently evaluating progress generally draws from consistently collected and reported sources.

- [All Payer Claims Database \(APCD\)](#): Claims data from commercial health plans, Medicare and Medicaid, with the first submission of claims data in June 2012. The purpose of the database is to allow for assessment of variations in health care cost and use.
- [The Attitudes and Behaviors Survey \(TABS\) on Health](#): A population-level survey of Colorado adults to identify and understand influential public health factors. It is administered every 3–4 years to 12,000 to 18,000 randomly selected adults to collect data on ongoing chronic diseases and health risks.
- [Behavioral Risk Factor Surveillance System \(BRFSS\)](#): An annual telephone survey that collects data about health-related behaviors, chronic health conditions and use of preventive services.
- [COHID \(Colorado Health Information Dataset\)](#): Provides access to state and local-level data and resources compiled by the Colorado Department of Public Health and Environment to help understand health and related issues affecting people in Colorado. Cancer incidence and mortality statistics can be found here by cancer type, age, sex, race, county, and other factors.
- [Colorado Central Cancer Registry \(CCCCR\)](#): The statewide cancer surveillance program that collects and reports data on cancer incidence and mortality, including type, stage at diagnosis and five-year survival rates.

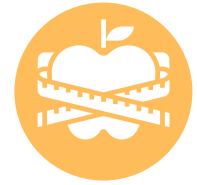
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## DATA SOURCES AND RESOURCES, CONTINUED



- [Colorado Child Health Survey \(CCHS\)](#): Designed to fill the health data gap in Colorado that exists for children ages 1–14, administered to BRFSS responding adults with a child in this age range.
  - [Colorado Environmental Public Health Tracking Network \(COEPHT\)](#): A web-based surveillance system designed to provide easily accessible data on environmental hazards, exposures and health effects.
  - [Colorado Health Access Survey \(CHAS\)](#): A statewide telephone survey that collects data on health insurance coverage, access to health care and use.
  - [County Health Rankings & Roadmaps](#): Snapshot of how health is influenced by where we live, learn, work, and play.
  - [Healthy Kids Colorado Survey \(HKCS\)](#): A single, comprehensive, biannual survey system to measure youth health behaviors in Colorado.
  - [National Cancer Institute \(NCI\) State Cancer Profiles](#): A system to characterize the cancer burden in a standardized manner in order to motivate action, integrate surveillance into cancer control planning, characterize areas and demographic groups, and expose health disparities. The focus is on cancer sites for which there are evidence based control interventions. Interactive graphics and maps provide visual support for deciding where to focus cancer control efforts.
  - [National Immunization Survey \(NIS\) Teen and Children](#): An annual national survey used to monitor vaccine coverage in relation to the Advisory Committee on Immunization Practices for children 6 months to 17 years (including Hepatitis B and HPV). The NIS consists of two parts, a phone survey for parents and a questionnaire for providers of the phone respondent's children to collect vaccination records.
  - [Palliative Care in Colorado: Trends, Gaps, and Opportunities to Improve Care](#): A multi-stakeholder effort to re-evaluate the state of Palliative Care in Colorado. This is the third version of this report and is intended to give a picture of the availability of Palliative Care Services throughout Colorado, as well as other key factors to help state-wide Palliative Care efforts. The survey was performed by Hospice Analytics with financial support from CDPHE, the Department of Health Care Policy and Finance (HCPF), and American Cancer Society Cancer Action Network.
  - [PLACES Data Portal](#): A collaboration between CDC, the Robert Wood Johnson Foundation, and the CDC Foundation, allows local health departments and jurisdictions regardless of population size and urban-rural status to better understand the burden and geographic distribution of health-related outcomes in their areas and assist them in planning public health interventions.
  - [United States Cancer Statistics Data Visualization Tool](#): The official federal cancer statistics from combined cancer registry data collected by CDC's National Program of Cancer Registries and the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program. These data are used to understand cancer burden and trends, support cancer research, measure progress in cancer control and prevention efforts, target action on eliminating disparities, and improve cancer outcomes for all.
  - [VISION \(Visual Information System for Identifying Opportunities and Needs\)](#): Provides access to chronic disease measures (including cancer) in Colorado by trend, county, health statistics region, risk factors, and demographics.
-

# PREVENTION

**1**

**DECREASE TOBACCO  
USE AMONG YOUTH &  
ADULTS**

**2**

**INCREASED  
PREVALENCE OF  
HEALTHY BEHAVIORS**

**3**

**INCREASED UPTAKE  
OF CLINICAL  
INTERVENTIONS TO  
PREVENT CANCER**

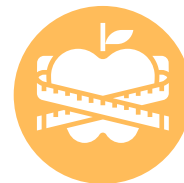
**4**

**DECREASED  
ENVIRONMENTAL  
EXPOSURES THAT  
LEAD TO CANCER**

Prevention continues to be one of the best tools in the fight against cancer. Individual behaviors, system improvements and state and local policy changes have made, and will continue to make, an impact on cancer prevention and control. Avoiding tobacco, eating well, exercising, maintaining a healthy weight, practicing sun safety, and reducing or avoiding exposure to carcinogens can lower a person's cancer risk. Discussing the history of cancer in one's family with a doctor can guide screening recommendations and referrals to genetic counseling. These ideas form the first four goals of the new state cancer plan.



# GOAL 1: DECREASE TOBACCO USE AMONG YOUTH AND ADULTS



## OBJECTIVE 1.1: Reduce initiation and use of tobacco products.

1. Implement evidence-based interventions to restrict minors' access to tobacco products and to reduce tobacco-related disparities among populations targeted by the tobacco industry, including tobacco retail licensing ordinances, restricting advertising of tobacco products and restricting the sale of menthol cigarettes and other flavored tobacco and nicotine products.
2. Increase the purchase price of all tobacco products, including electronic smoking devices and other nicotine products, restrict tobacco product couponing and other retailer and manufacturer-level price discounts. Protect the local authority to implement tobacco price increases and other tobacco control strategies.
3. Educate adolescents and young adults on the risks of all tobacco product use, including e-cigarettes, and support positive youth development skills, targeting young people under 18 years and 18-24-year-olds. Promote equitable enforcement of tobacco control policies and promote removal of laws that penalize people for purchasing, using or possessing tobacco products.
4. Attain fully-funded comprehensive tobacco control program that meets CDC-recommended levels.

## OBJECTIVE 1.2: Decrease exposure to secondhand smoke and electronic cigarette aerosols.

1. Educate, promote local adoption of and support implementation of smoke-and-vape-free policies in high density outdoor public places and indoor workplaces that are exempt from the Colorado Clean Indoor Air Act.
2. Educate and promote local adoption of smoke/tobacco-free policies to expand protections from secondhand smoke and electronic smoking device aerosols or "vapor" in multi-unit housing settings, county and municipal properties, and organizations not covered by the Colorado Clean Indoor Air Act.
3. Integrate screening for secondhand smoke and electronic smoking device aerosols or "vapor" exposure into standard patient care, discuss the health risks of secondhand exposure, and advise patients to establish personal tobacco-free home and car environments.

# Lower Your Cancer Risk



If you are...

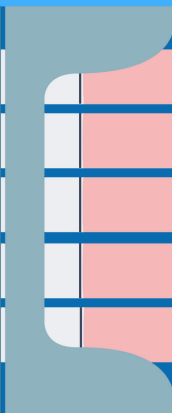


An adult between 50 to 80 years,  
have a 20 pack-year smoking history  
or currently smoke,  
or have quit within the past 15 years,  
you should get a **screening 1x year**.

## EXAMPLES

**1** x **30** = **30**  
PACK A DAY YEARS PACK-YEARS

**2** x **15** = **30**  
PACKS A DAY YEARS PACK-YEARS

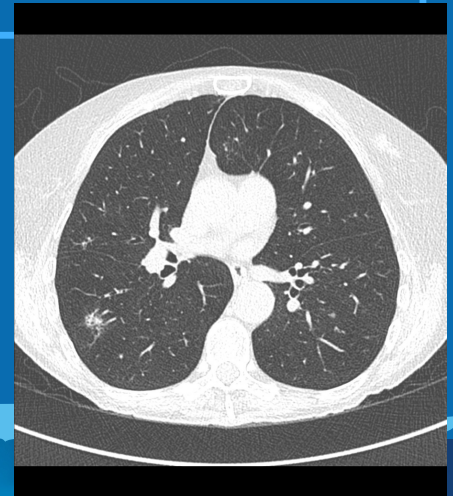


**Pack Year (PY) is used to calculate  
your risk for lung cancer  
the higher the number the more at  
risk you are**

## What is your PY?

## LOW DOSE CT SCAN

A low-dose of radiation to take pictures of  
areas inside the body



## Wanna Quit?

You can quit smoking for good and live a healthy, smoke-free life.  
Take the first step and call 1-800-QUIT-NOW for FREE support.

Free quit help:  
1-800-QUIT-NOW  
(1-800-784-8669)

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**OBJECTIVE 1.3: Promote quitting and increase successful quit attempts among people who use tobacco.**

- 1.** Institutionalize and standardize tobacco screening and evidence-based brief interventions such as Ask, Advise, Refer (AAR) or Ask, Advise, Assess, Assist and Arrange (5As).
- 2.** Implement health systems change strategies to increase access to and use of evidence-based tobacco treatments, including the QuitLine, particularly among populations experiencing tobacco-related disparities.
- 3.** Implement communications strategies that promote tobacco treatment to increase quit attempts and treatment use, focusing on populations experiencing tobacco-related disparities.
- 4.** Maintain and promote comprehensive coverage of tobacco cessation treatments with no barriers.





## GOAL 2: INCREASED PREVALENCE OF HEALTHY BEHAVIORS



### OBJECTIVE 2.1: Decrease the prevalence of overweight and obesity.

1. Promote and implement policy interventions in the built environment combining new or enhanced transportation systems (e.g., pedestrian and cycling paths) with new or enhanced land use design (e.g., proximity to a store, access to a public park) to promote physical activity among residents.
2. Increase access to and participation in evidence-based weight loss programs, such as the National Diabetes Prevention Program and WW (previously called WeightWatchers).
3. Develop and implement policies and programs that protect, promote and support breastfeeding-friendly environments.
4. Improve nutrition and physical activity environments for children younger than 18 years in early care and education settings and schools, especially those that serve low-income populations. For example, support high quality health education, comprehensive physical activity and physical education, high quality school programs and family and student engagement.
5. Increase access to worksite wellness programs that implement and communicate best practices in worksite wellness activities.
6. Increase healthy food and beverage retail opportunities, particularly in rural and underserved communities, by supporting healthy product procurement, placement and pricing strategies.
7. Implement food service guidelines in worksites, schools and public/community settings to improve the food and beverages offered and sold in cafeterias, cafes, snack bars, grills, concession stands, and vending machines.
8. Promote and support policies to reduce consumption of sugary beverages.
9. Offer evidence-based exercise classes (e.g., Walk with Ease, National Diabetes Prevention Program, Active Living Everyday, SilverSneakers, Girls on the Run) and fitness program support in community centers, senior centers, fitness and community wellness centers.

**NATIONAL**  
**DIABETES**  
**PREVENTION**  
**PROGRAM**

10. Build, strengthen and maintain social networks that provide supportive relationships for behavior change through walking groups or other community-based interventions.
11. Provide patients with prescriptions for physical activity, and/or fresh fruits and vegetables, accompanied by progress checks at office visits, counseling, activity logs, and exercise testing.
12. Place point-of-decision prompts and signage on or near stairwells, elevators, and escalators that encourage stair use.
13. Increase access to and consumption of fresh fruits, vegetables and whole grains.



# BUILT ENVIRONMENT & CANCER



The built environment, or the spaces and places where we live, work, and play on a day-to-day basis, determines nearly 80 percent of our ability to be healthy (1). The design of the built environment influences air quality, substance use, diet, physical activity, and cancer screening with impacts on breast cancer, lung cancer, colorectal cancer, and overall cancer risk (2). Designing communities with built environments that reduce people's dependence on cars and increase access to parks can improve physical activity and lower levels of air pollution. Increasing opportunities in communities for people to be physically active lowers the risk for developing several commonly occurring cancers (3).

Built environments designed for health make it easy for people to be physically active, eat healthy and connect socially as part of an everyday routine. Policy and environmental change strategies that connect routes such as sidewalks, trails, bicycle lanes, and public transit to destinations such as grocery stores, schools, worksites, libraries, parks, or health care facilities are proven to increase physical activity by making it safe and easy to walk, bicycle, or wheelchair roll for people of all ages and abilities.

Unfortunately, built environments that enhance health are not equitably distributed in our communities. In both urban and rural areas, neighborhoods close to sources of pollution, like highways or oil refineries; that lack parks with safe places to play; and that lack sidewalks or places to safely ride a bike, often experience negative health outcomes. By working alongside communities, the built environment can be shaped to make healthier choices available to everyone.

For more information, the Community Preventive Services Task Force recommends [combined built environment approaches](#) to increase physical activity. These approaches combine new or enhanced transportation systems (e.g., pedestrian and cycling paths) with new or enhanced land use design (e.g., proximity to a store, access to a public park) to promote physical activity among residents.

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(1) Robert Wood Johnson Foundation. (2017)

(2) Wray AJD, Minaker LM. Is cancer prevention influenced by the built environment? A multidisciplinary scoping review. *Cancer*. 2019 Oct 1;125(19):3299-3311. doi: 10.1002/cncr.32376. Epub 2019 Jul 9. PMID: 31287585

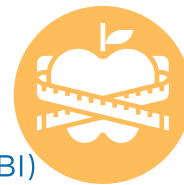
(3) CDC Physical Activity and Cancer <https://www.cdc.gov/physicalactivity/basics/pa-health/physical-activity-and-cancer.html>

(4) [The Community Guide](#)

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## OBJECTIVE 2.2: Decrease the proportion of adults exceeding dietary guidelines for moderate drinking.



1. Promote the use of electronic screening and brief intervention (e-SBI) to facilitate delivery of personalized feedback about risks and consequences of excessive drinking.
2. Educate the general public on cancer risk related to alcohol use.
3. Strengthen accountability in Colorado by holding social hosts liable for alcohol attributable harm.
4. Implement local social host ordinances to reduce underage drinking.
5. Hold retailers accountable for harms incurred by service to intoxicated or underage patrons.
6. Increase the purchase price of alcoholic beverages by raising state alcohol excise taxes and allowing local alcohol excise taxes on all alcoholic beverages.
7. Require alcoholic beverage labels to include a warning related to the increased risk of cancer, such as "According to the Surgeon General, consumption of alcoholic beverages can cause cancer, including breast and colon cancers."

### DID YOU KNOW? Drinking alcohol raises your risk of getting six kinds of cancer:

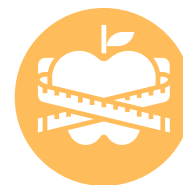
- Mouth and throat
- Voice box (larynx)
- Esophagus
- Colon and rectum
- Liver
- Breast (in women)



All types of alcoholic drinks, including red and white wine, beer, cocktails, and liquor, are linked with cancer. The more you drink, the higher your cancer risk.

The [Dietary Guidelines for Americans, 2020–2025](#), recommend that if you drink alcohol at all, drink in moderation—no more than one drink a day for women, and no more than two drinks a day for men. If you don't drink, don't start drinking because of any possible health benefits. (1)

(1) [Centers for Disease Control and Prevention](#)

**OBJECTIVE 2.3: Decrease exposure to Ultraviolet (UV) Radiation**

1. Raise adolescent and young adult awareness through school outreach regarding the risks of UV tanning.
2. Include warning labels on UV tanning device advertisements.
3. Prohibit use of indoor UV tanning devices by minors under 18.
4. Develop educational materials for state and local policymakers on the risks of indoor tanning.
5. Raise awareness of indoor tanning as a liability for institutions of higher education and implement strategies that reduce or eliminate indoor UV tanning.
6. Educate adults on the risks of indoor UV tanning devices.
7. Advocate for workplaces to establish sun safety guidelines, procedures and policies for workers.
8. Advocate for local governments and parks departments to establish design guidelines and policies to promote increased sun protection and shade.
9. Educate adults and children, in particular those who participate in outdoor recreation, on sun safety behaviors.
10. Advocate for schools, preschools and childcare centers to establish sun safety guidelines, procedures and policies.
11. Educate students, particularly those in Kindergarten through 8th grade, about sun safety and the effects of ultra-violet (UV) radiation; reinforce by modeling, demonstration or role-playing.



**DID YOU KNOW?**  
**The Colorado Melanoma Foundation has a traveling Sun Bus. Find a skin cancer screening near you!**



<https://www.thesunbus.org/calendar-of-events>

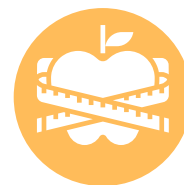
## GOAL 3: INCREASED UPTAKE OF CLINICAL INTERVENTIONS TO PREVENT CANCER



**OBJECTIVE 3.1: Increase collection and use of family history of cancer to ensure appropriate and risk-based cancer prevention messaging, screening and referrals.**

1. Support efforts, including those from the National Colorectal Cancer Roundtable, seeking to standardize family history data collection in electronic health records to allow providers to identify individuals whose family history meets the clinical criteria for a hereditary cancer syndrome and those who should be referred to a genetic counselor.
2. Educate providers on guidelines for family history collection and referral for comprehensive genetic counseling and testing. Evidence-based guidelines are available through the United States Preventive Services Task Force (USPSTF), the National Comprehensive Cancer Network (NCCN), the American Cancer Society (ACS) and the American College of Radiology (ACR).
3. Educate the public on the role of family history and potential genetic testing for hereditary cancer syndromes.
4. Implement family history screening tools in primary or specialty care settings to identify patients at risk for hereditary cancer.
5. Develop referral and communication systems to facilitate on-site or referred cancer risk assessment, genetic counseling, including tele-counseling, and testing services by a qualified genetics professional.
6. Promote access to genetic counseling based on risk assessment prior to genetic testing to review potential risks and benefits, including post-test risk and benefits when prophylactic options are under consideration.
7. Support genetic counselor workforce development.
8. Identify and share resources for genetic counseling and testing for at-risk individuals who are unable to pay.
9. Promote appropriate insurance coverage, especially Medicaid coverage, of genetic counseling, testing and ensuing clinical services for high-risk individuals.



**OBJECTIVE 3.2: Increase HPV and Hepatitis B vaccine uptake.**

1. Promote vaccination programs and requirements in schools and health systems.
2. Educate parents and/or eligible recipients about the Hepatitis B and HPV vaccine as a cancer prevention method.
3. Implement vaccine reminder and recall systems targeted to providers, patients, parents/guardians within the health systems and schools.
4. Participate in the Colorado Immunization Information System to track vaccine uptake within clinics.
5. Implement provider assessment and feedback quality improvement processes.
6. Implement standing provider orders for Hepatitis B and HPV vaccination.
7. Promote Hepatitis B and/or HPV vaccination series completion in pharmacies.
8. For non-vaccinating providers, establish relationships for referrals to providers and promote the completion of Hepatitis B and/or HPV vaccination series.
9. Promote HPV vaccination education and vaccine recommendation for the prevention of HPV-related oral and oropharyngeal cancer within the dental setting.
10. Promote hepatitis A vaccinations for people affected by hepatitis B.
11. Promote hepatitis A and hepatitis B vaccinations for people affected by hepatitis C.
12. Educate people who use drugs and other key populations on how to prevent hepatitis B, including harm reduction strategies that empower people to take charge of their health.
13. Promote legislation that allows persons age 15 and above to autonomously consent to HPV vaccination during a family planning or STI visit.
14. Promote universal hepatitis B vaccination at birth or prior to hospital discharge.
15. Implement standing orders to test all pregnant women for hepatitis B (HBsAg) at the delivery hospital if the test is not part of their prenatal records. Administer hepatitis B immune globulin and the first dose of the hepatitis B vaccine within 12 hours of birth to babies where mom's hepatitis B status is positive or unknown.
16. Develop and distribute hepatitis B vaccine education that can be used to help adults who are unvaccinated for hepatitis B obtain vaccination.



# ARTS AND WELLNESS

Arts & Wellness was formed in 2015 to bring awareness to a potential silent killer; cervical cancer. Arts & Wellness develops and implements plans to increase the rate of cervical cancer screenings and to increase awareness and the importance of HPV vaccination rate for children.

Since 2015, Arts & Wellness has provided cervical cancer screenings to 5,430 women who visited 9HealthFairs and Inner City Health Center. Arts and Wellness has participated in numerous health fairs providing brochures, pamphlets, and other educational materials in metro areas communities.

**Gladys Brown Jones Turnbough**  
**Cervical Cancer Survivor**  
**Arts and Wellness Founder**  
**"Remove the Cancer Fear;  
 Get Your Pap Smear"**



**DID YOU KNOW?** There are six types of cancers that are attributed to the Human Papillomavirus (HPV), including cervical, oropharyngeal, anal, penile, vaginal, and vulvar. While virtually all cases of cervical cancer are caused by the HPV (1). Oropharyngeal cancers are now the most common HPV-related cancer (2). Vaccination against HPV can prevent infection entirely and substantially lower the risk of cancer (3). Among individuals ages 13 to 17, only 70 percent of females and 56.9 percent of males are up to date with the recommended HPV vaccination series.

## WHO SHOULD GET THE HPV VACCINE?

- HPV vaccination is recommended for all preteens (including girls and boys) at age 11-12 years. All preteens need HPV vaccination, so they are protected from HPV infections that can cause cancer later in life.
- Teens and young adults through age 26 years who didn't start or finish the HPV vaccine series also need HPV vaccination (4).

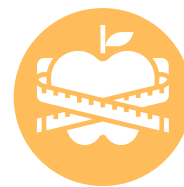
(1) Cancers caused by HPV. (17 November 2020). Retrieved 03 May 2021 from <https://www.cdc.gov/hpv/parents/cancer.html>

(2) HPV and Cancer. Retrieved 03 June 2021 from <https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hpv-and-cancer>

(3) Human papillomavirus (HPV) vaccination coverage among adolescents 13-17 years by State, HHS Region, and the United States. National Immunization Survey-Teen, 2012. (14 August 2020). Retrieved 03 May 2021 from <https://www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/data-reports/hpv/dashboard/2019.html>

(4) Centers for Disease Control and Prevention

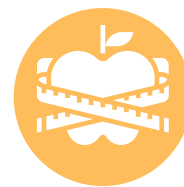
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**OBJECTIVE 3.3: Decrease chronic cases of Hepatitis C.**

1. Increase access to treatment and care by educating medical providers on how to treat Hepatitis C, with special focus in primary care settings.
  2. Educate people who use drugs and young people on how to prevent hepatitis C, including harm reduction strategies that empower people to take charge of their health.
  3. Educate people who use drugs and other key populations on the efficacy of newer hepatitis C treatments.
  4. Implement standing providers order for Hepatitis C testing for all pregnant women during each pregnancy.
  5. Educate people born between 1945 and 1965 on the importance of getting tested for hepatitis C.
  6. Implement standing provider orders for hepatitis C testing of all people age 18 and older.
  7. Promote access and coverage for hepatitis C treatment among public and private health plans.
  8. Increase access to telehealth options for people affected by hepatitis C in rural areas of the state.
  9. Any patient who has or had hepatitis B (no fibrosis score requirement), or hepatitis C post-treatment (who also had a fibrosis score of 3 or 4), or cirrhosis from a cause other than HBV or HCV should receive a liver ultrasound every six months to monitor for liver cancer (hepatocellular carcinoma).
  10. Educate persons living with chronic hepatitis B and C on the importance of maintaining care for their hepatitis to prevent complications such as liver cancer.
-



## GOAL 4: DECREASED ENVIRONMENTAL EXPOSURES THAT LEAD TO CANCER



**OBJECTIVE 4.1: Increase knowledge and community infrastructure to decrease exposure to radon.**

- 1.** Educate Colorado residents, home buyers and sellers, realtors and policymakers about the hazards of radon exposure, and the importance of radon testing and mitigation using credentialed radon service providers who follow consensus standards of practice.
- 2.** Educate builders, code officials, city councils and county commissioners on the hazards of radon exposure and the importance of adopting radon resistant new construction building codes.
- 3.** Promote environmental equity through radon education, free radon testing and the low income radon mitigation assistance program (LIRMA) directed at under-resourced communities.
- 4.** Provide radon education to the medical community, child care facilities, and schools.
- 5.** Support housing, finance, and insurance agencies to require radon testing and mitigation of all building types.
- 6.** Support policies to require radon notification and disclosure during real estate transactions.
- 7.** Provide radon test result data to the Center for Disease Control (CDC) National Environmental Health Tracking Network.

# ENDING LUNG CANCER STIGMA- ONE WHITE RIBBON AT A TIME



**Heidi Nafman Ondo, Lung Cancer Survivor  
& Pierre Onda, Caregiver and Physician**

The mission of **The White Ribbon Project** is to change the public perception of lung cancer. Decades of institutional messaging has minimized the fact that anyone with lungs can get lung cancer and reinforced the stigma that has been associated with this disease.

**Being a lifelong health enthusiast, health educator, fitness trainer, married to a primary care physician, my family and I were blindsided by my stage IIIA lung cancer diagnosis in October of 2018. This was an incidental finding. I was asymptomatic.**

In October of 2020, out of frustration over the lack of action on the part of cancer centers across the country to plan for lung cancer awareness month, I asked my husband to make a large white ribbon door hanger out of plywood for our front door. I posted a photo of it on a Facebook page for lung cancer survivors in Colorado. People immediately asked for them, and the demand grew so quickly that we now have White Ribbons across the United States, Canada, Europe, and in The Philippines. We have made and shipped over 600 of them at no cost to the recipients.

People who were hiding their diagnosis are excited to have a white ribbon. They have been taking pictures with their doctors, at their cancer centers, public landmarks, and their homes, and posting them on social media. No one is ashamed and they are telling their stories. They are humanizing the staggering statistics. Thanks to many strong survivor/advocates, ribbons have been shared at 27 NCI-designated comprehensive cancer centers, 25 VA hospitals, 17 community cancer centers, 7 lung cancer advocacy organizations, and all Foundation Medicine and Blueprint Medicine headquarters. The list keeps growing and anyone or institution interested in promoting lung cancer awareness is welcome.

The history of the breast cancer and HIV/AIDS movements has shown that collaboration between survivors, caregivers, and the medical community can break stigmas and promote empathy and compassion. Lung cancer is no different. No one deserves lung cancer and it's time to stand together and advocate for equitable research funding based on prevalence and mortality rate data.



[@TheWhiteRibbonProject](https://www.facebook.com/TheWhiteRibbonProject)



[www.thewhiteribbonproject.org/](http://www.thewhiteribbonproject.org/)

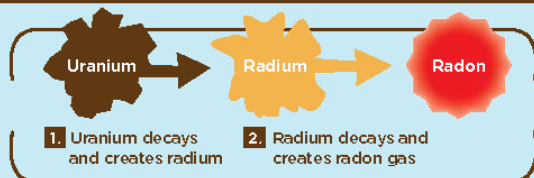


[@TheWRP4LC](https://twitter.com/TheWRP4LC)

# IS YOUR HOME SAFE FROM RADON?

## What is radon?

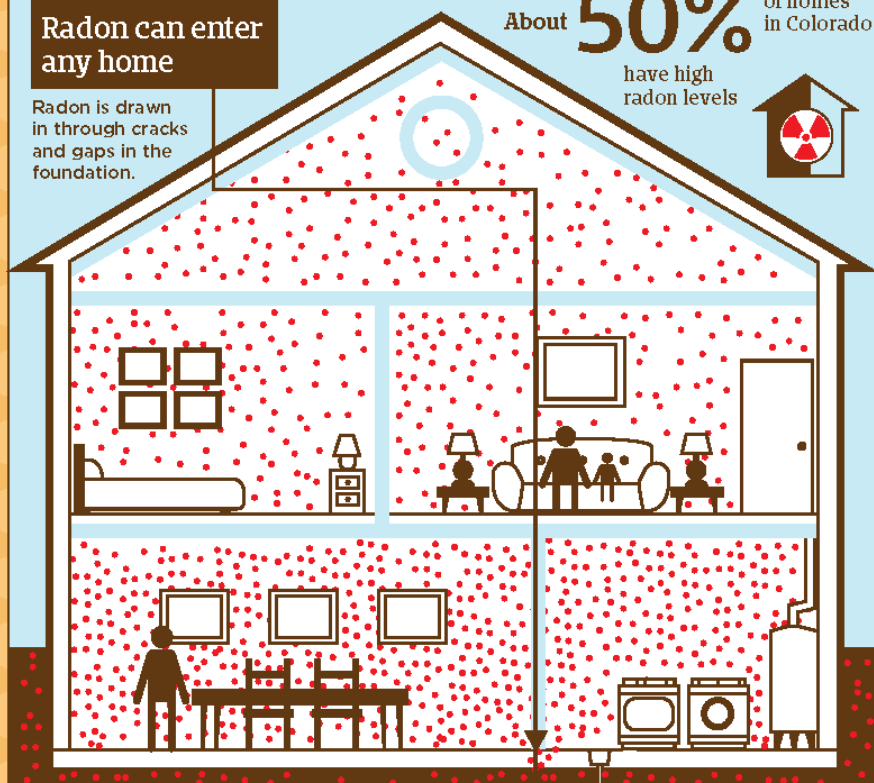
Radon is a naturally occurring invisible, odorless gas that comes from the natural radioactive breakdown of uranium in soil, rock, and water.



## Radon can enter any home

Radon is drawn in through cracks and gaps in the foundation.

About **50%** of homes in Colorado have high radon levels



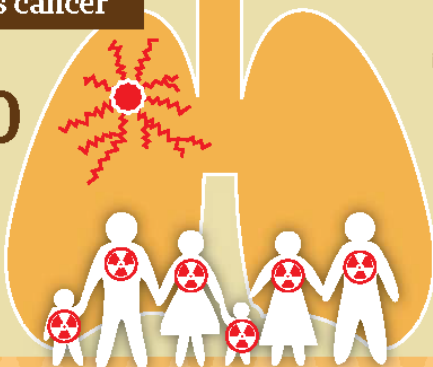
## Radon occurs naturally in soil

Due to the geology of Colorado, homes in our state have higher levels of radon than the national average.

## Radon causes cancer

Every year, over **20,000**

people die in the U.S. from lung cancer caused by radon.



Radon decays into radioactive particles that, when inhaled, can damage the DNA in sensitive lung cells. The damaged cells can become cancerous.

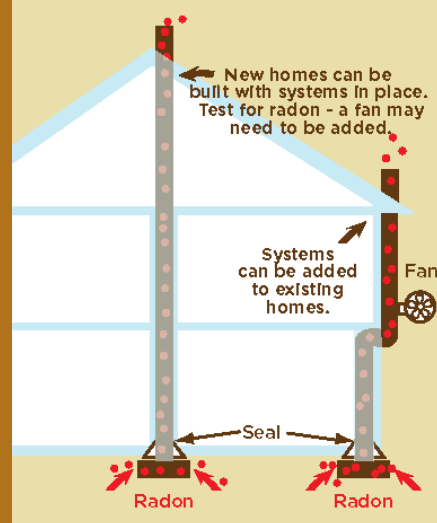
## Testing for radon is easy

Do-it-yourself radon test kits are easy to set up and are available for less than \$35.



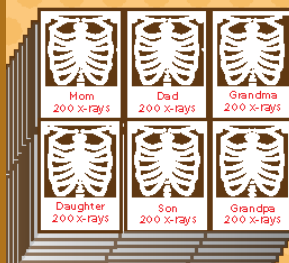
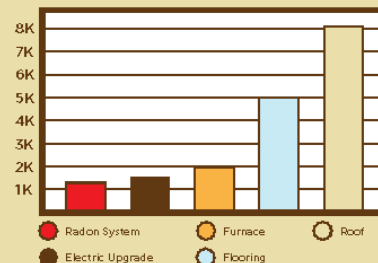
# RADON IN COLORADO

## Fixing the problem is easy and inexpensive



There are many options for radon mitigation. Contact your local health department for more information. Find a certified contractor at [ColoradoRadon.info](http://ColoradoRadon.info)

## Improvement cost comparisons



# 200 chest x-rays

That's more than three per week, per person, per year.

In Colorado, living in a home with average levels of radon (6.4pCi/L) for one year is like having 200 chest x-rays every year.

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**OBJECTIVE 4.2: Increase testing of household drinking water wells.**

1. Partner with local public health agencies to educate private drinking well water owners and consumers on the facts and risks associated with arsenic.
2. Encourage testing of wells, including arsenic sampling at least once, targeting the northeastern and southern areas of Colorado.
3. Partner with water testing labs to educate consumers on the importance of testing for cancer-related toxins.

**OBJECTIVE 4.3: Decrease exposure to asbestos and diesel exhaust.**

1. Encourage use of certified asbestos building inspectors prior to renovation or demolition activities.
  2. Educate homeowners on asbestos risk and requirements of the Air Quality Control Commission regulation 8, part B.
  3. Develop a state and intrastate system of electric vehicle supply equipment (EVSE) stations to increase their numbers and accessibility to promote and support local and long distance, commercial and fleet use of alternative fuels.
  4. Direct Colorado Clean Diesel Program efforts toward educating the public and businesses about the health, environmental, and economic benefits of transitioning from diesel equipment to all-electric or hybrid-electric equipment, while funding such projects through subgrants.
  5. Educate adults and students on the relationship between diesel exhaust and risks of respiratory illnesses and lung cancer.
  6. Promote and implement workplace policies to reduce exposure to carcinogens.
  7. Prioritize efforts in communities that are disproportionately impacted by diesel exhaust pollution.
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# SCREENING & EARLY DETECTION



## 5

### INCREASE HIGH QUALITY CANCER SCREENING AND EARLY DETECTION RATES

Screening for cancer using nationally recognized cancer screening guidelines is an effective strategy for reducing cancer mortality and burden. There are several screenable cancers, and researchers are continually working on better and more refined screening tests for detecting cancer earlier. Some screening tests, such as colonoscopy, actually prevent cancer by finding and removing precancerous polyps. This creates new opportunities for public health and the medical community to improve their health literacy, shared decision-making and risk communication strategies. As guidelines change and new screening tests emerge, clear communication to answer key questions will be important. When is the right time to be screened or tested? What are the risks and benefits of the different test options? Ensuring that Coloradans are informed to make screening and testing decisions in conjunction with providers can empower individuals to follow through with screening services.



## GOAL 5: INCREASED HIGH QUALITY CANCER SCREENING AND EARLY DETECTION RATES



**OBJECTIVE 5.1: Increase high quality, guideline-adherent, cancer screening rates among average risk individuals (1).**

1. Educate primary care providers on the importance of a provider recommendation and adhering to nationally recognized, evidence-based cancer screening guidelines such as those from the United States Preventive Services Task Force (USPSTF), National Comprehensive Cancer Network (NCCN), American Cancer Society (ACS) and American College of Radiology (ACR).
2. Promote informed decision-making at both the provider and individual level regarding the advantages and disadvantages of prostate cancer screening.
3. Promote informed decision-making at both the provider and individual level regarding breast cancer screening guidelines. Discussions should include the advantages and disadvantages related to the variations in how often and when to begin and end screening based on individual risk.
4. Educate the public, patients, and primary care providers on the importance of Low Dose CT for early detection of lung cancer among those who are high risk, and on the risks and benefits of screening.
5. Promote all modes of colorectal cancer screenings to providers and individuals as recommended by the American Cancer Society guidelines(2) or assigned an A or B rating by the United States Preventive Services Task Force (3).
6. Explore solutions to removing out of pocket expenses for follow-up colonoscopy for evaluation of abnormal results of stool-based and other non-colonoscopy screening tests.
7. Implement client reminder systems (e.g., print or phone)(4) to advise individuals in need of a cancer screening using evidence-based messaging.
8. Implement provider reminder and recall systems (5) to identify when an individual is in need of, or overdue for, a cancer screening test based on individual or family history risk.

1) Average-risk individuals are those not known to be at substantially elevated risk, including those without known inherited predisposition, without comorbidities known to increase cancer risk, and without previous diagnosis of cancer or pre-cancer. Source: ["Targeted Cancer Screening in Average-Risk Individuals."](#)

(2) [American Cancer Society Guideline for Colorectal Cancer Screening](#)

(3) [USPSTF Colorectal Cancer: Screening](#)

(4) Recommended for breast, cervical and colorectal cancer in [The Community Guide](#).

(5) Recommended for breast, cervical and colorectal cancer in [The Community Guide](#).



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9. Implement provider assessment and feedback interventions (1) that both evaluate provider performance in delivering or offering screening to clients and present providers with information about their performance in providing screening services, particularly through use of an electronic health record system.
  10. Deliver one-on-one (2) or group education (3) conducted by health professionals or trained lay people to motivate individuals to seek screenings. Use small media(4) to support this education (e.g., brochures or newsletters).
  11. Reduce structural barriers (5) that make it difficult for individuals to access cancer screening.
  12. Engage community health workers (CHWs) or health navigators (6) to implement one or more interventions to increase cancer screening (one-on-one and group education, client reminders, small media or reducing structural barriers).
  13. Implement multicomponent interventions (7) that combine strategies to increase community demand for cancer screening (client reminders, client incentives, small media, mass media, group education and one-on-one education), and access to cancer screening (reducing structural barriers and reducing client out-of-pocket costs). Improve multicomponent interventions by using together with the strategy to increase provider delivery of services (provider assessment and feedback, provider incentives and provider reminders).
  14. Implement workplace policies to support individuals to complete recommended cancer screenings.
  15. Collaborate with health plans to achieve increased cancer screening compliance rates, for example through the use of National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) cancer screening measures.
  16. Educate endoscopists on tracking adenoma detection rates as part of a colonoscopy quality improvement program, including implementation of provider assessment and feedback systems.
  17. Educate lawmakers on the health and economic benefits of high quality preventive cancer screenings.
  18. Develop an integrated approach to statewide cancer screening programs.

(1) Recommended for breast, cervical and colorectal cancer in [The Community Guide](#).

(2) Recommended for breast, cervical and colorectal cancer in [The Community Guide](#).

(3) Recommended for breast cancer in [The Community Guide](#).

(4) Recommended for breast, cervical and colorectal cancer in [The Community Guide](#).

(5) Recommended for breast and colorectal cancer in [The Community Guide](#).

(6) Recommended for breast, cervical and colorectal cancer in [The Community Guide](#).

(7) Recommended for breast, cervical and colorectal cancer in [The Community Guide](#).

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**OBJECTIVE 5.2: Increase high quality, guideline adherent, cancer screening rates among priority populations.**

1. Increase access to cancer screening services for colorectal, cervical, breast, and lung, in rural areas by implementing mobile services, traveling providers, transportation assistance (1), upgraded equipment or increased Medicaid reimbursement.
2. Partner with community-based organizations to reduce barriers (financial, cultural, structural or regional) to obtaining cancer screening services through engagement of community health workers, health navigators, and financial navigators.
3. Provide culturally relevant screening services for medically underserved communities and promote culturally sensitive informed decision-making about screening through engagement of community health workers and health navigators.
4. Facilitate enrollment in public and private health insurance.
5. Educate Medicaid-eligible Coloradans about their cancer screening coverage, including locations that accept Medicaid.
6. Collaborate with Medicaid to achieve increased cancer screening compliance rates among Medicaid recipients, for example through the use of National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) cancer screening measures.
7. Address limited local provider access for individuals due to insurance coverage, insurance plans accepted by providers, or provider capacity.
8. Educate employers on the importance of providing paid leave for cancer screenings (especially for hourly employees).
9. Encourage Medicaid to adopt lung CT screening guidelines that match the United States Preventive Services Task Force (USPSTF) guidelines.
10. Implement a tobacco-use history tool in electronic medical records to identify eligible, at-risk patients for lung cancer to alert caregivers of patients who are eligible for screening.

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(1) Promote use of Non-Emergent Medical Transportation (NEMT) benefit (a Health First Colorado benefit for members who don't have transportation to medical appointments).

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**OBJECTIVE 5.3: Increase early detection rates of non-screenable cancers.**

1. Increase awareness of the symptoms of non-screenable cancers among health care providers and individuals.
  2. Educate medical and health care students via structured programs about symptoms, risk factors, early detection, genetic counseling and genetic testing for non-screenable cancer types.
  3. Educate dental health professionals on how to assess an individual for signs of oral cancers, including HPV-related oral/oropharyngeal cancers.
  4. Support research studies, including randomized control trials, to investigate new and innovative cancer screening tests.
  5. Educate physicians on recognition of symptoms for ovarian cancer and relevant options of CA125 testing or pelvic Ultrasound.
  6. Educate pediatricians and other pediatric clinicians on the overt signs of pediatric cancers.
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# DIAGNOSIS & TREATMENT



## **CONSISTENT ACCESS TO QUALITY DIAGNOSTIC AND TREATMENT SERVICES ADHERENT WITH NATIONALLY RECOGNIZED GUIDELINES**

## **INCREASED PARTICIPATION IN HIGH QUALITY CLINICAL TRIALS**

Early diagnosis and improved and more specific treatment options are the cornerstones of the strategies that have reduced cancer mortality over the past 25 years. Communication of screening and treatment guidelines and pathways — to providers as well as insurers — is sometimes inconsistent and slow. The use of research to improve screening, treatment and palliative care can be challenging in a fragmented health care system. Barriers to accessing the right cancer care are many, with geography, cost and technology representing a few of them. During the next five years, further reductions in cancer mortality can be achieved by assisting providers, hospitals, policymakers and insurers in learning about and adopting the best and most appropriate practices for cancer diagnosis and treatment.

All Coloradans deserve access to cancer care that adheres to nationally accepted standards and is not cost prohibitive through either public or private insurance. Individuals also should have access to easily understandable health information about their cancer and the necessary support to help them navigate treatment. Cancer diagnostic and treatment services should take into consideration the differences among adult, young adult and pediatric cancers, and the differences in the values, obstacles and preferences of each individual patient.

## GOAL 6: CONSISTENT ACCESS TO QUALITY DIAGNOSTIC AND TREATMENT SERVICES ADHERENT WITH NATIONALLY RECOGNIZED STANDARDS



**OBJECTIVE 6.1: Increase the use of shared decision making with patients and/or caregivers about treatment, including the prevention or mitigation of long-term and late effects.**

1. Identify and implement a method to assess shared decision making processes and decision aid use among hospitals and/or practices that provide diagnosis and treatment services.
2. Implement sustainable shared decision making models and systems among treatment providers and practices.
3. Facilitate shared decision making between patient and provider regarding cancer treatment decisions among individuals making preference-sensitive treatment choices, including those with pediatric, adolescent and young adult cancers.
4. Engage health navigators to educate patients and caregivers on the importance of timely and informed decision making.
5. Educate all patients, including pediatric, adolescent and young adult patients and their parents, families and caregivers, about potential long-term and late effects of current treatment regimens.
6. Educate providers, patients and caregivers of children, adolescents, young adults and adults of child-bearing age about the potential impacts of cancer treatment on an individual's future fertility and options to preserve fertility.
7. Educate all patients, caregivers, survivors, as well as health care providers about the importance of open communication when using non-pharmacologic approaches.
8. Encourage and support access to genetic counseling and testing services for pediatric and adolescent patients.
9. Ensure availability of patient materials that adhere to health literacy standards such as the Agency for Healthcare Research and Quality (AHRQ) Health Literacy Universal Precautions Toolkit.



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**OBJECTIVE 6.2: Reduce financial barriers for individuals receiving quality diagnostic and cancer treatment.**

1. Identify and implement a method to assess the types and breadth of financial needs through financial assistance programs (both adult and pediatric/adolescent/young adult programs), treatment facility charity care programs or supportive service organizations.
  2. Educate patients, caregivers and providers on potential 'financial toxicity,' or unintended financial consequences of pursuing expensive cancer treatment regimens.
  3. Identify financial barriers to obtaining and sustaining quality diagnostic and treatment services, including potential public and private insurance barriers.
  4. Educate Coloradans on insurance benefits, coverage and enrollment, including development or implementation of tools to assist with balancing personal needs and considerations when choosing a health insurance plan.
  5. Educate and ensure implementation of [HB 19-1301](#) concerning follow-up imaging coverage for breast cancer. The act applies to policies and contracts issued or renewed on or after January 1, 2021.
  6. Educate and connect uninsured Coloradans with basic needs and medical cost resources to access quality cancer treatment in a timely manner.
  7. Educate decision makers (e.g., legislators, policy makers) regarding barriers to obtaining health plan coverage, including pharmacy benefits, to access treatment services.
  8. Evaluate financial assistance programs to identify optimal timing, amount and length of financial support for those in active treatment.
  9. Engage financial navigators, health navigators and care coordinators to assist patients, or parents and guardians of pediatric/adolescent or young adult cancer patients with overcoming financial barriers.
  10. Implement a universal financial assistance application accepted by Colorado nonprofit organizations that offer financial support to individuals and the families of pediatric, adolescent and young adult patients during cancer treatment.
  11. Increase consumer representation, in particular cancer survivors and caregivers, on boards of organizations serving cancer patients and survivors with a focus on reducing financial barriers.
  12. Identify and advocate for policies that could reduce the financial burden of cancer. Examples include health insurance expansion and Medicaid coverage of clinical trial enrollment.
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# ADDRESSING FINANCIAL TOXICITY



Carol's Wish Financial Navigation, a program of the Ovarian Cancer Alliance, provides expert financial navigation services to women across Colorado who have been diagnosed with gynecologic cancers, regardless of their income, insurance or immigration status. **The mission of the program is to ensure that nobody receives substandard care or goes without care for financial reasons.** Carol's Wish Navigators reach out to patients at the earliest possible time after diagnosis so they can provide proactive intervention, ideally avoiding financial toxicity altogether. Navigators create an individualized strategy for each patient based on her unique medical and financial circumstances and specific concerns, with the goal of first **removing any barriers to access to care**, and then supporting the patient through the treatment process and **ensuring the best possible health care coverage** through treatment and beyond.

Examples of assistance include:

- insurance optimization
- free and reduced cost drug, premium and copay assistance
- enrollment in government assistance programs
- community grants
- third party advocacy
- bill negotiation and resolution
- replacing lost income through disability.

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PATIENTS  
HELPED

\$540K

DOLLARS  
SAVED FOR  
PATIENTS

100%

EXCELLENCE  
RATING FROM  
PATIENTS

50%+

PAY FOR HEALTH  
CARE THEY  
COULDN'T  
OTHERWISE AFFORD

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**OBJECTIVE 6.3: Reduce geographic barriers to accessing specialty care for quality diagnostic and cancer treatment.**

1. Increase access to cancer diagnostic and treatment services in rural areas by implementing telemedicine, mobile services, traveling providers, transportation assistance (1), upgraded equipment or increased Medicaid reimbursement.
2. Conduct a needs assessment to identify regional barriers to accessing specialty diagnostic and cancer treatment, including availability of specialists and use of technology.
3. Collaborate with local or regional transportation councils or transit planning initiatives to address medical facility access.
4. Address limited local provider access for individuals due to insurance coverage, insurance plan acceptance by providers or provider capacity.
5. Engage community health workers, health navigators, social workers, and care coordinators to assist patients with overcoming barriers, including geographic or transportation.
6. Increase awareness of, and access to, board certified oncology specialists for individuals whose cancer type has demonstrated improved outcomes.
7. Increase consumer representation or engagement with boards of organizations serving cancer patients and the families of pediatric, adolescent and young adult patients with a focus on reducing geographic barriers.
8. Use incidence, late stage, and mortality rates from rural counties with high disparity indices to guide and target specific prevention and early screening strategies.

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( 1) Promote use of Non-Emergent Medical Transportation (NEMT) benefit (a Health First Colorado benefit for members who don't have transportation to medical appointments)

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**OBJECTIVE 6.4: Increase testing among individuals whose cancer treatment may benefit from targeted proven or emerging therapies.**



1. Educate pathologists, oncologists, surgeons, gastroenterologists, pulmonologists and other relevant health care providers about best practices for identification of somatic genomic and immunohistochemistry analysis of all cancers, including pediatric, adolescent and young adult cancers, to determine predictive markers of benefit from targeted therapy as described in National Comprehensive Cancer Network (NCCN) guidelines.
  2. Educate providers about rare markers associated with hereditary cancer syndromes that may inform surveillance plans, therapeutic practices and family screening plans.
  3. Disseminate information to laboratories and cancer specialists about best practices in tumor testing and molecular profiling as new guidelines are developed in this area.
  4. Advocate for universal microsatellite instable (MSI) or mismatch repair (MMR) protein testing for colorectal and endometrial cancers and for guideline-based molecular profiling of cancers when applicable.
  5. Advocate for universal genetic counseling and germline genetic testing in all patients diagnosed with pancreatic cancer, patients diagnosed with colorectal or endometrial cancer under age 50 or breast cancer diagnosed age 45 or under, as supported by the NCCN.
  6. Advocate for universal molecular testing for all FDA approved targeted drugs in patients who could benefit from biomarker driven therapies using panel-based testing, not single gene tests, whenever possible for time, tissue and cost efficiencies as supported by nationally recognized clinical guidelines and professional society recommendations such as the NCCN.
  7. Support research to develop or refine tumor markers, including proteomics or gene expression, and circulating-tumor DNA (ctDNA) in all patient populations, including pediatric, adolescent and young adults.
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## GOAL 7: INCREASED PARTICIPATION IN HIGH QUALITY CLINICAL TRIALS



**OBJECTIVE 7.1:** Increase education and awareness about high-quality clinical trials among all ages of individuals facing cancer treatment, providers and caregivers.

1. Promote and increase visibility of educational resources that contain comprehensive clinical trial considerations, links to resources and links to current clinical trials to patients and cancer care professionals.
2. Implement processes to systematically inform and encourage newly diagnosed patients and caregivers of the availability of clinical trials as a component of treatment planning.
3. Support a collaborative system for tracking patient molecular, clinical and epidemiological data in addition to clinical trial matching, such as the Oncology Research Information Exchange Network (ORIEN).
4. Create and promote educational resources to help individuals, their families and/or caregivers understand, evaluate and make informed decisions about participation in clinical trials, such as key questions to discuss with providers, treatment differences, the meaning of randomization and definitions of the three phases of clinical trials and awareness of Informed Consent Documents, including Youth Information Sheets for pediatric, adolescent and young adult patients. Ensure resources are linguistically and culturally tailored to the population.

## DISPARITIES IN CLINICAL TRIALS PARTICIPATION

An article from Western States  
Cancer Research NCORP



The percentage of people of color who participate in cancer clinical trials across Colorado and the nation overall is unacceptably low. According to the National Cancer Institute (NCI), about 25% of all clinical trial participants across the U.S. are minorities. In Colorado, it is likely that this figure is less than a quarter of clinical trial participants. According to the Census Bureau's American Community Survey, 16% of the population of our state is non-White.



## DISPARITIES IN CLINICAL TRIALS, CONTINUED

Adding context, the American Cancer Society indicates that there are 28,630 cases of cancer expected to be diagnosed in Colorado in 2021. While an estimated 20% of all adult cancer patients are eligible to participate in a trial, only 3-5% enroll, according to the NCI. This figure likely drops substantially for people of color and people living in rural areas of the state. Based on NCI estimates, 85% of cancer patients are treated in their own community. If there is not a clinical trial open in their own community, as is the case in many rural areas of Colorado, it is even less likely that a cancer patient will enroll.



Most cancer patients in Colorado who will enroll in research studies in the coming five years will be White. This is due to many barriers disproportionately affecting communities of color and rural communities, especially indigenous people, many of whom live in Southwest Colorado.

Access to care and under-utilization of preventive care are two important elements that contribute to disparities in cancer clinical trial participation. Access to care is influenced by a web of factors, such as insurance status and proximity to health care facilities. Changes that have been implemented as a result of the Affordable Care Act are already helping to address the issue of access to health care by making recommended cancer screening and prevention interventions more affordable and expanding Medicaid.

Racism is a public health crisis, and we know it deeply impacts cancer patients. Racial and ethnic minorities face poorer outcomes and are less frequently enrolled in clinical trials. Western States Cancer Research NCORP CEO & Executive Director, Lisa Switzer, testified in early 2020 at both the State House and Senate in favor of HB 1232, a bill that mandates Medicaid to cover clinical trials. The bill passed in both the House and Senate and was signed into law in 2021 by the Governor.

**Patient navigation**, which is a strategy to help patients maneuver through the complex health care system in our country, has also shown promise as a means of addressing cancer health disparities. Navigators can help patients overcome the multitude of barriers that can derail access to quality care, such as insufficient finances, lack of childcare, insufficient paid sick leave and lack of transportation.

Another barrier are **myths** surrounding cancer clinical trials that widely exist that mislead patients to believe they would not receive the standard of care or better.

Often, **physicians** themselves are barriers to patient enrollment on clinical trials, because taking on research, in addition to primary or specialty care, is time-intensive and involves collaborating with a Site Management Organization to ensure the trial is maintaining its regulatory requirements.

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## DISPARITIES IN CLINICAL TRIALS, CONTINUED

Further, health care providers may not offer their patients the opportunity to participate in a trial for many reasons. For example, patients may have comorbidities—other medical conditions—that may make it difficult for them to tolerate aggressive therapy.

And some clinicians may not offer a clinical trial to a patient based on assumptions about the patient. For instance, a provider may assume that a patient lives too far away from the trial location and would have trouble making it to the clinic for trial visits. Or a provider might assume that a patient does not have the social support to adhere to the treatment regimen or would have trouble understanding a very complex trial protocol and be unable to decide whether to participate.

NCI encourages health care providers to question these assumptions. But it is only a start. Newer national advocacy organizations such as Latinos in Clinical Research are likely to help improve clinical trial participation from communities of color. The purpose of Latinos in Clinical Research is to increase Latino participation within the clinical research industry. This includes both employment in the field, as well as increasing participation in clinical trials and reducing disparities overall.

Although there has been substantial progress in cancer treatment, screening, diagnosis, and prevention over the past several decades, addressing cancer health disparities—such as higher cancer death rates, less frequent use of proven screening tests, and higher rates of advanced cancer diagnoses—in certain populations is an area in which progress has not kept pace.

These disparities are frequently seen in people from low-socioeconomic groups, certain racial/ethnic populations, and those who live in geographically isolated areas.

Documented cancer health disparities nationally include:

- a higher incidence of a particularly aggressive form of breast cancer (the triple-negative subtype) among Black women than women of other racial/ethnic groups
- substantially higher rates of prostate cancer incidence and death among Black men than men of other racial/ethnic groups
- higher rates of kidney cancer among American Indian and Alaska Natives than other racial/ethnic groups
- higher rates of liver cancer among Asian and Pacific Islanders than other racial/ethnic groups
- higher rates of cervical cancer incidence and death among Hispanic and Black women than women of other racial/ethnic groups

There has been some recent evidence of progress against cancer health disparities, including reductions in lung and prostate cancer deaths among Black men over the past decade. However, many of the same population groups that experience cancer health disparities are also significantly underrepresented in cancer clinical trials.

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**OBJECTIVE 7.2: Reduce barriers to clinical trial participation.**

1. Identify and address barriers to clinical trial participation in order to increase diversity among clinical trial participants.
2. Develop mechanisms to reduce travel expenses related to clinical trial participation.
3. Implement screening processes at cancer care settings to identify patients eligible for clinical trials.
4. Ensure standardized data collection and reporting mechanisms to reduce variation in reporting of patient demographics, in addition to tracking income, insurance status and education of trial participants.
5. Identify and implement strategies to improve efficiency and resources related to clinical trial coordination for physicians, including paperwork and data management.
6. Educate legislators, employers and insurance carriers to promote policies that support availability of, patient access to, and participation in clinical trials.
7. Educate private health plans about the ACA requirement to cover routine medical care for patients of all ages enrolled in approved clinical trials.
8. Increase the availability and diversity of clinical trial protocols in Colorado.





# SURVIVORSHIP & END OF LIFE CARE



## 8

### **IMPROVE PHYSICAL, MENTAL, EMOTIONAL, BEHAVIORAL, AND FINANCIAL WELL-BEING AMONG PEOPLE AFFECTED BY CANCER**

Upon diagnosis, cancer survivors and their families enter a new world full of physical, mental, spiritual, social and financial challenges. These challenges begin with diagnosis and extend far beyond the period of treatment. It is essential to provide services and support that equip survivors and families to better face and overcome these challenges, including palliative care throughout survivorship.

The cancer mortality rate has been falling consistently for most cancers over the past 20 years, increasing the number of survivors in Colorado. There were more than 315,00 cancer survivors in Colorado in 2020. This number will continue to rise as cancer screening and treatment continue to improve and extend the length of life, the state's population grows and the number of older adults increases. Building and improving upon the resources available to Colorado's cancer survivor community is essential to meeting the needs of this growing population. Education and advocacy can play a critical role among policymakers in achieving many of these objectives.


## GOAL 8: IMPROVE PHYSICAL, MENTAL, EMOTIONAL, BEHAVIORAL, AND FINANCIAL WELL-BEING AMONG PEOPLE AFFECTED BY CANCER



### OBJECTIVE 8.1 Improve physical well-being among cancer survivors and caregivers.

1. Educate people of all ages diagnosed with cancer and their families and caregivers about maintaining a healthy lifestyle as a way to decrease the risk of cancer recurrence, side effects from treatment, additional primary cancers and/or other comorbidities. Implement evidence-based health behavior change and self-management programs for, or adapted to, people affected by cancer.
2. Educate patients, caregivers, providers, employers, and school officials on the needs of individuals, specifically children, adolescents and young adults during and after cancer treatment.
3. Assess the availability and use of cancer prehabilitation and rehabilitation services (i.e. lymphedema treatment), including those provided in clinical settings and community programs. Promote access where needed.
4. Assess the availability and use of oncology-certified social workers and registered dietitians who provide services to people of all ages affected by cancer. Promote access as needed.
5. Implement and promote evidence-based complementary and alternative therapies (as well as research) for non-clinical approaches (e.g. physical activity, yoga, or massage) to improve the quality of lives for those affected by cancer.
6. Provide a mechanism for identifying and promoting comprehensive Colorado-specific resources such as a directory or referral service that spans all age ranges.
7. Assess health insurance coverage of supportive services related to physical health for people affected by cancer. Identify gaps, barriers and solutions.
8. Educate oncology providers on evidence-based brief interventions and referral best practices for tobacco and vape use.
9. Provide direct education to survivors on the effects of tobacco on treatment efficacy, recurrence risk and second cancers.



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10. Integrate tobacco use screening, including assessment of relapse risk in former tobacco users, and referral to QuitLine or other tobacco treatment services as a standard of survivorship care.
  11. Advance policies that reduce barriers to accessing evidence-based cessation treatments, including out-of-pocket costs and prior authorization requirements.
  12. Promote safe use of opioids to include reversal for overdose (Narcan), storage and disposal of opioids.
  13. Educate people affected by cancer about non-pharmacological options to treat pain and symptoms.
  14. Explore coverage/reimbursement for non-pharmacologic service providers through public and private insurance and other mechanisms.
  15. Educate cancer survivors on non-pharmacologic options.
  16. Educate cancer centers and primary care providers on the importance of nutrition and physical activity as a means to prevent, improve treatment outcomes, and reduce the risk of cancer recurrence and secondary cancers.

### CANCER SURVIVOR

An individual is considered a cancer survivor from the time of cancer diagnosis through the course of his or her life. This definition is widely accepted by groups such as the National Coalition for Cancer Survivorship (NCCS), The National Cancer Institute's Office of Cancer Survivorship (NCI OCS), The Centers for Disease Control and Prevention (CDC), and the American Society for Clinical Oncology (ASCO).

### CANCER SURVIVORSHIP

In cancer, survivorship focuses on the health and life of a cancer survivor. It covers the physical, psychosocial, and economic issues of cancer, beyond the diagnosis and treatment phases. Survivorship includes issues related to the ability to get health care and follow-up treatment, late effects of treatment, second cancers, and quality of life. Family members, friends, and caregivers are also considered part of the survivorship experience. While anyone who has ever been diagnosed with cancer is a cancer survivor, work and research in this area tends to focus on the post-treatment period until the end of life (as defined by NCI).

### CAREGIVER

A caregiver is the person(s) who most often helps the person with cancer and is not paid to do so. Caregivers may be partners, family members, or close friends. Most often, they're not trained for the caregiver job. Caregivers also have emotional, social, and financial demands and unmet needs, and may have questions about treatment and side effects, how to find helpful resources, and ways to practice self-care. Caregivers may find it hard to cope with the emotional and physical aspects of caring for someone with cancer. Caregivers may feel burdened when caring for cancer patients. Caregiver burden may be increased by certain factors, such as gender and age (as defined by NCI and ACS).

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**OBJECTIVE 8.2 Improve mental, emotional, and behavioral health among cancer survivors and caregivers.**

1. Educate people of all ages diagnosed with cancer and their families about mental, emotional, and behavioral health. Support behavioral health integration initiatives in Colorado.
  2. Educate patients, caregivers, and providers on evidence-based integrative medicine approaches.
  3. Educate patients, caregivers, providers, employers, and school officials on the mental health needs of individuals during and after cancer treatment, specifically adolescents and young adults.
  4. Provide access to behavioral health providers and research-tested psychosocial support programs for survivors and caregivers. Assess and address availability of these services in rural regions.
  5. Establish and implement policies and protocols at hospitals, treatment centers and medical offices to ensure provision of distress screening for patients of all ages during medical visits. Support referrals and follow up services based on the screening assessment.
  6. Provide a mechanism for consolidated state cancer resources such as a directory or referral service that includes mental health and spans all age ranges. Establish a database of local regional providers and programs that provide evidence based integrative medicine practices.
  7. Develop and implement research projects to measure the effectiveness of support groups or other psychosocial interventions for understudied cancer types, including effective play therapy groups for pediatric patients.
  8. Promote and assess evidence-based and promising practices provided in and outside of clinical settings to improve mental and emotional health (e.g. physical activity, exercise, yoga, spirituality, meditation or mentor programs) for patients of all ages.
  9. Support research to increase our knowledge and effective utilization of integrative medicine and mindfulness practices that support emotional well-being.
  10. Conduct a literature review of transition clinic outcomes to identify and support mental health needs among pediatric, adolescent and young adult survivors.
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**OBJECTIVE 8.3: Improve transitions throughout the continuum of care for all people affected by cancer.**

1. Educate primary care providers on, and increase adherence to, nationally recognized, evidence-based follow-up guidelines such as the National Comprehensive Cancer Network (NCCN), the American Cancer Society (ACS), the United States Preventive Services Task Force (USPSTF), the American College of Radiology (ACR), and the American College of Sports Medicine's Exercise is Medicine Initiative.
2. Disseminate materials for all people affected by cancer regarding the importance of follow-up care through clinical cancer care organizations as well as non-profit cancer support organizations. Support the use of survivorship care plans when available.
3. Educate the public and medical communities regarding the differences between palliative and hospice/end-of-life care.
4. Support research on the benefits of palliative care during chronic illness in addition to end of life stages.
5. Assess barriers to follow-up care among pediatric, adolescent and young adult cancer survivors. Promote access where needed.
6. Educate providers and the general public on what palliative care is, how it can benefit quality of life for both patients and caregivers, how it can support patient-centered decision making, and when the right time is to involve palliative care.
7. Implement telehealth/tele-palliative care to increase access to palliative care services.
8. Assess reimbursement barriers to telehealth and implement a plan to improve reimbursement and access to services.
9. Implement identification and tracking of cancer survivors in electronic medical records, in particular for pediatric and adolescent survivors, for whom there may be a long period of time between cancer diagnosis and treatment and health care as an adult.

**QUALITY OF LIFE**

The term quality of life describes one's overall enjoyment of life. Many clinical trials assess the effects of cancer and its treatment on the quality of life of cancer survivors. These studies measure aspects of an individual's sense of well-being, and ability to carry out various activities (as defined by the IOM, NCI, & ACS).

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# RETHINKING THE SURVIVORSHIP CARE PLAN



The [Commission on Cancer](#) (CoC) is a consortium of professional organizations dedicated to improving survival & quality of life for cancer patients through standard setting, which promotes cancer prevention, research, education, & monitoring of comprehensive quality care. Today, there are more than 1,500 CoC-accredited cancer programs in the United States & Puerto Rico. CoC accreditation encourages hospitals, treatment centers, & other facilities to improve their quality of care through various cancer-related programs & activities. One of the requirements for accreditation was that cancer centers were to distribute survivorship care plans (SCP) to their patients once treatment was completed & they would be transitioning back to their primary care providers for routine care.

A survivorship care plan (SCP) is a record of a patient's cancer & treatment history, as well as recommendations for future surveillance, possible long term effects of treatment, & lifestyle changes or recommendations for staying healthy. However, developing SCP's proved to be challenging for cancer centers & effectiveness of the use of SCP's was less than expected.

Based on their findings, the CoC modified their Survivorship Care Standard in 2020 & while the CoC still recommends & encourages that patients receive a survivorship care plan, delivery is no longer required. Instead, the new CoC standard requires cancer centers to have a minimum of three Survivorship Program Services "...directed at meeting the needs of cancer patients treated with curative intent." They provide suggestions on what services a facility may provide, & require annual approval of the programs by the Cancer Committee, as well as annual reporting on the monitoring and improvements.

Lutheran Medical Center's Survivorship Committee decided that getting resources into the survivor's hands and supporting their specific goals/vision in survivorship should be their focus. They created a Survivorship Assessment tool that is completed at each post-treatment follow-up visit, currently post-treatment through year 1. At each follow-up visit the RN reviews the Assessment & discusses any concerns the patient may be having as well as provides them resources specific to their needs. Items covered by the Assessment include, but are not limited to; understanding of the surveillance plan, major concerns related to work, fear of recurrence, fatigue, depression, normalcy, managing side effects. Lutheran also offers support for healthy weight/lifestyle, sleep, intimacy, lymphedema, neuropathy, memory/concentration, chronic pain, & other physical limitations. Survivors are also offered an opportunity to set a health-related goal that triggers a member of the support team to engage with them on their goal.

Lutheran is in the first six months of utilizing the Assessment Tool & feedback from their providers has been positive! Lutheran survivorship support staff appreciate the availability of resources and the automated trigger for having more in-depth discussions on survivorship with their patients. Referrals to Support Services have not necessarily increased, but they believe this is because the resources are available at the follow-up visits, so patients are getting what they need in real time.

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**OBJECTIVE 8.4: Decrease risk of financial toxicity among people affected by cancer.**

1. Provide education to health professionals and health navigators about the financial risks associated with cancer treatment and its effects on cancer patients and their families.
  2. Provide education to people diagnosed with cancer and their families regarding resources and services that help them manage their finances and to remain or become financially stable.
  3. Identify effective ways to reduce or mitigate financial toxicity for cancer patients. Refer to reliable and reputable sources (including financial advocates and navigators) for financial assistance to cancer patients and survivors and their families during and after cancer treatment (such as foundations, prescription assistance programs, and government assistance programs).
  4. Establish patient financial assistance programs, including assistance for co-pays, insurance premiums, and basic living expenses (rent, utilities, phone, food, childcare, transportation costs, etc.)
  5. Identify and share clinic-based and community-based resources that provide free/low-cost financial assistance and advocacy to reduce economic barriers to care.
  6. Establish or refer to free/low-cost programs that provide education and advocacy services to help patients and their families select affordable and appropriate health insurance, maximize patient's health insurance benefits and credit/debt counseling.
  7. Establish or refer to free/low-cost programs that provide career coaching and job guidance to individuals or caregivers when cancer has affected their ability to work or continue their education and skill training.
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**DID YOU KNOW? National Healthcare Decision Day is April 16th every year.**

### TO DO LIST:

- ☐ Advance Directive
- ☐ MOST Form
- ☐ Power of Attorney
- ☐
- ☐
- ☐

## THE DIFFERENCE BETWEEN PALLIATIVE CARE AND END-OF-LIFE CARE

Palliative care and end-of-life care are often discussed together, and sometimes used interchangeably, but they are different.

### PALLIATIVE CARE

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain and stress of serious illness, whatever the diagnosis. The goal is to improve the quality of life for both the patient and the family. Palliative care is provided by a team of physicians, nurses and other specialists who work with a patient's other health care providers to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment.

### END-OF-LIFE CARE

End-of-life care, or hospice care, is given to a person with a limited life expectancy, and seeks to meet the medical and physical needs of the person. It can also meet psychological, spiritual and social needs of the person and his or her family. This care includes palliative care and is focused on symptom management rather than treatment to prolong life.

# CROSS-CUTTING



## 9

### INCREASED PATIENT ENGAGEMENT AND HEALTH LITERACY

Coloradans are faced with important decisions about cancer risk at all points along the cancer continuum. There are decisions to be made about prevention behaviors, screening options, treatment options, post-treatment care and support, and end-of-life care. These choices require people to understand basic information about health and health care, comprehend information about risk, weigh the risks and benefits of each decision, and use the best information available to make a choice that resonates with their culture, values and priorities.

When the public, cancer survivors and caregivers have the skills and information needed to engage in these decision-making processes, positive outcomes for all can be a reality. When such skills and tools are lacking, decision making can be a frustrating experience. The objectives below demonstrate the commitment to providing Coloradans with tools to navigate the health care system and the many choices that can be made along the cancer continuum of care.

## GOAL 9: INCREASED PATIENT ENGAGEMENT AND HEALTH LITERACY



**OBJECTIVE 9.1: Increase health navigator and community health worker services along the cancer care continuum.**

1. Identify the current and projected health navigator and community health worker workforce needed in the cancer care continuum (prevention to end-of-life care).
2. Promote competency-based and accessible training for lay health navigators and community health workers within the cancer care continuum.
3. Promote use of the Colorado Health Navigator Registry.
4. Promote the implementation of evidence-based health navigator and community health worker services within the cancer care continuum.



**DID YOU KNOW?** Colorado is home to the [Patient Navigator Training Collaborative \(PNTC\)](#)? The PNTC provides national leadership for the development, education, standardization and sustainability of the growing patient navigation workforce.



**Patient  
Navigator  
Training  
Collaborative**



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**OBJECTIVE 9.2: Increase Coloradans' understanding of general health, medical and insurance information.**

1. Assess organizational practices, using a standardized tool such as the Agency for Healthcare Research and Quality (AHRQ) Health Literacy Universal Precautions Toolkit or a framework such as the Ten Attributes of Health Literate Health Care Organizations from the Institute of Medicine, to determine current health literacy practices. Develop and implement actions to improve them.
  2. Develop and implement consumer tools (print and online) that aid in informed decision making during health insurance enrollment and renewal periods.
  3. Use targeted approaches and tailored communication to ensure clear communication channels (oral, written and online) for the purpose of making health related decisions
  4. Revise or identify new cancer prevention, screening, survivor or caregiver materials that meet health literacy standards, for example the AHRQ Health Literacy Universal Precautions Toolkit.
  5. Disseminate health literacy standards to pediatricians, community health workers and health navigators, primary care and oncology providers, in addition to cancer treatment centers, hospitals and clinics.
  6. Increase consumer representation, in particular cancer survivors and caregivers, on boards of organizations serving cancer patients and survivors.
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**OBJECTIVE 9.3: Increase patient-centered decision making.**

1. Educate oncology providers on patient-centered decision making and the importance of decisions regarding treatment being made by the patient and those who matter most rather than the provider. Provide tools and resources to providers on patient-centered decision making. Educate patients, their loved ones, caregivers, and providers about patient-centered decisions.
2. Assess barriers to patient-centered decision making. Promote access where needed.
3. Liaison with organizations to improve treatment decisions, fertility preservation, genetic testing, and advance care planning.

**The SHARE Approach: A Model for Shared Decision Making (1)**

(1) [Agency for Healthcare Research and Quality](#)



Everyone in Colorado has a role  
to play in preventing and  
controlling cancer, and in  
supporting Colorado's cancer  
survivors.



TOGETHER - WE CAN MAKE A  
DIFFERENCE!

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